Gary Kawlewski
Dir. of Finance & Operations
Buffalo-Hanover-Montrose Schools
Independent School District 877

214 1st Ave NE, Buffalo, MN 55313
P: 763-682-8708 F: 763-682-8785
E: gkawlewski@bhmschools.org
W: www.bhmschools.org

TO: **All Employees**

SUBJECT: **Employee Health Care Exchange Notification**

Dear Employee:

Per the Exchange Notification requirements of the **Patient Protection and Affordable Care Act**, we are informing you of the availability of the Health Insurance Marketplace (aka Exchange) in your state of residence. The attached model notice provides you with the required Exchange Notification information.

It's Your Choice!
While the Exchange provides you with an alternative to your current health plan, it's entirely your choice to stay with your current health plan or enroll in the Exchange. You may:

- Stay in your current health plan or select another plan we offer (if available)
- Choose an Exchange health plan for yourself and/or for your family

Exchange vs. Employer Health Plan Coverage

- The Exchange health plans offer coverage effective dates on or after 1-1-2014.
- The payment of premium for the Exchange programs is your responsibility. Your exchange premiums will NOT be payroll deducted. You will have to pay the Exchange directly; with after-tax dollars. This is different from your current health plan contributions that are paid with pre-tax dollars through the convenience of payroll deduction.
- If you choose to elect Exchange coverage you will forfeit the contributions you would otherwise receive for the cost of your current employer-sponsored coverage.
- If you choose to leave your current health plan, you will not be able to re-enroll until our next annual open enrollment period unless you have a "life qualifying event" such as loss of your spouse's employment, change in marital status, death or birth of a child, etc.

Have Exchange questions? If you live in Minnesota, please visit **MNsure.org** or call MNsure's customer service number: **1-855-366-7873**.

If you live in Iowa, North Dakota, South Dakota or Wisconsin, please visit: **HealthCare.gov** for exchange information.

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 1-31-2017)

PART A: General Information

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

What is the Health Insurance Marketplace?

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

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

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

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

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

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

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact Gary Kawlewski, Director of Finance & Operations, 763.682-8708.

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

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

PART B: Information About Health Coverage Offered by Your Employer

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

3. Employer name Independent School District 877		4. Employer Identification Number (EIN) 41-6004776
5. Employer address 214 1st Ave NE		6. Employer phone number 763-682-8700
7. City Buffalo	8. State MN	9. ZIP code 55313
10. Who can we contact about employee health coverage at this job? Gary Kawlewski		
11. Phone number (if different from above) 763-682-8708	12. Email address gkawlewski@bhmschools.org	

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:
  - ☐ All employees. Eligible employees are:
  - ☑ Some employees. Eligible employees are:

    See attached eligibility information.

- With respect to dependents:
  - ☑ We do offer coverage. Eligible dependents are:

    See attached eligibility information.

  - ☐ We do not offer coverage.

☐ If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, HealthCare.gov will guide you through the process. Here's the employer information you'll enter when you visit HealthCare.gov to find out if you can get a tax credit to lower your monthly premiums.

ELIGIBILITY

Eligible Employees

Full-time employees working a minimum of 30 hours per week are eligible.

This Plan covers only those employees who work in the United States (U.S.) or its Territories. Employees who work and reside in foreign countries are not eligible for coverage. Employees who are U.S. citizens or permanent residents of the U.S. working outside of the U.S. on a temporary basis are eligible.

Eligible Dependents

NOTE: If both you and your spouse are employees of the employer, you may be covered as either an employee or as a dependent, or both. Your eligible dependent children may be covered under either parent's coverage, but not both.

Spouse

1. Married spouse.

Dependent Children

1. Natural-born dependent children to age 26.

2. Legally adopted children and children placed with you for legal adoption to age 26. Date of placement means the assumption and retention by a person of a legal obligation for total or partial support of a child in anticipation of adoption of the child. The child's placement with a person terminates upon the termination of the legal obligation of total or partial support.

3. Stepchildren to age 26.

4. Dependent children for whom you or your spouse have been appointed legal guardian to age 26.

5. Grandchildren to age 26 who live with you continuously from birth and are financially dependent upon you.

6. Otherwise eligible children of the employee who are required to be covered by reason of a Qualified Medical Child Support Order (QMCSO), as defined in Minnesota statute §518A.41. The Plan has detailed procedures for determining whether an order qualifies as a QMCSO. You and your dependents can obtain, without charge, a copy of such procedures from the Plan Administrator.

Disabled Dependents

1. Unmarried disabled dependent children who reach the limiting age while covered under this Plan if all of the following apply:

    a. primarily dependent upon you;

    b. are incapable of self-sustaining employment because of physical disability, developmental disability, mental illness, or mental disorders;

    c. for whom application for extended coverage as a disabled dependent child is made within 31 days after reaching the age limit. After this initial proof, the Claims Administrator may request proof again two (2) years later, and each year thereafter; and

    d. must have become disabled prior to reaching limiting age.

2. Disabled dependents if both of the following apply:

   a. incapable of self-sustaining employment by reason of developmental disability, mental illness or disorder, or physical disability; and

   b. chiefly dependent upon the group member for support and maintenance.

Preexisting Condition Limitation for Late Entrants - age 19 and older

A preexisting condition limitation applies to Late Entrants - age 19 and older. A preexisting condition is defined as a medical condition for which medical advice, diagnosis, care, or treatment was recommended or received during the six (6) months immediately preceding the enrollment date.

For such a condition, benefits for you and your covered dependents will be payable only after a period of 18 consecutive months beginning from the enrollment date. This period will be reduced by any prior continuous qualifying creditable coverage, provided no gap in coverage greater than 63 days has occurred. At your request and with appropriate authorization the Claims Administrator will assist you in obtaining a certificate of creditable coverage from your prior plan.

Preexisting condition does not include genetic information alone in the absence of a diagnosis for a condition related to the genetic information, or an existing pregnancy.

Effective Date of Coverage

Coverage for you or your eligible dependents who were eligible on the effective date of the Plan will take effect on that date.

Adding New Employees

1. If the Plan Administrator receives your application within 30 days after you become eligible, coverage for you and your eligible dependents starts on the first of the month following the date of eligibility.

2. If the Plan Administrator receives your application more than 30 days after you become eligible, you and your eligible dependents will be considered a Late Entrant unless you meet the requirements of the special enrollment period. Please refer to "Coverage Effective Date for Late Entrants" in this section to determine when coverage will begin.

Adding New Dependents

This section outlines the time period for application and the date coverage starts.

Adding spouse and/or stepchildren

1. If the Plan Administrator receives the application within 30 days of the date of marriage, coverage for your spouse and/or stepchildren starts on the date of marriage.

2. If the Plan Administrator receives the application more than 30 days after the date of marriage, your spouse and/or stepchildren will be considered Late Entrants unless your spouse and/or stepchildren meet the requirements of the Special Enrollment Period. Please refer to "Coverage Effective Date for Late Entrants" in this section to determine when coverage will begin.

Adding newborns and children placed for adoption

The Plan Administrator requests that you submit written application to add your newborn child or newborn grandchild within 90 days of the date of birth. Coverage for your newborn child or newborn grandchild starts on the date of birth.

The Plan Administrator requests that you submit written application to add your adopted child within 90 days of the date of placement. Coverage for your adopted child starts on the date of placement.

Adding disabled children or disabled dependents

A disabled dependent may be added to the Plan if the disabled dependent is otherwise eligible under the Plan. Coverage starts the first of the month following the day the Plan Administrator receives the application. A disabled dependent will not be denied coverage and will not be subject to any preexisting condition limitation period.

Special Enrollment Periods

Special enrollment periods are periods when an eligible employee or dependent may enroll in the health plan under certain circumstances **after they were first eligible for coverage**. The eligible circumstances are: 1) a loss of other group health plan coverage; 2) loss of Medical Assistance (Medicaid) or Children's Health Insurance Program (CHIP) coverage; 3) eligibility for premium assistance; or 4) acquiring a new dependent. The request for enrollment must be within 30 days (unless otherwise noted) of the eligible circumstance.

Newborns, newborn grandchildren, and children placed for adoption are eligible as of the date of birth, adoption or placement for adoption - see "Eligible Dependents" in the "Eligibility" section.

1. Loss of Group Health Plan Coverage

   Employees or dependents who are eligible but not enrolled in the health plan may enroll for coverage in the health plan as special enrollees upon a loss of other health plan coverage if all of the following conditions are met:

   a. the employee or dependent was covered under a group health plan or other health insurance coverage at the time coverage was previously offered to the employee or dependent;

   b. the employee must complete any required written waiver of coverage and state in writing that, at such time, other health insurance coverage was the reason for declining enrollment;

   c. the employee’s or dependent’s coverage is terminated because: his/her COBRA continuation has been exhausted (not due to failure to pay premium or for cause), he/she is no longer eligible for the plan due to a divorce, death of the employee, termination of employment, reduction in hours, cessation of dependent status, all employer contributions towards the coverage were terminated, the individual no longer lives or works in an HMO service area, or the individual incurs a claim that would meet or exceed a lifetime limit on all benefits; and

   d. the employee or dependent requests enrollment not later than 30 days after the termination of coverage or employer contribution, or the meeting or exceeding of the lifetime limit on all benefits.

   Coverage for employees or dependents (other than newborns, newborn grandchildren and children placed for adoption – see "Eligibility" section) who are eligible to enroll in the Plan under the Special Enrollment Periods provision will be effective the day after the termination of prior coverage or the date of claim denial due to meeting or exceeding the lifetime limit on all benefits.

2. Loss of Medical Assistance (Medicaid) or Children's Health Insurance Program (CHIP) Coverage

   Employees or dependents who are eligible but not enrolled in the health plan may enroll for coverage in the health plan as special enrollees upon the loss of Medicaid or CHIP coverage if all the following conditions are met:

   a. the employee or dependent was covered under Medicaid or CHIP at the time coverage was previously offered to the group member or dependent;

   b. the employee must complete any required written waiver of coverage and state in writing that, at such time, Medicaid or CHIP coverage was the reason for declining enrollment; and

   c. the employee or dependent must request enrollment no later than 60 days after the termination of Medicaid or CHIP coverage.

3. Eligibility for Premium Assistance

   Employees or dependents who are eligible but not enrolled in the health plan may enroll for coverage in the health plan as special enrollees upon becoming eligible for premium assistance through the Medical Assistance (Medicaid) or Children's Health Insurance Program (CHIP) if all the following conditions are met:

   a. the employer must submit any required documentation indicating that the employee and/or dependents are eligible for premium assistance through Medicaid or CHIP; and;
   b. the employee or dependent must request enrollment no later than 60 days after becoming eligible for premium assistance through Medicaid or CHIP.

4. Acquiring a New Dependent

   Eligible employees who are either enrolled or not enrolled in the health plan may enroll themselves and eligible dependents in the health plan as special enrollees when the eligible employee member experiences a marriage, birth, adoption or placement for adoption. These events provide the eligible employee, spouse or child(ren) the opportunity to apply for coverage under the Plan during Special Enrollment Periods.

   Coverage for employees or dependents (other than newborns, newborn grandchildren and children placed for adoption – see "Eligibility" section) who are eligible to enroll in the Plan under the Special Enrollment Periods provision will be effective on the date of marriage, birth, adoption or placement for adoption.

Coverage Effective Date for Late Entrants

Late entrants - age 19 and older are subject to a preexisting condition limitation period described in the Preexisting Condition Limitations section. Credit will be given for prior continuous qualifying creditable coverage, provided no gap in coverage greater than 63 days has occurred. Coverage for late entrants starts on the first of the month following the day the late application is received.