Health Insurance Marketplace Notice – Affordable Care Act

Beginning January 1, 2014, the Patient Protection and Affordable Care Act (commonly referred to as the Affordable Care Act) requires most U.S. citizens and legal residents to have a minimum amount of health insurance for themselves and dependents or pay a tax penalty when they file their Federal Income Tax Return. Additionally, starting October 1, 2013, you will have the option to buy health insurance through your state's online Health Insurance marketplace. This notice is intended to help you understand what this Federal mandate and the new Marketplace means to you.

What You Need to Know

Constellation Schools is required by law to provide you with this notice about the Health Insurance Marketplace, which offers a new way to buy health insurance beginning in 2014. To assist you as you evaluate your options for health coverage, this notice provides some basic information about the Marketplace and coverage that may be available to you under the Group Insurance Plan that we sponsor (Constellation Schools United Health Care Plan).

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. 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 be eligible for a new kind of tax credit that lowers the monthly premium you would otherwise pay for health insurance you buy through the Marketplace. Your eligibility for the credit, and the amount of your savings, depends on your household income. **However, you will not be eligible for lower Marketplace premiums if you are eligible for Constellation Schools United Health Care Plan coverage that meets certain standards.**

Does Constellation Schools United Health Care Plan Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. You generally are **not** eligible for the tax credit that lowers your monthly Marketplace premiums if you are eligible for coverage under the Constellation Schools United Health Care Plan. However, you may be eligible for the tax credit if you are not eligible for coverage under the Constellation Schools United Health Care Plan, if the only coverage for which you are eligible under the Constellation Schools United Health Care Plan does not provide the minimum value standard (the benefit costs covered by the plan is no less that 60 percent of such cost), or if the Constellation Schools United Health Care Plan is unaffordable to you. Constellation Schools United Health Care Plan coverage will be considered unaffordable to you if the amount you must pay for coverage that covers you (but not any other members of your family) is more that 9.5% of your household income for the year.

Note: *Constellation Schools pays the majority of the cost of coverage for employees who participate in the Constellation Schools United Health Care Plan. If you purchase health insurance through the Marketplace instead of enrolling in the Constellation Schools United Health Care Plan, you will lose the Company's contribution. Also, the Company's contribution – as well as your employee contribution to the cost of the Constellation Schools United Health Care Plan, is excluded from your income for Federal and State income tax purposes. By contrast, payments for coverage through the marketplace are made on an after-tax basis.*

How Can I Get More Information?

The Marketplace can help you evaluate your coverage options including the eligibility for coverage through the Marketplace and its cost. Please visit www.HealthCare.gov for more information, including an online application for health insurance coverage and contract information for a Health Insurance marketplace in your area. Following, is the information that you will be asked to provide.

Employer: *Constellation Schools, 5730 Broadview Road, Parma Ohio 44134*

Employer Identification Number: *80-0432457*

Employer Phone Number: 216 712-7600

Employer Contact: Kristin Mitchell (mitchell.kristin@constellationschools.com)

Constellation Schools offers health coverage to eligible employees: all full time year round and teaching staff working 30 hours or more.

Constellation Schools offers health coverage to dependent children and spouses who are not eligible for coverage at their place of employment.

Constellation Schools meets the minimum value standard (the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

Constellation Schools Medical/Dental/Vision Insurance Election Form
Pre-Tax Payroll Deduction Form 2016/2017 – OPEN ENROLLMENT

Please complete each section. ☐ I have reviewed my coverage. I do not wish to make changes.

□ **New Enrollment, Coverage Begins** _____ □ **Change to Exiting Coverage, effective** _____

□ **Cancel Coverage (complete reverse side), Cancel Coverage effective** _____

As an eligible employee in Constellation Schools IRC Sec. 125 "Premium Only" Cafeteria Plan, I acknowledge that the purpose of the plan is to enable employees to have payroll-deducted portions of benefit premium made before taxes are calculated. All employees who enroll in a benefit plan with a payroll deduction participate in the pre-tax program.

Employee Name (printed) _____ **SSN** _____

Signature _____ **Date of Birth** _____

Home Address _____ **City, State, Zip** _____

School/Location _____ **Date of Hire** _____

MEDICAL COVERAGE	CHECK COVERAGE DESIRED	BUY UP PLAN EMPLOYEE COST (PER PAY)	CORE PLAN (NO PAYROLL DEDUCTION/NO COST TO EMPLOYEE)
Employee Only		$ 52.82	$ 0.00
Employee + Spouse		$ 137.32	$ 0.00
Employee + child(ren)		$ 124.81	$ 0.00
Family (Spouse & Child(ren)		$ 232.12	$ 0.00

____ I elect the medical BUY UP Plan. I understand my per pay deduction will be $ _____.

____ I elect the medical CORE PLAN. I understand there is no payroll deduction.

____ I am not interested in medical coverage at this time. Please complete WAIVER on the reverse side.

DENTAL COVERAGE	CHECK COVERAGE DESIRED	EMPLOYEE COST (PER PAY)
Employee Only		$ 3.47
Employee + Spouse		$ 8.97
Employee + child(ren)		$ 9.87
Family (Spouse & Child(ren)		$ 17.42

____ I elect the dental coverage. I understand my per pay deduction will be $ _____.

____ I am not interested in dental coverage at this time. Please complete WAIVER on the reverse side.

VISION COVERAGE	CHECK COVERAGE DESIRED	EMPLOYEE COST (PER PAY)
Employee Only		$ .48
Employee + Spouse		$ 1.21
Employee + child(ren)		$ 1.15
Family (Spouse & Child(ren)		$ 2.17

____ I elect the vision coverage. I understand my per pay deduction will be $ _____.

____ I am not interested in vision coverage at this time. Please complete WAIVER on the reverse side.

DEPENDENT INFORMATION – Indicate information for spouse or dependents that you wish to cover.

Name	Date of Birth	SSN	Relationship

Effective Date of Coverage _____ *Deductions Begin* _____ *Entered in ADP* _____

Scanned & Emailed to Corporate Health Services/A. Chilia _____ *Verified Against Update* _____

LIFE INSURANCE

Constellation Schools provides $ 50,000 in life insurance to eligible employees at no cost to the employee.

Beneficiary's Full Name	Address	Relationship

WAIVER OF COVERAGE

Complete this section ONLY if you are declining coverage for medical, dental and/or vision coverage offered through Constellation Schools as indicated on the front side of this form. By waiving medical coverage, you are waiving coverage of a medical plan that is offered at NO COST to you (Medical Core Plan) and waiving coverage to a BUY UP plan which requires an employee contribution.

MEDICAL COVERAGE	I am waiving coverage as indicated with an "X"
Employee Only	
Employee + Spouse	
Employee + child(ren)	
Family (Spouse & Child(ren)	

Reason for declining medical coverage: _____

_____

DENTAL COVERAGE	I am waiving coverage as indicated with an "X"
Employee Only	
Employee + Spouse	
Employee + child(ren)	
Family (Spouse & Child(ren)	

VISION COVERAGE	I am waiving coverage as indicated with an "X"
Employee Only	
Employee + Spouse	
Employee + child(ren)	
Family (Spouse & Child(ren)	

I waive coverage as indicated above. I am aware that I am NOT accepting coverage offered to me through Constellation Schools.

Employee Name (printed) _____ **Signature** _____

School _____ **Date** _____

Constellation Schools

SPOUSAL INSURANCE QUESTIONNAIRE

EMPLOYEE NAME: _____
please print

LOCATION/SCHOOL: _____

SPOUSE'S NAME: _____

YES	NO		
☐	☐	1.	I am married. (If you checked "NO", please sign and date below)
☐	☐	2.	I decline coverage through Constellation Schools. I am covered under my spouse's healthcare plan.
☐	☐	3.	My spouse is eligible for coverage through his/her employer or is covered through his/her retirement plan. If you checked "no", your spouse may be covered under the Constellation Schools Plan.

NOTE: **If spouse's eligibility status changes, the Human Resource department of Constellation Schools must be advised in writing within 30 days of said change.**

☐	☐	4.	My spouse has healthcare coverage with his/her employer and/or retirement plan.

NOTE: **IF YOU ANSWERED YES TO STATEMENT 4, PLEASE BE ADVISED THAT YOUR SPOUSE IS NOT ELIGIBLE FOR THE CONSTELLATION HEALTHCARE PLAN UNLESS CIRCUMSTANCES CHANGE.**

☐	☐	5.	My spouse is not employed and does not have access to healthcare coverage.

NOTE: **I understand that if my spouse becomes employed and eligible for his/her employer's healthcare plan, he/she *MUST* enroll in said plan and the Human Resource department of Constellation must be advised in writing of his/her new healthcare coverage within 30 days.**

I attest that the above information is truthful and accurate as of this date. I further understand that providing false information may result in disciplinary action, forfeiture of my spouse's coverage under the Constellation healthcare plan AND I may be responsible for the full premium payment of my spouse's coverage back to the date of his/her eligibility with his/her employer.

_____ _____
Employee Signature *Date*

To be completed by Spouse's Employer

Spouse's Company Name: _____

Employee is ☐ full-time ☐ part-time

Employer Sponsored medical plan is available to employee **Yes** ☐ **No** ☐

Employee is ☐ is not ☐ enrolled in our employee-sponsored medical plan

Representative Signature: _____

Date: _____ Title: _____

Phone No: _____