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# Phoenix Union High School District

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## Employee Benefits Enrollment Guide

Plan Year: 2023-2024



# Open Enrollment is here!

The Open Enrollment period will be from May 1, 2023, through 5:00pm on Wednesday, May 31, 2023, for benefits effective on July 1, 2023.

The Phoenix Union High School District (PXU) offers you and your eligible family members a comprehensive and valuable benefits program. We encourage you to take this opportunity to educate yourself about your options and choose the best coverage for you and your family for the upcoming plan year.

Included in this Guide are summaries of the different benefit options and costs for the period of July 1, 2023, through June 30, 2024. For detailed information, please refer to the 2023-2024 PXU Open Enrollment webpage @ [www.pxu.org/Page/23217](http://www.pxu.org/Page/23217). This Guide also includes important Notices regarding your PXU benefits.

Please review the Guide carefully and contact the District's Employee Benefits Coordinator, Cyndy Nelke, @ [nelke@phoenixunion.org](mailto:nelke@phoenixunion.org) or 602-764-1538 if you have any questions.

## Non-Compliance Alert

Open Enrollment is **MANDATORY** for all eligible employees for the upcoming plan year.

If you do not complete Open Enrollment, your current plan elections except for any pre-tax Flexible Spending Accounts or Health Savings Account elections will roll over for the 2023-2024 plan year. **Also, if you are currently enrolled in Employee Only coverage on the Middle Option, it will be changed to the Low Option.** You will also lose the opportunity to review and update other valuable information.

## Plan Changes

**Medical** – The Blue Cross Blue Shield of AZ medical premiums will increase effective 7/1/2023 and the “anchor” plan will change to the Low Option. Hence, **the Middle Option will no longer be free.** PXU will continue to cover the full premium for the Employee Only tier for the Low, Alliance and HDHP Options. Also, the High, Middle and Low Options will no longer be considered “grandfathered health plans” and will fully comply with the Affordable Care Act. The insurance premiums and design for all other plans will not change.

## Who is eligible?

You are eligible to elect benefits if you are:

- A permanent classified or contracted employee of the District working a minimum of 24 hours of service per week.
- If you are eligible to elect benefits, you are also eligible to elect benefits for your eligible dependents. Under our plan, eligible dependents include your:
  - lawful spouse (marriage certificate required for mid-year enrollment); and
  - domestic partner (affidavit required); and
- the following children under age 26 whether married or unmarried: natural children, adopted children or children placed for adoption, stepchildren, domestic partner children, children under a QMCSO, children under a legal guardianship order and/or foster children. Disabled adult children who are age 26 or older and unmarried can continue coverage if they otherwise meet the eligibility requirements of the plan. Note: If a child whose coverage has already terminated under this Plan due to reaching the age limit becomes disabled, said child is not eligible to re-enroll as a disabled adult dependent child under this Plan.

## How to enroll

- Read through this Guide carefully. This Guide gives you important information to help you understand all your benefit options. If you need more information, be sure to contact the District's Employee Benefits Coordinator @ 602-764-1538 or [nelke@phoenixunion.org](mailto:nelke@phoenixunion.org).
- Decide which benefits are best for you and your family. The District offers you a choice of five medical plan options, a health savings account (HDHP only), two dental plan options, vision insurance, voluntary life insurance, a short-term disability (STD) plan, and pre-tax flexible spending accounts.
- Complete your Open Enrollment on the **Employee Access/iVisions** web portal- detailed instructions are available on the Open Enrollment Home page.
- Note: All medical, dental and vision benefit deductions from your paycheck will be on a **pre-tax basis**. If you want to pay your premiums with **after-tax dollars**, please contact Cyndy Nelke at [nelke@phoenixunion.org](mailto:nelke@phoenixunion.org) and ask for the "Flex Plan Option Form". The completed Form is due back to Cyndy Nelke @ CEE-5<sup>th</sup> Floor or Fax # 602-274-0484 or [nelke@phoenixunion.org](mailto:nelke@phoenixunion.org) by 5:00pm on Wednesday, May 31, 2023.

Exception: If you are enrolling a domestic partner and/or domestic partner's child(ren) into your medical/dental/vision plans and they do not qualify as tax dependents under IRS rules, the corresponding paycheck deduction must be post-tax. If this does not apply to your situation, please notify Cyndy Nelke @ CEE-5<sup>th</sup> Floor or Fax # 602-274-0484 or email to [nelke@phoenixunion.org](mailto:nelke@phoenixunion.org).

**Do not forget, your enrollment deadline is Wednesday, May 31, 2023 @ 5:00pm. Late elections cannot be accepted.**



## Post Enrollment

- If you are a new voluntary life insurance applicant, or you are increasing your and/or your spouse's current election amount by more than \$10,000 for a maximum election of \$50,000 or increasing your and/or your spouse's current election amount by any amount over \$50,000, please make sure to complete the Evidence of Insurability (EOI) questionnaire on-line @ [www.standard.com/mhs](http://www.standard.com/mhs) no later than June 15, 2023. Failure to do so will result in the cancellation of your new or increased supplemental life election. **Note: completion of the EOI questionnaire does not guarantee coverage.** If applicable, your life insurance election will be subject to medical underwriting for approval.
- If you are enrolling/re-enrolling a domestic partner and/or a domestic partner's child(ren), please complete and return the Domestic Partner Affidavit to Cyndy Nelke @ CEE-5<sup>th</sup> Floor or Fax # 602-274-0484 or [nelke@phoenixunion.org](mailto:nelke@phoenixunion.org) by 5:00pm on Wednesday, May 31, 2023. Failure to do so will result in the disqualification of said dependents.
- Next school year, verify that all applicable benefit deductions are being taken from your paycheck. Please contact the Employee Benefits office with any discrepancies.

## Changing your coverage during the year

Medical, dental and vision premiums are deducted from your paycheck on a pre-tax basis—giving you the advantage of not paying tax on your healthcare premium dollars (unless you let us know that you want to pay premiums with after tax dollars by completing the Flex Plan Options form or you are enrolling a domestic partner and/or domestic partner's child(ren) who do not qualify as tax dependents under IRS rules).

*With the pre-tax feature, IRS rules require that you cannot change your elections until the next Open Enrollment period unless you have a qualified mid-year change in status event (or HIPAA Special Enrollment event). You must notify the Plan in writing within 31 days of certain changes in you or your family's status. See page 25 for more information or contact the District Employee Benefits Office.*

## Medical Plans

The District gives you a choice of five medical plan options. Understanding the differences between the medical plan options can help you decide which plan is best for you and your dependents. Three of the plan options, High, Middle and Low, are preferred provider organization (PPO) plans accessing the Blue Cross Blue Shield of Arizona (BCBSAZ) network of providers. With PPO plans, you can see any provider you wish, but you get greater cost savings by using in-network PPO physicians, hospitals, labs and urgent care centers. This is important to consider since you share in the cost of care in the form of deductibles, co-pays and coinsurance. Our Alliance and HDHP plan options are still PPOs, but utilize the smaller BCBSAZ Alliance network for in-network services in the state of Arizona.

The 2023-2024 Summaries of Benefits and Coverage (SBC) and other important information is available online @ [www.pxu.org](http://www.pxu.org). You can also request hard copies of these, as well as the Plan Document, by contacting the District's Employee Benefits Coordinator at 602-764-1538.

## How can you be a wise Health Care Consumer and get the most value out of the Medical Plan?

Below are ways you can be a wise health care consumer and get value out of the medical plan you elect.

- ✓ **Use in-network BCBSAZ (PPO) providers.** They charge less, and you pay less. And, Preventive Care is free when provided by in-network PPO providers.
- ✓ **Choose Generic drugs when possible.** Ask your Doctor if a generic drug is appropriate for you. You'll pay less for generic drugs than for brand name drugs.
- ✓ **Have a chronic health condition like diabetes, asthma, arthritis, heart disease, etc.?** One of the best things you can do for that condition is to take the medication your Doctor recommends for you. Make medication compliance your habit to a healthier life.
- ✓ **Keep current with your Preventive/Wellness care** to help identify any health risk factors (like high blood pressure, high blood sugar, weight creeping above the recommended range) and to stay current on recommended immunizations.
- ✓ **Not feeling well?** Call your in-network Doctor's office for help. Or, use an in-network Urgent Care facility instead of an emergency room (ER), if medically appropriate.

- ✓ **Precertify** your elective hospital admission, certain prescription drugs, and other services, as explained in the BCBSAZ medical plan booklets to help avoid a financial penalty.

## Terms to Know

**Co-pay.** A set amount you pay for a covered health-related service or supply.

**Access Fees.** Like a co-pay, this is a specific dollar amount you pay at the point of care at provider facilities, such as emergency room visits at hospitals.

**Co-insurance.** Co-insurance is how you and the plan split the cost for covered services. For example, 80% co-insurance means the plan pays 80% and you would be responsible for 20%.

**Deductible.** The amount you must pay each plan year for certain covered services/supplies before benefits are paid by the plan.

**Out-of-Pocket Maximum (OOP Max).** The maximum amount of deductibles, copays (all Options except HDHP) and coinsurance you pay each year in covered healthcare expenses before the plan starts paying 100% of most covered expenses.

## Prescription drug benefits (Retail & Mail Order)

For each medical plan except the HDHP, you have outpatient prescription drug coverage utilizing the BCBSAZ tiered co-pay pharmacy benefit. BCBSAZ classifies outpatient prescription drugs in 4 levels. Your co-pay is lowest at Level 1. For the HDHP, you will pay a percentage.

*Tip: For the greatest cost savings, verify that your prescribed medication is on the Prescription Medication Guide (a formulary of preferred drugs). A copy of the listing is available online at [www.azblue.com](http://www.azblue.com). Also, remember to discuss generic equivalents with your provider; they are your least expensive drug option.*

## High Option

This is the option with the lowest deductible but is also the most expensive plan that the District offers. You must meet an annual deductible before the plan begins to pay certain eligible expenses. You may also have additional costs in coinsurance and co-pays.

## Middle Option

This plan also has a low deductible but will add a monthly premium effective July 1<sup>st</sup>. You must meet an annual deductible before the plan begins to pay certain eligible expenses. You may also have additional costs in coinsurance and co-pays.

## Low Option

This plan option may be preferred if you need medical coverage for your family and desire a lower monthly premium. For this plan, the District pays 100% of the employee premium in addition to a portion of the dependent premium. You have an annual deductible to meet, and you share in the cost with higher coinsurance and co-pays.

## Alliance Option

This plan option follows the same plan design as the Low Option Plan but utilizes a smaller network for in-network services thereby reducing the monthly premium substantially. You have an annual deductible to meet, and you share in the cost with higher coinsurance and co-pays.

## High Deductible Health Plan (HDHP) with Health Savings Account (HSA)

This plan also utilizes the smaller Alliance network and pays nothing toward health care services, except for in-network preventive care, until the deductible has been met. To offset the higher deductible, under IRS regulations, a Health Savings Account (HSA) may be opened to set aside money to pay for eligible health care expenses.

The District pays 100% of the employee premium and contributes up to \$1,500 to the corresponding HSA. By adding funds to the HSA in lieu of subsidizing dependent premiums, the employee will have more flexibility in how the District's contribution is used.

## Health Savings Account (HSA)

An HSA is an account that lets you set aside money on a pre-tax basis to pay for qualified medical expenses, as defined in the tax law. See [IRS Publication 502 \(PDF\)](#) for more information.

By using pre-tax dollars in an HSA to pay for deductibles, copayments, coinsurance, and other qualified expenses, including some dental, drug, and vision expenses, you can lower your overall health care costs.

- PXU will contribute up to \$1,500 into your HSA and you can contribute more if you choose. Your enrollment portal will apply limits automatically.
- You can also invest the funds in your HSA and any unused funds from the plan year will carry-over indefinitely. Note: this account is not tied to your PXU employment
- You can contribute to an HSA **only** if you have an HSA-eligible HDHP.

Note: Employees who elect the HDHP with HSA option can not also elect a Medical Flexible Spending Account (see page 20). Instead, they have the option of electing a Limited Care Flexible Spending Account (FSA). The Limited Care FSA is limited to Dental and Vision expenditures only (no medical); please plan accordingly.

Medical Option	Monthly Premium	Annual Deductible	Annual In-network Out-of-Pocket (OOP) Maximum	Annual Best-Case Scenario	Annual Worst Case Scenario	Pros	Cons
High	\$ 193.46	\$ 200.00	\$ 1,000.00	\$ 2,321.52	\$ 3,321.52	Lowest Deductible (\$200)	Most Expensive plan in all scenarios
						Broad Network	Monthly Premium
Middle	\$104.32	\$ 500.00	\$ 1,000.00	\$ 1,251.84	\$ 2,251.84	Low Deductible (\$500)	Monthly Premium
						Broad Network	
						Least Expensive plan in worst case scenario	
Low	\$ -	\$ 1,000.00	\$ 4,000.00	\$ -	\$ 3,000.00	No Monthly Premium	
						Broad Network	
Alliance	\$ -	\$ 1,000.00	\$ 3,000.00	\$ -	\$ 3,000.00	No Monthly Premium	Limited Network
						Best Dependent Premiums	
HDHP	\$ -	\$ 3,000.00	\$ 6,000.00	\$ (1,500.00)	\$ 4,500.00	No Monthly Premium	Limited Network
						Includes \$1500 HSA Annual Employer Contribution	No co-pays
						Least Expensive plan in best case scenario	Highest deductible before plan starts paying

Note: All plans pay preventative care @ 100% and cover the same services. Best- and worst-case scenarios above are based on premiums, deductibles and In-network Out-of-Pocket maximums for "Employee Only" coverage and do not include additional costs for co-pays or other fees.

For more information and specific treatment example pricing, not including affiliated premiums, please review the full Summaries of Benefits.

	In-Network Coverage Only	Member Cost Sharing
<b>High Plan</b>	Preventative Services (Plan pays 100%)	0%
	Individual/Family Annual Deductible	\$200/\$400
	Office Visit Co-pays: PCP/Specialist	\$15/\$25
	OOP Max Individual/Family	\$1,000/\$2,000
	Emergency Room co-pay	\$150
	Urgent Care co-pay	\$35
	**Coinsurance (Plan pays 90%)	10%
	Prescription Drugs (Retail)	\$10/\$40/\$60/\$80
<b>Middle</b>	Preventative Services (Plan pays 100%)	0%
	Individual/Family Annual Deductible	\$500/\$1,000
	Office Visit Co-pays: PCP/Specialist	\$15/\$25
	OOP Max Individual/Family	\$1,000/\$2000
	Emergency Room co-pay	\$150
	Urgent Care co-pay	\$35
	**Coinsurance (Plan pays 80%)	20%
	Prescription Drugs (Retail)	\$10/\$40/\$60/\$80
<b>Low</b>	Preventative Services (Plan pays 100%)	0%
	Individual/Family Annual Deductible	\$1,000/\$2,000
	Office Visit Co-pays: PCP/Specialist	\$25/\$35
	OOP Max Individual/Family	\$3000/\$6,000
	Emergency Room co-pay	\$150
	Urgent Care co-pay	\$50
	**Coinsurance (Plan pays 80%)	20%
	Prescription Drugs (Retail)	\$10/\$40/\$60/\$80
<b>Alliance</b>	Preventative Services (Plan pays 100%)	0%
	Individual/Family Annual Deductible	\$1,000/\$2,000
	Office Visit Co-pays: PCP/Specialist	\$25/\$35
	OOP Max Individual/Family	\$3000/\$6000
	Emergency Room co-pay	\$150
	Urgent Care co-pay	\$50
	**Coinsurance (Plan pays 80%)	20%
	Prescription Drugs (Retail)	\$10/\$40/\$60/\$80
<b>HDHP</b>	Preventative Services (Plan pays 100%)	0%
	Individual/Family Annual Deductible	\$3,000/\$6,000
	PCP/Specialist Office visits (Plan pays 80%)	Subject to Deductible then 20%
	OOP Max Individual/Family	\$6,000/\$12,000
	Emergency Room (Plan pays 80%)	Subject to Deductible then 20%
	Urgent Care (Plan pays 80%)	Subject to Deductible then 20%
	**Coinsurance (Plan pays 80%)	20%
	Prescription Drugs-Retail & mail-order (Plan pays 80%)	Subject to Deductible then 20%
	**Coinsurance is based on the allowed amount of covered services after the plan year deductible is met	

## Paying for your medical benefits

The following chart shows what you would pay in premiums for medical coverage for the 2023-2024 plan year. Note: the biweekly payroll deduction amount is based on 24 deductions per plan year if you are a 12 month employee and 21 deductions per plan year if you have a less than 12 month work contract.

2023-2024 Employee Premiums for Medical Plans			
		Biweekly Deduction	Biweekly Deduction
Medical Plans (BCBSAZ)	Monthly	12 Month Contracts	< 12 Month Contracts
<b>High Option</b>			
Employee Only	\$ 193.46	\$ 96.73	\$ 110.55
Employee + Spouse	\$ 1,060.62	\$ 530.31	\$ 606.07
Employee + Child(ren)	\$ 640.44	\$ 320.22	\$ 365.97
Employee + Spouse & Children	\$ 1,974.48	\$ 987.24	\$ 1,128.27
<b>Middle Option</b>			
Employee Only	\$ 104.32	\$ 52.16	\$ 59.61
Employee + Spouse	\$ 873.44	\$ 436.72	\$ 499.11
Employee + Child(ren)	\$ 493.40	\$ 246.70	\$ 281.94
Employee + Spouse & Children	\$ 1,684.84	\$ 842.42	\$ 962.77
<b>Low Option</b>			
Employee Only	\$ 0.00	\$ 0.00	\$ 0.00
Employee + Spouse	\$ 654.32	\$ 327.16	\$ 373.90
Employee + Child(ren)	\$ 321.22	\$ 160.61	\$ 183.55
Employee + Spouse & Children	\$ 1,345.72	\$ 672.86	\$ 768.98
<b>Alliance Option</b>			
Employee Only	\$ 0.00	\$ 0.00	\$ 0.00
Employee + Spouse	\$ 303.96	\$ 151.98	\$ 173.69
Employee + Child(ren)	\$ 45.94	\$ 22.97	\$ 26.25
Employee + Spouse & Children	\$ 803.46	\$ 401.73	\$ 459.12
<b>HDHP/HSA Option</b>			
Employee Only	\$ 0.00	\$ 0.00	\$ 0.00
Employee + Spouse	\$ 728.50	\$ 364.25	\$ 416.29
Employee + Child(ren)	\$ 430.48	\$ 215.24	\$ 245.99
Employee + Spouse & Children	\$ 1,490.08	\$ 745.04	\$ 851.47



## Dental Insurance Plans

The District gives you a choice of two dental plans. Understanding the differences between the dental plans can help you decide which plan is best for you and your dependents.

## Total Dental Administrators – Summit Care (TDA)

TDA has an extensive network of dental providers throughout Arizona. The Prepaid Dental Plan provides coverage for services and treatment for diagnostic, preventive, restorative, and routine oral surgery. There is no co-pay for most preventive and diagnostic services. Additional services are paid according to the TDA fee schedule. For more detailed information on the fee schedule, please refer to the TDA Summary of Benefits on the District website @ [www.pxu.org](http://www.pxu.org). ***Note: To receive benefits, you must use in-network TDA dental providers.***

## Delta Dental – Indemnity Plan

The Indemnity Dental Plan utilizes the Delta Dental of Arizona network of dentists, or you can see any dentist and submit a claim form for reimbursement. Reimbursement is based on Delta Dental's fee schedule. This plan covers preventive dental services such as oral cleanings, examinations, and X-rays. Preventive care is covered at 100% with no deductible. Basic services are covered at 80% and major services are covered at 50% after you have been on the plan for 6 months (continuous). Orthodontic services are available for children, 8 to 18 years old, after 12 months (continuous) on the plan.

## Dental Plan Comparison

The following chart compares the highlights of our two dental plan options. For more detailed information, please refer to the dental Benefit Summaries @ [www.pxu.org](http://www.pxu.org).

TDA	Delta Dental
HMO - Assigned Dentist	PPO - Any Dentist. In-network - lower costs
Basic cleanings - \$0 co-pay twice/year	Basic cleanings - 100% twice/year
X-rays - \$0 co-pay once/year	X-rays - 100% once/year
Basic services - co-pay system	Basic services - 80%
Major services - discounts	Major services - 50% - 6 month waiting period
	\$50/year deductible, \$1500/year max

## Paying for your dental insurance

The following chart shows the dental coverage premiums for the 2023-2024 plan year. Note: the biweekly payroll deduction amount is based on 24 deductions per plan year if you are a 12 month employee and 21 deductions per plan year if you have a less than 12 month work contract.

2023-2024 Employee Premiums for Dental Plans			
		Biweekly Deduction	Biweekly Deduction
Dental Plans	Monthly	12 Month Contracts	< 12 Month Contracts
<b>Total Dental Administrators</b>			
Employee	\$ 9.75	\$ 4.88	\$ 5.58
Employee + 1	\$ 19.51	\$ 9.76	\$ 11.15
Employee + 2 or more	\$ 25.70	\$ 12.85	\$ 14.69
<b>Delta Dental of AZ</b>			
Employee	\$ 33.52	\$ 16.76	\$ 19.16
Employee + 1	\$ 67.02	\$ 33.51	\$ 38.30
Employee + 2 or more	\$ 88.46	\$ 44.23	\$ 50.55

## Vision Insurance Plan

The District offers one vision plan via VSP. Understanding the features of this plan can help you decide if this plan is right for you and your dependents.

The following chart highlights the benefits of our vision insurance via VSP. For more detailed information, please refer to the VSP Summary of Benefits on the District website @ [www.pxu.org](http://www.pxu.org).

<b>Plan Name</b> VSP Choice Plan <b>Provider Network</b> VSP Network Providers	<b>Frequency of Benefits</b> Eye Exam..... once every plan year Lenses ..... once every plan year Frame..... once every plan year Contacts (in lieu of glasses) once every plan year * Plan year begins July 1st
<b>Copays</b> Total (eye exam/glasses) ..... \$10 Contact Lens Exam ..... Up to \$60	<b>Allowances (glasses or contacts)</b> Frame..... \$160 Basic Frame..... \$210 Featured Contact Lenses ..... \$140 Costco, Sam's Club & Walmart Frame ..... \$90
<b>Out-of-Network Schedule</b>	
Exam: Lenses: Single vision Lined bifocal Lined trifocal Progressives Frame Elective contact lenses (in lieu of lenses & frame)	Up to \$45  Up to \$30 Up to \$50 Up to \$65 Up to \$50 Up to \$70 Up to \$105
<b>Additional Plan Features</b>	
Anti-Reflective Coating=\$30 Copay, Scratch Resistant Coating=\$0 Copay; Diabetic Eyecare Plus Program = \$20 Copay	

## Paying for your vision insurance

The following chart shows the vision coverage premiums for the 2023-2024 plan year. Note: the biweekly payroll deduction amount is based on 24 deductions per plan year if you are a 12 month employee and 21 deductions per plan year if you have a less than 12 month work contract.

2023-2024 Employee Premiums for Vision Plan			
		Biweekly Deduction	Biweekly Deduction
	Monthly	12 Month Contracts	< 12 Month Contracts
Employee	\$ 7.78	\$ 3.89	\$ 4.45
Employee + 1	\$ 15.55	\$ 7.78	\$ 8.89
Employee + 2 or more	\$ 25.05	\$ 12.53	\$ 14.32

## Life & AD&D Insurance

Life insurance is an important part of your financial security, especially if others depend on you for support. Accidental Death & Dismemberment (AD&D) is designed to provide a benefit to you and/or your beneficiaries in the event of accidental death or dismemberment.

## Basic Life Insurance

Basic life insurance coverage via the Standard Insurance Company is provided to all eligible employees. This coverage is automatic and paid 100% by the District. You receive one times your base annual earnings with a minimum benefit of \$25,000 (maximum benefit restrictions may apply).

**Note:** This policy has an automatic age reduction provision whereby the payable benefit referenced above will be reduced to the following percentages:

Age of Employee	Payable Percentage
70	65%
75	45%
80	30%

**\*Minimum benefit of \$25,000 still applies**

**Note:** The District's Life Insurance Policy is available on the District's website @ [www.pxu.org](http://www.pxu.org).

## Beneficiary Designation

The beneficiary you designate for your Basic Life insurance will also be the beneficiary for your Voluntary Life insurance if applicable - see next section for details on our voluntary policy.

## Voluntary Life Insurance

In addition to your District-paid life insurance, you have the option to purchase additional (voluntary/supplemental) life insurance, underwritten by the Standard Insurance Company. You can purchase coverage for yourself, your spouse and your dependent child(ren).

## Coverage options for Voluntary Life Insurance

Voluntary life insurance coverage is available for you and your spouse in increments of \$10,000, to a maximum of \$300,000. ***Note: You must have employee coverage to elect spouse coverage and your spouse cannot have higher coverage than you. Also, employees cannot have personal coverage and be covered as a spouse through another District employee.***

Voluntary life insurance coverage is available for your dependent child(ren) up to age 26: \$2,500, \$5,000, \$7,500 or \$10,000. You must have employee coverage to elect child(ren) coverage. You pay only one premium to cover all your children.

## Voluntary Life cont.

**Note: You can apply for voluntary life insurance only during the annual open enrollment period.**

### Evidence of Insurability (EOI)

If you are a new voluntary life insurance applicant, or you are increasing your and/or your spouse's current election amount by more than \$10,000 for a maximum of \$50,000 or increasing your and/or your spouse's current election amount by any amount over \$50,000 then you must provide proof of good health (evidence of insurability) and be approved for coverage by the insurance company.

The Evidence of Insurability (EOI) questionnaire is available online @ [www.standard.com/mhs](http://www.standard.com/mhs) and should be completed no later than June 15, 2023.

**Note:** This policy has an automatic age reduction provision whereby the insurance amount elected will be reduced to the following percentages:

Age of Employee	Payable Percentage
70	65%
75	45%
80	30%

If you fall within these parameters, you have two choices: 1) you can apply for an increased benefit during this Open Enrollment (EOI will apply) or 2) you can convert the amount lost due to age reduction to an individual policy. If you wish to convert, please contact Cyndy Nelke @ [nelke@phoenixunion.org](mailto:nelke@phoenixunion.org) or 602-764-1538 for the necessary paperwork.

**Note:** The District's Life Insurance Policy is available on the District's website @ [www.pxu.org](http://www.pxu.org).

## Paying for your voluntary life insurance

Voluntary life insurance rates for you and your spouse are based on your age as of July 1st. The monthly rates are listed below. Premiums for voluntary life insurance benefits are set up through payroll deductions on an after-tax basis. The monthly premiums for each age band and insurance level are available on the District website @ [www.pxu.org](http://www.pxu.org).

2023-2024 Supplemental Life Insurance Rates	
Employee Age	Employee Rate
Under 30	\$0.039
30-34	\$0.050
35-39	\$0.061
40-44	\$0.088
45-49	\$0.139
50-54	\$0.233
55-59	\$0.345
60-64	\$0.519
65-69	\$0.743
70+	\$0.743
Employee Age	Spouse Rate
Under 30	\$0.060
30-34	\$0.080
35-39	\$0.090
40-44	\$0.100
45-49	\$0.150
50-54	\$0.230
55-59	\$0.430
60-64	\$0.660
65-69	\$1.270
70+	\$2.060
	Child(ren) Rate
Benefit Amount	\$0.05
\$2,500.00	\$0.13
\$5,000.00	\$0.27
\$7,500.00	\$0.40
\$10,000.00	\$0.53

## Disability insurance

Disability Insurance provides income replacement should you become disabled and unable to work due to illness or injury.

## Short Term Disability

Short-term disability (STD) insurance through Sun Life provides you with a weekly check of \$100 to \$1,900, in any \$100 increment you choose, to replace a portion of your income-up to two-thirds of your total base weekly salary if you are totally disabled and unable to work. Benefits start on the sixth day of illness/disability and are payable for up to 12 weeks. *This benefit has a workers' compensation exclusion and pre-existing condition limitations apply to all applications (new and increases).*

## Paying for your Short Term Disability insurance

You pay for the STD benefit through payroll deductions and rates are based on the amount of benefit you elect and are shown on the following STD rate chart. You can elect any benefit level up to your maximum gross annual salary. Note: the biweekly payroll deduction amount is based on 24 deductions per plan year if you are a 12 month employee and 21 deductions per plan year if you have a less than 12 month work contract.

2023-2024 Employee Premiums for STD Plan				
Minimum Salary	Weekly Benefit	Monthly Premium	Biweekly Deduction 12 Month Contract	Biweekly Deduction <12 Month Contract
\$ 7,796.10	\$ 100.00	\$ 4.80	\$ 2.40	\$ 2.75
\$ 15,592.20	\$ 200.00	\$ 9.60	\$ 4.80	\$ 5.49
\$ 23,388.31	\$ 300.00	\$ 14.40	\$ 7.20	\$ 8.23
\$ 31,184.41	\$ 400.00	\$ 19.20	\$ 9.60	\$ 10.98
\$ 38,980.51	\$ 500.00	\$ 24.00	\$ 12.00	\$ 13.72
\$ 46,776.61	\$ 600.00	\$ 28.80	\$ 14.40	\$ 16.46
\$ 54,572.71	\$ 700.00	\$ 33.60	\$ 16.80	\$ 19.20
\$ 62,368.82	\$ 800.00	\$ 38.40	\$ 19.20	\$ 21.95
\$ 70,164.92	\$ 900.00	\$ 43.20	\$ 21.60	\$ 24.69
\$ 77,961.02	\$ 1,000.00	\$ 48.00	\$ 24.00	\$ 27.43
\$ 85,757.12	\$ 1,100.00	\$ 52.80	\$ 26.40	\$ 30.18
\$ 93,553.22	\$ 1,200.00	\$ 57.60	\$ 28.80	\$ 32.91
\$ 101,349.33	\$ 1,300.00	\$ 62.40	\$ 31.20	\$ 35.66
\$ 109,145.43	\$ 1,400.00	\$ 67.20	\$ 33.60	\$ 38.40
\$ 116,941.53	\$ 1,500.00	\$ 72.00	\$ 36.00	\$ 41.14
\$ 124,737.63	\$ 1,600.00	\$ 76.80	\$ 38.40	\$ 43.89
\$ 132,533.73	\$ 1,700.00	\$ 81.60	\$ 40.80	\$ 46.63
\$ 140,329.84	\$ 1,800.00	\$ 86.40	\$ 43.20	\$ 49.37
\$ 148,125.94	\$ 1,900.00	\$ 91.20	\$ 45.60	\$ 52.11

## Mid-Term Disability

Mid-term disability insurance through the Sun Life Insurance Company provides a weekly income of up to 66 2/3% of your base weekly pay (maximum of \$2,500) for a maximum of 90 calendar days if you cannot work due to a non-occupational, accidental injury or illness (including pregnancy). Benefits are available after a 90-day waiting period and after you have exhausted any remaining sick leave. **This coverage is provided automatically for employees and paid for by the District.**

## Long-Term Disability

Long-term disability (LTD) insurance provides a weekly income of up to 66 2/3% of your base monthly pay if you are disabled and unable to work. Coverage is provided through the Arizona State Retirement System (ASRS) and is available after six months of disability and after you have exhausted any remaining sick leave. **This coverage is provided automatically for employees as part of their ASRS enrollment.** Please call Broadspire with any questions you have regarding LTD benefits at 1-877-232-0596.

Note: Employees who are already retired with the ASRS are not eligible for LTD benefits since they are already receiving their pension.

## Flexible Spending Accounts (FSAs)

Flexible Spending Accounts (FSAs) allow you to set aside a portion of your pay on a pre-tax basis to be used later to reimburse yourself for certain out-of-pocket expenses. By taking advantage of pre-tax deductions, you minimize your taxes paid thereby maximizing your take-home pay.

**You must use the Online system and enroll/re-enroll each year if you want this coverage; you do not have the option of confirming your current coverage.**

## FSA options

- Medical Reimbursement Account (MRA) – a general purpose account to pay for eligible health care expenses (medical, dental, vision and/or hearing).
- Dependent Care Spending Account (DCA) – an account to pay for eligible dependent care (day care) expenses.
- Limited Care Reimbursement Account (Limited) - an account to pay for eligible dental and/or vision expenses only (no medical) for use with an HSA. This will be offered to HDHP participants in lieu a MRA.



## How FSAs work

You contribute with pre-tax deductions from your pay into one or both accounts up to the maximum permitted (as outlined below). Then you use the money in your accounts to reimburse yourself for eligible expenses you incur between July 1, 2023, and June 30, 2024.

**Medical Reimbursement Account or  
Limited Flexible Spending Account Max:  
\$2,500/year**

**Dependent Care Spending Account Max:  
\$5,000/year**

Because FSA deductions are taken from your pay before taxes are withheld, you avoid paying taxes on that money.

## Debit Card

The District will be utilizing the Debit Card Option again for the 2023/2024 plan year. This card will enable you to pay for certain eligible expenses up-front rather than going through the claim reimbursement process.

**Note:** If you are currently enrolled in a MRA, DCA or Limited FSA for the 2022/2023 plan year and will be re-enrolling for the 2023/2024 plan year, do not destroy your Debit Card. You will be using the same card for the 2023/2024 plan year; it will be reloaded on 7/1/2023 with your new election amount.

## Eligible Expenses

The following are some examples of eligible medical and dependent care expenses that can be reimbursed from your Medical Reimbursement Account or Dependent Care Spending Account:

## MRA

- Annual deductibles for medical, dental, and vision plans
- Coinsurance
- Co-pays for medical care and prescription drugs
- Dental expenses that are not covered by the Dental plan (excluding cosmetic services)
- Vision expenses that are not covered by the Vision plan
- Hearing aid expenses
- Over the counter (OTC) drugs/medications
- Special equipment for the handicapped that are not covered under the medical plan

## DCA (Daycare)

- Child or elder care, when care is provided to allow you to work

## Limited

- Annual deductibles for dental and vision plans only
- Coinsurance for dental and vision plans only
- Dental expenses that are not covered by the Dental plan (excluding cosmetic services)
- Vision expenses that are not covered by the Vision plan

*If you have any questions as to whether an expense is eligible for coverage, call our FSA administrator BASIC at (800) 444-1922 ext 1 or visit them online, [www.basiconline.com](http://www.basiconline.com).*

## FSA Contributions

Your elected FSA contributions will be deducted automatically each pay period. Maximum contributions are shown below. If you or your spouse are also enrolled in a Health Savings Account (HSA) Qualified Plan, you will be subject to different limitations and will be given the option of choosing a Limited Use FSA in lieu of a MRA which can only be utilized for dental and/or vision expenses. If you fall in this category, please contact BASIC at (800) 444-1922 ext. 297 for clarification.

To estimate how much you want deducted each pay period, calculate your eligible expenses for the new plan year. The following worksheet is designed to help you do this. **Note: When calculating your Limited FSA expenses include dental and vision expenses only – no medical.**

### Worksheet: Estimate Your FSA Expenses for 2023-2024

Medical		Dependent Care	
Deductibles/Co-pays	\$ _____	Childcare Expenses (Daycare)	\$ _____
Prescription Drugs	\$ _____	Elder Care Expenses (Eldercare)	\$ _____
Glasses, Contact lenses, etc.	\$ _____	Other Eligible Expenses	\$ _____
Hearing Aids and Batteries	\$ _____		
Dental Expenses	\$ _____		
Other Eligible Expenses	\$ _____		
Total per Year*	\$ _____	Total Per Year*	\$ _____

\* Divide this amount by **20** (the number of deductions per plan year) to get the amount that will be deducted each pay period.

**Medical or Limited Reimbursement Account Max: \$2,500/year**  
**Dependent Care Spending Account Max: \$5,000/year**

## Use-it-or-lose-it rule for the FSAs

The amount you choose to contribute each year to your MRA and DCA accounts should reflect your best estimate of expected eligible out-of-pocket expenses—and maybe a little less—because this plan does not have a carryover provision so unused funds in your account at the end of the plan year shall be forfeited, so estimate your expenses carefully.

Remember: If electing a Limited FSA, only dental and vision expenses are eligible - no medical.

**Note: You can continue to file claims until September 30, 2024, for expenses incurred between July 1, 2023, and June 30, 2024.**

## Employee Assistance Program

The employee assistance program (EAP) is an employer-paid benefit for employees and their family members. Jorgensen Brooks Group (JBG) is our EAP provider, with professionals available throughout Arizona.

The EAP provides a full range of counseling, educational, and referral services for individuals and families, such as:

- ✓ marriage concerns
- ✓ stress and job-related issues
- ✓ child and domestic abuse issues
- ✓ substance abuse assessments.

You receive up to six (6) free counseling sessions per person per problem per plan year. Any services you receive are kept strictly confidential. JBG professional counselors can help. You can reach JBG 24 hours a day, seven days a week, toll free at 888-520-5400 or find information online at <https://jorgensenbrooks.com/>.

*This Enrollment Guide contains highlights of the Phoenix Union High School District benefits program. Complete information can be found in the plan's legal documents (Plan Document). If there is a conflict between this Guide and the plan's legal document(s), the legal documents will prevail. Phoenix Union High School District reserves the right to amend, replace or terminate any benefit program at any time for any reason. If one of these events occurs, you will be notified. Receipt of this Guide does not guarantee benefits eligibility.*

## For more information

PXU Employee Benefits Office  
4502 N. Central Avenue, Phoenix, AZ 85012  
(602) 764-1538 [nelke@phoenixunion.org](mailto:nelke@phoenixunion.org)

Medical Plan Provider Network  
(PPO Preferred and Participating Only In-Network  
Providers)  
Blue Cross and Blue Shield of Arizona (BCBSAZ)  
(602) 864-4861 [www.azblue.com](http://www.azblue.com)

Total Dental Administrators Health Plan, Inc. (TDA)  
(602) 266-1995 [www.totaldentaladmin.com](http://www.totaldentaladmin.com)

Delta Dental of AZ  
(602) 938-3131 [www.deltadentalaz.com](http://www.deltadentalaz.com)

Vision Service Plan (VSP)  
(800) 877-7195 [www.vsp.com](http://www.vsp.com)

District Life Insurance – Employee Benefits Office  
(602) 764-1538 [www.pxu.org](http://www.pxu.org)

Voluntary Life Insurance - Standard  
(602) 764-1538 [www.pxu.org](http://www.pxu.org)

Mid-term Disability Coverage – Employee Benefits  
Office  
(602) 764-1538 [www.pxu.org](http://www.pxu.org)

Short-term Disability Coverage - SunLife  
Eleanor Brockhurst and Associates  
(602) 263-9265  
[meredithmoore@brockhurstassociates.com](mailto:meredithmoore@brockhurstassociates.com)

Long-term Disability Coverage - Broadspire through the  
ASRS  
(877) 232-0596

Flexible Spending Accounts - BASIC  
(800) 444-1922 ext 1 [www.basiconline.com](http://www.basiconline.com)

Employee Assistance Program (EAP) Jorgensen Brooks  
Group (JBG)  
(888) 520-5400 <https://jorgensenbrooks.com/>

# Phoenix Union High School District (PUHSD)

## Important Employee Benefit Program Notices

Updated 5/1/2023

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

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### MID-YEAR CHANGES TO YOUR HEALTH CARE BENEFIT ELECTIONS

**IMPORTANT:** After this open enrollment period is completed, generally you **will not** be allowed to change your benefit elections or add/delete dependents until next years' open enrollment, unless you have a Special Enrollment Event or a Mid-year Change in Status Event as outlined below:

- **Special Enrollment Event:**

**Loss of Other Coverage Event:** If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if your employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within **31 days** after your or your dependents' other coverage ends (or after the employer stops contributing towards the other coverage).

**Marriage, Birth, Adoption Event:** In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within **31 days** after the marriage, birth, adoption, or placement for adoption.

**Medicaid/CHIP Event:** You and your eligible dependents may also enroll in this plan if you (or your dependents):

- have coverage through Medicaid or a State Children's Health Insurance Program (CHIP) and you (or your dependents) lose eligibility for that coverage. However, you must request enrollment within **60 days** after the Medicaid or CHIP coverage ends.
- become eligible for a premium assistance program through Medicaid or CHIP. However, you must request enrollment within 60 days after you (or your dependents) are determined to be eligible for such assistance.

To request special enrollment or obtain more information, contact the District's Employee Benefits Specialist at 602-764-1538.

- **Mid-Year Change in Status Event:**

Because the District pre-taxes benefits for active employees, we are required to follow Internal Revenue Service (IRS) regulations on if and when benefits can be changed in the middle of a plan year. The following events **may** allow certain changes in benefits mid-year, **if** permitted by the IRS:

- Change in legal marital status (e.g. marriage, divorce/legal separation, death).
- Change in number or status of dependents (e.g. birth, adoption, death).
- Change in employee/spouse/dependent's employment status, work schedule, or residence that affects their eligibility for benefits.
- Coverage of a child due to a QMCSO.
- Entitlement or loss of entitlement to Medicare or Medicaid.

- Certain changes in the cost of coverage, composition of coverage or curtailment of coverage of the employee or spouse's plan.
- Changes consistent with Special Enrollment rights and FMLA leaves.

You must notify the plan in writing within **31 days** of the mid-year change in status event by contacting the District's Employee Benefits Specialist at 602-764-1538. The Plan will determine if your change request is permitted and if so, changes become effective prospectively, on the first day of the month, following the approved change in status event (except for newborn and adopted children, who are covered back to the date of birth, adoption, or placement for adoption).

#### **IMPORTANT REMINDER TO PROVIDE THE PLAN WITH THE TAXPAYER IDENTIFICATION NUMBER (TIN) OR SOCIAL SECURITY NUMBER (SSN) OF EACH ENROLLEE IN A HEALTH PLAN**

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

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

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

If you have not yet provided the social security number (or other TIN) for each of your dependents that you have enrolled in the health plan, please contact the District's Employee Benefits Specialist at 602-764-1538.

#### **IRS FORMS TO BE PROVIDED TO YOU IN 2023**

Under the Affordable Care Act, employers (and in some cases insurance companies) are required to provide full-time employees, as well as other employees enrolled in a medical plan, with IRS Form 1095. The 1095 form should be provided to you annually.

For each month of the calendar year that you were enrolled in a medical plan, this 1095 form documents that you (and any enrolled family members) met the federal requirement to have "minimum essential coverage or MEC," meaning group medical plan coverage.

If you receive a 1095 form this year, **you should keep it in a safe place** with your other tax records because you may need to produce it if requested by the IRS. (For large employers, a copy of the form 1095 will also be provided to the IRS.)

Reminder: if you have not been covered by a medical plan during the calendar year you will not receive a Form 1095-B. If you have been covered by various medical plans during the calendar year, you may receive more than one IRS form.

### **MEDICARE NOTICE OF CREDITABLE COVERAGE REMINDER**

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

To find out whether the prescription drug coverage under the medical plan options offered by the District are or are not creditable you should review the Plan's

Medicare Part D Notice of Creditable Coverage available in this enrollment guide and available from the District's Employee Benefits Coordinator at 602-764-1538.

### **PRIVACY NOTICE REMINDER**

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 requires health plans to comply with privacy rules. These rules are intended to protect your personal health information from being inappropriately used and disclosed. The rules also give you additional rights concerning control of your own healthcare information.

This Plan's HIPAA Privacy Notice explains how the group health plan uses and discloses your personal health information. You are provided a copy of this Notice when you enroll in the Plan and the Notice is also in this enrollment guide. You can get another copy of this Notice from the District's Employee Benefits Specialist at 602-764-1538.

### **WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998 (WHCRA) ANNUAL NOTICE REMINDER**

You or your dependents 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, copayments, and coinsurance applicable to other medical and surgical benefits provided under the various medical plans offered by the District. For more information on WHCRA benefits, contact the District's Employee Benefits Coordinator at 602-764-1538.



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

The health benefits available to you represent a significant component of your compensation package. They also provide important protection for you and your family in the case of illness or injury.

As required by law, across the US, insurance companies and group health plans like ours are providing plan participants with a consumer-friendly **Summary of Benefits and Coverage (SBC)** as a way to help understand and compare medical plan benefits. Choosing a health coverage option is an important decision. To help you make an informed choice, the SBC summarizes and compares important information in a standard format.

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

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

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

To get a free copy of the most current Summary of Benefits and Coverage (SBC) documents for our medical plan options, go to [www.phoenixunion.org](http://www.phoenixunion.org) or for a paper copy, contact the District's Employee Benefits Specialist at 602-764-1538.

## NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT NOTICE

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

Also, under federal law, plans may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, the Plan may not, under federal law, require that a Physician or other Health Care Practitioner obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain precertification. For information on precertification for a length of stay longer than 48 hours for vaginal birth or 96 hours for C-section, contact Blue Cross Blue Shield of Arizona (BCBSAZ) at 877-864-4899 to precertify the extended stay. If you have questions about this Notice, contact the District's Employee Benefits Specialist at 602-764-1538.

## FAMILY AND MEDICAL LEAVE ACT (FMLA) REMINDER

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



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

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

All covered employers are required to display and keep displayed a poster prepared by the Department of Labor summarizing the major provisions of The Family and Medical Leave Act (FMLA) and telling employees about their rights and responsibilities and how to file a complaint. We display the FMLA poster at our worksite. More information on FMLA is available at: <http://www.dol.gov/whd/fmla/> or contact the District's Employee Benefits Specialist at 602-764-1538.

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

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

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

## COBRA COVERAGE REMINDER

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

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

Qualifying events may include termination of employment, reduction in hours of work making the employee ineligible for coverage, death of the employee, divorce/legal separation, or a child ceasing to be an eligible dependent child under the terms of the plan, if a loss of coverage results.

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

The maximum period of COBRA coverage is generally either 18 months or 36 months, depending on which qualifying event occurred.

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

If you have questions about COBRA contact the District's Employee Benefits Coordinator at 602-764-1538.

## FLEXIBLE SPENDING ACCOUNT PLAN DOCUMENT/SUMMARY PLAN DESCRIPTION

The Flex Plan Documents and Summaries of Benefits and Coverage for each medical plan option are available on the Employee Benefit Documents page of the District website @ [www.pxu.org](http://www.pxu.org). You can also request a copy of any of the above and/or a copy of the Summary Plan Description from the District's Employee Benefits Coordinator at 602-764-1538.

## KEEP THE PLAN NOTIFIED OF CHANGES IN ELIGIBILITY FOR BENEFITS

### YOU ARE REQUIRED TO PROVIDE TIMELY NOTICE

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

Notify the District of any of these changes within 31 days. Note that for certain changes, like divorce or a child reaching the limiting age, if you do not notify the Plan within 60 days of that change, the opportunity to elect COBRA will not apply.

**Failure to give your employer (the District) a timely notice of the above noted events may:**

- a. cause you, your Spouse and/or Dependent Child(ren) to lose the right to obtain COBRA Continuation Coverage,
- b. cause the coverage of a Dependent Child to end when it otherwise might continue because of a disability,
- c. cause claims to not be able to be considered for payment until eligibility issues have been resolved,
- d. result in your liability to repay the Plan if any benefits are paid to an ineligible person. The Plan has the right to offset the amounts paid against the participant's future medical, dental, and/or vision benefits.

In accordance with the requirements in the Affordable Care Act, your employer will not retroactively cancel coverage (a rescission) except when premiums are not timely paid, or in cases when an individual performs an act, practice or omission that constitutes fraud, or makes an intentional misrepresentation of material fact that is prohibited by the terms of the Plan. Keeping an ineligible dependent enrolled (for example, an ex-spouse, overage dependent child, etc.) is considered fraud. If you have questions about eligibility contact District's Employee Benefits Specialist at 602-764-1538.

#### IMPORTANT NOTICES ATTACHED

The following pages include important notices for you and your family:

- Health Insurance Marketplace Notice
- Medicare Part D Notice
- The District's HIPAA Privacy Notice
- Premium Assistance Under Medicaid and CHIP Notice



# New Health Insurance Marketplace Coverage

## Options and Your Health Coverage

Form Approved

OMB No. 1210-0149 (expires 6-30-2023)

### PART A: General Information

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

#### What is the Health Insurance Marketplace?

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

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

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

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

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

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

#### How Can I Get More Information?

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

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

## PART B: Information About Health Coverage Offered by Your Employer

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

3. Employer name Phoenix Union High School District		4. Employer Identification Number (EIN) 86- 6000534	
5. Employer address 4502 N. Central Ave.		6. Employer phone number 602-764-1538	
7. City Phoenix		8. State AZ	9. ZIP code 85012
10. Who can we contact at this job? Cyndy Nelke			
11. Phone number (if different from above)		12. Email address nelke@phoenixunion.org	

You are not eligible for health insurance coverage through this employer. You and your family may be able to obtain health coverage through the Marketplace, with a new kind of tax credit that lowers your monthly premiums and with assistance for out-of-pocket costs.

## Important Notice from Phoenix Union High School District about Prescription Drug Coverage for People with Medicare

This notice is for people with Medicare.  
Please read this notice carefully and keep it where you can find it.

This Notice has information about your current prescription drug coverage with Phoenix Union High School District and the prescription drug coverage available for people with Medicare. It also explains the options you have under Medicare's prescription drug coverage and can help you decide whether or not you want to enroll in that Medicare prescription drug coverage. At the end of this notice is information on where you can get help to make a decision about Medicare's prescription drug coverage.

- **If you and/or your family members are not now eligible for Medicare, and will not be eligible during the next 12 months, you may disregard this Notice.**
- **If, however, you and/or your family members are now eligible for Medicare or may become eligible for Medicare in the next 12 months, you should read this Notice very carefully.**

This announcement is required by law whether the group health plan's coverage is primary or secondary to Medicare. Because it is not possible for our Plan to always know when a Plan participant or their eligible spouse or children have Medicare coverage or will soon become eligible for Medicare we have decided to provide this Notice to all plan participants.

Prescription drug coverage for Medicare-eligible people is available through Medicare prescription drug plans (PDPs) and Medicare Advantage Plans (like an HMO or PPO) that offer prescription drug coverage. All Medicare prescription 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.

**Phoenix Union High School District has determined that the prescription drug coverage is "creditable" under the following medical plan options: High Option Plan, Middle Option Plan, Low Option Plan, Alliance Medical Plan and High Deductible Health Plan (HDHP).**

"Creditable" means that the value of this Plan's prescription drug benefit is, on average for all plan participants, expected to pay out as much as or more than the standard Medicare prescription drug coverage will pay.

Because the plan options noted above are, on average, at least as good as the standard Medicare prescription drug coverage, **you can elect or keep prescription drug coverage under the High, Middle, Low, Alliance and HDHP Option plans and you will not pay extra if you later decide to enroll in Medicare prescription drug coverage.** You may enroll in Medicare prescription drug coverage at a later time, and because you maintain creditable coverage, you will not have to pay a higher premium (a late enrollment fee penalty).

### REMEMBER TO KEEP THIS 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).

## WHEN CAN YOU JOIN A MEDICARE DRUG PLAN?

Medicare-eligible people can enroll in a Medicare prescription drug plan at one of the following 3 times:

- when they first become eligible for Medicare; or
- during Medicare's annual election period (from October 15<sup>th</sup> through December 7<sup>th</sup>); or
- for beneficiaries leaving employer/union coverage, you may be eligible for a two-month Special Enrollment Period (SEP) in which to sign up for a Medicare prescription drug plan.

When you make your decision whether to enroll in a Medicare prescription drug plan, you should also compare your current prescription drug coverage, (including which drugs are covered and at what cost) with the coverage and cost of the plans offering Medicare prescription drug coverage in your area.

### YOUR RIGHT TO RECEIVE A NOTICE

You will receive this notice at least every 12 months and at other times in the future such as if the creditable/non-creditable status of the prescription drug coverage through this plan changes. You may also request a copy of a Notice at any time.

### WHY CREDITABLE COVERAGE IS IMPORTANT (When you will pay a higher premium (penalty) to join a Medicare drug plan)

If you do not have creditable prescription drug coverage when you are first eligible to enroll in a Medicare prescription drug plan and you elect or continue prescription drug coverage under a non-creditable prescription drug plan, then at a later date when you decide to elect Medicare prescription drug coverage you may pay a higher premium (a penalty) for that Medicare prescription drug coverage for as long as you have that Medicare coverage.

Maintaining creditable prescription drug coverage will help you avoid **Medicare's late enrollment penalty**. This **late enrollment penalty** is described below:

If you go 63 continuous days or longer without creditable prescription drug coverage (meaning drug coverage that is at least as good as Medicare's 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 either Medicare prescription drug coverage or coverage under a creditable prescription drug plan. You may have to pay this higher premium (the penalty) as long as you have Medicare prescription drug coverage.

For example, if 19 months pass where you do not have creditable prescription drug coverage, when you decide to join Medicare's drug coverage your monthly premium will always be at least 19% higher than the Medicare base beneficiary premium. Additionally, if you go 63 days or longer without prescription drug coverage you may also have to wait until the next October to enroll for Medicare prescription drug coverage.

**WHAT ARE MY CHOICES?**

You can choose any **one** of the following options:

Your Choices:	What you can do:	What this option means to you:
Option 1	You can select or keep your current medical and prescription drug coverage with High, Middle, Low or Alliance Medical plans, and <b>you do not have to enroll in a Medicare prescription drug plan.</b>	<p>You will continue to be able to use your prescription drug benefits through High, Middle, Low or Alliance Medical plans.</p> <ul style="list-style-type: none"><li>• You may, in the future, enroll in a Medicare prescription drug plan during Medicare's annual enrollment period (during October 15th -December 7th of each year).</li><li>• As long as you are enrolled in creditable drug coverage you will not have to pay a higher premium (a late enrollment fee) to Medicare when you do choose, at a later date, to sign up for a Medicare prescription drug plan.</li></ul>



Your Choices:	What you can do:	What this option means to you:
Option 2	<p>You can select or keep your current medical and prescription drug coverage with High, Middle, Low or Alliance Medical plans and also enroll in a Medicare prescription drug plan.</p> <p>If you enroll in a Medicare prescription drug plan you will need to pay the Medicare Part D premium out of your own pocket.</p>	<p>Your current coverage pays for other health expenses in addition to prescription drugs.</p> <p>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. Having dual prescription drug coverage under this Plan and Medicare means that this Plan will coordinate its drug payments with Medicare, as follows:</p> <ul style="list-style-type: none"> <li>• for Medicare eligible Retirees and their Medicare eligible Dependents, Medicare Part D coverage pays primary and this group health plan pays secondary.</li> <li>• for Medicare eligible Active Employees and their Medicare eligible Dependents, this group health plan pays primary and Medicare Part D coverage pays secondary.</li> </ul> <p>Note that you may not drop just the prescription drug coverage under the High, Middle, Low or Alliance Medical plans. That is because prescription drug coverage is part of the entire medical plan. Generally, you may only drop medical plan coverage at this Plan's next Open Enrollment period.</p> <p>Note that each Medicare prescription drug plan (PDP) may differ. Compare coverage, such as:</p> <ul style="list-style-type: none"> <li>• PDPs may have different premium amounts</li> <li>• PDPs cover different brand name drugs at different costs to you;</li> <li>• PDPs may have different prescription drug deductibles and different drug copayments;</li> <li>• PDPs may have different networks for retail pharmacies and mail order services.</li> </ul>

## FOR MORE INFORMATION ABOUT YOUR OPTIONS UNDER MEDICARE'S PRESCRIPTION DRUG COVERAGE

More detailed information about Medicare plans that offer prescription drug coverage is available in the "Medicare & You" handbook. A person enrolled in Medicare (a "beneficiary") will get a copy of this handbook in the mail each year from Medicare. A Medicare beneficiary may also be contacted directly by Medicare-approved prescription drug plans.

For more information about Medicare prescription drug plan coverage:

- Visit [www.medicare.gov](http://www.medicare.gov).
- Call your State Health Insurance Assistance Program (see 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.

### Para más información sobre sus opciones bajo la cobertura de Medicare para recetas médicas.

Revise el manual "Medicare Y Usted" para información más detallada sobre los planes de Medicare que ofrecen cobertura para recetas médicas. Visite [www.medicare.gov](http://www.medicare.gov) por el Internet o llame GRATIS al 1 800 MEDICARE (1-800-633-4227). Los usuarios con teléfono de texto (TTY) deben llamar al 1-877-486-2048. Para más información sobre la ayuda adicional, visite la SSA en línea en [www.socialsecurity.gov](http://www.socialsecurity.gov) por Internet, o llámeles al 1-800-772-1213 (Los usuarios con teléfono de texto (TTY) deberán llamar al 1-800-325-0778).

**For people with limited income and resources**, extra help paying for a Medicare prescription drug plan is available. Information about this extra help is available from the Social Security Administration (SSA). For more information about this extra help, visit SSA online at [www.socialsecurity.gov](http://www.socialsecurity.gov), or call them at 1-800-772-1213 (TTY 1-800-325-0778).

### For more information about this notice or your current prescription drug coverage contact:

Phoenix Union High School District  
ATTN: Employee Benefits Coordinator  
4502 N. Central Ave., Phoenix, AZ 85012  
Phone Number: 602-764-1538

As in all cases, Phoenix Union High School District reserves the right to modify benefits at any time, in accordance with applicable law. This document (dated May 1, 2023) is intended to serve as your Medicare Notice of Creditable Coverage, as required by law.

## Phoenix Union High School District: HIPAA Notice of Privacy Practices

Este aviso está disponible en Español si lo solicitas. Por favor contacte el oficial de privacidad indicado a continuación.

### *Purpose of This Notice*

**This Notice describes how medical information about you may be used and disclosed and how you can get access to this information.**

**Please review it carefully.**

This Notice is required by law.

The Phoenix Union High School District group health plan, including the administration of the self-funded Medical Plan options, Medical/Health Reimbursement Account (also known as a Health Flexible Spending Account) and COBRA benefit, (hereafter referred to as the “Plan”), is required by law to take reasonable steps to maintain the privacy of your personally identifiable health information (called **Protected Health Information or PHI**) and to inform you about the Plan’s legal duties and privacy practices with respect to protected health information including:

1. The Plan’s uses and disclosures of PHI,
2. Your rights to privacy with respect to your PHI,
3. The Plan’s duties with respect to your PHI,
4. Your right to file a complaint with the Plan and with the Secretary of the U.S. Department of Health and Human Services (HHS),
5. The person or office you should contact for further information about the Plan’s privacy practices, and
6. To notify affected individuals following a breach of unsecured protected health information.

The Plan Sponsor has **amended its Plan documents** to protect your PHI as required by Federal law.

PHI use and disclosure by the Plan is regulated by the Health Insurance Portability and Accountability Act (HIPAA). You may find these rules in Section 45 of the Code of Federal Regulations, Parts 160 and 164. The regulations will supersede this Notice if there is any discrepancy between the information in this Notice and the regulations. The Plan will abide by the terms of the Notice currently in effect. The Plan reserves the right to change the terms of this Notice and to make the new Notice provisions effective for all PHI it maintains.

You may receive a Privacy Notice from a variety of the insured group health benefit plans offered by the District. Each of these notices will describe your rights as it pertains to that plan and in compliance with the Federal regulation, HIPAA. This Privacy Notice however, pertains to your protected health information related to the District’s self-funded medical plan options, administration of the Medical/Health Reimbursement Account (also known as a Health Flexible Spending Account) and COBRA benefit (the “Plan”) and outside companies contracted to help administer Plan benefits, called “business associates.”

### **Effective Date**

The effective date of this Notice is **May 1, 2023** and this notice replaces notices previously distributed to you.

### **Privacy Officer**

The Plan has designated a Privacy Officer to oversee the administration of privacy by the Plan and to receive complaints. The Privacy Officer may be contacted at:

**Privacy Officer for Phoenix Union High School District (PUHSD)**  
 Attn: Human Resources Department  
 4502 N. Central Ave. Phoenix, AZ 85012  
 Telephone: 602-764-1538 Confidential fax #: 602-274-0484

## Your Protected Health Information

The term “**Protected Health Information**” (PHI) includes all information related to your past, present or future health condition(s) that individually identifies you or could reasonably be used to identify you and is transferred to another entity or maintained by the Plan in oral, written, electronic or any other form.

**PHI does not include** health information contained in employment records held by Phoenix Union High School District in its role as an employer, including but not limited to health information on disability, work-related illness/injury, sick leave, Family or Medical Leave (FMLA), life insurance, dependent care flexible spending account, drug testing, etc.

PHI also does not include health information that has been de-identified. **De-identified information** is information that does not identify you and there is no reasonable basis to believe that the information can be used to identify you.

## When the Plan May Disclose Your PHI

Under the law, the Plan may disclose your PHI without your written authorization in the following cases:

- **At your request.** If you request it, the Plan is required to give you access to your PHI in order to inspect it and copy it.
- **As required by an agency of the government.** The Secretary of the Department of Health and Human Services may require the disclosure of your PHI to investigate or determine the Plan’s compliance with the privacy regulations.
- **For treatment, payment or health care operations.** The Plan and its business associates will use your PHI (except psychotherapy notes in certain instances as described below) without your consent, authorization or opportunity to agree or object in order to carry out treatment, payment, or health care operations.

The Plan may disclose PHI to the Plan Sponsor for purposes of treatment, payment and health care operations in accordance with the Plan amendment. The Plan may disclose PHI to the Plan Sponsor for review of your appeal of a benefit or for other reasons related to the administration of the Plan.

Definitions and Examples of Treatment, Payment and Health Care Operations	
<b>Treatment is health care.</b>	<p>Treatment is the provision, coordination or management of health care and related services. It also includes but is not limited to coordination of benefits with a third party and consultations and referrals between one or more of your health care providers.</p> <ul style="list-style-type: none"> <li>• <b>For example:</b> The Plan discloses to a treating specialist the name of your treating primary care physician so the two can confer regarding your treatment plan.</li> </ul>

<p><b>Payment</b> is paying claims for health care and related activities.</p>	<p>Payment includes but is not limited to making payment for the provision of health care, determination of eligibility, claims management, and utilization review activities such as the assessment of medical necessity and appropriateness of care.</p> <ul style="list-style-type: none"> <li>• <b>For example:</b> The Plan tells your doctor whether you are eligible for coverage or what percentage of the bill will be paid by the Plan. If we contract with third parties to help us with payment, such as a claims payer, we will disclose pertinent information to them. These third parties are known as “business associates.”</li> </ul>
<p><b>Health Care Operations</b> keep the Plan operating soundly.</p>	<p>Health care operations includes but is not limited to quality assessment and improvement, patient safety activities, business planning and development, reviewing competence or qualifications of health care professionals, underwriting, enrollment, premium rating and other insurance activities relating to creating or renewing insurance contracts. It also includes disease management, case management, conducting or arranging for medical review, legal services and auditing functions including fraud and abuse compliance programs and general administrative activities.</p> <ul style="list-style-type: none"> <li>• <b>For example:</b> The Plan uses information about your medical claims to refer you to a health care management program, to project future benefit costs or to audit the accuracy of its claims processing functions.</li> </ul>

In addition, the Plan may use or disclose “summary health information” to the Plan Sponsor for obtaining premium bids or modifying, amending or terminating the group health Plan. **Summary health information** is information that summarizes claims history, claims expenses or type of claims experienced by individuals for whom the Plan Sponsor has provided health benefits under a group health plan. Identifying information will be deleted from summary health information, in accordance with HIPAA. The Plan may not (and does not) use your genetic information that is PHI for underwriting purposes.

Although the Plan does not routinely obtain psychotherapy notes, generally, an authorization will be required by the Plan before the Plan will use or disclose psychotherapy notes about you. Psychotherapy notes are separately filed notes about your conversations with your mental health professional during a counseling session. They do not include summary information about your mental health treatment. However, the Plan may use and disclose such notes when needed by the Plan to defend itself against litigation filed by you.

The Plan generally will require an authorization form for uses and disclosure of your PHI for sales or marketing purposes if the Plan receives direct or indirect payment from the entity whose product or service is being marketed or sold. You have the right to revoke an authorization at any time.

## Use or Disclosure of Your PHI Where You Will Be Given an Opportunity to Agree or Disagree Before the Use or Release

Disclosure of your PHI to family members, other relatives and your close personal friends without your written consent or authorization is allowed if:

- The information is directly relevant to the family or friend’s involvement with your care or payment for that care, and
- You have either agreed to the disclosure or have been given an opportunity to object and have not objected.

Under this Plan your PHI will automatically be disclosed to internal employer departments as outlined below. **If you disagree with this automatic disclosure by the Plan you may contact the Privacy Officer to request that such disclosure not occur without your written authorization:**

- In the event of your death while you are covered by this Plan, when the Plan is notified it will automatically communicate this information to the following internal departments: Payroll, Human Resources, Technology and Community Relations.

- In the event the Plan is notified of a work-related illness or injury, the Plan will automatically communicate this information to the District's Workers' Compensation Insurance Carrier, District Workers' Compensation Coordinator, Site Workers' Compensation Coordinator and Safety Department to allow the processing of appropriate paperwork.
- In the event the Plan is notified of a condition that may initiate a short term disability benefit, the Plan will automatically communicate this information to the Employee Benefits Specialist to allow the processing of appropriate paperwork.
- In the event the Plan is notified of a situation where it may be possible to initiate a medical leave under the Family and Medical Leave Act (FMLA) benefit, the Plan will automatically communicate this information to the Assistants to the Human Resource Administrators to allow the processing of appropriate FMLA paperwork.

**Note that PHI obtained by the Plan Sponsor's employees through Plan administration activities will NOT be used for employment related decisions.**

## Use or Disclosure of Your PHI Where Consent, Authorization or Opportunity to Object Is Not Required

In general, the Plan does not need your written authorization to release your PHI if required by law or for public health and safety purposes. The Plan and its Business Associates are allowed to use and disclose your PHI **without** your written authorization under the following circumstances:

1. When *required by law*.
2. When permitted for *purposes of public health activities*. This includes reporting product defects, permitting product recalls and conducting post-marketing surveillance. PHI may also be used or disclosed if you have been exposed to a communicable disease or are at risk of spreading a disease or condition, if authorized by law.
3. To a school about an individual who is a student or prospective student of the school if the protected health information that is disclosed is limited to *proof of immunization*, the school is required by State or other law to have such proof of immunization prior to admitting the individual and the covered entity obtains and documents the agreements to this disclosure from either a parent, guardian or other person acting in loco parentis of the individual, if the individual is an unemancipated minor; or the individual, if the individual is an adult or emancipated.
4. When authorized by law to report information about *abuse, neglect or domestic violence* to public authorities if a reasonable belief exists that you may be a victim of abuse, neglect or domestic violence. In such case, the Plan will promptly inform you that such a disclosure has been or will be made unless that notice would cause a risk of serious harm. For the purpose of reporting child abuse or neglect, it is not necessary to inform the minor that such a disclosure has been or will be made. Disclosure may generally be made to the minor's parents or other representatives, although there may be circumstances under Federal or state law when the parents or other representatives may not be given access to the minor's PHI.
5. To a public health oversight agency for *oversight activities authorized by law*. These activities include civil, administrative or criminal investigations, inspections, licensure or disciplinary actions (for example, to investigate complaints against providers) and other activities necessary for appropriate oversight of government benefit programs (for example, to investigate Medicare or Medicaid fraud).
6. When required *for judicial or administrative proceedings*. For example, your PHI may be disclosed in response to a subpoena or discovery request, provided certain conditions are met, including that:
  - the requesting party must give the Plan satisfactory assurances a good faith attempt has been made to provide you with written Notice, and
  - the Notice provided sufficient information about the proceeding to permit you to raise an objection, and
  - no objections were raised or were resolved in favor of disclosure by the court or tribunal.

7. When required for **law enforcement health purposes** (for example, to report certain types of wounds).
8. For **law enforcement purposes** if the law enforcement official represents that the information is not intended to be used against the individual, the immediate law enforcement activity would be materially and adversely affected by waiting to obtain the individual's agreement and the Plan in its best judgment determines that disclosure is in the best interest of the individual. Law enforcement purposes include:
  - identifying or locating a suspect, fugitive, material witness or missing person, and
  - disclosing information about an individual who is or is suspected to be a victim of a crime.
9. When required to be given **to a coroner or medical examiner** to identify a deceased person, determine a cause of death or other authorized duties. When required to be given **to funeral directors** to carry out their duties with respect to the decedent; for use and disclosures for cadaveric **organ, eye or tissue donation** purposes.
10. For **research**, subject to certain conditions.
11. When, consistent with applicable law and standards of ethical conduct, the Plan in good faith believes the use or disclosure is necessary to prevent or lessen a serious and **imminent threat to the health or safety** of a person or the public and the disclosure is to a person reasonably able to prevent or lessen the threat, including the target of the threat.
12. When authorized by and to the extent necessary to comply with **workers' compensation** or other similar programs established by law.
13. When required, for **specialized government functions**, to military authorities under certain circumstances, or to authorized Federal officials for lawful intelligence, counter intelligence and other national security activities.

Any other Plan uses and disclosures not described in this Notice will be made only if you provide the Plan with written authorization, subject to your right to revoke your authorization, and information used and disclosed will be made in compliance with the minimum necessary standards of the regulation.

## Your Individual Privacy Rights

### A. You May Request Restrictions on PHI Uses and Disclosures

You may request the Plan to restrict the uses and disclosures of your PHI:

- To carry out treatment, payment or health care operations, or
- To family members, relatives, friends or other persons identified by you who are involved in your care.

The Plan, however, is not required to agree to your request if the Plan Administrator or Privacy Officer determines it to be unreasonable, for example, if it would interfere with the Plan's ability to pay a claim.

The Plan will accommodate an individual's reasonable request to receive communications of PHI by alternative means or at alternative locations where the request includes a statement that disclosure could endanger the individual. You or your personal representative will be required to complete a form to request restrictions on the uses and disclosures of your PHI. To make such a request contact the Privacy Officer at their address listed on the first page of this Notice.

### B. You May Inspect and Copy Your PHI

You have the right to inspect and obtain a copy (in hard copy or electronic form) of your PHI (except psychotherapy notes and information compiled in reasonable contemplation of an administrative action or proceeding) contained in a "designated record set," for as long as the Plan maintains the PHI. You may request your hard copy or electronic information in a format that is convenient for you, and the Plan will honor that request to the extent possible. You may also request a summary of your PHI.

A **Designated Record Set** includes your medical records and billing records that are maintained by or for a covered health care provider. Records include enrollment, payment, billing, claims adjudication and case or medical management record systems maintained by or for a health plan or other information used in whole or in part by or for the covered entity to make decisions about you. Information used for

quality control or peer review analyses and not used to make decisions about you is not included in the designated record set.

The Plan must provide the requested information within 30 days of its receipt of the request, if the information is maintained onsite or within 60 days if the information is maintained offsite. A single 30-day extension is allowed if the Plan is unable to comply with the deadline and notifies you in writing in advance of the reasons for the delay and the date by which the Plan will provide the requested information.

You or your personal representative will be required to complete a form to request access to the PHI in your Designated Record Set. Requests for access to your PHI should be made to the Plan's Privacy Officer at their address listed on the first page of this Notice. The Plan reserves the right to charge a reasonable cost-based fee for creating or copying the PHI or preparing a summary of your PHI.

If access is denied, you or your personal representative will be provided with a written denial describing the basis for the denial, a description of how you may exercise those review rights and a description of how you may complain to the Plan's Privacy Officer or the Secretary of the U.S. Department of Health and Human Services.

**C. *You Have the Right to Amend Your PHI***

You or your Personal Representative have the right to request that the Plan amend your PHI or a record about you in a designated record set for as long as the PHI is maintained in the designated record set. The Plan has 60 days after receiving your request to act on it. The Plan is allowed a single 30-day extension if the Plan is unable to comply with the 60-day deadline (provided that the Plan notifies you in writing in advance of the reasons for the delay and the date by which the Plan will provide the requested information).

If the Plan denied your request in whole or part, the Plan must provide you with a written denial that explains the basis for the decision. You or your personal representative may then submit a written statement disagreeing with the denial and have that statement included with any future disclosures of your PHI. You should make your request to amend PHI to the Privacy Officer at their address listed on the first page of this Notice.

You or your personal representative may be required to complete a form to request amendment of your PHI. Forms are available from the Privacy Officer at their address listed on the first page of this Notice.

**D. *You Have the Right to Receive an Accounting of the Plan's PHI Disclosures***

At your request, the Plan will also provide you with an accounting of disclosures by the Plan of your PHI during the six years (or shorter period if requested) before the date of your request. The Plan will not provide you with an accounting of disclosures related to treatment, payment, or health care operations, or disclosures made to you or authorized by you in writing. The Plan has 60 days after its receipt of your request to provide the accounting. The Plan is allowed an additional 30 days if the Plan gives you a written statement of the reasons for the delay and the date by which the accounting will be provided. If you request more than one accounting within a 12-month period, the Plan will charge a reasonable, cost-based fee for each subsequent accounting.

**E. *You Have the Right to Request that PHI be Transmitted to You Confidentially***

The Plan will permit and accommodate your reasonable request to have PHI sent to you by alternative means or to an alternative location (such as mailing PHI to a different address or allowing you to personally pick up the PHI that would otherwise be mailed), if you provide a written request to the Plan that the disclosure of PHI to your usual location could endanger you. If you believe you have this situation, you should contact the Plan's Privacy Officer to discuss your request for confidential PHI transmission.

**F. *You Have the Right to Receive a Paper or Electronic Copy of This Notice Upon Request***

To obtain a paper or electronic copy of this Notice, contact the Plan's Privacy Officer at their address listed on the first page of this Notice. This right applies even if you have agreed to receive the Notice electronically.

**G. *Breach Notification***

If a breach of your unsecured protected health information occurs, the Plan will notify you.



## Your Personal Representative

You may exercise your rights to your protected health information (PHI) by designating a person to act as your Personal Representative. Your Personal Representative will generally be required to produce evidence (proof) of the authority to act on your behalf **before** the Personal Representative will be given access to your PHI or be allowed to take any action for you.

Under this Plan, proof of such authority will include (1) a completed, signed and approved Appoint a Personal Representative form; (2) a notarized power of attorney for health care purposes; (3) a court-appointed conservator or guardian; or, (4) for a Spouse under this Plan, the absence of a Revoke a Personal Representative form on file with the Privacy Officer.

**This Plan will automatically recognize your legal Spouse as your Personal Representative and vice versa, without you having to complete a form to Appoint a Personal Representative.** However, you may request that the Plan **not** automatically honor your legal Spouse as your Personal Representative by completing a form to Revoke a Personal Representative (copy attached to this notice or also available from the Privacy Officer).

**If you wish to revoke your Spouse as your Personal Representative, please complete the Revoke a Personal Representative form and return it to the Privacy Officer and this will mean that this Plan will NOT automatically recognize your Spouse as your Personal Representative and vice versa.**

The recognition of your Spouse as your Personal Representative (and vice versa) is for the use and disclosure of PHI related to treatment, payment and health care operations purposes under this Plan and is not intended to expand such designation beyond what is necessary for this Plan to comply with HIPAA privacy regulations.

You may obtain a form to Appoint a Personal Representative or Revoke a Personal Representative by contacting the Privacy Officer at their address listed on this Notice. The Plan retains discretion to deny access to your PHI to a Personal Representative to provide protection to those vulnerable people who depend on others to exercise their rights under these rules and who may be subject to abuse or neglect.

Because HIPAA regulations give adults certain rights and generally children age 18 and older are adults, if you have **dependent children age 18 and older** covered under the Plan, and the child wants you, as the parent(s), to be able to access their protected health information (PHI), that child will need to complete a form to Appoint a Personal Representative to designate you (the employee/retiree) and/or your Spouse as their Personal Representatives.

The Plan will consider a parent, guardian, or other person acting *in loco parentis* as the Personal Representative of an unemancipated minor (a child generally under age 18) unless the applicable law requires otherwise. **In loco parentis** may be further defined by state law, but in general it refers to a person who has been treated as a parent by the child and who has formed a meaningful parental relationship with the child for a substantial period of time. Spouses and unemancipated minors may, however, request that the Plan restrict PHI that goes to family members as described above under the section titled "Your Individual Privacy Rights."

## The Plan's Duties

The Plan is required by law to maintain the privacy of your PHI and to provide you and your eligible dependents with Notice of its legal duties and privacy practices. The Plan is required to comply with the terms of this Notice. However, the Plan reserves the right to change its privacy practices and the terms of this Notice and to apply the changes to any PHI maintained by the Plan.

**Notice Distribution:** The Notice will be provided to each person when they initially enroll for benefits in the Plan (the Notice is provided in the Plan's Initial Enrollment packets). The Notice is also available on the Plan's website: [www.phoenixunion.org](http://www.phoenixunion.org). The Notice will also be provided upon request. Once every three years the Plan will notify the individuals then covered by the Plan where to obtain a copy of the Notice. This Plan will satisfy the requirements of the HIPAA regulation by providing the Notice to the named insured (covered employee) of the Plan; however, you are encouraged to share this Notice with other family members covered under the Plan.

**Notice Revisions:** If a privacy practice of this Plan is changed affecting this Notice, a revised version of this Notice will be provided to you and all participants covered by the Plan at the time of the change. Any revised version of the Notice will be distributed within 60 days of the effective date of a material change to the uses and disclosures of PHI, your individual rights, the duties of the Plan or other privacy practices stated in this Notice.

Material changes are changes to the uses and disclosures of PHI, an individual's rights, the duties of the Plan or other privacy practices stated in the Privacy Notice. Because our health plan posts its Notice on its website ([www.phoenixunion.org](http://www.phoenixunion.org)), we will prominently post the revised Notice on that website by the effective date of the material change to the Notice. We will also provide the revised notice, or information about the material change and how to obtain the revised Notice, in our next annual mailing to individuals covered by the Plan.

## Disclosing Only the Minimum Necessary Protected Health Information

When using or disclosing PHI or when requesting PHI from another covered entity, the Plan will make reasonable efforts not to use, disclose or request more than the minimum amount of PHI necessary to accomplish the intended purpose of the use, disclosure or request, taking into consideration practical and technological limitations.

As described in the amended Plan document, the Plan may share PHI with the Plan Sponsor for limited administrative purposes, such as determining claims and appeals, performing quality assurance functions and auditing and monitoring the Plan. The Plan shares the minimum information necessary to accomplish these purposes.

## Your Right to File a Complaint

**If you believe that your privacy rights have been violated, you may file a complaint with the Plan in care of the Plan's Privacy Officer, at the address listed on the first page of this Notice.** Neither your employer nor the Plan will retaliate against you for filing a complaint.

You may also file a complaint (within 180 days of the date you know or should have known about an act or omission) with the Secretary of the U.S. Department of Health and Human Services by contacting their nearest office as listed in your telephone directory or at this website (<https://www.hhs.gov/ocr/about-us/contact-us/index.htm>) or this website: <http://www.hhs.gov/ocr/privacy/hipaa/complaints/index.html> or contact the Privacy Officer (noted on the first page) for more information about how to file a complaint.

## If You Need More Information

If you have any questions regarding this Notice or the subjects addressed in it, you may contact the Plan's Privacy Officer at the address listed on the first page of this Notice.

- *Attachment (Form to Revoke a Personal Representative)*

## Phoenix Union High School District Form to Revoke a Personal Representative

Complete the following chart to indicate the name of the Personal Representative to be revoked:

	Plan Participant:	Person to be Revoked as my Personal Representative:
Name (print):		
Address (City, State, Zip):		
Phone:	(    )	(    )

I, \_\_\_\_\_ (Name of Participant or Beneficiary)

hereby revoke the authority of \_\_\_\_\_ (Name of Personal Representative)

☐ to act on my behalf,

☐ to act on behalf of my dependent child(ren), named:

\_\_\_\_\_,

in receiving any protected health information (PHI) that is (or would be) provided to a personal representative, including any individual rights regarding PHI under HIPAA, effective \_\_\_\_\_, 20\_\_\_\_.

I understand that PHI has or may already have been disclosed to the above named Personal Representative prior to the effective date of this form.

\_\_\_\_\_  
Participant or Beneficiary's Signature

\_\_\_\_\_  
Date

Acknowledgement by the Privacy Officer: \_\_\_\_\_ Date: \_\_\_\_\_,  
20\_\_\_\_

Once completed, please return this form to the:  
**Privacy Officer for Phoenix Union High School District (PUHSD)**  
 Attn: Human Resources Department  
 4502 N. Central Ave. Phoenix, AZ 85012  
 Telephone: 602-764-1538 Confidential fax #: 602-274-0484

## 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](http://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](http://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](http://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, 2023. Contact your State for more information on eligibility –**

ALABAMA – Medicaid	ALASKA – Medicaid
Website: <a href="http://myalhipp.com/">http://myalhipp.com/</a> Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: <a href="http://myakhipp.com/">http://myakhipp.com/</a> Phone: 1-866-251-4861 Email: <a href="mailto:CustomerService@MyAKHIPP.com">CustomerService@MyAKHIPP.com</a> Medicaid Eligibility: <a href="https://health.alaska.gov/dpa/Pages/default.aspx">https://health.alaska.gov/dpa/Pages/default.aspx</a>
ARKANSAS – Medicaid	CALIFORNIA – Medicaid
Website: <a href="http://myarhipp.com/">http://myarhipp.com/</a> Phone: 1-855-MyARHIPP (855-692-7447)	Website: Health Insurance Premium Payment (HIPP) Program <a href="http://dhcs.ca.gov/hipp">http://dhcs.ca.gov/hipp</a> Phone: 916-445-8322 Fax: 916-440-5676 Email: <a href="mailto:hipp@dhcs.ca.gov">hipp@dhcs.ca.gov</a>
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	FLORIDA – Medicaid

<p>Health First Colorado Website:  <a href="https://www.healthfirstcolorado.com/">https://www.healthfirstcolorado.com/</a>  Health First Colorado Member Contact Center:  1-800-221-3943/ State Relay 711  CHP+: <a href="https://hcpf.colorado.gov/child-health-plan-plus">https://hcpf.colorado.gov/child-health-plan-plus</a>  CHP+ Customer Service: 1-800-359-1991/ State Relay 711  Health Insurance Buy-In Program  (HIBI): <a href="https://www.mycohibi.com/">https://www.mycohibi.com/</a>  HIBI Customer Service: 1-855-692-6442</p>	<p>Website:  <a href="https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html">https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html</a>  Phone: 1-877-357-3268</p>
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GEORGIA – Medicaid	INDIANA – Medicaid
<p>GA HIPP Website: <a href="https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp">https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp</a>  Phone: 678-564-1162, Press 1  GA CHIPRA Website:  <a href="https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra">https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra</a>  Phone: (678) 564-1162, Press 2</p>	<p>Healthy Indiana Plan for low-income adults 19-64  Website: <a href="http://www.in.gov/fssa/hip/">http://www.in.gov/fssa/hip/</a>  Phone: 1-877-438-4479  All other Medicaid  Website: <a href="https://www.in.gov/medicaid/">https://www.in.gov/medicaid/</a>  Phone 1-800-457-4584</p>
IOWA – Medicaid and CHIP (Hawki)	KANSAS – Medicaid
<p>Medicaid Website:  <a href="https://dhs.iowa.gov/ime/members">https://dhs.iowa.gov/ime/members</a>  Medicaid Phone: 1-800-338-8366  Hawki Website:  <a href="http://dhs.iowa.gov/Hawki">http://dhs.iowa.gov/Hawki</a>  Hawki Phone: 1-800-257-8563  HIPP Website:  <a href="https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp">https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp</a>  HIPP Phone: 1-888-346-9562</p>	<p>Website: <a href="https://www.kancare.ks.gov/">https://www.kancare.ks.gov/</a>  Phone: 1-800-792-4884  HIPP Phone: 1-800-766-9012</p>
KENTUCKY – Medicaid	LOUISIANA – Medicaid
<p>Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website:  <a href="https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx">https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx</a>  Phone: 1-855-459-6328  Email: <a href="mailto:KIHIPPPROGRAM@ky.gov">KIHIPPPROGRAM@ky.gov</a>  KCHIP Website:  <a href="https://kidshealth.ky.gov/Pages/index.aspx">https://kidshealth.ky.gov/Pages/index.aspx</a>  Phone: 1-877-524-4718  Kentucky Medicaid Website: <a href="https://chfs.ky.gov">https://chfs.ky.gov</a></p>	<p>Website: <a href="http://www.medicicaid.la.gov">www.medicicaid.la.gov</a> or <a href="http://www.ldh.la.gov/lahipp">www.ldh.la.gov/lahipp</a>  Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)</p>
MAINE – Medicaid	MASSACHUSETTS – Medicaid and CHIP
<p>Enrollment Website:  <a href="https://www.mymaineconnection.gov/benefits/s/?language=en_US">https://www.mymaineconnection.gov/benefits/s/?language=en_US</a>  Phone: 1-800-442-6003  TTY: Maine relay 711  Private Health Insurance Premium Webpage:  <a href="https://www.maine.gov/dhhs/ofi/applications-forms">https://www.maine.gov/dhhs/ofi/applications-forms</a>  Phone: 1-800-977-6740</p>	<p>Website: <a href="https://www.mass.gov/masshealth/pa">https://www.mass.gov/masshealth/pa</a>  Phone: 1-800-862-4840  TTY: (617) 886-8102</p>

TTY: Maine relay 711	
<b>MINNESOTA – Medicaid</b>	<b>MISSOURI – Medicaid</b>
Website: <a href="https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp">https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp</a> Phone: 1-800-657-3739	Website: <a href="http://www.dss.mo.gov/mhd/participants/pages/hipp.htm">http://www.dss.mo.gov/mhd/participants/pages/hipp.htm</a> Phone: 573-751-2005
<b>MONTANA – Medicaid</b>	<b>NEBRASKA – Medicaid</b>
Website: <a href="http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP">http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP</a> Phone: 1-800-694-3084 Email: <a href="mailto:HSHSHIPPPProgram@mt.gov">HSHSHIPPPProgram@mt.gov</a>	Website: <a href="http://www.ACCESSNebraska.ne.gov">http://www.ACCESSNebraska.ne.gov</a> Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178

<b>NEVADA – Medicaid</b>	<b>NEW HAMPSHIRE – Medicaid</b>
Medicaid Website: <a href="http://dhcfp.nv.gov">http://dhcfp.nv.gov</a> Medicaid Phone: 1-800-992-0900	Website: <a href="https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program">https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program</a> Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 5218
<b>NEW JERSEY – Medicaid and CHIP</b>	<b>NEW YORK – Medicaid</b>
Medicaid Website: <a href="http://www.state.nj.us/humanservices/dmahs/clients/medicaid/">http://www.state.nj.us/humanservices/dmahs/clients/medicaid/</a> Medicaid Phone: 609-631-2392 CHIP Website: <a href="http://www.njfamilycare.org/index.html">http://www.njfamilycare.org/index.html</a> CHIP Phone: 1-800-701-0710	Website: <a href="https://www.health.ny.gov/health_care/medicaid/">https://www.health.ny.gov/health_care/medicaid/</a> Phone: 1-800-541-2831
<b>NORTH CAROLINA – Medicaid</b>	<b>NORTH DAKOTA – Medicaid</b>
Website: <a href="https://medicaid.ncdhhs.gov/">https://medicaid.ncdhhs.gov/</a> Phone: 919-855-4100	Website: <a href="http://www.nd.gov/dhs/services/medicalserv/medicaid/">http://www.nd.gov/dhs/services/medicalserv/medicaid/</a> Phone: 1-844-854-4825
<b>OKLAHOMA – Medicaid and CHIP</b>	<b>OREGON – Medicaid</b>
Website: <a href="http://www.insureoklahoma.org">http://www.insureoklahoma.org</a> Phone: 1-888-365-3742	Website: <a href="http://healthcare.oregon.gov/Pages/index.aspx">http://healthcare.oregon.gov/Pages/index.aspx</a> <a href="http://www.oregonhealthcare.gov/index-es.html">http://www.oregonhealthcare.gov/index-es.html</a> Phone: 1-800-699-9075
<b>PENNSYLVANIA – Medicaid and CHIP</b>	<b>RHODE ISLAND – Medicaid and CHIP</b>
Website: <a href="https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx">https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx</a> Phone: 1-800-692-7462 CHIP Website: <a href="http://Children's Health Insurance Program (CHIP) (pa.gov)">Children's Health Insurance Program (CHIP) (pa.gov)</a> CHIP Phone: 1-800-986-KIDS (5437)	Website: <a href="http://www.eohhs.ri.gov/">http://www.eohhs.ri.gov/</a> Phone: 1-855-697-4347, or 401-462-0311 (Direct Rlte Share Line)
<b>SOUTH CAROLINA – Medicaid</b>	<b>SOUTH DAKOTA - Medicaid</b>

Website: <a href="https://www.scdhhs.gov">https://www.scdhhs.gov</a> Phone: 1-888-549-0820	Website: <a href="http://dss.sd.gov">http://dss.sd.gov</a> Phone: 1-888-828-0059
<b>TEXAS – Medicaid</b>	<b>UTAH – Medicaid and CHIP</b>
Website: <a href="http://gethipptexas.com/">http://gethipptexas.com/</a> Phone: 1-800-440-0493	Medicaid Website: <a href="https://medicaid.utah.gov/">https://medicaid.utah.gov/</a> CHIP Website: <a href="http://health.utah.gov/chip">http://health.utah.gov/chip</a> Phone: 1-877-543-7669
<b>VERMONT– Medicaid</b>	<b>VIRGINIA – Medicaid and CHIP</b>
Website: <a href="#">Health Insurance Premium Payment (HIPP) Program   Department of Vermont Health Access</a> Phone: 1-800-250-8427	Website: <a href="https://www.coverva.org/en/famis-select">https://www.coverva.org/en/famis-select</a> <a href="https://www.coverva.org/en/hipp">https://www.coverva.org/en/hipp</a> Medicaid/CHIP Phone: 1-800-432-5924
<b>WASHINGTON – Medicaid</b>	<b>WEST VIRGINIA – Medicaid and CHIP</b>
Website: <a href="https://www.hca.wa.gov/">https://www.hca.wa.gov/</a> Phone: 1-800-562-3022	Website: <a href="https://dhhr.wv.gov/bms/">https://dhhr.wv.gov/bms/</a> <a href="http://mywvhipp.com/">http://mywvhipp.com/</a> Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
<b>WISCONSIN – Medicaid and CHIP</b>	<b>WYOMING – Medicaid</b>
Website: <a href="https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm">https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm</a> Phone: 1-800-362-3002	Website: <a href="https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/">https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/</a> Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since January 31, 2023, or for more information on special enrollment rights, contact either:

U.S. Department of Labor  
Services

Employee Benefits Security Administration  
[www.dol.gov/agencies/ebsa](http://www.dol.gov/agencies/ebsa)  
1-866-444-EBSA (3272)

U.S. Department of Health and Human

Centers for Medicare & Medicaid Services  
[www.cms.hhs.gov](http://www.cms.hhs.gov)  
1-877-267-2323, Menu Option 4, Ext. 61565

### Paperwork Reduction Act Statement

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

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

OMB Control Number 1210-0137 (expires 1/31/2026)