Washoe County School District
Every Child, By Name And Face, To Graduation

Risk Management Office
425 East Ninth Street
PO BOX 30425
Reno, NV 89520-3425
(775) 348-0343

December 4, 2023

To: All Retirees Not Covered by District Health Insurance

From: Risk Management

Re: **Health Insurance Open Window– Benefit Year 2024**

Open Window will run from December 1, 2023 through January 31, 2024. During *Open Window,* you may enroll in a District Health plan for a January 1, 2024 effective date when enrollment paperwork is received by December 31, 2023. Enrollment after January 1, 2024, will have a February 1, 2024 effective date.

Enclosed, you will find information on the District's health plans, benefit comparisons of the plans, premium schedules, and summary information on other benefits.

IMPORTANT NOTE:
Per the Plan Document, a member must enroll in Medicare Part A & B when they become eligible. Failure to enroll would result in medical claims only being paid at 20% by the Health Plan. All eligible members should enroll when coverage is available.

DISTRICT HEALTH PLANS
QUESTIONS & ANSWERS

What is the effective date of coverage changes? January 1, 2024 for paperwork received in the Risk Management Department no later than December 31, 2023.

Are there any "Pre-existing Condition Limitations" if I change plans? No

What health plan options do I have to select from? The District offers retirees **two** options. These include:

1. PPO – Uses **Anthem** provider network
2. QHDHP (Qualified High Deductible Health Plan) – Uses **Anthem** provider network

Can I select one plan for myself and a different plan for my dependents?
No, dependents must take the same plan as the retiree.

What is the Effective Date of Coverage if I add my dependent: January 1, 2024 (if paperwork is received in the Risk Management Department no later than December 31, 2023). If paperwork is received between January 1 – January 31, 2024, then the effective date would be February 1, 2024.

- **Is Evidence of Insurability Required?:** No
- **Are there Pre-existing Condition Limitations:** There are no pre-existing condition limitations.

If enrolling family members, please include the appropriate documentation for eligibility verification: marriage/birth certificate, domestic partnership, or latest tax return.

Have questions?
Call the Risk Management Office at (775)348-0343.

DISTRICT'S DENTAL PLAN

What type of plan is the District's Dental Plan?
It's a Self-funded Dental Plan with a Preferred Provider Dentist component.

Who processes the claims? Anthem BCBS – P.O. Box 5747, Denver, CO 80217

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 allow a preferred provider dentist would be your responsibility.

How do I find out if my dentist is on the PPO dentist list? Contact Anthem at (833)914-0825

What is the annual limit? $2,000 per person; Unlimited for children to age 19

What are the deductibles and co-insurance percentages for this plan?

- $50/member deductible; $100/family deductible
- Covers preventive care at 100% with no deductible
- Covers restorative care at 80%
- Covers major care at 80%

What are the premiums?
See the Premium Schedules on page 6. The premiums listed included both medical and dental premiums.

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

Is orthodontia covered?
Yes. For children up to age 19

VISION BENEFITS

Do all Retirees have vision coverage? No, only those that elected to continue the coverage at retirement.

If I don't have vision coverage, can I add it now?
Yes, you may during the month of January of even numbered years, by completing attached Open Enrollment form.

Who provides my vision coverage and what is the premium? Vision Service Plan (VSP) provides the coverage and the premium is $14.27/month.

Who's covered? You and your eligible dependents**.**

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. Or call (800)877-7195

What are the benefits?

- Eye Examination — Once each 12 months (On the day following your last date of service)
- Spectacle Lenses — Once each 24 months (On the day following your last date of service)
- Frame — Once each 24 months (On the day following your last date of 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.

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.

ANTHEM PPO/QHDHP HIGHLIGHTS

Benefits	***PPO Plan***			***QHDHP***	
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's visit, outpatient services, X-ray & Lab services, or urgent care services ($125 maximum for all services/year/ family)				
	PPO PROVIDERS	**NON-PPO PROVIDERS**		**In-Network**	**Out-Of-Network**
Calendar Year Deductible: • Per Member • Per Family	 $500 $1,000	 $1,500 $3,000		 $3,200 $5,000	 $3,200 $5,000
Coinsurance	80%	60%		80%	80%
Out-of Pocket Maximum:	$4,000 per member $8,000 per family	$8,00 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	50% of UCR After Deductible		80% after deductible	60% after deductible
Outpatient Surgery	80% After Deductible	50% 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 and $200 co-pay	60% of UCR after deductible and $200 co-pay		80% after deductible	80% after deductible
Substance Abuse Care -	Outpatient - $35 co-payment Inpatient – 80% of PPO after deductible	Outpatient – 50% of UCR after deductible Inpatient – 50% 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					

Premium Schedules Effective January 1, 2024

Coverage Level	PPO Plan: Monthly Premiums		QHDHP Plan: Monthly Premiums
Retiree Only (No Subsidy)	$802.12		$634.45
Classified Retiree (With Subsidy) ***Subsidy is for CLASSIFIED employees only who were hired prior to July 1, 1999, with 15 years of continuous work. Certified (Teachers and Admin) are not eligible for subsidy.**	$507.70		$407.09
Spouse	$470.48		$246.10
1 Child	$290.85		$95.12
2 Children	$566.18		$328.08
Family	$743.59		$475.48

PLEASE NOTE:

1. Dependent premiums are in addition to the retiree premium.
2. Vision coverage is an additional $14.27 per month.
3. If GAP coverage is elected for retiree, then all dependents must carry GAP.

Please note that this *Open Window* 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. Copies are available from the Risk Management Office. Any conflict between the information contained herein and the provisions of said plan document or contract shall govern any plan document or contract.

WASHOE COUNTY SCHOOL DISTRICT HEALTH PLAN NOTICES

Please read the following Important Health Plan Notices

- *Children's Health Insurance Program (CHIP)*
- *General Notice of COBRA Rights*
- *Health Insurance Exchange Notice*
- *Special Enrollment Rights*
- *The Women's Health and Cancer Rights Act*
- *Notice of Privacy Practices*
- *Medicare Part D Creditable Coverage Notice*

CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healhcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

If you live in Nevada you may be eligible for assistance in paying your employer health plan premiums. Contact the **Nevada Medicaid at 1-800-992-0900,** http://dwss.nv.gov for more information on eligibility.

To see if any other states have added a premium assistance program or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

GENERAL NOTICE OF COBRA RIGHTS

This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it**. The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. For additional information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Risk Management Department at 775/348-0343.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace (such as Silver State Health Insurance Exchange). By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happen:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to Washoe County School District, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

When is COBRA Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, or the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event.

You Must Give Notice of Some Qualifying Events

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 31 days after the qualifying event occurs. Your notice must provide the type of qualifying event, the date of the qualifying event, and the name and address of the employee, spouse or dependent who underwent the qualifying event. You must provide this notice to the Risk Management Department.

How is COBRA Coverage Provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended:

- ***Disability extension of 18-month period of continuation coverage:*** If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage.

- ***Second qualifying event extension of 18-month period of continuation coverage:*** If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family may extend their COBRA continuation coverage, for a maximum of 36 months (as measured from the first qualifying event), if notice of the second qualifying event is properly

given to the Plan. This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

If You Have Questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan Contact Information

Washoe County School District
425 East Ninth Street
Reno, Nevada 89523
775/348-0343

Shorter Maximum for Health FSAs

The maximum federal COBRA period for a health flexible spending arrangement (health FSA) maintained by the Employer (if there is a positive account balance as of the date of the qualifying event) ends on the last day of the plan year in which the qualifying event occurred. If there is a negative account balance as of the date of the qualifying event, no COBRA coverage will be offered.

HEALTH INSURANCE EXCHANGE NOTICE

This notice provides some basic information about the Marketplace and employment-based health coverage.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. For eligible employees, the health plan offered by the District qualifies as affordable and meets essential coverage standards set by the Affordable Care Act. Because of this, you and your family will not qualify to receive any credits or subsidies if you purchase coverage from a Marketplace, regardless of your income or family size. If you are a seasonal employee, temporary employee or are in your waiting period for benefits and do not have access to other coverage, you may still qualify for reduced premiums through a Marketplace plan.

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, the employer contribution –as well as your employee contribution to employer-offered coverage- is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about your coverage, please review your summary plan description or contact the District's Risk Management office at 775/348-0343.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the marketplace and its cost. Please visit **HealthCare.gov** for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

SPECIAL ENROLLMENT RIGHTS

HIPAA requires we notify you about your right to later enroll yourself and eligible dependents for coverage in Washoe County School District's health plan under "special enrollment provisions" briefly described below.

- **Loss of Other Coverage**. If you decline enrollment for yourself or for an eligible dependent because you have other group health plan coverage or other health insurance, you may be able to enroll yourself and your dependents under the Washoe County School District's health plan if you or your dependents lose eligibility for that other coverage, or if the other employer stops contributing toward your or your dependents' other coverage. You must request enrollment within 31 days after you or your dependents' other coverage ends, or after the other employer stops contributing toward the other coverage.
- **New Dependent by Marriage, Birth, Adoption, or Placement for Adoption**. If you gain a new dependent as a result of a marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your new dependents under Washoe County School District's health plan. You must request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption. In the event you acquire a new dependent by birth, adoption, or placement for adoption, you may also be able to enroll your spouse, if your spouse was not previously covered.
- **Enrollment Due to Medicaid/CHIP Events**. If you or your eligible dependents are not already enrolled in Washoe County School District's health plan, you may be able to enroll yourself and your eligible dependents if: (i) you or your dependents lose coverage under a state Medicaid or children's health insurance program (CHIP), or (ii) you or your dependents become eligible for premium assistance under state Medicaid or CHIP. You must request enrollment within 60 days from the date of the Medicaid/CHIP event. The CHIP Model Notice containing additional information about this right as well as contact information for state assistance is included in the CHIP Model Notice.

Please contact the Risk Management office at 775/348-0343 for details, including the effective dates of coverage applicable to each of these special enrollment provisions. Additional information regarding your rights to enroll in group health coverage is found in the applicable group health plan summary plan description(s) or insurance contract(s).

THE WOMEN'S HEATH & CANCER RIGHTS ACT OF 1998

In the case of an employee or dependent who receives benefits under the plan in connection with a mastectomy and who elects breast reconstruction (in a manner determined in consultation with the attending physician and the patient), coverage will be provided for:

- Reconstruction of the breast on which mastectomy has been performed, including nipple and areola reconstruction and re-pigmentation to restore the physical appearance of the breast;
- Surgery and reconstruction on the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment for physical complications of all stages of mastectomy, including lymphedemas.

Coverage for reconstructive breast surgery may not be denied or reduced on the grounds that it is cosmetic in nature or that it otherwise does not meet the coverage definition of "medically necessary". Benefits will be provided on the same basis as for any other illness or injury under the Plan.

If you would like more information on WHCRA benefits, call the Risk Management office at 775/348-0343.

NOTICE OF PRIVACY PRACTICES

Washoe County School District Group Health Plan **425 E. Ninth Street, Reno, NV 89523**	**Privacy Officer Contact Information: 775/348-0343** **Riskmanagement@washoeschools.net**

Your Information, Your Rights, Our Responsibilities
This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you. You have the right to:

- **Get a copy of your health and claims records.** You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this. We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
- **Correct your health and claims records**. You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this. We may say "no" to your request, but we'll tell you why in writing within 60 days.
- **Request confidential communications**. You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. We will consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not.
- **Ask us to limit the information we share**. You can ask us **not** to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.

- **Get a list of those with whom we've shared your information**. You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
- **Get a copy of this privacy notice**. You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
- **Choose someone to act for you**. If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.
- **File a complaint if you believe your privacy rights have been violated**. You can complain if you feel we have violated your rights by contacting our Privacy Officer (contact information is on Page 1 of this Notice).

You can also file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/. We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation
- Contact you for fundraising efforts

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we *never* share your information unless you give us written permission:

- Marketing purposes
- Sale of your information

Our Uses and Disclosures

How do we typically use or share your health information?
We typically use or share your health information in the following ways.

- **Help manage the health care treatment you receive.** We can use your health information and share it with professionals who are treating you. *Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.*
- **Run our organization.** We can use and disclose your information to run our organization and contact you when necessary. **We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage.** This does not apply to long term care plans. *Example: We use health information about you to develop better services for you.*

- **Pay for your health services.** We can use and disclose your health information as we pay for your health services. *Example: We share information about you with your dental plan to coordinate payment for your dental work.*
- **Administer your plan.** We may disclose your health information to your health plan sponsor for plan administration. *Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.*

How else can we use or share your health information?
We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html**.**

- **Help with public health and safety issues.** We can share health information about you for certain situations such as:
    - Preventing disease
    - Helping with product recalls
    - Reporting adverse reactions to medications
    - Reporting suspected abuse, neglect, or domestic violence
    - Preventing or reducing a serious threat to anyone's health or safety
- **Do research.** We can use or share your information for health research.
- **Comply with the law.** We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
- **Respond to organ and tissue donation requests and work with a medical examiner or funeral director.** We can share health information about you with organ procurement organizations. We can also share health information with a coroner, medical examiner, or funeral director when an individual dies.
- **Address workers' compensation, law enforcement, and other government requests.** We can use or share health information about you:
    - For workers' compensation claims
    - For law enforcement purposes or with a law enforcement official
    - With health oversight agencies for activities authorized by law
    - For special government functions such as military, national security, and presidential protective services
- **Respond to lawsuits and legal actions.** We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Additional Restrictions on Use and Disclosure
Certain federal and state laws may require special privacy protections that restrict the use and disclosure of certain health information, including highly confidential information about you. "Highly confidential information" may include confidential information under Federal laws governing alcohol and drug abuse information and genetic information as well as state laws that often protect the following types of information:

1. HIV/AIDS
2. Mental health
3. Genetic tests
4. Alcohol and drug abuse
5. Sexually transmitted diseases and reproductive health information
6. Child or adult abuse or neglect, including sexual assault.

If a use or disclosure of health information described above in this notice is prohibited or materially limited by other laws that apply to us, it is our intent to meet the requirements of the more stringent law. Attached to this notice is a "Federal and State Amendments" document summarizing additional restrictions.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html**.**

Changes to the Terms of This Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site, and we will mail a copy to you.

WASHOE COUNTY SCHOOL DISTRICT
Medicare Part D Creditable Coverage Notice

IMPORTANT NOTICE
ABOUT YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Washoe County School District and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. Washoe County School District has determined that the prescription drug coverage offered by the District is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join a Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year on October 15 to December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens to Your Current Coverage If You Decide to Join a Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current District coverage will not be affected. If you do decide to join a Medicare drug plan and drop your current District coverage, be aware that you and your dependents will be able to get this coverage back. For information about reinstatement to the District coverage, please contact the Risk Management office at 775/343-0343.

When Will You Pay a Higher Premium (Penalty) to Join a Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with the District and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as

long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice or Your Current Prescription Drug Coverage

Contact the Risk Management Office at 775/343-0343. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through the District changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage…

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date:	10/31/2019
Name of Entity/Sender:	Washoe County School District
Contact--Position/Office:	Risk Management Office
Address:	425 East Ninth Street
Phone Number:	(775) 348-0343

YOUR RIGHT TO FILE A COMPLAINT WITH THE PLAN OR THE HHS SECRETARY

If you believe that your privacy rights have been violated, you may complain to the Plan in care of the following officer:
(Washoe County School District Risk Manager, PO Box 30425 Reno, Nevada 89520-3425, 775-348-0343, Riskmanagement@washoeschools.net).
You may file a complaint with the Secretary of the U.S. Department of Health and Human Services, Hubert H. Humphrey Building, 200 Independence Avenue S.W., Washington, D.C. 20201.
The Plan will not retaliate against you for filing a complaint.

WHOM TO CONTACT AT THE PLAN FOR MORE INFORMATION

If you have any questions regarding this notice or the subjects addressed in it, you may contact the following officer: (Washoe County School District Risk Manager, PO Box 30425 Reno, Nevada 89520-3425, 775-348-0343, Riskmanagement@washoeschools.net)

WASHOE COUNTY SCHOOL DISTRICT
RETIREE ELECTION FORM - BENEFIT YEAR 2024
OPEN WINDOW

(Forms must be returned to Risk Management by December 31, 2023 for a January 1, 2024 effective date).

Return to: Washoe County School District
Risk Management Office
PO Box 30425
Reno, NV 89520-3425

Questions? Call: (775)348-0343 or Email: RiskManagement@washoeschools.net

Please Print

Name: Last			First		M.I.
Social Security Number:	Date of Birth:	Phone:	Email Address:		
Address:		City:		State:	Zip:

Medical Plan Selection (check only one)
_____Preferred Provider Organization (PPO)
_____Qualified High Deductible Health Plan (QHDHP)

_____ Add Gap Coverage
_____ Add Vision Coverage

Add/Delete:
Name of Spouse:_____SSN_____DOB_____

Add/Delete:
Name of Child:_____SSN_____DOB_____
(If more children need to be added/deleted, please put information on back of form).

If enrolling family members, please include the appropriate documentation for eligibility verification, marriage/birth certificate, domestic partnership, or latest tax return.

I authorize WCSD to deduct premiums from my PERS retirement check. I understand these premiums are subject to periodic changes, therefore, I authorize WCSD to deduct these changes from my PERS check as required. If the premium is unable to be deducted from my PERS check for any reason, I understand that I am liable to submit payment by the 25th of each month. If payment is not received by WCSD by the 25th of the month my benefits may be terminated without notification.

_____ _____
Signature Date