FAIRFIELD PUBLIC SCHOOLS
Benefit Enrollment
Open Enrollment

Addendum to Employee Self Service User Guide
Version 10.5
https://fairfieldboe.munisselfservice.com

LOG IN:

Username: first initial, last name, last 4 of your social security

ie: jsmith1234

Password: first time log on – the last 4 of your social security

You will be prompted to change it – please make note of it

PLEASE DO NOT CHANGE THE HOME PHONE THAT SAYS PRIMARY. THERE SHOULD BE ONE LISTED BELOW IT – THAT ONE CAN BE CHANGED.

PLEASE DO NOT CHANGE YOUR WORK E-MAIL – ONLY ADD OR UPDATE THE ALTERNATE E-MAIL

PLEASE ADD EMERGENCY CONTACT INFORMATION.

HELP:

Technical Support e-mail contactess@fairfieldschools.org

For questions regarding personal information e-mail hress@fairfieldschools.org

For questions regarding Open Enrollment e-mail insurance@fairfieldschools.org

BENEFIT ENROLLMENT

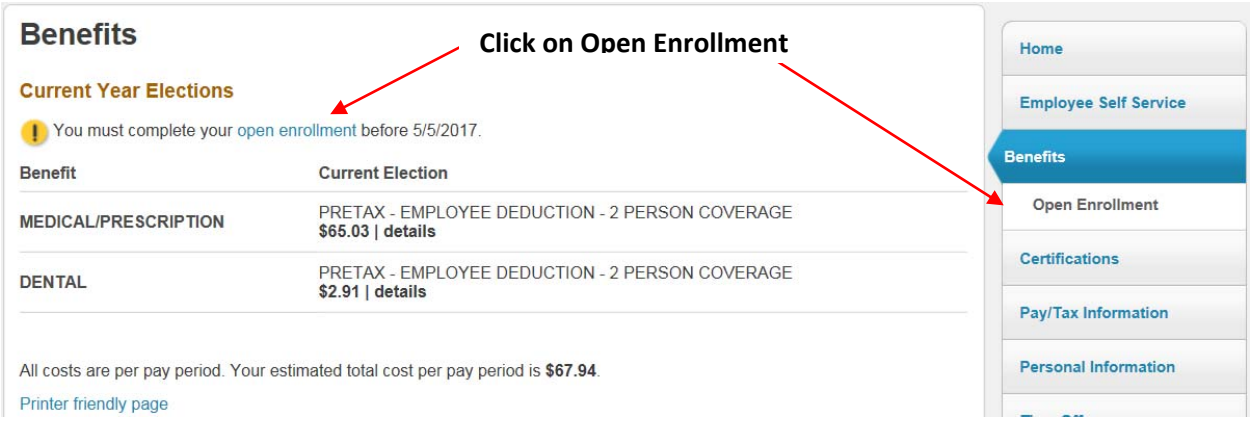
Benefits provides a summary of your current-year benefit elections. Using this option, you can view and change current-year benefits elections and make elections for the upcoming year during the open-enrollment period.

OPEN ENROLLMENT

Log into Employee Self Service (ESS).

Click on Benefits

Your "Current Year Elections" and current cost per pay period will display below. These deduction amounts refers to "estimated" for employees with adjustments and or FSA fees



PLEASE READ THOROUGHLY

Open Enrollment

Make Elections

Your elections have been submitted, but you can still make changes until they are approved.

If you make any further changes, click "Continue" to review and submit them. *You must submit any changes by 5/5/2017.*

Action is required of all benefit eligible employees, whether you want to change your insurance election, maintain current coverage, or decline coverage. Inaction will result in a loss of coverage.

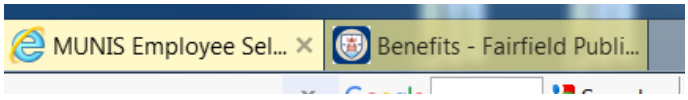
For information about the insurance plans, the Health Enhancement Program (HEP), rates or the Pre-Tax/Post-Tax Options, please visit the Fairfield Public Schools (FPS) website at: http://fairfieldschools.org/faculty-staff/benefits/

IMPORTANT NOTES:

- **Employees that elect the Medical/Prescription coverage for themselves and any eligible family member(s) are encouraged to participate in the Health Enhancement Program (HEP). (CTHEP.com). Failure to participate in HEP and comply with HEP requirements will result in a $100/mo premium cost increase for each month you remain out of compliance; you will also be subject to annual medical deductibles.**
- **Employees that elect the Medical/Prescription coverage for themselves and any eligible family member(s) must provide a social security number for each member enrolled OR you MUST complete the "Oxford SSN Refusal Letter" and return it to the Insurance Department.**
- **If you elect to participate in any of the benefit options below, you authorize Fairfield Public Schools (FPS) to reduce your compensation by the amount of your required contributions that you have elected under the Pre-Tax/Post-Tax Employee Contribution Option. The amount of your required contribution for the 2017-2018 Fiscal Year is set forth on the applicable rate schedule found here http://fairfieldschools.org/faculty-staff/benefits/**
- **Secretaries choosing the "Spouse Not Offered Insurance" options MUST provide a new "Spousal Benefit Affidavit" to be eligible. If the Insurance Department does not receive a new affidavit, you will not be eligible to receive the discounted rates.**
- **10 month Secretaries and, Paraprofessionals have slightly higher per pay period deductions in order to cover the July and August insurance coverage. These deductions are not included in the per pay period calculations below.**

Links have been provided to help you navigate easily to important information. All links are in blue

When you click on a link, if you hold the "Ctrl" (control) key down while clicking on the link, it will open in a new tab.



If you do not hold the "Ctrl" key down, the link will bring you out to the desired site; however, you will need to hit the back button to get back to ESS.

Select the Benefit you would like to make an election for; your choices are

<u>Medical/Prescription and Dental</u> – Decline Benefits – click "Decline benefit"

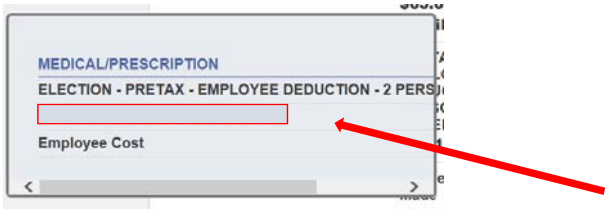
No Changes-to keep the current level of coverage (and dependents)- click "No changes"

Make New Election – to make a change to your current level of coverage, add benefits or to add dependents, click "Make New Election"

<u>Health Care FSA and Dependent Care FSA</u> – Because you must make this election on a yearly basis, You only have a choice to "Decline benefit" or "Make New ` Election"

Benefit	Current Election	New Election	
MEDICAL/PRESCRIPTION	PRETAX - EMPLOYEE DEDUCTION - 2 PERSON COVERAGE $65.03 | details	Election Not Made	Decline benefit | No changes | Make New Election
DENTAL	PRETAX - EMPLOYEE DEDUCTION - 2 PERSON COVERAGE $2.91 | details	Election Not Made	Decline benefit | No changes | Make New Election
HEALTH CARE FSA	No Election Made	Election Not Made	Decline benefit | Make New Election
DEPENDENT CARE FSA	No Election Made	Election Not Made	Decline benefit | Make New Election

To view the details of your current coverage, hover over the word "details"



your dependents will appear here.

To decline the benefit – click "Decline benefit" – New Election column will change from "Election Not Made" to "Declined"

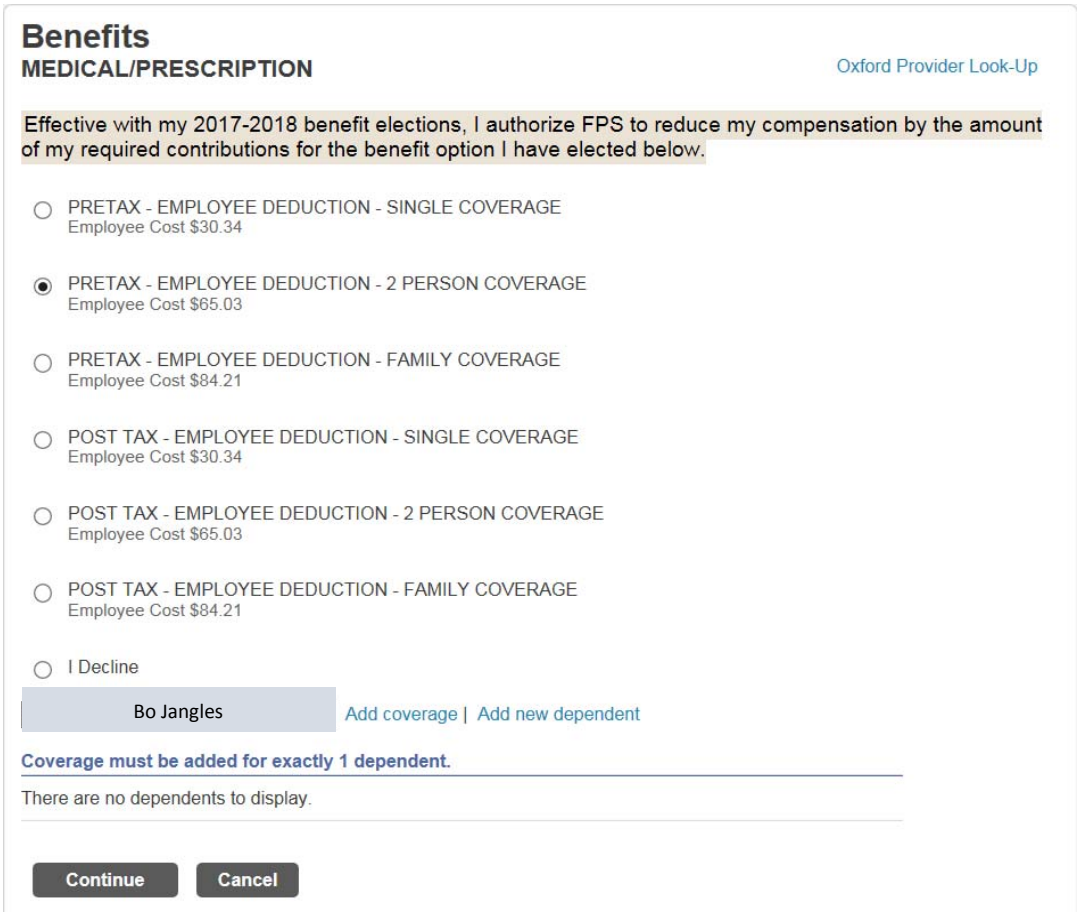
PRETAX - EMPLOYEE DEDUCTION - 2 PERSON COVERAGE	Declined

To keep the same level of benefits, click "No changes" – New Election column will change from "Election Not Made" to a replica of current benefits.

PRETAX - EMPLOYEE DEDUCTION - 2 PERSON COVERAGE	PRETAX - EMPLOYEE DEDUCTION - 2 PERSON COVERAGE

Your dependent information from your current coverage will copy over to new year elections.

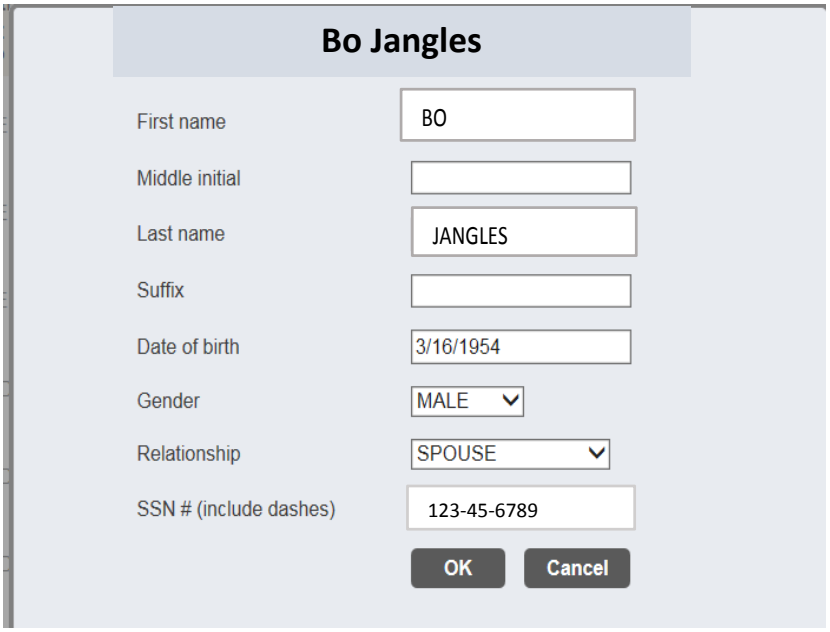
To make a change to your benefits or add the benefit for 2017-2018, click "Make New Election"



Link to Vendor website is provided in the upper right corner

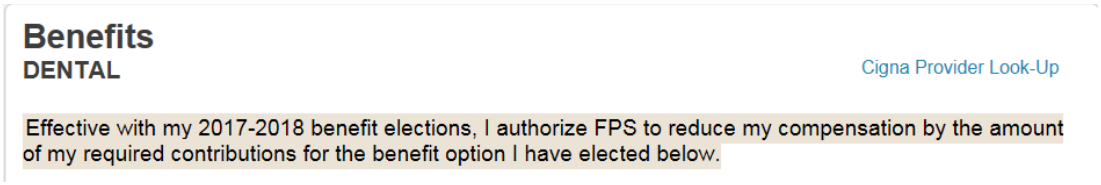
For single coverage you only need to click continue (no dependents involved).

To add a dependent already in our system – click "Add coverage", review the dependent information, and click "OK" – please confirm name and social security number match what is currently on your dependents' social security card; mismatched name and social security errors under the Affordable Care Act (ACA) will be rejected by the IRS.



Your dependent(s) information will appear here. Please confirm prior to adding. If you want your dependents to be covered, you MUST add each one individually.

To add a new dependent – click "Add new dependent" Enter all information, including Social Security Number and click "OK". Please confirm that the name and social security number entered here match what is currently on your dependents' social security card; mismatched name and social security numbers will be rejected by the IRS. If a Social Security number is not added, the "Oxford SSN Refusal Letter" must be completed and provided to the insurance department.



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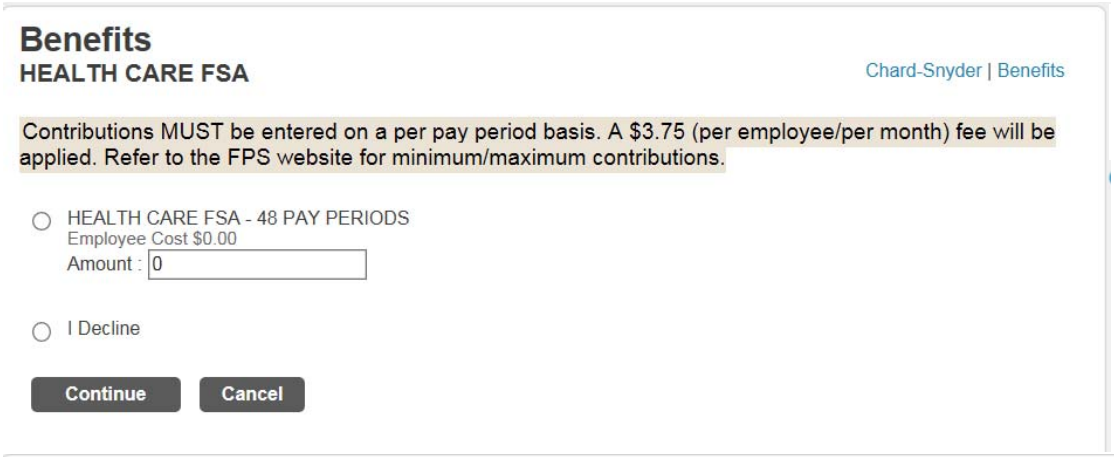

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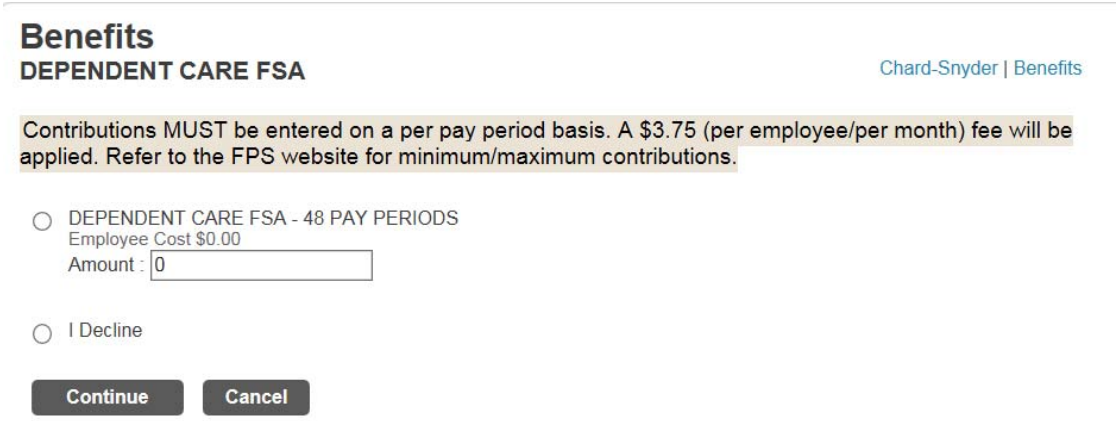


Link to Vendor website is provided in the upper right corner

FSA elections (Health Care and Dependent) must be made on a yearly basis. You only have a choice to "Decline benefit" or "Make New Election"

You MUST make a selection for each benefit option. You will not be allowed to continue if you do not.

Open Enrollment

Please make an election for each benefit before continuing.

Make Elections

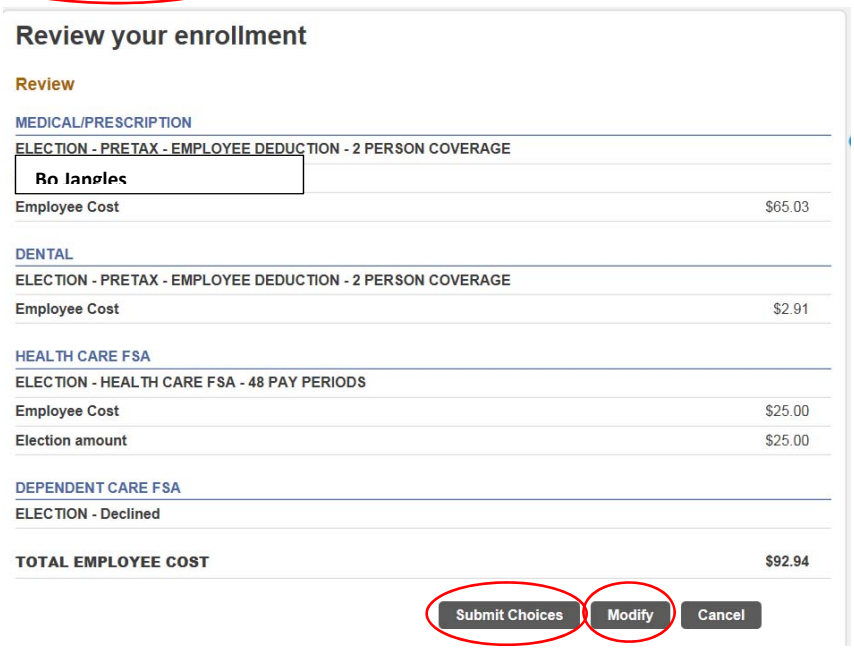
Benefit	Current Election	New Election	
MEDICAL/PRESCRIPTION	PRETAX - EMPLOYEE DEDUCTION - 2 PERSON COVERAGE **$65.03 | details**	PRETAX - EMPLOYEE DEDUCTION - 2 PERSON COVERAGE **$65.03 | details**	Decline benefit | Change New Election
DENTAL	PRETAX - EMPLOYEE DEDUCTION - 2 PERSON COVERAGE **$2.91 | details**	PRETAX - EMPLOYEE DEDUCTION - 2 PERSON COVERAGE **$2.91 | details**	Decline benefit | Change New Election
HEALTH CARE FSA	No Election Made	Election Not Made	Decline benefit | Make New Election
DEPENDENT CARE FSA	No Election Made	Declined	Change New Election

When you are done making your selections, click "Continue"

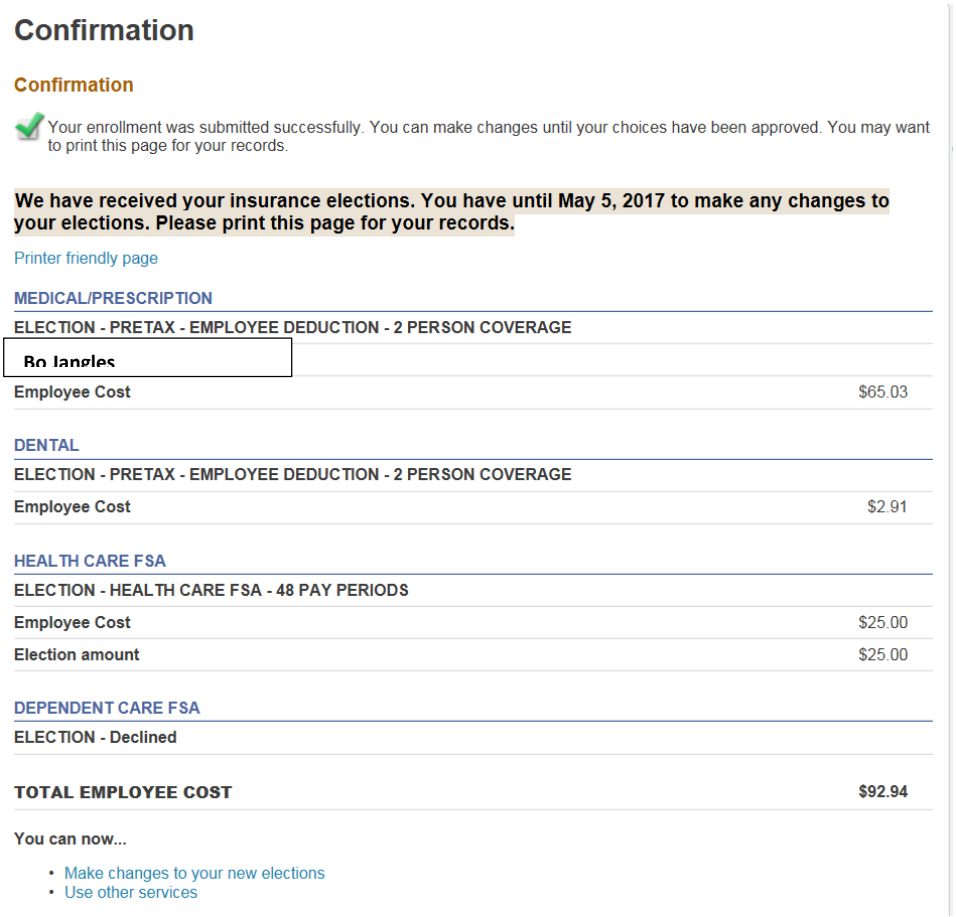
Benefit	Current Election	New Election	
MEDICAL/PRESCRIPTION	PRETAX - EMPLOYEE DEDUCTION - 2 PERSON COVERAGE **$65.03 | details**	PRETAX - EMPLOYEE DEDUCTION - 2 PERSON COVERAGE **$65.03 | details**	Decline benefit | Change New Election
DENTAL	PRETAX - EMPLOYEE DEDUCTION - 2 PERSON COVERAGE **$2.91 | details**	PRETAX - EMPLOYEE DEDUCTION - 2 PERSON COVERAGE **$2.91 | details**	Decline benefit | Change New Election
HEALTH CARE FSA	No Election Made	HEALTH CARE FSA - 48 PAY PERIODS **$25.00 | details**	Decline benefit | Change New Election
DEPENDENT CARE FSA	No Election Made	Declined	Change New Election

Continue

You will be asked to "Review your Enrollment" information. Please verify the elections you made are listed correctly and dependents, if applicable. If not, click on "Modify" and make corrections. If correct, click "Submit Choices".



Once you "Submit Choices" you will receive a Confirmation of your elections. We suggest that you print a copy for your records.



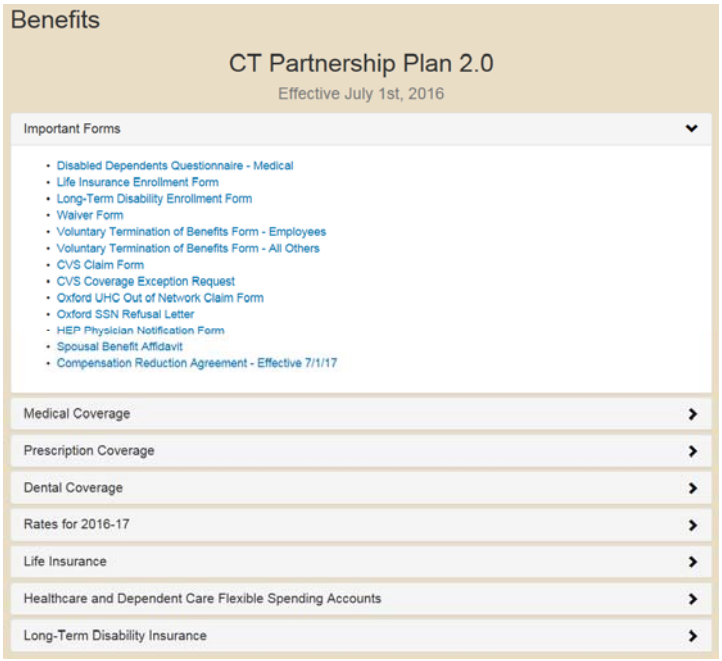
Elections MUST be made on/or before May 5, 2017.

LINKS:

You can get to these pages by clicking on the links in ESS or from the hyperlinks provided below.

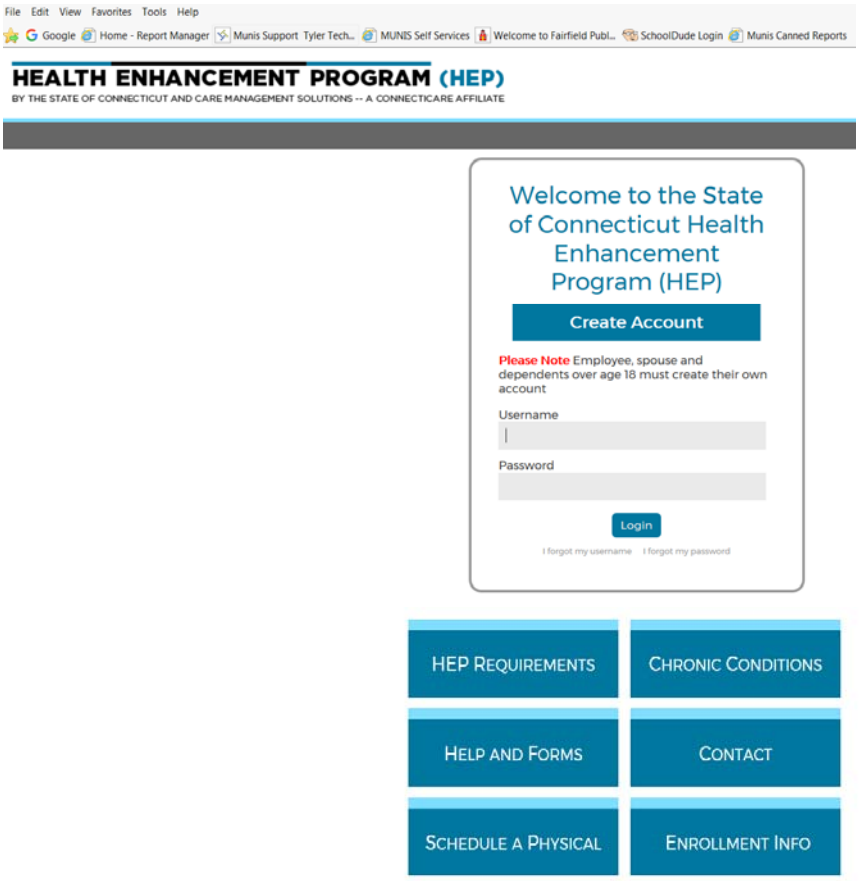
BENEFITS

http://fairfieldschools.org/faculty-staff/benefits/



CTHEP.com

https://www.connect2yourhealth.com/ParticipantPortal/Default.aspx



"Oxford SSN Refusal Letter"

http://cdn.fairfieldschools.org/faculty-staff/benefits/2016/Oxford_SSN_Refusal_Letter.pdf

The Centers for Medicare & Medicaid Services (CMS) is the federal agency that oversees the Medicare program. Many Medicare beneficiaries have other private group health plan (GHP) insurance in addition to their Medicare benefits. There are federal rules that determine whether Medicare or the other GHP insurance pays first.

Section 111 of the Medicare, Medicaid and SCHIP Extension Act of 2007 (MMSEA), a new federal law that became effective January 1, 2009, requires that group health insurance plans, certain claims processing third- party administrators, and certain employer self-funded/self-administered plans report specific information about Medicare beneficiaries who have other group coverage. This reporting is to assist CMS and other health insurance plans to properly coordinate payment of benefits among plans so that your claims are paid promptly and correctly.

Subscribers and dependents should routinely cooperate in furnishing either their Social Security Number (or Health Insurance Claim Number (HICN) if they do not have a SSN available) as requested by their group health plan. If an individual refuses to furnish a SSN or HICN, please complete the form below and submit to your employer group. **If an individual refuses to furnish a SSN or HICN, please complete the form below, submit the completed form to the Oxford Enrollment Department, and maintain a copy of your record.**

Oxford Enrollment Department
P.O. Box 29142
Hot Springs, AR 71903

MS-09-436 (Rev1 – 3/04/14)

Refusal to Provide Requested SSN or HCIN Information

Subscriber Name (Please Print)

Subscriber's Plan ID

For the reason(s) listed below, I have not provided the information requested. I understand that if I am a Medicare beneficiary and I do not provide the requested information, I may be violating obligations as a beneficiary to assist Medicare in coordinating benefits to pay my claims correctly and promptly.

Reason(s) for Refusal to Provide Requested Information

Name of Individual Providing This Information (Please Print)

Signature of Individual Providing This Information

Date

MS-09-436 (Rev1 – 3/04/14)

"Spousal Benefit Affidavit"

http://cdn.fairfieldschools.org/faculty-staff/benefits/2016/Spousal_Benefit_Affidavit.pdf

FAIRFIELD BOARD OF EDUCATION
SPOUSAL BENEFITS AFFIDAVIT

I, _____, being duly sworn, depose and state that:

1. I am over the age of eighteen and believe in the obligations of an oath.

2. I am employed by the Fairfield Board of Education as a _____ and I am a member of the bargaining unit known as the Fairfield Association of Educational Office Professionals ("FAEOP") which is subject to a collective bargaining agreement ("CBA") with the Fairfield Board of Education.

3. My spouse, , is, or was, employed by _____. Through this employer, my spouse was eligible for and received health insurance.

4. Due to the change in circumstances described below, my spouse is not otherwise eligible for health insurance from his or her employer.

My spouse's eligibility for insurance changed for the following reason(s):

_____
_____
_____
_____

(Attach additional sheets as necessary. Said attachments shall be subject to the same acknowledgement as this affidavit.)

1

5. As evidence of the change of circumstances described in Paragraph 4, I attach copies of the following documents hereto:

_____

_____

_____

_____

6. As a result of the change in circumstances regarding my spouse's eligibility described in Paragraphs 4 and 5, I am seeking to pay the "Two Person & Family" premium cost share rate contained in Appendix D of the CBA and not the "Spouse employed-eligible elsewhere" premium cost share rate contained in Appendix D of the CBA.

7. In making this affidavit, I understand that if it is not true that the Fairfield Board of Education shall be entitled to reimbursement for the difference between the "Spouse employed - eligible elsewhere" premium cost share rate contained in Appendix D of the CBA and the premium cost share rate for "Two Person & Family" contained in Appendix D of the CBA.

ACKNOWLEDGEMENT

I acknowledge that the statements contained in this affidavit are true and accurate to the best of my knowledge and belief and that the documents attached hereto are true and accurate copies under the pains and penalties of perjury.

_____

_____

Date

State of Connecticut

County of _____ ss: _____

On this the _____day of_____ , 2017, before me, ,
the undersigned officer personally appeared _____, known to me (or satisfactorily proven) to be the person whose name is subscribed to the within instrument and acknowledge that she executed the same for the purposes therein contained.

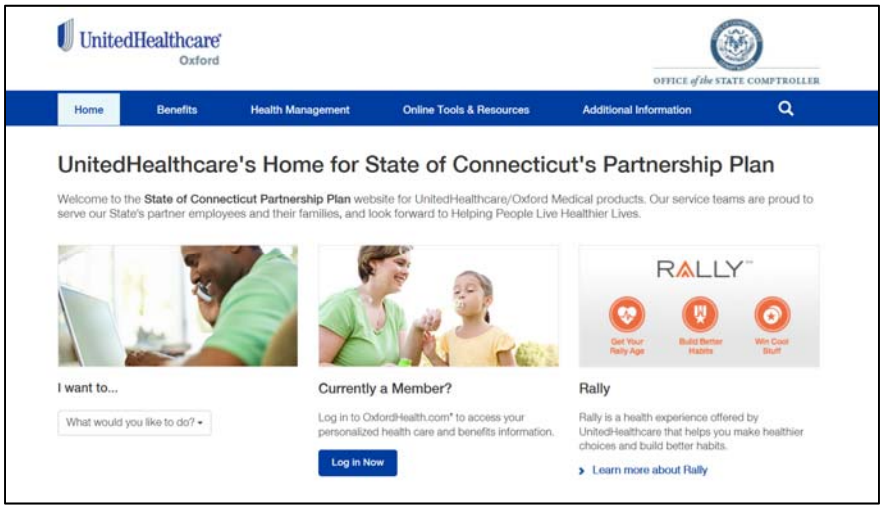
In witness whereof I hereunto set my hand

_____

Notary Public/ Commissioner of the Superior Court My Commission Expires:_____

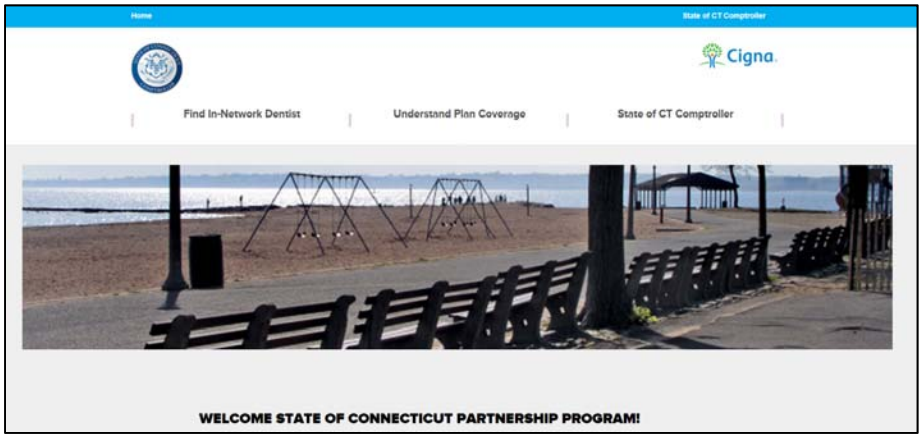
3

Oxford Provider Look-Up



http://partnershipstateofct.welcometouhc.com/

Cigna Provider Look-Up



https://www.cigna.com/sites/stateofct-partnership/

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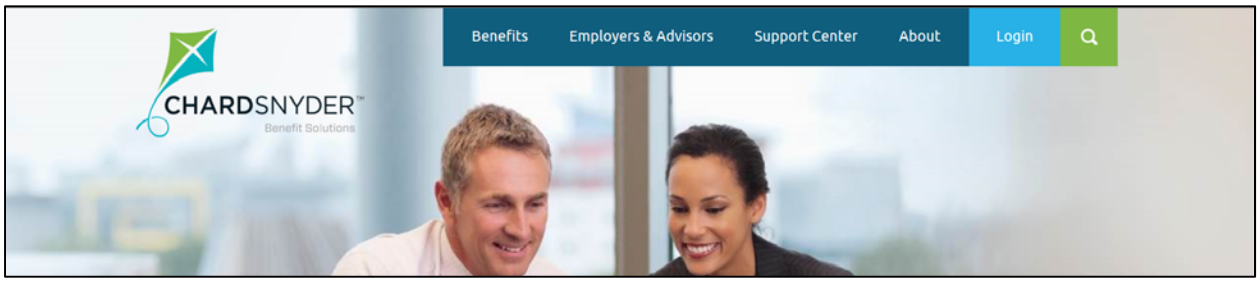

http://www.chard-snyder.com/