

2021

Benefit Enrollment Guide

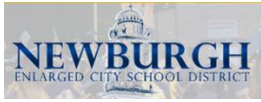
866-573-4768

Table of Contents

▪ Welcome	4
▪ Eligibility & Enrollment	5
▪ iNavigator Enrollment Portal	6
▪ NYSHIP Medical	7
▪ MVP Medical	8
▪ Health Reimbursement Arrangement (HRA)	9
▪ MVP Pharmacy Overview	10-11
▪ MVP Brand/Generic Difference Program	12
▪ Frequently Asked Questions	13
▪ RX Discount Programs	14-15
▪ Wellness Programs	16-17
▪ MVP Mom Meals	18-19
▪ MVP GIA	20-21
▪ Resources	22
▪ Health Insurance Marketplace	23
▪ General Notices	24-25
▪ CHIP	26
▪ Creditable Coverage	27
▪ Notes	28-29

Please Note: This enrollment guide is a summary of the benefits provided to benefit eligible employees. Newburgh Enlarged City School District reserves the right to modify, amend, suspend or terminate any plan at any time for any reason without prior notification. The plans described in this guide are governed by insurance contracts and plan documents, which are available for examination upon request. We have attempted to make explanations of the plans in this guide as accurate as possible. However, should there be any discrepancy between this guide and the provisions of the insurance contract or plan documents, the provisions of the insurance contract or plan documents will govern. In addition, you should not rely on any descriptions of these plans, since the written descriptions in the insurance contracts or plan documents will always govern.

This is the only written summary of benefits. Please consult the Plan Document for more detailed information.



124 Grand Street
Newburgh, NY 12550
Phone Number: 845 - 563-3467
www.newburghschools.org

Dear Employee:

Welcome to our 2021 Benefits Open Enrollment! Our goal is to provide you and your family with cost-efficient and comprehensive benefits. These programs are reviewed annually to ensure they are in-line with the current trends and remain in compliance with government regulations such as the Health Care Reform legislation. Please read this Benefits Guide to gather important details about your benefits and learn about your contributions as an aid to making your final decisions.

The definition of “full-time” for healthcare benefit eligibility purposes is working on average 30 or more hours per week. Newburgh Enlarged City School District will track your hours and notify you if you are eligible for benefits. More information on eligibility to participate in our healthcare plan can be found in the Summary Plan Description, which can be obtained by contacting our Human Resources department.

Open Enrollment

Open Enrollment is the window of opportunity to make changes to your benefit elections or enroll if you previously waived coverage. It is the time of year to make sure that you have enrolled in the health benefits that meet your healthcare needs and fit into your overall financial plan. Ask yourself:

- Does your current coverage meet your family’s needs?
- Did you get married, divorced, have a child or another qualifying status change since you last looked at your benefits?
- Were you covered under a spouse and now would like to be covered primarily by your employer?
- Verify that your enrolled dependents meet the definition of an eligible dependent. Medical coverage is provided for dependent children up to their 26th birthday under Health Care Reform. Other benefit plans are subject to plan age limits.

A copy of this Benefit Guide, the Summary of Benefits and Coverage (SBC) for our medical plans, along with the Glossary of Health Coverage and Medical Terms, and CHIRPA Notice are available on the Newburgh Enlarges City School District’s website located at <https://newburghschools.org/healthbenefits.php> as well as on iNavigator. Upon request a paper copy will be provided at no charge.

Under the Affordable Care Act you are required to maintain healthcare coverage for yourself and your dependent children.

Changing Your Benefits After Open Enrollment

After open enrollment you may change your benefits only if you have met a qualified status change, such as loss of other medical coverage, the birth of a child, divorce or a child reaching the coverage maximum age limit. Changes must be made within 30 days of the qualified life event and proof of the life event is required at the time of the change.

Please do not hesitate to contact Keisha Martinez, Health Benefits Specialist at (845) 563-3467 or Kathy Gordineer, Marshall & Sterling Account Manager at (866) 573-4768 ext.2481 with any questions or concerns regarding your benefits. We are here to help!

Sincerely,

Michael McLymore

Assistant Superintendent of Human Resources

Eligibility & Enrollments

Eligibility

Employees who are regularly scheduled to work at least 30 hours a week are eligible to participate in the Newburgh Enlarged City School District Benefits Program. If you enroll in coverage, you may also enroll your “eligible dependents” into the medical plan.

Additionally, Variable Part Time employee’s who meet the full time definition defined by the Affordable Care Act (ACA), are eligible to participate in the medical plan(s). If eligible, you may also enroll your “eligible dependents” into a medical plan. Your “eligible dependents” include:

Eligible Dependents:

Same or opposite sex spouse

Unmarried/married dependent children (not their spouse or dependents) to their 26th birthday

Unmarried dependent children (not their spouse or dependents) of any age who are physically or mentally disabled

Termination of Benefits Coverage

Your benefits coverage ends as follows:

If you were subject to a two month waiting period as a new hire, then you will receive a two month extension of medical coverage from the last date worked. If the two month waiting period was waived, then your medical benefits will terminate on the last day of the month in which you ended employment.

Medicare Eligible

If you are actively working and you or your spouse is eligible for Medicare benefits, please see the outline below:

Medicare Eligibility Reason	Primary Payor	Secondary Payor
Over 65 years of age	Group Health Plan	Medicare
Under 65 Due to disability	Group Health Plan	Medicare

New Hires

New hires and newly eligible employees may enroll in the Health and Welfare plans when they first join Newburgh Enlarged City School District. New hires must elect benefits within 31 days of their date of hire; otherwise, they will have to wait until the next Open Enrollment period to elect benefits.

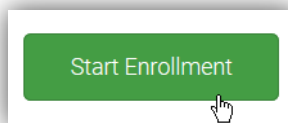
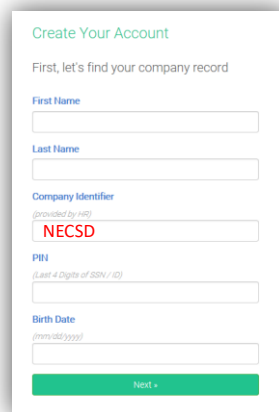
The following provides an overview of benefit election requirements and effective dates.

Benefit	Action Required	Benefit Effective Date
Medical	New Hires and Newly Eligible Employees must actively elect these benefits	New Hires and Newly Eligible Employees are eligible 2 months following their date of hire.

iNavigator

With iNavigator, employees enjoy convenient online access to benefits coverage, 24 hours a day, seven days a week. You can update your personal profile, report life events, make eligible benefits elections and qualifying enrollment changes, and also have access to a complete document library.

- **BEGIN** using iNavigator by going to <https://marshallsterling.employeeenavigator.com>
- **FIRST TIME** users will select “Register as a new user” to create a User Name and Password. We highly recommend using a work email for your username, if possible, to help make it easier to remember. You will need your Company Identifier, which is: **NECSD**
- **EXISTING** users will proceed by logging in with their username and password. See below if you have forgotten your username or password.



To Enroll in Benefits

1. If you are a first time user, after you have completed any onboarding tasks, you will be led to begin your enrollments. If you skip them during registration, or if you are a returning user, click Start Enrollments from your home screen.
2. Complete your personal information – please note all fields will be required. Click “Save and Continue”.
3. Complete dependent information. You can “add dependents” and fill out the needed information. When all dependents have been added, click “Save and Continue”
4. From here you will be taken one by one through each benefit your company offers. If a certain benefit allows dependents to be enrolled, you will see a section at the top “Who am I enrolling?”, where you can click off each dependent that you want to enroll on that individual plan.
5. You can select “Compare” to compare plans if more than one is offered, or click “Details” for information on an individual plan. There will be a column on the right for helpful resources, which will contain benefit summaries or any other needed information. As you make each selection, click “Save and Continue”
6. If any of your selections require forms to be filled out (i.e. a beneficiary form for a life insurance plan), these forms will immediately pop-up after that benefit has been elected and must be filled out.
7. Lastly, upon completion of enrollment, you will be prompted to sign your benefits, and then may print a copy of your enrollment summary. **Enrollment is not complete until you “Click to Sign” on your enrollment summary and see the checkmark that says “acknowledged and Submitted”.**

Forgot Your Username and/or Password?

1. Click on “Reset Password”
2. Under “Employees”, select “Click Here”
3. Enter your username and select “Next”
 - If you have forgotten your username, click “Don’t know your username?” Otherwise, skip to step #4. You will be asked for your company identifier (see above), first and last name, and your PIN, which is the last four digits of your SSN. Fill in these fields and select “Request a Reset”. You will see “Password Reset Has Started” and you will be prompted to check your email for instructions. Proceed with step #5.
4. Enter your birth year for verification. You will see “Password Reset Has Started” and you will be prompted to check your email for instructions.
5. Go to your email and click on “Password Reset” and enter new password. Select “Change Password” after entering. Don’t forget – passwords must be between 6 and 20 characters and include both a number and a symbol.
6. You should now be logged in and you will receive an email that your password has been reset.



Medical



You can select a medical plan option or waive coverage altogether, if you're covered under another plan (for example, a spouse's plan). You may choose the medical plan options that best suits your individual or family needs. The **NYSHIP** and **MVP PPO** (Preferred Provider Organization) plans contain in and out-of-network benefits. Benefits are determined at the point the member decides to use either in-network or out-of-network services, giving the members greater freedom of choice. When a member remains in-network or uses a participating provider, benefits are provided with lower out of pocket expenses and no deductible or claim forms. Members choosing out-of-network benefits will have reduced benefits and higher out of pocket costs.

Plan Features	NYSHIP	
	In-Network Only	Out-of-Network
Deductible / Maximum Period	Calendar Year (1/1-12/31)	
Calendar Year Deductibles (Indiv / Family)	N/A	\$1,250 per enrollee
Deductible Type	N/A	Embedded
Calendar Year Out-of-Pocket Max (Indiv / Family)	Medical: \$5,150/10,300 RX: \$2,750/\$5,500	\$3,750 per enrollee
Out-of-Pocket Type	Embedded	Embedded
Medicare Part D Coverage	Creditable	
Referral Needed	No	
Network	The Empire Plan	N/A
HRA Funding	N/A	N/A
Preventive Care	Covered in Full	20% Co-insurance after Deductible
Primary Care Visit	\$25 Copay	20% Co-insurance after Deductible
Specialist Visit	\$25 Copay	20% Co-insurance after Deductible
Diagnostic Lab	Office: \$25 Copay Outpatient: \$40 Copay	Office: 20% Co-insurance after Deductible Outpatient: 10% or \$75 Coinsurance after deductible (whichever is greater)
X-Rays		
Complex Images		
Prenatal Office Visit	Covered in Full	20% Co-insurance after Deductible
Delivery (Maternity)	Covered in Full	20% Co-insurance after Deductible
Inpatient Services (Maternity)	Covered in Full	10% Co-insurance after Deductible
Hospital Outpatient Services	Office: \$25 Copay Non-Hospital: \$50 Copay Hospital: \$95 Copay	Office: 20% Co-insurance after Deductible Outpatient: 10% or \$75 Coinsurance after deductible (whichever is greater)
Hospital Inpatient Services	Covered in Full	10% Coinsurance after Deductible
Mental Health Outpatient Services	\$25 Copay	20% Co-insurance after Deductible
Emergency Room	\$100 Copay	\$100 Copay
Land/Air Ambulance	\$70 Copay	\$70 Copay
Urgent Care	Office: \$30 Copay Hospital Owned Urgent Care: \$50 Copay	Office: 20% Co-insurance after Deductible Hospital Owned: 10% or \$75 Coinsurance after deductible (whichever is greater)
Retail Pharmacy / RX (30 Day Supply)	\$5 / \$30 / \$60	Claims for your out-of-pocket costs may be eligible for partial reimbursement
Retail Pharmacy / RX (31-90 Day Supply)	\$10 / \$60 / \$120	
Mail Order Pharmacy / RX (90 Day Supply)	\$5 / \$55 / \$110	

• Aggregate Deductible: The entire family deductible must be met before copay or coinsurance is applied for any individual family member.

• Embedded Deductible: Each covered family member only needs to satisfy his/her individual deductible, not the entire family deductible, prior to receiving plan benefits.

• Inpatient admissions, outpatient surgery, x-rays, high level imaging, mental health and substance abuse require preauthorization. Please refer to your Certificate of Coverage for detailed information.

You can select a medical plan option or waive coverage altogether, if you're covered under another plan (for example, a spouse's plan). You may choose the medical plan options that best suits your individual or family needs. The **NYSHIP** and **MVP PPO** (Preferred Provider Organization) plans contain in and out-of-network benefits. Benefits are determined at the point the member decides to use either in-network or out-of-network services, giving the members greater freedom of choice. When a member remains in-network or uses a participating provider, benefits are provided with lower out of pocket expenses and no deductible or claim forms. Members choosing out-of-network benefits will have reduced benefits and higher out of pocket costs.

Plan Features	MVP PPO plan	
	In-Network	Out-of-Network
Deductible / Maximum Period	Calendar Year (January 1-December 31)	
Plan Year Deductibles (Indiv / Family)	\$2,500 / \$5,000	\$5,000 / \$10,000
Deductible Type	Aggregate	Aggregate
Plan Year Out-of-Pocket Max (Indiv / Family)	\$2,500 / \$5,000	\$10,000 / \$20,000
Out-of-Pocket Type	Embedded	Aggregate
Medicare Part D Coverage	Creditable	Creditable
Referral Needed	No	No
Network	MVP Preferred HD PPO and Cigna National	N/A
HRA Funding	\$2,500 / \$5,000	See Page 9
Preventive Care	Covered in Full	20% Co-insurance after Deductible
Primary Care Visit	Covered in Full after Deductible	20% Co-insurance after Deductible
Specialist Visit	Covered in Full after Deductible	20% Co-insurance after Deductible
Diagnostic Lab	Covered in Full after Deductible	20% Co-insurance after Deductible
X-Rays	Covered in Full after Deductible	20% Co-insurance after Deductible
Complex Images	Covered in Full after Deductible	20% Co-insurance after Deductible
Prenatal Office Visit	Covered in Full	20% Co-insurance after Deductible
Delivery (Maternity)	Covered in Full after Deductible	20% Co-insurance after Deductible
Inpatient Services (Maternity)	Covered in Full after Deductible	20% Co-insurance after Deductible
Hospital Outpatient Services	Covered in Full after Deductible	20% Co-insurance after Deductible
Hospital Inpatient Services	Covered in Full after Deductible	20% Co-insurance after Deductible
Mental Health Outpatient Services	Covered in Full after Deductible	20% Co-insurance after Deductible
Emergency Room	Covered in Full after Deductible	Covered in Full after Deductible
Land/Air Ambulance	Covered in Full after Deductible	Covered in Full after Deductible
Urgent Care	Covered in Full after Deductible	20% Co-insurance after Deductible
Retail Pharmacy / RX (30 Day Supply)	Covered in Full after Deductible	In-Network Only
Mail Order Pharmacy / RX (90 Day Supply)	Covered in Full after Deductible	In-Network Only

• Aggregate Deductible: The entire family deductible must be met before copay or coinsurance is applied for any individual family member.

• Aggregate Out-of-Pocket Maximum: The entire family out-of-pocket maximum must be met, at which time medical services would be covered 100% for remainder of the plan year.

• Inpatient admissions, outpatient surgery, x-rays, high level imaging, mental health and substance abuse require preauthorization. Please refer to your Certificate of Coverage for detailed information.

Health Reimbursement Account

Plan Year: January 1, 2021 to December 31, 2021



How your health reimbursement account works:

- 1** Your employer deposits money
Into your HRA.

In-Network

\$2,500 Employee/Individual/Self

\$5,000 Employee/Spouse/Family

Out-of-Network

\$4,000 Employee/Individual/Self

\$7,000 Employee/Spouse/Family

Out-of-Network for Co-insurance

\$3,000 Employee/Individual/Self

\$4,000 Employee/Spouse/Family



- 3** 100% of the Single/Family in-network deductible
will be paid automatically from your account.

Employee/Individual/Self is responsible for the first \$1,000/\$3,000 in out-of-network deductible expenses. The remaining \$4,000/\$7,000 out-of-network deductible will be paid automatically from your account.

Employee/Individual/Self is responsible for the first \$2,000/\$6,000 in out-of-network co-insurance expenses. The remaining \$3,000/\$4,000 out-of-network co-insurance will be paid automatically from your account.



- 2** Show your showyour medical ID card
and bring your HRA card to swipe at the
pharmacy.

- Doctor submits services to insurance.
- After the pharmacist processes the claim through MVP, they will ask for payment at time of service. Use your HRA card to make the payment
- If Rx applies to the deductible, the cost of medication will be paid automatically.



- 4** MVP Healthcare® will pay provider
directly for all non-pharmacy claims. Save
copy of your EOB. MVP may contact you
asking to provide documentation to verify
charge.

Questions Regarding HRA benefit should
be directed as follows;
mypendingaccounts@mvphealthcare.com
(888) 222-9931

Substantiation

Always keep your receipts. According to IRS guidelines, all transactions must be verified for coverage. Members may be required to submit all applicable EOBs as proof they have accumulated the \$2,500/\$5,000 in in-network deductible expenses or for the \$4,000/\$7,000 in out-of-network deductible expenses or for the \$3,000/\$4,000 in out-of-network Co-insurance as deemed by MVP to be reimbursed by the HRA.

Filing Claims

EOBs can be accessed through the member's Log-In via www.mvphealthcare.com

All Manual Claims must be submitted with an MVP Manual Claim form and an itemized bill from the Provider.

MVP Healthcare

P.O. Box 2207

Schenectady, NY 12301

Fax: (585) 327-5746

Claims Run-Out Period

The MVP HRA has a 90 day run out period from January 1st, 2021 to March 31st, 2021 for the previous plan year (January 1st, 2020 to December 31st, 2020). If a claim comes in during the run out, MVP will pay it from the HRA in the same way that MVP does during the plan year. If the member paid out-of-pocket for a service, they will need to submit to the HRA for a reimbursement. However, if it is discovered that the provider billed MVP and MVP also paid that provider from the HRA (in addition to the member paying the provider out-of-pocket), the member will need to go back to the provider to get a reimbursement.



Pharmacy Benefits Overview



Your MVP Health Care® (MVP) pharmacy benefits cover thousands of medications on the MVP approved drug list. Choose from a vast selection of participating pharmacies, or take advantage of convenient mail and specialty pharmacy services through CVS Caremark®, MVP's Pharmacy Benefit Manager for retail, specialty, and mail service prescription drug coverage. Generally, benefits are available for up to a 30-day supply of medically necessary prescription medications at a participating local retail pharmacy and may allow up to a 90-day supply through the CVS Caremark Mail Service Pharmacy.

The MVP Prescription Drug Formulary

The MVP Formulary is our approved list of covered medications that are proven safe and effective, and provide clinical value to treat your condition. The Formulary also lists medications that require prior authorization, are subject to step therapy* or quantity limits, or are available through mail delivery.

Formulary Co-Pays

The Formulary is divided into tiers to make it easier for you and your doctor to choose the most appropriate, lowest cost drug. Check your prescription drug rider, schedule of benefits, or summary plan description to find your co-pay for each tier.

- **Tier 1**—With the lowest co-pay, drugs in Tier 1 generally include FDA-approved generic drugs that are as safe and effective as their brand-name counterparts.
- **Tier 2**—At a mid-range co-pay, these are preferred brand-name drugs and also may include generics.
- **Tier 3**—This highest co-pay tier includes brand-name drugs and new drugs that are in the review process.

Brand/Generic Difference Program

FDA-approved generic drugs have a lower co-pay and offer the same clinical benefits as the brand-name drug. If you and your doctor determine that you must use the brand-name drug, you may be responsible for the generic co-pay plus the difference in cost between the generic and the brand-name drug.

Specialty Medications

CVS Specialty® dispenses injectable and oral medications that treat specialty conditions or are high cost, and provides these valuable services:

- Pharmacy-trained clinical teams, which include pharmacists and nurses, offer support and answer patient and physician questions about medications for complex medical conditions.
- Ancillary supplies, such as syringes and needles, are provided at no additional cost.

To learn how to order a prescription or to see if a medication is available through the specialty pharmacy, visit mvphealthcare.com and select *Members*, then *Prescription Benefits*. You can also check with your local retail CVS Pharmacy® to see if your specialty medication is available.

Mail Service Pharmacy

If your benefit allows, maintenance medications that are taken on a regular basis are available by mail service. Save time and money when you buy these drugs in larger quantities and have them delivered right to your door. Your co-pay for a 90-day supply of medication will generally be less than going to a local retail pharmacy monthly for the same amount of medication.



Visit mvphealthcare.com and select *Members*, then *Prescription Benefits* for the current Formulary and Preventive Drug Lists. If you have questions about your Prescription Drug Benefit, call the MVP Customer Care Center at the number on the back of your MVP Member ID card.

*In some cases, MVP may require you to first try one drug to treat your medical condition before covering another drug for that condition.

This is a summary of certain general aspects of MVP Health Care Prescription Drug Benefits, which may vary by employer plan, product, or service area. Check with your employer for details. Consult your plan documents for a complete list of covered benefits, limitations, and exclusions. Formulary information is available by calling the MVP Customer Care Center. Pharmacies and providers participating in our network and mail order vendors are independent contractors and are neither employees nor agents of MVP Health Care or its affiliates. This summary is not an offer of coverage. If there are any differences between the information contained herein and a specific plan document, the plan document will be controlling.

CVS Caremark employees are trained regarding the appropriate way to handle your private health information. 106-52484A 081120

MVPCCMM0005 (07/2020) ©2020 MVP Health Care

MVP Members Save at CVS Pharmacy

Save 20% In Store and Online

Prescription benefits from MVP include a discount on CVS Pharmacy brand health-related items*.

- **Save 20% on thousands of products**, including over-the-counter medications (such as allergy, cold and flu, or pain relievers), contact lens solution, first aid, and oral hygiene products.¹
- Use your discount at any CVS Pharmacy location or online at [cvs.com](https://www.cvs.com).
- This program is included with most MVP prescription plans at no additional cost to you.

Online and On-the-Go with MVP and CVS Caremark

Your MVP membership comes with a variety of online tools to help you with your prescription drug benefits. *Sign In* to your member account at mvphealthcare.com and select *Pharmacy (CVS Caremark)*. Stay up to date on medication costs, manage your personal health and wellness information, and search for generic medication alternatives to save money.

Find Ways to Save

From using generic medicines to setting up mail order service for maintenance medications, you can choose the right ways to save money based on your plan and prescriptions.

Order Prescriptions

Purchase qualified maintenance drugs—at a savings to both you and MVP—and have them delivered right to your door. Use the *Find a Pharmacy* tool at mvphealthcare.com to locate participating pharmacies near your home or within a specific zip code.

Get information About Medications

Learn more about specific drug interactions and possible side effects.

Start Saving Today

If you already have an MVP ExtraCare Health Card, just present it when you make purchases at CVS. New members can visit bit.ly/extracarehealth to get started, or call **1-800-SHOP-CVS** if you need help.

Download the CVS Caremark Mobile App

- Refill and renew mail service prescriptions.
- Identify unknown pills from the Pill Identifier.
- Check for drug interactions among medications.
- Check order status and prescription history.
- Check drug coverage and costs.
- Find local pharmacies.

Visit caremark.com/mobile for more information.



*The 20% discount is restricted to items purchased for the cardholder, spouse, or dependents.

¹Excludes prescriptions, alcohol, tobacco, lottery tickets, postage stamps, gift cards, money orders, prepaid cards, and photofinishing, and is not valid on other items reimbursed by a governmental program. Some exclusions apply. Not available with all plans.

Health benefit plans are issued or administered by MVP Health Plan, Inc.; MVP Health Insurance Company; MVP Select Care, Inc.; and MVP Health Services Corp., operating subsidiaries of MVP Health Care, Inc. Not all plans available in all states and countries.

BRAND/GENERIC DIFFERENCE PROGRAM

The Brand/Generic Difference Program is designed to promote the use of generic medications when there is an equivalent – but more expensive – brand product. Brand/Generic Difference pricing is defined as the difference between the cost of the brand drug and the cost of the generic drug **plus** the member's generic copay. When a brand drug has an FDA approved generic equivalent (also called a multi-source brand), Brand Generic Difference pricing will apply to each prescription.

Less than two percent of all brand drugs are subject to Brand/Generic Difference pricing.

An example of Brand/Generic Difference pricing when a member has a \$10/\$30/\$50 Rx copay plan is as follows:

Brand Drug	cost = \$310.19
Generic (equivalent) Drug	cost = <u>\$208.15</u>
	difference in cost = \$102.04
	plus generic copay + <u>\$ 10.00</u>
	= \$112.04 total member cost for Brand Drug

Highlights and exceptions to the Brand/Generic Difference Program are as follows:

- Brand/Generic Difference pricing does not apply to single source drugs (drugs that do not have a generic equivalent) or generic drugs.
- Brand/Generic Difference pricing applies to formulary and non-formulary drugs.
- May reduce 3rd tier copay; if the cost of the brand drug is less than the Brand/Generic Difference calculation, only the cost of the brand drug will apply. **A member will never pay more than what the drug actually costs.**
- Copay exceptions for medical necessity may be considered on a case-by-case basis. Prescribing practitioners must submit for prior authorization demonstrating that the brand drug is medically necessary over all other formulary products. Requests must indicate "copay exception".

HIGH-DEDUCTIBLE HEALTH PLANS

The Brand/Generic differential dollars do not apply to deductibles or out-of-pocket maximums. Examples of a plan with a \$1,200 deductible, \$10/\$30/\$50 Rx copay and \$2,500 out-of-pocket maximum are as follows:

BEFORE deductible is met	Cost of Brand	\$120.00
\$1,200 deductible,	Cost of Generic	- <u>\$35.00</u>
\$10/\$30/\$50 Rx copay,	Difference	\$85.00
\$2,500 OOP Max		
	Member pays \$120 (cost of the brand) because the deductible has not been met. Of this, \$35 is applied to the deductible and OOP Max	
AFTER deductible is met	Cost of Brand	\$120.00
\$1,200 deductible,	Cost of Generic	- <u>\$35.00</u>
\$10/\$30/\$50 Rx copay,	Difference	\$85.00 + \$10.00 generic copay = \$95.00
\$2,500 OOP Max		
	Since the deductible has been met, member pays the Brand/Generic Difference. Given that the Brand/Generic differential does not apply towards the deductible or OOP Max, only \$10.00 will apply to the OOP Max	

*If there is no copay/coinsurance after a deductible is met, then the member would only pay the difference between the cost of the brand and the cost of the generic drug.

Frequently Asked Questions

MVP PPO Medical Plan and HRA

January 1, 2021 through December 31, 2021



MVP PPO Medical Plan

Q. Will I receive a new MVP ID card?

A. Yes, if you are enrolling in the plan for the first time, you (and spouse) will. If you are already enrolled and not making any plan changes, you will not receive a new card. Please be sure to give this to all your providers and pharmacies to ensure claims are processed correctly with MVP.

Q. What if I need additional card for dependents?

A. Call MVP Customer Care at 1-888-687-6277 -or- go on line to www.mvphealthcare.com to place order –or call Kathy Gordineer M&S Account Manager at 866-573-4768 ext. 2481.

Q. What to do if providers want upfront payment?

A. Show your wallet-sized ID card, which would indicate to providers they should directly bill MVP.

Q. How will Out of Network work?

A. Refer to your benefit guide for details.

Q. How do I find/obtain a copy the plan Summary of Benefits and Coverage (SBC) for my medical plans along with Glossary of Health Coverage and Medical Terms and CHIPRA Notice?

A. This is available on the school intranet and iNavigator employee benefit portal. Upon request, a paper copy will be provided at no charge.

Health Reimbursement Arrangement (HRA)

Q. Will I receive a new HRA debit card?

A. No, only if your card is expiring. The HRA debit cards are good for 3 years.

Q. When do I use my new debit card from MVP?

A. The only time the employee will have to use their HRA debit card is to pay for prescriptions **only!**

Remember to show your pharmacy both your MVP insurance ID card as well as your new HRA debit card

Q. What about non-pharmacy claims?

A. Your HRA includes an integrated reimbursement feature to automate payment of your medical claims. When you get care that is billed to MVP, payment will automatically be deducted from your HRA and sent to your provider on your behalf.

Q. What type of balance notification will enrollees receive regarding debit card?

A. MVP provides a balance statement via monthly email. If you have no access or will not use computer, then you can call MVP Flexible Benefits (HRA) at 1-888-222-9931 to request a statement faxed or mailed to you or you can obtain the balance over the phone.

Q. Will I have online access to my HRA account?

A. Yes, on the MVP HRA member site www.mywealtheonline.com/MVPHealthCare select "Register" to create your unique username and password.

Q. How will Out of Network work?

A. Refer to your benefit guide for details.

Q. What is the turnaround time for payments made by MVP to physician or hospital on enrollee's behalf?

A. Providers remit claims, payments are processed weekly.

Rx Discount Programs

Purchases through a discount program will not apply toward your annual deductible or the annual out-of-pocket max.



www.blinkhealth.com

Same Medication, Same Pharmacy, Lower Price

No matter if you are insured, uninsured or something in between, we offer some of the lowest prices on over 15,000 medications. Simply pay online before you pick up at your pharmacy to save up to 95%. No membership fees. Fully refundable.

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Find savings of up to 95% on over 15,000 medications
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You'll get a Blink Card – that's your proof of purchase. You can print it out. We'll also text it to you.
- **Pick Up At Your Pharmacy**
When your pharmacist asks for payment, show them your Blink Card. You'll pay nothing at the pharmacy.



www.goodrx.com

Stop Paying Too Much For Your Prescriptions!

Every GoodRx collects millions of prices and discounts from pharmacies, drug manufacturers and other sources. Here's how you can use it to save:

- **Use GoodRx's Drug Price Search to Compare Prices**
See which pharmacy near you offers the best price. We don't sell the Medications, we tell you where you can get the best deal on them.
- **GoodRx Will Show You Prices, Coupons, Discounts & Savings Tips**
Get your prescriptions cheaper with deals at pharmacies near you.
- **Download GoodRx's iPhone or Android App**
Get drug prices and coupons on the go.
- **Receive A Discount Savings Card**
Keep your GoodRx card in your wallet for easy access when you need it.

Rx Discount Programs



www.onerx.com

The FREE Rx savings solution for all employees

One Rx mobile solution puts the tools to control prescription drug spending at the fingertips of both insured and uninsured employees. With One Rx...

- **Know Out-of-pocket Costs in Real Time**
Employees save money by seeing their personalized out-of-pocket for a drug being prescribed, right at the point of care.
- **Be Alerted to Insurance Restrictions**
Increase adherence by knowing if step therapy or prior authorization is required before you try to fill the script.
- **Save Instantly**
Redeem Rx coupons & discounts instantly. See local pharmacy pricing.



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"Patient Health & Safety Is Part of Our Company Culture"

DoctorSolve is a trusted, established online pharmacy intermediary with more than 200,000 customers. Every member of their trained and professional staff is committed to ensuring that your health is protected, and you have a trusted source for pure and safe Canadian prescription drugs.

- **A Trusted Source For Prescriptions**
All prescriptions are filled by a professionally registered pharmacist.
- **The Support You Need**
DoctorSolve understands that patients not only require information, but reassurance and support. Their customer service relies on providing unassuming, compassionate advice.
- **Safety Service Guarantee**
Every member of our trained and professional staff is committed to ensuring that your health is protected, and you have a trusted source for pure and safe medication.



Welcome to WellBeing Rewards

Earn **\$600** on your path to well-being!

MVP Health Care® is committed to helping you along your path to better health. By making healthy choices, you can earn up to \$600, per contract, per calendar year, with WellBeing Rewards.*

Earning Rewards is Simple

Earn up to \$200 for completing health-related activities.

Each point is equal to \$1 and can be redeemed in increments of \$50.

Personal Health Assessment <i>Required</i>	50 points
Biometric Screening/Health Risk Screening	100 points
Online Classes <i>(10 points each class completed)</i>	50 points
Quarterly Well-Being Challenges <i>(25 points each challenge completed)</i>	100 points
Email Tips Sign-Up	10 points

Well-Being Attestations

Preventive Screening	30 points
Health Care Literacy	10 points
Physical Fitness	10 points
Mind & Spirit	10 points
Surroundings	10 points
Social	10 points

New! Preventive Screenings

Mammogram	30 points
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New! Diabetic Screenings

Diabetic Retinal Eye Exam	20 points
Diabetic Blood Test (Hba1c)	20 points
Diabetic Urine Test for Protein	20 points

New! Colorectal Cancer Screenings

Points earned for completion of one screening

Colonoscopy	30 points
FIT Test	20 points
Cologuard™	20 points

Track Activity Effortlessly with Connected!

Collect up to \$200 more for tracking your activity with a wearable fitness device or an online app.**

Connected! Activity Tracking

8,000 Steps, 30-Minute Workout, or one Workout via the ASHConnect™ app	1 credit per day
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Receive Reimbursements

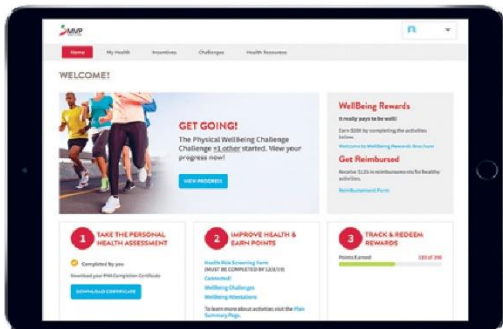
MVP will reimburse you up to \$200 for expenses associated with activities, tools, and online apps that enhance your well-being, like sport memberships, mindfulness apps, park passes, and more.

WellBeing
REWARDS

be active • choose healthy • earn rewards

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Getting Started



1 Access Your MVP Online Account

Visit mvphealthcare.com and *Sign In* or *Register*, then select *Begin Your Path to Well-Being*.

2 Complete Activities and Earn Points

Your well-being homepage is where you see what tasks you have completed and if any still need your attention. From here you can download the *Well-Being Reimbursement* form. Follow the instructions on the form to receive reimbursements.

3 Redeem Your Earned Points

Points can be redeemed in increments of \$50, but you must complete the Personal Health Assessment before the Redeem button will be available on your well-being homepage.

! Issues logging into your MVP online account?

Call MVP eSupport at **1-888-656-5695**.

Important Dates to Remember

January 15

Your program will reset on your well-being homepage, and it will include credit for all activities completed January 1 and forward of the new calendar year.

December 1

The Health Risk Screening form must be submitted to receive points for the calendar year.

December 31

All points must be redeemed, or they will be forfeited permanently.

Well-Being Discounts

Get discounts on popular health and fitness brand products and services, including athletic apparel and gear, activity tracking devices, and fitness equipment with the ChooseHealthy® program.

Enroll in the Active&Fit Direct™ program for access to 11,000+ fitness centers and 1,500+ digital fitness videos for a low monthly fee.

Learn More About MVP WellBeing Rewards

Visit mvphealthcare.com and *Sign In*, then select *Begin Your Path to Well-Being*. Or call the MVP Customer Care Center at the number on the back of your MVP Member ID card.

* This benefit is not available on Vermont Individual and Small Group Standard plans or New York Essential plans. \$600 WellBeing Rewards is offered as a buy-up option on self-funded plans.

** The Healthyroads® program and MVP Health Care do not cover the cost of wearable fitness devices/apps.

WellBeing Rewards is administered in part by Healthyroads, Inc. (Healthyroads). Healthyroads, a well-being program operated by American Specialty Health Management, Inc., (ASH Management), may use and/or provide your plan sponsor, or other entities that have contracted with your plan sponsor to administer your plan, with information (such as program activity points) involving your participation in our programs so that your plan sponsor or its contracted entity can administer the applicable incentive program. ASH Management may also use personal information obtained from your participation in our programs to provide you with other Healthyroads services on behalf of your plan sponsor. By participating in this program, you acknowledge that ASH Management may use and/or provide this information as stated above. If you think you might be unable to meet a standard for a reward under this wellness program, you might qualify for an opportunity to earn the same reward by different means. Contact your plan sponsor and they will work with you (and, if you wish, with your doctor) to find a wellness program with the same reward that is right for you in light of your health status. Incentives may be taxable income that you are responsible to report.

The Healthyroads program is provided by American Specialty Health Management, Inc. (ASH Management), the ChooseHealthy program is provided by ChooseHealthy, Inc., and the Active&Fit Direct program is provided by American Specialty Health Fitness, Inc., all subsidiaries of American Specialty Health, Inc. (ASH). ASHConnect, Healthyroads, ChooseHealthy, and Active&Fit Direct are registered trademarks of ASH and used with permission herein. Other names and logos may be trademarks of their respective owners.

Health benefit plans are issued or administered by MVP Health Plan, Inc.; MVP Health Insurance Company; MVP Select Care, Inc.; and MVP Health Services Corp., operating subsidiaries of MVP Health Care, Inc. Not all plans available in all states and counties.



**MOM'S
MEALS®**



Better Health Begins with the Meals We Eat

At Mom's Meals, our programs are tailored to your needs. When recovering from a hospital stay, we ensure you get the nutrition you need for better health at every stage in life.

Health-Specific Menus

Dietitian designed to support the nutritional needs of most common health conditions

Reliability

High quality, refrigerated meals arrive at your home when you need them the most

Simple

Meals last for 14 days in the fridge—just heat, eat and enjoy in 2 minutes or less

How it Works

- 1** Your MVP Case Manager will call after you are discharged from the hospital
- 2** Mom's Meals will conduct a Welcome Call to confirm your order
- 3** Fourteen meals are delivered to your home

Sample Menu

Your well-being is important to us. Meal by meal, bite by bite, we are with you to provide the nutrition you need.

BREAKFAST

FRUIT BREAKFAST PIZZA
and Turkey Sausage

**HAM, EGG & CHEESE
SCRAMBLE**
and Peaches with Cherries

LUNCH

BEEF STEW
and Corn Bread

**BBQ PULLED PORK
SANDWICH**
and Potato Salad

DINNER

CHEESE LASAGNA
and Spiced Fruit Crisp

**TURKEY BREAST WITH
WILD RICE**
and Spiced Fruit Medley

The Right Nutrition

Menus tailored to meet the needs of most major health conditions.

- ♥ Heart-Friendly
- 🍷 Renal-Friendly
- 💧 Diabetes-Friendly
- 🌾 Gluten Free
- 🥕 Vegetarian
- 🍲 Pureed
- ↓ Lower Sodium
- 🎗 Cancer Support
- ✓ General Wellness

“ Mom’s Meals continues to help me heal. After my surgery, I was told to stay off my feet. Thanks to the ease of your meals, I have been able to do so.

I LOVE IT! ”

- Happy Customer



Contact MVP Health Care® for more information.
1-866-942-7966 (TTY: 1-800-662-1220)
Monday-Friday, 8:30 am — 5 pm
Eastern Time

When you need care...

Start with

GiaSM



Helping you get the right care, right away!

Chronic issues, sudden symptoms, accidents or anxiety, questions and concerns...we all need care from time to time. But where should you turn first? **Start with GiaSM—included free with your health plan from MVP Health Care[®] (MVP)!**

Gia is your ultimate health care connection.

Available 24/7 by mobile app, phone, or web, Gia expertly assesses your health needs and quickly refers you to the right care. You can also use Gia's simple but powerful search tool, giving you helpful and relevant health information you can trust.

Gia saves you time and money.

Get instant advice about any health care concern, from home or anywhere. And, Gia will refer you to the care you need—MVP's FREE telemedicine services or, when necessary, in-person care from nearby doctors, specialists, labs, pharmacies, and more.

Gia is your connection to MVP's FREE telemedicine services.

Including:

- 24/7 Emergency Care and Urgent Care
- Mental Health and Psychiatry
- Primary Care
- Physical Therapy*
- And more

Ready to get started? See reverse for more details.



It's easy to get started with *Gia*SM

1. Download the free **Gia by MVP** app or visit **GoAskGia.com**.

The **Gia by MVP** app is available on the App Store® or on Google Play.™



2. Create an account.

If registering via the **Gia** app, launch the app, select *Create New Account*, and follow the prompts.

If registering via **GoAskGia.com**, complete the required fields, and follow the additional prompts.

Have your MVP Member ID card handy!



You'll be asked to provide basic information, such as your name and email, date of birth, and MVP Subscriber or Member ID. Once your health insurance information is verified, your account will be created.



3. Start with **Gia**.

Once you've created an account, simply choose how you want to connect.

- Use the **Gia by MVP** app
- Visit **GoAskGia.com**
- Call **1-877-GoAskGia** (1-877-462-7544)

It's just one more way that MVP is making health insurance more convenient, more supportive, and more personal for you.

*Available on Large Group and select ASO plans.

Telemedicine services from MVP Health Care are provided by UCM Digital Health, Amwell and Physera at no cost-share for members. (Plan exceptions may apply.) Members' direct or digital provider visits may be subject to co-pay/cost-share per plan.

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Health benefit plans are issued or administered by MVP Health Plan, Inc.; MVP Health Insurance Company; MVP Select Care, Inc.; and MVP Health Services Corp., operating subsidiaries of MVP Health Care, Inc. Not all plans available in all states and counties.

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Gia_CommPT (1/21)

Resources

Before Enrolling, be sure to:

- **Consider your options.** Make sure you get the coverage that best suits your needs. Discuss with your spouse, partner or other family members to consider all sources of benefits coverage.
- Our insurance carriers offer a number of tools and resources available through their web sites that can help support your decision making process. You can reach the carriers at:



NYSHIP

www.empireplanproviders.com/provider.htm

(877) 769-7447

MVP

www.mvphealthcare.com

(888) 687-6277

MVP Flexible Benefits
(HRA)

www.mywealthcareonline.com/mvphealthcare

(888) 222-9931

Marshall & Sterling – Rachel Kelly

rkelly@marshallsterling.com

Marshall & Sterling – Jamie Dunne

jdunne@marshallsterling.com

Keep this guide handy - refer to the information in this guide to help you make wise benefit choices.



New Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: General Information

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

What is the Health Insurance Marketplace?

The Marketplace is designed to find health insurance that meets your needs and fits your budget. The Marketplace offers “one-stop shopping” to find and compare private health 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 2011 for coverage starting as early as January 1, 2012.

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.

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. 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% of such costs.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact:

Keisha Martinez
Health Benefits Specialist
(845) 563-3467
kmartinez@necsd.net

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

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

General Group Health Plan Notices

Patient Protection Disclosure Notice

If your health plan generally allows the designation of a primary care provider, you have the right to designate any primary care provider who participates in the network and who is available to accept you or your family members. For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from your health insurance carrier or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in your network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals.

The Women's Health and Cancer Rights Act of 1998

Do you know that your plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services, including all stages of reconstruction and surgery to achieve symmetry between the breasts, prosthesis and complications resulting from a mastectomy, including lymph edema? Contact your employer for more information.

The Women's Health and Cancer Rights Act (WHCRA), signed into law on October 21, 1998, contains protections for patients who select breast reconstruction in connection with a mastectomy. Plans offering coverage for a mastectomy must also cover reconstructive surgery and other benefits related to a mastectomy.

Women's Health and Cancer Rights Act (WHCRA):

- Applies to group health plans for plan years starting on or after October 21, 1998.
- Applies to group health plans, health insurance companies or HMOs, if the plan or coverage provides medical and surgical benefits with respect to mastectomy.
- Requires coverage for reconstructive surgery in a manner determined in consultation with the attending physician and the patient.

Under WHCRA, mastectomy benefits must include coverage 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;
- Prosthesis and treatment of physical complications of the mastectomy, including lymph edema;

Under WHCRA mastectomy benefits may be subject to annual deductibles and coinsurance consistent with those established for other benefits under the plan or coverage. Therefore, the following **in-network** copays, deductibles and coinsurance apply:

Benefit	NYSHIP	MVP PPO HDHP
Deductible	N/A	\$2,500 / \$5,000
PCP Office Visit	\$25 Copay	0% Co-insurance after deductible
Specialist Office Visit	\$25 Copay	0% Co-insurance after deductible
Inpatient Hospital Admission	No Charge	0% Co-insurance after deductible
Emergency Room	\$100 Copay	0% Co-insurance after deductible

The law also contains prohibitions against:

- Plans and issuers denying patients eligibility or continued eligibility to enroll or renew coverage under the plans to avoid the requirements of WHCRA.
- Plans and issuers providing incentives to, or penalizing, physicians to induce them to provide care in a manner inconsistent with the WHCRA.

If you would like more information on WHCRA benefits, call your plan administrator.

Newborns' and Mothers' Health Protection Act

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

HIPAA Special Enrollment Rights

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

In addition, this special enrollment opportunity will not be available when other coverage ends unless you provide a written statement now explaining the reason that you are declining coverage for yourself or your dependent(s). Failing to accurately complete and return this form for each person for whom you are declining coverage will eliminate this special enrollment opportunity for the person(s) for whom a statement is not completed, even if other coverage is currently in effect and is later lost. In addition, unless you indicate in the statement that you are declining coverage because other coverage is in effect, you will not have this special enrollment opportunity for the person(s) covered by the statement. (See the paragraph below, however, regarding enrollment in the event of marriage, birth, adoption or placement for adoption.)

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

A special enrollment opportunity may be available in the future if you or your dependent(s) lose other coverage. This special enrollment opportunity will not be available when other coverage ends, however, unless you provide a written statement now explaining the reason that you are declining coverage for yourself or your dependent(s). Failing to accurately complete and return this form for each person for whom you are declining coverage will eliminate this special enrollment opportunity for the person(s) for whom a statement is not completed, even if other coverage is currently in effect and is later lost. In addition, unless you indicate in the statement that you are declining coverage because other coverage is in effect, you will not have this special enrollment opportunity for the person(s) covered by the statement. (See the paragraph above, however, regarding enrollment in the event of marriage, birth, adoption or placement for adoption.)

Effective April 1, 2009 special enrollment rights also exist in the following circumstances:

- If you or your dependent(s) experience a loss of eligibility for Medicaid or your State Children's Health Insurance Program (SCHIP) coverage; or
- If you or your dependent(s) become eligible for premium assistance under an optional state Medicaid or SCHIP program that would pay the employee's portion of the health insurance premium.

Note: In the two above listed circumstances only, you or your dependent(s) will have sixty (60) days to request special enrollment in the group health plan coverage. An individual must request this special enrollment within sixty (60) days of the loss of coverage described at bullet one, and within sixty (60) days of when eligibility is determined as described at bullet two. To request special enrollment or obtain more information, contact your HR representative.

Keisha Martinez
Health Benefits Specialist
(845) 563-3467
kmartinez@necsd.net

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call 1-866-444-EBSA (3272).

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list includes states where employees currently reside which offer a premium assistance program as of July 31, 2020. Contact your State for more information on eligibility.

If you reside in a different state, please contact HR for more information on whether or not a premium assistance program is available there, as well as State contact information if applicable.

NEW JERSEY – Medicaid and CHIP	NEW YORK - Medicaid
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831

To see if any other states offer a premium assistance program, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-44-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Important Notice About Your Prescription Drug Coverage and Medicare

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

A plan's prescription drug coverage is considered creditable coverage if the amount the plan expects to pay on average for prescription drugs for individuals covered by the plan is the same or more than what standard Medicare prescription drug coverage would be expected to pay on average.

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

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

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with your employer and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

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

For More Information About This Notice Or Your Current Prescription Drug Coverage...

Contact Marshall & Sterling at (866) 573-4768.

Notes

[illegible]

[illegible]

**Marshall
& Sterling**
GROUP BENEFITS

Our People Are Your Best Insurance

www.marshallsterling.com/group-benefits

866-573-4768