

WASHOE COUNTY SCHOOL DISTRICT

Risk Management Office

Questions/Answers and Highlights effective 1/1/2022 for the District's:

- ***Benefits Video***
- ***HDHP/HSA Plans***
- ***PPO Plans***
- ***GAP Plan***
- ***Dental Plan***
- ***Basic Term Life Insurance***
- ***Vision Plan***
- ***Legal Plan***
- ***Section 125 Program***
- ***Wellness Program***
- ***Submitting Forms to Enroll***

BENEFITS VIDEO

Where can I go to learn more about the District Insurance?

Risk Management has a video available on the District's website, it is located under the Risk Management Department. The link for the website is <http://washoeschools.net/risk>.

QUALIFIED HIGH DEDUCTIBLE HEALTH PLAN (QHDHP)

Overview

What is the QHDHP Plans?

The QHDHP is a self-funded comprehensive major medical/RX plan with a High Deductible preferred provider component. See "Highlights" of the QHDHP Plans on page 7.

Do they cover services worldwide? No, benefits are only covered within the United States.

Who processes and administers the claims?

- Anthem Blue Cross Blue Shield, P.O. Box 5747, Denver, CO 80217-5747, 833-914-0825

PREFERRED PROVIDERS

What are Preferred Providers?

Providers who **are** contracted to provide services at a contracted fee.

What are Non-Preferred Providers?

Providers who **are not** contracted to provide services at a contracted fee.

How do I find out if my doctor is a PPO provider?

- Contact Anthem Blue Cross Blue Shield at 833-914-0825; or their web page at www.anthem.com.

What are the QHDHP Hospitals in Washoe County?

- Renown Regional Medical Center, Renown South Meadows, Carson Tahoe Medical Center, Northern Nevada Medical Center and Saint Mary's Regional Center.

What if I receive emergency services from a Non-PPO provider?

If it meets the definition of an "Emergency", you will receive reimbursement at the PPO level of benefit (no reduction in level of benefit) once your deductible has been met.

DEDUCTIBLES/CO-INSURANCE/CO-PAYMENTS

What is a deductible?

It's the amount of billed charges you must first pay before the plan will pay any charges.

The QHDHP/HSA Plans have a calendar year deductible of \$2,800 per person and \$5,000 per family when you use preferred providers. If you use non-preferred providers, the deductibles are \$2,800 per person and \$5,000 per family.

What is co-insurance and co-insurance limit?

Co-insurance is the percentage of the cost both you and the plan share for covered expenses after you have met your deductible. The co-insurance limit is the total amount of eligible billed charges that the co-insurance is applied to before the plan will pay your benefits at 100%. The QHDHP/HSA Plans have an annual out-of-pocket maximum of \$6,550 per person and \$13,100 per family when you use preferred providers. For non-preferred providers, the annual out-of-pocket maximum is \$6,550 per person and \$13,100 per family.

Does the QHDHP Plan have co-payments?

Yes, but only on the Prescription plan once the deductible has been met.

What are Usual, Customary, and Reasonable Fees (UCR)?

The QHDHP/HSA contracted fees, or when applicable, charges that are within the usual level of charges in your locality for similar medical treatment, services, and supplies as determined by the Plan Administrator.

PRECERTIFICATION

Are there any procedures I must follow to ensure I receive full benefits for certain services?

Yes, you must have all inpatient hospital admissions pre-certified. If it is an elective hospitalization, it must be pre-certified before you're admitted. If it is an emergency, it must be pre-certified within 72 hours of being admitted. You must also have any outpatient procedure over \$10,000 pre-certified.

Who pre-certifies these services?

- Your physician needs to contact Anthem Blue Cross Blue Shield at 833-914-0825.

What happens if I don't follow these procedures?

Your allowable charges will be reduced by 50% with payment made against that reduced amount and it will not apply towards your Co-insurance Limit.

PREFERRED PROVIDER ORGANIZATION (PPO) PLAN

OVERVIEW

What is the PPO Plan?

The PPO is a Self-funded Comprehensive Major Medical Plan with a Preferred Provider Organization (PPO) component. See "Highlights" of the PPO Plans on page 7.

Do they cover services worldwide? No, benefits are only covered within the United States.

Who processes and administers the claims?

- Anthem Blue Cross Blue Shield, P.O. Box 5747, Denver, CO 80217-5747, 833-914-0825

PREFERRED PROVIDERS

What are Preferred Providers?

Providers who **are** contracted to provide services at a contracted fee.

What are Non-Preferred Providers?

Providers who **are not** contracted to provide services at a contracted fee.

How do I find out if my doctor is a PPO provider?

- Contact Anthem Blue Cross Blue Shield at 833-914-0825; or their web page at www.anthem.com.

What are the PPO Hospitals in Washoe County?

- Renown Regional Medical Center, Renown South Meadows, Carson Tahoe Medical Center, Northern Nevada Medical Center and Saint Mary's Regional Medical Center.

What if I need services that cannot be provided by a PPO provider?

You will receive reimbursement at the PPO level of benefit (no reduction in level of benefit).

What if I receive emergency services from a Non-PPO provider?

If it meets the definition of an "Emergency", you will receive reimbursement at the PPO level of benefit (no reduction in level of benefit).

DEDUCTIBLES/CO-INSURANCE/CO-PAYMENTS

What is a deductible?

It's the amount of billed charges you must first pay before the plan will pay any charges.

The PPO Plans have a calendar year deductible of \$500 per person and \$1,000 per family when you use preferred providers. If you use non-preferred providers, the deductibles increase to \$1,500 per person and \$3,000 per family.

What is co-insurance and co-insurance limit?

Co-insurance is the percentage of the cost both you and the plan share for covered expenses after you have met your deductible. The co-insurance limit is the total amount of eligible billed charges that the co-insurance is applied to before the plan will pay your benefits at 100%. The PPO Plans have an annual out-of-pocket maximum of \$4,000 per person and \$8,000 per family when you use preferred providers. For non-preferred providers, the annual out-of-pocket maximum is \$8,000 per person and \$16,000 per family.

Does the PPO Plans have a co-payments?

Yes, they have a \$35 co-payment for primary care physician office visits, and a \$50 co-payment for specialist physician visits.

What are Usual, Customary, and Reasonable Fees (UCR)?

The PPO contracted fees, or when applicable, charges that are within the usual level of charges in your locality for similar medical treatment, services, and supplies as determined by the Plan Administrator.

PRECERTIFICATION

Are there any procedures I must follow to ensure I receive full benefits for certain services?

Yes, you must have all inpatient hospital admissions pre-certified. If it is an elective hospitalization, it must be pre-certified before you're admitted. If it is an emergency, it must be pre-certified within 72 hours of being admitted. You must also have any outpatient procedure over \$10,000 pre-certified.

Who pre-certifies these services?

- Your physician needs to contact Anthem Blue Cross Blue Shield at 833-914-0825.

What happens if I don't follow these procedures?

Your allowable charges will be reduced by 50% with payment made against that reduced amount and it will not apply towards your Co-insurance Limit.

OVERVIEW OF PRESCRIPTION DRUG BENEFIT

Does the QHDHP Plan and the PPO Plan have a prescription drug benefit?

Yes it is administered by Anthem. The PPO is subject to a \$50 per member deductible and the QHDHP is subject to the plan deductible (\$2800/member) before a co-pay applies.

How are prescription drugs covered?

Please see "Highlights" on page 7.

What are "preferred-brand" name drugs?

Brand-name drugs that are included on the plan's preferred brand name list (formulary).

Can the list of "preferred-brand" name drugs change?

Yes, the list changes every year. So, a preferred-brand name drug not on the list in 2021 could be on the list in 2022. Likewise, a preferred-brand name drug on the list in 2021 may not be on the list for 2022. The formulary may also change during the year if a drug brand name drug goes generic or over-the-counter.

OVERVIEW OF GAP PLAN

What is the GAP Plan? The GAP Plan (through American Fidelity Insurance Company) is designed to help cover some of your out-of-pocket expenses with the PPO Plan. It will pay up to \$1,000 per inpatient hospital confinement, up to \$200 for certain outpatient services, up to \$200 for emergency room visits and up to \$25/doctor visit/x-ray or lab (limit of \$125/family). If you cover your dependents, they will also have the GAP Plan coverage. There are specific exclusions to this plan, so please read carefully the GAP Plan brochure in your packet. (Please note that the "Pre-Existing Conditions" exclusion has been waived.) To be reimbursed by the GAP Plan, you'll need to submit to American Fidelity the Explanation of Benefits" (EOB) you receive from the Plan administrator along with an American Fidelity GAP claim form.

OVERVIEW OF DISTRICT'S DENTAL PLAN

What type of dental plan does the District offer? The District offers the Self-funded Dental Plan with a Preferred Provider Dentist component.

Are my dependents covered for dental? Yes, if they are covered by a District medical plan.

What happens if I don't use a Preferred Provider Dentist? Any expenses from a non-preferred dentist that exceed the amount the plan would pay a preferred provider dentist would be your responsibility.

How do I find out if my dentist is on the Dental Plan's dentist list? Contact Anthem Blue Cross Blue Shield at 833-914-0825 or visit their web page at www.anthem.com.

Dental Plan Highlights

BENEFIT (based on Eligible Expenses)

| CO-PAYMENTS, DEDUCTIBLES, ANNUAL MAXIMUMS | |
|--|--|
| Annual Maximum | \$2,000 per member Unlimited for children to age 19 |
| Deductible | \$50/member; \$100/family |
| Office Visit Co-payment | No Co-payment |
| DIAGNOSTIC AND PREVENTIVE SERVICES | |
| Routine and Emergency Exams | Covered at 100% |
| All X-rays | Covered at 100% |
| Teeth Cleaning | Covered at 100% |
| Sealants | Covered at 100% |
| RESTORATIVE DENTISTRY AND PROSTHETICS | |
| Fillings | Covered at 80% |
| Permanent Crowns | Covered at 80% |
| Complete Upper or Lower Denture | Covered at 80% |
| Bridge – per tooth | Covered at 80% |
| Implants | Covered at 80% |
| ENDODONTICS AND PERIODONTICS | |
| Root canal therapy – anterior | Covered at 80% |
| Root canal therapy – bicuspid | Covered at 80% |
| Root canal therapy – molar | Covered at 80% |
| Osseous Surgery – per quadrant | Covered at 80% |
| Root Planing – per quadrant | Covered at 80% |
| ORAL SURGERY | |
| Routine Extraction – Single Tooth | Covered at 80% |
| Surgical Extraction | Covered at 80% |
| ORTHODONTIA | |
| Pre-Orthodontic Service | Not Covered |
| Comprehensive Orthodontia | Not Covered |
| MISCELLANEOUS | |
| Local Anesthesia (Novocain) | Covered at 80% |
| After Hours Emergency Care | Covered at 80% |
| Missed Appointment Fee | Not Covered |
| Out of Area Emergency Care - Reimbursement up to: | Covered at 80% |

PPO/QHDHP HIGHLIGHTS

| Benefits | PPO Plan | | QHDHP/HSA | |
|--|--|---|---|---|
| GAP Plan | GAP Plan will reimburse up to \$1,000/inpatient hospital admit; up to \$200 for certain outpatient services; and up to \$25 per non-routine doctor visits, outpatient services, X-ray & Lab services, or urgent care services (\$125 maximum for all services/year/family) GAP Plan is NOT available for QHDHP/HSA. | | | |
| | PPO PROVIDERS | NON-PPO PROVIDERS | In-Network | Out-Of-Network |
| Calendar Year Deductible: | | | | |
| • Per Member | \$500 | \$1,500 | \$2,800 | \$2800 |
| • Per Family | \$1,000 | \$3,000 | \$5,000 | \$5,000 |
| Coinsurance | 80% | 60% | 80% | 60% |
| Out-of Pocket Maximum: | \$4,000 per member \$8,000 per family | \$8,000 per member \$16,000 per family | \$6,550 per member \$13,100 per family | \$6,550 per member \$13,100 per family |
| Inpatient Hospital Services | 80% After Deductible | 60% of UCR After Deductible | 80% after deductible | 60% after deductible |
| Outpatient Surgery | 80% After Deductible | 60% of UCR After Deductible | 80% after deductible | 60% after deductible |
| Primary Care Office Visit | \$35 co-payment | 60% of UCR After Deductible | 80% after deductible | 60% after deductible |
| Specialist Office Visit | \$50 co-payment | 60% of UCR After Deductible | 80% after deductible | 60% after deductible |
| Urgent Care Facility | \$65 co-payment | 60% of UCR After Deductible | 80% after deductible | 60% after deductible |
| Chiropractic (50 visits/yr) | \$35 co-payment | 60% of UCR After Deductible | 80% after deductible | 60% after deductible |
| Physical Therapy (50 visits/yr.) | \$35 co-payment | 60% of UCR After Deductible | 80% after deductible | 60% after deductible |
| Ambulance | 80% After Deductible | 60% of UCR After Deductible | 80% after deductible | 60% after deductible |
| X-ray & Lab Services | 80% After Deductible | 60% of UCR After Deductible | 80% after deductible | 60% after deductible |
| Home Health Care (100 visits/year) | 80% After Deductible | 60% of UCR After Deductible | 80% after deductible | 60% after deductible |
| Emergency Room | 80% after deductible; \$200 co-pay | 60% of UCR after deductible; \$200 co-pay | 80% after deductible | 80% after deductible |
| Substance Abuse Care -Outpatient -Inpatient | Outpatient - \$50 co-payment Inpatient – 80% of PPO after deductible | Outpatient – 60% of UCR after deductible Inpatient – 60% of UCR after deductible | 80% after deductible | 60% after deductible |
| Prescription Drugs – Retail -Deductible -Co-Payment Generic -Co-Payment Preferred Brand -Co-Payment Non Preferred Mail Order (90 Day Supply) -Co-Payment Generic -Co-Payment Preferred Brand -Co-Payment Non-Preferred | \$50 per member \$15 \$25 \$50 \$10 \$50 \$100 | | Subject to Plan Deductible before co-pay applies \$15 \$25 \$50 \$10 \$50 \$100 | |

Note: UCR is defined at the PPO Allowable Rate

2022 Premium Schedule for PPO and QHDHP/HSA Plans with Premium Discount*

PPO

| Coverage Level | 26 Pay Periods 12 Month Classified EEs | 18 Pay Periods 9/10/11 Month Classified EEs | Monthly Premium Full-Time Certified & Administrative EEs | Monthly Premium .5 FTE Certified & Administrative EEs |
|-----------------------|---|--|---|--|
| Employee Only | \$0 | \$0 | \$0 | \$401.15 |
| Employee + Spouse | \$210.44 | \$303.97 | \$455.95 | \$857.10 |
| Employee + 1 Child | \$131.07 | \$189.33 | \$283.99 | \$685.14 |
| Employee + 2 Children | \$251.82 | \$363.74 | \$545.61 | \$946.77 |
| Employee + Family | \$333.79 | \$482.13 | \$723.19 | \$1,124.34 |

QHDHP/HSA (HSA Contribution for 2022 is \$1,898.16 to Member on this Plan)

| Coverage Level | 26 Pay Periods 12 Month Classified EEs | 18 Pay Periods 9/10/11 Month Classified EEs | Monthly Premium Full-Time Certified & Administrative EEs | Monthly Premium .5 FTE Certified & Administrative EEs |
|-----------------------|---|--|---|--|
| Employee Only | \$0 | \$0 | \$0 | \$314.66 |
| Employee + Spouse | \$107.16 | \$154.78 | \$232.17 | \$546.83 |
| Employee + 1 Child | \$41.41 | \$59.83 | \$89.74 | \$404.40 |
| Employee + 2 Children | \$142.85 | \$206.34 | \$309.50 | \$624.16 |
| Employee + Family | \$207.03 | \$299.04 | \$448.56 | \$763.22 |

NOTE: District-paid premiums for Certified Employees on part-time contracts are prorated based on FTE. These rates will be adjusted for School Police and Certified Administrators per their negotiated agreements.

***See "Wellness Program" on page 12 for explanation of Premium Discounts. Premiums are increased by \$40 per month without Premium Discount.**

BASIC GROUP TERM LIFE OVERVIEW

What type of life insurance coverage is it?

It's Group Term Life Insurance with Accidental Death & Dismemberment Coverage. It does not build "cash value".

How much coverage do I have?

Certified/Classified: \$40,000; Confidential Classified: \$50,000; and Administrators: \$250,000

How much does this coverage cost me?

Your life insurance and AD&D coverage is District-paid so there is no cost to you unless you are a part-time contracted teacher in which case your District-paid premiums will be prorated based on FTE.

Can I continue this coverage when I retire?

Yes, up to a maximum of \$200,000 but certain restrictions and limitations on coverage amounts will apply.

Will my limits ever change?

Yes, currently the amount will reduce by 50% at age 70. This is also subject to change.

What do I need to do if I need to change my beneficiary?

Contact Risk Management immediately if you need to change your life insurance beneficiary for any reason e.g., marriage, divorce, or death.

VISION BENEFITS OVERVIEW

Who provides my vision coverage? A company called Vision Service Plan (VSP).

Who is covered and do I have to pay any premiums for this coverage?

You and your eligible dependents are covered and the premium is District-paid so there is no cost to you unless you are a part-time contracted teacher in which case your District-paid premiums will be prorated based on FTE. For example, if you are a .5 FTE, your cost would be \$6.73/month.

Do I have to have my dependents covered by District medical coverage to have vision coverage?

No

How do I find out when I am or my dependents are eligible for exam, lenses and frames?

Please visit the VSP website at www.vsp.com.

What are the benefits?

- | | |
|--------------------|---|
| • Eye Examination | Once each 12 months (From your last date service) |
| • Spectacle Lenses | Once each 24 months (From your last date service) |
| • Frame | Once each 24 months (From your last date service) |

Does the vision plan have a preferred provider list? Yes

Do I have to use a preferred provider?

No, but benefits will be paid at a reduced reimbursement schedule if you use a non-preferred provider.

Are there any "out-of-pocket" costs for me?

Yes, there is a \$10 per member co-payment for the eye examination. There may also be additional charges for such items as: Blended and/or Oversize Lenses; Contact Lenses; Progressive Lenses; Photochromic or tinted lenses other than Pink 1 or 2; Coated or Laminated Lenses; A frame that exceeds the plan allowance; UV protected Lenses.

COMPREHENSIVE GROUP LEGAL SERVICES PLAN OVERVIEW

What is the Comprehensive Group Legal Services Plan?

It's a voluntary benefit through Hyatt Legal Plans and it covers certain legal services for you. Please note that if you enroll in this plan you may not stop coverage for one year.

What is the cost of the plan?

The cost is \$19.80 per month or \$9.14 biweekly which is payroll deducted.

What does it cover?

In addition to the fully covered services such as wills, real estate closings and debt collection defense, the plan also includes unlimited telephone advice and office consultation with a local attorney. If you use a Participating Attorney, there are no claims forms or out-of-pocket expenses for the attorney's fees.

How can I get more information about the plan?

If you have questions or would like to see the list of attorneys, call Hyatt's Client Service Center at 800/ 821-6400.

SECTION 125 BENEFIT PROGRAM OVERVIEW

What is a Section 125 Benefit Program? It's a program under Section 125 of the Internal Revenue Code that allows an employer to take certain employee deductions on a "pretax" or "before tax" basis.

What kind of deductions can I make under the Section 125 Benefit Program? The program consists of two parts that include:

- **Premium Conversion Plan** – Allows dependent medical/health and cancer insurance premiums to be paid on a pretax basis.
- **Flexible Spending Accounts** – There are two types:
 - **Dependent Day Care Expenses** – Allows you to set aside up to \$5,000 per year on a pretax basis to pay for day care expenses for your children under the age of 13.
 - **Non-reimbursed Medical Expenses** – Allows you to set aside up to \$2,700 per year on a pretax basis to pay for expenses not covered by insurance such as deductibles, co-payments, and orthodontia. **Please note**, if you are signing up for the QHDHP/HSA, you will not be eligible for a flexible spending account for medical expenses. Instead, you can make the same contributions directly into your HSA on a tax free basis. You may be eligible for a Limited Purpose Flexible Spending Account, please talk to your American Fidelity representative.

How does the Premium Conversion Plan work?

Example: **After-Tax**

| | |
|------------------------------|----------------|
| Monthly Salary | \$2,000 |
| Tax – 25% | \$ 500 |
| Net Income Before Deductions | \$1,500 |
| Monthly Insurance Premium | \$ 200 |
| Final Net Income | \$1,300 |

Pre-tax Under Section 125 Program

| | |
|---------------------------|----------------|
| Monthly Salary | \$2,000 |
| Monthly Insurance Premium | \$ 200 |
| Income Before Tax | \$1,800 |
| Tax – 25% | \$ 450 |
| Final Net Income | \$1,350 |

As you can see, you would have an extra \$50 in your take-home pay under the Section 125 Program.

How does a Flexible Spending Account work? Assume you have a dependent in braces & you pay \$100 per month for this service, the program would work as follows:

| | |
|------------------------------|----------------|
| <u>After-Tax</u> | |
| Monthly Salary | \$2,000 |
| Tax – 25% | <u>\$ 500</u> |
| Net Income Before Deductions | \$1,500 |
| Monthly Dentist Payment | <u>\$ 100</u> |
| Final Net Income | \$1,400 |

| | |
|---|----------------|
| <u>Pre-tax Under Section 125 Program</u> | |
| Monthly Salary | \$2,000 |
| Monthly Dentist Payment | <u>\$ 100</u> |
| Income Before Tax | \$1,900 |
| Tax – 25% | <u>\$ 475</u> |
| Final Net Income | \$1,425 |

As shown, you'd have an extra \$25 in your take-home pay under the Section 125 Program.

When does the Section 125 Plan Year start and end?

It runs from January 1 through December 31.

When are deductions made?

They're taken from your check each month if you're Certified/Administrator and biweekly if you're a classified employee.

Are there any fees for the Premium Conversion Plan? No

Are there any fees for the Flexible Spending Accounts? No

Who administers the Flexible Spending Accounts?

American Fidelity

How do I get reimbursed if I sign up for a Flexible Spending Account?

You simply use the preloaded debit card on qualified medical expenses or submit a receipt to American Fidelity. You will receive additional information and vouchers from American Fidelity after you enroll.

When can I enroll into a Section 125 Benefit Program?

Please contact American Fidelity at 775-829-1313 for details.

What happens if I don't use all the money set aside in my Flexible Spending Account by the end of December?

IMPORTANT! You will forfeit any unused moneys.

Can I stop my Section 125 Benefit Program deductions at anytime?

IMPORTANT! No, you cannot stop your deductions until the beginning of the next plan year unless you have a qualifying event. However, remember that all Section 125 changes/elections must be renewed every year.

WELLNESS PROGRAM

The District has implemented a comprehensive Wellness Program for employees and spouses covered by District medical insurance. It offers programs that promote healthy lifestyles, decrease the risk of disease, and enhance the quality of life.

Employees may reduce their premiums by \$40 per month if they complete and submit an annual Health Assessment. The premium for their spouse, if covered by District medical insurance, may also be reduced by \$40 per month by having their spouse complete and submit an annual Health Assessment.

Please note that if your health insurance coverage with the District becomes effective on or after June 1, 2022 you will **NOT** need to complete and submit an annual Health Assessment and you will automatically receive the premium discount for the remainder of the current year and the following year. However, you will need to complete and submit an assessment for 2023. When the time comes for you to do your screening, you will receive additional information from the Wellness Office.

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IMPORTANT! 90-DAY WINDOW TO ENROLL

You have a 90 day waiting period from the date you enter into an eligible benefited position. You must return your completed paperwork into Risk Management within that 90 day period. If these forms are not received in the Risk Management Department within the 90 days, you will not be enrolled until the 1st of the month following receipt of your completed paperwork in Risk Management. You will **NOT** be able to add dependents until the next open enrollment unless you have a qualifying event. Adding dependents or making changes during open enrollment will take effect January 1st of the next calendar year.

IMPORTANT NOTE: It takes approximately 30 days to process submitted forms. To ensure your coverage starts on your effective date without delay, please turn your forms into the Risk Management Office within 60 days.

Please note that this information is a summary of the various benefit programs offered to Plan Members. It is not meant as a full explanation of the benefits provided by these programs. Please refer to the plan document or contract for specific benefits and provisions. Any conflict between the information contained herein and any plan document or contract shall be governed by the provisions of said plan document or contract.