MEDICAL

Important Notice

Medicare Part D

2016 Medicare Part D Notice

The above Medicare Part D notice is required to be sent out by October 15th of each year. This notice has information about your current prescription drug coverage with the District and your options under Medicare's prescription drug coverage.

Medical Plans

The District is self-insured for the medical insurance and uses Aetna Insurance Company as a Third Party Administrator (TPA) to utilize their network of providers, to administer the benefits and to process claims. The

District offers three Plans (Plan 3769, Plan 5773 and High Deductible Health Plan - HDHP) to choose from that best meets the needs of the employee and/or their dependents. All regular employees working at least 30 hours per week are entitled to employee only medical insurance. The District gives every eligible employee flex credits to apply towards their medical insurance. The amount is $6,872.40 annually.

For more information, please watch the video below.

Click play to view the video or follow this link
https://www.youtube.com/watch?v=vH2V95iDQu0

Dependent Eligibility

Spouse - Legally married;

Children - Employee's natural, newborn, adopted, foster, step child(ren) (or a child for whom the Covered Employee has been court-appointed as legal guardian or legal custodian) may be covered until the end of the calendar year in which he/she turn 26 years of age with NO Criteria (such as dependent marital status, student status, financial dependency on the Covered Employee, etc.)

Employees receive $286.35 in Flex Credits each pay period to apply toward the purchase of Medical, Dental, Vision and/or Cancer insurance benefits (Core Health Benefits). (Keep in mind....subtract $286.35 from each premium below for the actual premium employees will pay per period.)

**For the High Deductible Health Plan, a Health Savings Account (HSA) is tied to this plan to help offset the plan year deductible. The Board still contributes $286.35 towards the employee, however, the excess of premium in the cost of the medical does not go towards voluntary benefits (dental, medical and/or vision) or dependent premiums. The excess will be placed in a HSA. The amount is $82.70 per pay / $1984.80 annually. Therefore, $203.65 of the $286.35 Board Contribution is applied to HDHP premiums and the remaining $82.70 is applied to

the HSA.

The premiums are per paycheck and are deducted twice a month, the 15th and the last day of the month.

Medical Premiums

Tiers	Plan 3769	Plan 5773	High Deductible Health Plan (HDHP)**
Employee Only	$272.70	$255.96	$203.65
Employee / Spouse	$660.33	$618.21	$552.35
Employee / Child	$409.70	$384.00	$326.89
Employee / Children	$574.56	$538.06	$475.20
Employee / Family	$832.43	$779.04	$707.17

******* ATTENTION 20 PAY EMPLOYEES *******

PLEASE NOTE: The premiums listed above are based on 24-pay periods. Employee who receive 20 pay checks (i.e. 186- day work schedule), will pay the rates listed above with an additional 20% pre-pay which will be applied toward summer coverage. The Flex Credit amount also includes an extra 20% summer contribution.

Other

- **Easy Comparison of Health Plans**
- **3769 - Summary of Benefits**
- **5773 - Summary of Benefits**

Frequently Asked Questions About Medical Insurance

What is an Health Savings Account (HSA)?
An HSA is like an FSA as in regards to eligible expenses. The same eligible expenses for FSA applies to an HSA.

There a few differences, however:

- Unlike an FSA, the money in your account is yours. It can increase every year as there is no "USE IT or LOSE IT" rule. You can take the funds with you when retiree / terminate employment. The money keeps accruing.
- You must be under the age of 64 to enroll as you can not contribute to a HSA if you are 65 years old. But, once you turn 65 years old, you can use the money in your account to pay for insurance premiums.

To be eligible for HSA, you:

- **MUST** be covered under a high deductible health plan
- **MUST** have no other health coverage
- **MUST** be 63 or younger to enroll
- **MUST NOT** be enrolled in Medicare (employee or dependents)
- **MUST NOT** be claimed as a dependent on some one else's tax return
- **MUST NOT** have a standard (or full purpose) Flexible Spending Account (FSA) or HRA; AND Your spouse **MUST NOT** have a full purpose FSA.

HSA funds are on a calendar year basis per the IRS, however, our plan is on a benefit year (4/1 to 3/31). It is important that your contributions do not exceed the maximum allowed per calendar year. With an HSA, you are able to adjust your contributions throughout the year.

The maximum contribution allowed for Year 2017 is: Individual- $3400; Family- $6750. The Board contributes $1,984.80 annually from the Board Paid Flex credit. You may contribute an additional amount up to the maximum allowed. Please review your contributions on a regular basis so that you do not exceed the calendar year maximum allowed.

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How can I waive Medical Insurance?

An employee may elect to waive the medical insurance provided that proof of other group coverage is given (ie. copy of ID card). The District will then provide $25 per pay check towards the purchase of certain voluntary benefits (dental, vision and/or cancer insurance) only. It can not be received as additional compensation. This option is only allowed: 1) as a New Hire - within 30 days of hire date; 2) during the District's annual Open Enrollment period; OR 3) as a Qualifying Event - within 60 days of obtaining new coverage to drop / waive the District's plan.

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What are the coverage Effective Dates?

- New employees and their dependents - medical insurance will be effective the first of the month following 45-day waiting period.
- Open Enrollment - elections / changes made in February, however not effective until April 1st.
- Qualifying Events (outside Open Enrollment) - 1st of the month following the event date, except for birth / adoption which is the date of birth or adoption /placement. (See Adding Newborn information below)

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Will I need a referral?

With these plans, no referrals from the Primary Care Physician (PCP) are needed to see a Specialist. However, it is the responsibility of the employee / patient to make sure the provider is in the network. The Aetna Choice POS II (open access)Network of providers are the same for all three (3) plans. The most up-to-date way to find out if a provider is in the network, is to use the Aetna web link (http://www.aetna.com/dse/search?site_id_=dse)

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How do I locate a Provider

The most up-to-date way to find out if a provider is in the network, is to use the Aetna web link http://www.aetna.com/dse/search?site_id_=dse. However, when making your appointments, you should always verify with the providers that they are on the Aetna Choice POS II Network.

Please copy the above web link to your web browser and follow the instruction below:

- Fill in the box "Who or What are you looking for" by indicating the name or speciality of the Provider you are looking for. You can also select from one of the Provider Types, Conditions or Procedures listed below

the two (2) search boxes by clicking on the appropriate selection

- Fill in the "where" box (you can search by Zip Code, City or State
- You will then need to select your plan AETNA CHOICE POS II (open access) and hit continue
- Your search results should then appear

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How do I add my newborn?

Coverage for newborns is NOT automatic. You must physically enroll the newborn by completing two (2) forms and provide proof of birth.

You have 60 days from the date of birth to physically add the newborn to your medical plan. If you complete the required paperwork within 30 days after the birth, no premium will be charged for the first 30 days of life. If the required paperwork is completed between the 31st and the 60th day after birth, you will be charged the applicable premium for the child from the date of birth. In the event you do not complete the required paperwork to add the newborn within 60 days of the birth of the newborn child, you will not be able to add the newborn until the District's annual Open Enrollment. The effective date then would be April 1st of that year.

The Effective Date of coverage for a newborn child shall be the date of birth.

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How does my prescription coverage work?

The District's prescription drug plan includes mandatory generics when available and a Mandatory Mail Order for maintenance drugs. Maintenance drugs are prescribed to be taken on a long term basis to treat an existing medical condition. There are two ways to access maintenance medication; through the Aetna RX Mail Order Program or retail at your local CVS Pharmacy. For your non-maintenance medication you may utilize the other in-

network pharmacies such as Publix, Walgreens, Walmart and Target. For more information on Aetna RX please CLICK HERE for the Aetna RX brochure.

Pleae CLICK HERE for the Aetna RX Order Form

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