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

August 30, 2022

To: COBRA Beneficiaries

Fr: Risk Management Office

Re: **Health Insurance Open Enrollment – Benefit Year 2023 and Federally required Summary of Benefits and Coverage**

Open Enrollment will run from September 1 through November 1, 2022. During *Open Enrollment**,** you may:

1. Change your District health plan.
2. Add/delete dependents.

*All changes will be effective January 1, 2023.

Enclosed, you'll find information on the District's health plans, benefit comparisons of the plans and premium schedules. If you would like to make a medical plan change, then you **must** complete the attached election form and return it to Isolved Participant Team, P.O. Box 949, Coldwater, MI 49036-0949

DISTRICT HEALTH PLANS
QUESTIONS & ANSWERS

Have premiums changed? No, see the "Premium Schedules" on page 8.

What is the effective date of coverage changes? January 1, 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 **two** options. These include:

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

What is the Effective Date of Coverage if I add my dependent: January 1, 2023

- **Is Evidence of Insurability Required? :** No

- **Are there Pre-existing Condition Limitations:**
  There are no pre-existing condition limitations.

To what age may I enroll/cover my child/children? Under the Health Care Reform bill, you may cover your child/children to age 26. They do not have to be a full-time student, living with you and/or dependent upon you for financial support.

How long will *Open Enrollment* last? From September 1, 2022 through November 1, 2022. After November 1st, you will not be able to make a change until next year's Open Enrollment.

Have questions? Call Anthem at (833) 914-0825

GROUP HEALTH PLANS (PPO)
ANTHEM

QUESTIONS & ANSWERS

What type of plan is this? It is a Self-funded Comprehensive Major Medical Plan with a Preferred Provider Organization (PPO) component.

Do they cover services worldwide? No, coverage is only good within the United States

What are Preferred Providers or PPOs? Providers who **are** contracted to provide services at a contracted fee.

What are Non-Preferred Providers or Non-PPOs? Providers who **are not** contracted to provide services at a contracted fee.

How do I find out if my doctor is a PPO provider? You may access the Anthem provider directory by entering **YFW** in the **Identification Number or Alpha Prefix** box at:
https://www.anthem.com/find-doctor or call: Phone Number: (833) 914-0825

Do I need a referral from my Primary Care doctor to see a Specialist? No

Who are the PPO Hospitals in Washoe County?
- They are Renown Regional Medical Center, Renown South Meadows, St. Mary's Hospital, Carson Tahoe Hospital and Northern Nevada 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" as defined in our Plan Document, you will receive reimbursement at the PPO level of benefit.

Must I follow any procedures to ensure I receive full benefits for certain services? Yes
- All elective inpatient hospital admissions must be pre-certified before you're admitted.
- All emergency inpatient hospital admissions must be pre-certified within 72 hours of being admitted.

Who pre-certifies these services?

- Your physician needs to contact *Anthem at (833) 914-0825*

What happens if I don't follow these procedures? Your benefit will be reduced to 50% and it will not apply towards your Co-insurance Limit.

Who processes and administers the claims?

- **Anthem BCBS – P.O. Box 5747, Denver, CO 80217-5747.**

What is a deductible? It's the amount of allowed charges you must first pay before the plan will pay any charges.

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 and the co-insurance limit is the total amount of eligible expenses that the co-insurance is applied to before the plan will pay your benefits at 100%.

For example, if the plan has a co-insurance percentage of 80% and a co-insurance limit of $15,000, you would pay 20% of the first $15,000 of eligible expenses you incurred during the year or $3,000. Any eligible expenses that you would incur during the year that exceeded the $15,000 would be covered at 100% for the remainder of the year.

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.

Do these plans have a *prescription drug plan*? Yes, it is administered by Anthem BCBS and has a:

- $50 per member annual deductible
- generic drugs have a $15 per prescription co-payment at retail (after deductible has been met)/$10 mail order
- specialty drugs (e.g., self/infusion injected drugs) have a $25 co-payment (after deductible has been met)
- "preferred brand name" drugs have a $25 co-payment (after deductible has been met)
- "non-preferred brand name" drugs have a $50 co-payment (after deductible has been met)

(Note: If you opt for a brand-name drug and there is no medical necessity for its use over a generic drug, you will be required to pay the brand-name co-payment plus the difference in price between the brand-name drug and its generic equivalent.)

Do these plans have a mail order prescription drug program? Yes, but only for prescription drugs that have been determined by Anthem to be maintenance prescription drugs. You will receive a 90-day supply through mail order rather than a 30-day supply from your pharmacy. There is no deductible on mail order prescriptions and the co-payments are as follows:

- generic drugs have a $10 per prescription co-payment
- "preferred brand name" drugs have a $50 co-payment
- "non-preferred brand name" drugs have a $100 co-payment

(Note: If you opt for a brand-name drug and there is no medical necessity for its use over a generic drug, you will be required to pay the brand-name co-payment plus the difference in price between the brand-name drug and its generic equivalent.)

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 on or after January 1, 2023? Yes, the list changes every year. So, a preferred-brand name drug not on the list in 2022 could be on the list in 2023. Likewise, a preferred-brand name drug on the list in 2022 may not be on the list for 2023. The formulary may also change during the year if, for example, a brand name drug goes generic or over-the-counter.

QUALIFIED HIGH DEDUCTIBLE HEALTH PLAN (QHDHP)
ANTHEM

QUESTIONS & ANSWERS

Is there an annual maximum benefit amount? No.

What type of plan is this? It is a Self-funded Comprehensive Major Medical Plan.

Do they cover services worldwide? No, coverage is only good within the United States.

What are Preferred Providers or PPOs? Providers who **are** contracted to provide services at a contracted fee.

What are Non-Preferred Providers or Non-PPOs? Providers who **are not** contracted to provide services at a contracted fee.

How do I find out if my doctor is a PPO provider? You may access the Anthem provider directory by entering **YFW** in the **Identification Number or Alpha Prefix** box at:
https://www.anthem.com/find-doctor/ or call: Phone Number: (833) 914-0825

Do I need a referral from my Primary Care doctor to see a Specialist? No

Who are the PPO Hospitals in Washoe County?

- They are Renown Regional Medical Center, Renown South Meadows, St. Mary's Hospital, Carson Tahoe Hospital and Northern Nevada 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" as defined in our Plan Document, you will receive reimbursement at the PPO level of benefit.

Must I follow any procedures to ensure I receive full benefits for certain services? Yes

- All elective inpatient hospital admissions must be pre-certified before you're admitted.
- All emergency inpatient hospital admissions must be pre-certified within 72 hours of being admitted.

Who pre-certifies these services?

- Your physician needs to contact *Anthem at (833) 914-0825*

What happens if I don't follow these procedures? Your benefit will be reduced to 50% and it will not apply towards your Co-insurance Limit.

Who processes and administers the claims?

- **Anthem BCBS – P.O. Box 5747, Denver, CO 80217-5747.**

What is a deductible? It's the amount of allowed charges you must first pay before the plan will pay any charges.

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 and the co-insurance limit is the total amount of eligible expenses that the co-insurance is applied to before the plan will pay your benefits at 100%.

For example, if the plan has a co-insurance percentage of 80% and a co-insurance limit of $15,000, you would pay 20% of the first $15,000 of eligible expenses you incurred during the year or $3,000. Any eligible expenses that you would incur during the year that exceeded the $15,000 would be covered at 100% for the remainder of the year.

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.

Do these plans have a *prescription drug plan*? Yes, it is administered by Anthem BCBS and has a:

- $3,000 per member combined medical and prescription annual deductible
- generic drugs have a $15 per prescription co-payment at retail (after deductible has been met)/$10 mail order
- specialty drugs (e.g., self/infusion injected drugs) have a $25 co-payment (after deductible has been met)
- "preferred brand name" drugs have a $25 co-payment (after deductible has been met)
- "non-preferred brand name" drugs have a $50 co-payment (after deductible has been met)

(Note: If you opt for a brand-name drug and there is no medical necessity for its use over a generic drug, you will be required to pay the brand-name co-payment plus the difference in price between the brand-name drug and its generic equivalent.)

Do these plans have a mail order prescription drug program? Yes, but only for prescription drugs that have been determined by Anthem to be maintenance prescription drugs. You will receive a 90-day supply through mail order rather than a 30-day supply from your pharmacy. There is no deductible on mail order prescriptions and the co-payments are as follows:

- generic drugs have a $10 per prescription co-payment
- "preferred brand name" drugs have a $50 co-payment
- "non-preferred brand name" drugs have a $100 co-payment

(Note: If you opt for a brand-name drug and there is no medical necessity for its use over a generic drug, you will be required to pay the brand-name co-payment plus the difference in price between the brand-name drug and its generic equivalent.)

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 on or after January 1, 2023? Yes, the list changes every year. So, a preferred-brand name drug not on the list in 2022 could be on the list in 2023. Likewise, a preferred-brand name drug on the list in 2022 may not be on the list for 2023. The formulary may also change during the year if, for example, a brand name drug goes generic or over-the-counter.

DISTRICT'S DENTAL PLAN

QUESTIONS & ANSWERS

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**

Are there any plan changes?
No.

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?
You may find a dental provider by accessing Anthem's provider directory. Enter **YFW** in the **Identification Number** or **Alpha Prefix** box at the following link: https://www.anthem.com/find-doctor/ or call Anthem at: (833) 914-0825.

What is the annual limit? $2,000 per person; Children up to age 19 – unlimited

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

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

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

Is orthodontia covered? No

VISION BENEFITS

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

How do I find out when I am or my dependents are eligible for exam, lenses and frames? Please visit our website at www.washoeschools.net/risk and click on "Vision - Benefits" or the VSP website at www.vsp.com.

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.

PPO/QHDHP HIGHLIGHTS

Benefits	***PPO Plan***		***QHDHP(HIGH DEDUCTIBLE)***	
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, 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	$3,000 $5,000	$3,000 $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 and $200 co-pay	60% of UCR After Deductible and $200 co-pay	80% after deductible	80% after deductible
Substance Abuse Care $39,000 Lifetime Maximum -Withdrawal ($1,500/year max) -Inpatient ($10,000/year max) -Outpatient ($2,500/year max)	Outpatient - $50 co-payment Inpatient - 80% of PPO after deductible	Outpatient – 50% of UCR after deductible Inpatient – 50% of UCR after deductible	80% after deductible	80% after deductible
Prescription Drugs **Retail:** -Deductible -Co-payment: Generic -Co-payment: Preferred Brand -Co-payment: Non-Preferred **Mail Order** (Maintenance Drugs Only; 90 Day Supply; No Deductible) -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

COBRA PREMIUM SCHEDULES
Effective January 1, 2023

	PPO	QHDHP(High Deductible)
Coverage Level	**Monthly Premium**	**Monthly Premium**
Beneficiary Only	$800.68	$624.24
Beneficiary + Spouse	$1,265.75	$861.05
Beneficiary + 1 Child	$1,090.35	$715.77
Beneficiary + 2 Children	$1,357.21	$939.93
Beneficiary + Family	$1,538.33	$1,081.77

Please note that this *Open Enrollment* 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.

WASHOE COUNTY SCHOOL DISTRICT HEALTH PLAN NOTICES

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.healthcare.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.

COVID-19 Temporary Deadline Extension for Participant Notices

In accordance with federal guidance, the Plan Administrator shall disregard the period from March 1, 2020 until 60 days after the announced end of the COVID-19 National Emergency or such other date announced by the Agencies in any future notice ("Outbreak Period") when determining the deadline for the following participant actions:

- The 60-day period for individuals to notify the plan of a COBRA qualifying event (e.g. divorce/legal separation, child attaining age 26, or SSA disability determination);
- The 60-day election period for COBRA continuation coverage after receipt of the COBRA Election Notice; and,
- The date for making COBRA premium payments (e.g. 45-day initial payment deadline and/or 30 day grace period for subsequent payments).

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:

3

- ***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.

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit https://www.medicare.gov/medicare-and-you.

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 89512
(775) 348-0343

Special COBRA Rule for Health FSAs

COBRA coverage under the Health FSA will be offered only to qualified beneficiaries losing coverage who have underspent accounts. A qualified beneficiary has an underspent account if the annual limit elected by the covered employee, reduced by the reimbursable claims submitted up to the time of the qualifying event, is equal to or more than the amount of the premiums for Health FSA COBRA coverage that will be charged for the remainder of the Plan Year. Health FSA COBRA coverage will only last until the end of the Plan Year during which the qualifying event occurred. **The use-it-or-lose rule will continue to apply, so any unused funds (in excess of any carryover amount, if applicable) will be forfeited at the end of the Plan Year (and grace period if applicable) and the Health FSA COBRA coverage will be terminated**.
If applicable, any carryover funds remaining in a Health FSA account after the end of the Plan Year in which a qualifying event occurred will continue to be available to reimburse health care expenses until the qualified beneficiary's other COBRA coverage (e.g. medical, dental, vision) ends.

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 fort 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 89512**	**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) 348-0343.

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) 348-0343. **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:	08/15/2023
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 Rights and Protections Against Surprise Medical Bills

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

What is "balance billing" (sometimes called "surprise billing")?
When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.
"Out-of-network" describes providers and facilities that haven't signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called "**balance billing**." This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.
"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

You are protected from balance billing for:

Emergency services

If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan's in-network cost-sharing amount (such as copayments and coinsurance). You **can't** be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **can't** balance bill you and may **not** ask you to give up your protections not to be balance billed.
If you get other services at these in-network facilities, out-of-network providers **can't** balance bill you, unless you give written consent and give up your protections.
You're never required to give up your protections from balance billing. You also aren't required to get care out-of-network. You can choose a provider or facility in your plan's network.

When balance billing isn't allowed, you also have the following protections:

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.
- Your health plan generally must:
  - Cover emergency services without requiring you to get approval for services in advance (prior authorization).
  - Cover emergency services by out-of-network providers.
  - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
  - Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

If you believe you've been wrongly billed, the federal phone number for information and complaints is: 1-800-985-3059. Visit www.cms.gov/nosurprises/consumers for more information about your rights under federal law.

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 Employee Benefit 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 Employee Benefit Manager, PO Box 30425 Reno, Nevada, 89520-3425, (775) 348-0343, Riskmanagement@washoeschools.net)