Matthew C. Fedders
Superintendent of Schools

Vicki Hummer
Director of Special Services

Central Vermont Supervisory Union

Renee D. Badeau
Director of Curriculum

Christopher F. Locarno
Director of Finance & Facilities

Committed to cultivating within all our students the knowledge, skills, and character essential to becoming purposeful, productive and engaged members of their world.

October, 20, 2023

To All CVSU Employees:

It's that time of year again! Open Enrollment for Health Insurance (BCBS) and FSA's (Flexible Spending Account) for the 2024 calendar year, is finally here (try to contain your excitement)!
The documents are attached to this email, but if you do not have access to a printer, please let me know and I can send you a paper copy in the interoffice or regular mail.
Directions on what forms to complete and how to complete them., are also attached.
Please take a few minutes to read thru each form carefully.

We are requesting that all open enrollment documents are returned to the central office by November 13th. This will allow staff more than 3 weeks to review and complete any of the forms that pertain to you.

During this open enrollment time, myself (Heidi Trombly) and Chris Locarno will be available (via phone, email or in person visits) to assist you with any questions you may have.

There are 3 different options on how to return your completed documents:

1. Scan and email to htrombly@cvsu.org
2. Bring documents directly to central office
3. Place documents in an interoffice mail folder and give to building secretary

**** Please be sure you have thoroughly completed each form before returning it****

THINGS YOU MUST DO:

Please review, complete and return documents to the Central Office no later than **Monday, November 13th.**

You have 3 options when returning your completed forms:

1. Scan and email to htrombly@cvsu.org
2. Bring documents directly to the Central office
3. Place documents in interoffice mail in designated area with your building secretary

Documents that need to be completed:

csONE FSA Enrollment (sections A-G):

A. Account Holder Information (your personal information)
B. Dependent Information (any employee dependents, i.e. spouse, children)
C. Election Agreement (Please read)
D. Direct Deposit Setup (Leave Blank-not needed)
E. Health FSA- This is the Flexible Spending Account (payroll deducted) and this is where you would elect to set aside money to cover your portion of the deductible or to use for eye exams, glasses and/or dental expenses
F. Dependent Care FSA (Childcare expenses for children under age of 13)
G. Payroll Details (Business office will complete)

Declaration of Health Coverage (HC-2 Form):

If you have health insurance elsewhere (not with CVSU), please complete this form

Blue Cross Blue Shield Enrollment Form:

Complete this form **ONLY** if you are making changes to your current plan (remove/add dependents/spouse) or if you are enrolling for the first time
** If no changes, you do **NOT** need to complete this form**

Please do not hesitate to reach out to the CVSU central/business office staff.
If you have any questions, please feel free to call, email or make an appointment with Heidi Trombly (htrombly@cvsu.org or 802-433-7032). We are here to help and happy to assist!
If you have any specific questions about your personal health care expenses/usage, you can call BCBS directly at 800-247-2583 or visit www.vehi.org

Central Vermont Supervisory Union

csONE BENEFIT SOLUTIONS

FSA ENROLLMENT FORM

INSTRUCTIONS:

1. Please complete, sign and date this form. (* = Required Fields)
2. Return it to your supervisor or HR Department.

A. Account Holder Information (Please print):

*Name (Last, First, MI)	*Social Security Number	*Date of Birth	*Hire Date

*Address	*City	*State	*Zip

*Home Phone Number ( )	*Daytime Phone Number ( )	*Email Address	* # Pay Periods

B. Dependent Information

Name	Social Security Number	Date of Birth	Relationship

C. Election Agreement

I agree to have my gross salary reduced, in accordance with section 125 of the Internal Revenue Code, to contribute to the Flexible Spending Account in the amount indicated below. My employer can make these contributions on my behalf. This salary reduction arrangement will continue until:

- I terminate employment with my present employer; or
- I have a change in family status (e.g. marriage, divorce, birth or adoption of a child, death of a spouse or dependent, or change in my or my spouse's employment status) that makes it necessary for me to modify this agreement: or
- The end of the plan year covered by this agreement. For future plan years, I will have the opportunity to modify this agreement; or
- My employer terminates, suspends, or modifies this plan.

I understand that if I do not return this form to my employer, they will assume I do not want to participate in the Employee Reimbursement Account program.

I understand that if my participation should end due to a qualifying event, prior to the plan year's end, I am able to submit eligible claims to my Flexible Spending Account that were incurred prior to the end date of my participation.

I understand that contributions to the Flexible Spending Account can only be used for eligible expenses within each plan. I further understand that if I do not use the funds in my Employee Reimbursement Account during the plan year, those funds will not be paid to me; they will be forfeited. I also understand that reimbursement expenses cannot be claimed as credits or deductions on my personal tax return.

D. Direct Deposit Setup

*Bank Name	*Account Type ☐ Checking or ☐ Savings
*Routing Number	Illustration of Bottom of Check
*Account Number	Routing Number / Account Number

FSA Type	Annual Election	# Pay Periods	Amt Each Pay Period
E. Health FSA Use for health expenses ex. copays, deductibles, prescriptions	$_____	_____	$_____
F. Dependent Care FSA Can be used for child care expenses for children under 13. $5,000.00 max or $2,500.00 if married filing separately	$_____	_____	$_____

G. Payroll Details

Pay Schedule	Salary Reduction
☐ weekly ☐ bi-weekly ☐ semi-monthly ☐ other: _____	Begins with payroll dated _____ and continues through _____

In the event our group does not pass the necessary nondiscrimination tests, I authorize my employer to make any necessary reductions to my election in order to conform with the nondiscrimination rules.

*Employee Signature: _____ Date: _____

BlueCross BlueShield of Vermont
An Independent Licensee of the Blue Cross and Blue Shield Association.

Submit one of three ways: email, fax, or mail.
See page 2 for more information.

VEHI
Enrollment and Change Form

Please provide all information and print in ink or type.

Requested effective date

Section 1: EMPLOYER/EMPLOYEE INFORMATION

Employer name:

Employee Type: ☐ Licensed ☐ Non-Licensed ☐ Confidential / Municipal ☐ Private School / Other

Group /division #: (office use only)

Employment status: ☐ Active ☐ Continuation (COBRA)

Health Plan Selection: ☐ Platinum ☐ Gold ☐ Gold CDHP ☐ Silver CDHP

Health coverage type: ☐ Employee only ☐ Employee/spouse (including party to a civil union/domestic partner) ☐ Employee/child(ren) ☐ Family

Health care spending account: ☐ Health Reimbursement Arrangement (HRA): all plans ☐ Health Savings Account (HSA): Silver CDHP only ☐ None / Opt-out

Last name: **First name:** **Social Security number**** (SSN):**

Mailing address: PCP Name NPI No.***

City: **State:** **ZIP code:**

Are you a current patient? ☐ Yes ☐ No

Phone number: **Email address:**

☐ resides outside of BCBSVT provider network (no PCP required)

Date of birth (DOB): **Gender:** ☐ Male ☐ Female

Marital status: ☐ Single ☐ Married / party to a civil union ☐ Domestic Partner**

Section 2: NEW ENROLLMENT (Check one, then go to SECTION 4)

☐ Open enrollment ☐ New hire/re-hire ☐ Continuation of coverage (COBRA) ☐ Refusal ☐ Spouse turning age 65

☐ Transferred from another BCBSVT plan Transferring from certificate no. ____________________

Section 3: CHANGE/CANCELLATION

Change: Effective date / /

☐ Birth
☐ Adoption placement date
☐ Marriage/Civil Union
☐ Divorce
☐ Address change
☐ Name change
☐ PCP change
☐ Court ordered change**
☐ Loss of coverage**

Cancel: Date of cancellation / /

☐ Voluntary cancel (signature required) ____________________
☐ Left employment (group benefits manager signature) ____________________
☐ Other (explain) ____________________

Section 4: LIST ALL DEPENDENTS BELOW TO BE ADDED OR REMOVED

Dependent Information **** Important note: SSN required for all members.

Primary Care Provider (PCP) Information (required)

☐ Add ☐ Remove (Spouse / party to a civil union / domestic partner) SSN**** Gender PCP Name NPI No.***
Last Name First Name DOB ☐ Male ☐ Female
Are you a current patient? ☐ Yes ☐ No
☐ resides outside of BCBSVT provider network (no PCP required)

☐ Add ☐ Remove SSN**** Gender PCP Name NPI No.***
Last Name First Name DOB ☐ Male ☐ Female
Are you a current patient? ☐ Yes ☐ No
☐ resides outside of BCBSVT provider network (no PCP required)

☐ Add ☐ Remove SSN**** Gender PCP Name NPI No.***
Last Name First Name DOB ☐ Male ☐ Female
Are you a current patient? ☐ Yes ☐ No
☐ resides outside of BCBSVT provider network (no PCP required)

☐ Add ☐ Remove SSN**** Gender PCP Name NPI No.***
Last Name First Name DOB ☐ Male ☐ Female
Are you a current patient? ☐ Yes ☐ No
☐ resides outside of BCBSVT provider network (no PCP required)

☐ Add ☐ Remove SSN**** Gender PCP Name NPI No.***
Last Name First Name DOB ☐ Male ☐ Female
Are you a current patient? ☐ Yes ☐ No
☐ resides outside of BCBSVT provider network (no PCP required)

Please see section 6 on page 2 for employee signature

Employer name: Employee name:

Section 5: OTHER INSURANCE INFORMATION

If you obtain health insurance coverage with us, will you or any of your dependents be covered with another health or dental insurance plan (including Medicare or Medicaid)?

☐ **Yes** (please complete the applicable section below) ☐ **No**

MEDICAL

Insurance company (name and address)		
Policyholder name	Policy certificate no.	Group no.
Effective date	Type of coverage ☐ 1-person ☐ 2-person ☐ Family	

DENTAL

Insurance company (name and address)		
Policyholder name	Policy certificate no.	Group no.
Effective date	Type of coverage ☐ 1-person ☐ 2-person ☐ Family	

Section 6: SUBSCRIBER SIGNATURE

I certify that the statements on this application and all information I've furnished is true and complete to the best of my knowledge. I authorize any health care provider to disclose to Blue Cross and Blue Shield of Vermont, or its designated agent, any information acquired in connection with my past or future care or treatment or that of any dependent named herein or hereafter added to my coverage. I understand that no right whatsoever is created by this application and that the same shall not be considered accepted unless and until the contract is actually issued by Blue Cross and Blue Shield of Vermont. I UNDERSTAND THAT MY BENEFITS ARE GOVERNED BY THE PROVISIONS OF MY VEHI BENEFITS DESCRPITION AND OUTLINE OF COVERAGE.

SIGN HERE

▶Employee's signature _____ date _____◀

Return this form to your Central Office for processing. Central Office can submit one of three ways:

Email: asinbox@bcbsvt.com **Fax:** (802) 371-3329 **Mail:** Blue Cross and Blue Shield of Vermont
P.O. Box 186
Montpelier, VT 05601-0186

NOTICE: Discrimination is Against the Law

Blue Cross and Blue Shield of Vermont (BCBSVT) complies with applicable federal and state civil rights laws and does not discriminate, exclude people or treat them differently on the basis of race, color, national origin, age, disability, gender identity or sex.

BCBSVT provides free aids and services to people with disabilities to communicate effectively with us. We provide, for example, qualified sign language interpreters and written information in other formats (e.g., large print, audio or accessible electronic format).

BCBSVT provides free language services to people whose primary language is not English. We provide, for example, qualified interpreters and information written in other languages.

If you need these services, please call (800) 247-2583. If you would like to file a grievance because you believe that BCBSVT has failed to provide services or discriminated on the basis of race, color, national origin, age, disability, gender identity or sex, contact:

Civil Rights Coordinator
Blue Cross and Blue Shield of Vermont
PO Box 186
Montpelier, VT 05601
(802) 371-3394
TDD/TTY: (800) 535-2227
civilrightscoordinator@bcbsvt.com

You can file a grievance by mail, or email at the contacts above. If you need assistance, our civil rights coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
Office for Civil Rights
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
(800) 368-1019
(800) 537-7697 (TDD)

For free language-assistance services, call (800) 247-2583.

ARABIC
للحصول على خدمات المساعدة اللغوية المجانية، اتصل على الرقم (800) 247-2583.

CHINESE
如需免費語言協助服務，請致電 (800) 247-2583。

[illegible]
Tajaajila gargaarsa afaan hiikuu kaffaltii malee argachuuf (800) 247-2583 bilbilaa.

FRENCH
Pour obtenir des services d'assistance linguistique gratuits, appelez le (800) 247-2583.

GERMAN
Kostenlose fremdsprachliche Unterstützung erhalten Sie unter (800) 247-2583.

ITALIAN
Per i servizi gratuiti di assistenza linguistica, chiamare il numero (800) 247-2583.

JAPANESE
無料の通訳サービスのご利用は、(800) 247-2583までお電話ください。

NEPALI
निःशुल्क भाषा सहायता सेवाहरूका लागि, (800) 247-2583 मा कल गर्नुहोस्।

PORTUGUESE
Para serviços gratuitos de assistência linguística, ligue para o (800) 247-2583.

RUSSIAN
Чтобы получить бесплатные услуги переводчика, позвоните по телефону (800) 247-2583.

SERBO-CROATIAN (SERBIAN)
Za besplatnu uslugu prevođenja, pozovite na broj (800) 247-2583.

SPANISH
Para servicios gratuitos de asistencia con el idioma, llame al (800) 247-2583.

TAGALOG
Para sa libreng mga serbisyo ng tulong pangwika, tumawag sa (800) 247-2583.

THAI
สำหรับการให้บริการความช่วยเหลือด้านภาษาฟรี โทร (800) 247-2583

VIETNAMESE
Để biết các dịch vụ hỗ trợ ngôn ngữ miễn phí, hãy gọi số (800) 247-2583.

If you are adding a dependent child, age 26 or older, contact customer service at (800) 344-6690 for further instructions.

* = Includes Party to a Civil Union or Domestic partner
** = Additional Documentation Required
*** = See our "Find-a-Doctor" tool at **www.bcbsvt.com/findadoctor**
**** = SSN required for all members (Federal mandate requires the collection of SSN)

Vermont Department of Taxes PO Box 547 Montpelier, VT 05601-0547 Phone: (802) 828-2551

VT Form HC-2	DECLARATION OF HEALTH CARE COVERAGE	This form must be completed annually by all uncovered employees. Employers must retain this form for 3 years.

Employer: This form is **only** to be completed by employees if you offer to pay a portion of a health care plan that provides hospital and physicians services to at least some of your employees. You must retain all employee declaration forms together in a file for three years and be able to produce them in the event of an audit.

Employer's Legal Name *(Please print)* _____

Employee: Complete and sign this form and return it to your employer. The purpose of this form is to obtain information regarding your health care coverage. The information you provide on this form will be used solely for purposes of determining if your employer must pay Health Care Contributions as required under Vermont law at 32 V.S.A § 10503.

Employee's Full Name *(Please print)*	
Employee ID or Social Security Number	**Date of Birth**

Will the employee be under the age of 18 for the entire calendar year? ☐ YES ☐ NO

If **YES**, stop. Please sign the bottom of the form and submit it to your employer.

If **NO**, please continue to complete this form and submit it to your employer.

Check the box beside the statement that best describes your health care coverage.

1. My employer offers health care coverage to me.

- ◯ I have accepted the health care coverage offered and provided by my employer.

2. My employer offers health care coverage to me, and I have not accepted my employer's coverage.

- ◉ I have health care coverage that includes hospital and physicians services from a source other than Medicaid or Vermont Health Benefit Exchange.

  My coverage is provided through: _____
- ◯ I am a full-time employee and have health care coverage as an individual through the Vermont Health Benefit Exchange.
- ◯ I have Medicaid.
- ◯ I have no health care coverage.

3. My employer does not offer health care coverage to me.

- ◯ I am a part-time employee who works fewer than 30 hours per week, **and** I have coverage from a source other than Medicaid that offers hospital and physicians services.
- ◯ I am a seasonal employee who expects to work for this employer 20 or fewer weeks during this calendar year, **and** I have coverage from a source other than Medicaid that offers hospital and physicians services.
- ◯ I have health care coverage that offers hospital and physicians services.

  My coverage is provided through: _____
- ◯ I am a part-time or seasonal employee, and I do not have health care coverage **or** I am covered by Medicaid.
- ◯ I have no health care coverage.

☐ **I certify the above information is accurate and true to best of my knowledge and belief.**

Employee Signature _____ Date _____

Note: If your health care coverage changes within the year, you must complete a new Declaration of Health Care Coverage.