WASHOE COUNTY SCHOOL DISTRICT
Risk Management Office

Questions/Answers and Highlights effective 1/1/06 for the District's:

- ***Group Health Plan***
- ***Health Maintenance Plan***
- ***Dental Plan***
- ***Basic Term Life Insurance***
- ***Supplemental Term Life Insurance***
- ***Vision Plan***
- ***Legal Plan***
- ***Section 125 Program***
- ***Employee Assistance Program***
- ***Wellness Program***

GROUP HEALTH PLAN OVERVIEW

What type of plan is the Group Health Plan?
A Self-funded Comprehensive Major Medical Plan with a Preferred Provider Organization (PPO) component.

Does it cover services worldwide?
Yes

Is there a lifetime maximum benefit amount?
Yes, it's $2 million.

Does the Group Health Plan have more than one plan of benefits?
Yes, it has two benefit plans called the *"Low Deductible" Plan* and *the "High Deductible"/GAP Plan*.

What is the GAP Plan?
The GAP Plan (through American Fidelity Insurance Company) is designed to help cover some of your out-of-pocket expenses with the *"High Deductible" Plan*. It will pay up to $1,000 per inpatient hospital confinement, up to $200 for certain outpatient services, and up to $25/doctor visit (limit of $125/family). If you cover your dependents, they will also have the GAP Plan coverage. There are specific exclusions to this plan, so please carefully read the GAP Plan brochure in your packet. (Please note that the "Pre-Existing Conditions" exclusion has been waived.) To be reimbursed by the GAP Plan, you'll need to submit to American Fidelity the "Explanation of Benefits" (EOB) you receive from CDS Group Health. If you select this plan, American Fidelity will send you more information regarding this process.

How are the plans different?
A Benefit Comparison is provided on the pages that follow.

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?
Contact *Saint Mary's Preferred Health Care Networ*k at (775)770-6900 or (800)433-3077. You may also visit their web site at www.saintmarysreno.com (click on "Visit Health Plans", then click on "Health Plan Members", then click on "Provider Directory").

What are the PPO Hospitals in Washoe County?
Saint Mary's Regional Medical Center 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", you will receive reimbursement at the PPO level of benefit (no reduction in level of benefit).

What is a deductible?
It's the amount of billed 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 billed charges 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 70% and a co-insurance limit of $10,000, you would pay 30% of the first $10,000 you incurred during the year or $3,000. Any eligible expenses that you would incur during the year that exceeded the $10,000 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.

Are there any procedures I must follow to ensure I receive full benefits for certain services?
Yes, you must have all inpatient hospital admissions pre-certified. If it is an elective hospitalization, it must be pre-certified before you're admitted. If it is an emergency, it must be pre-certified within 72 hours of being admitted. Also, all elective outpatient surgical and any procedures, services or supplies that exceed $1,000 must be pre-certified.

Who pre-certifies these services?
*Saint Mary's Preferred Health Care Networ*k at (775)770-6900 or (800)433-3077

What happens if I don't follow these procedures?
Your allowable charges will be reduced by 50% with payment made against that reduced amount and it will not apply towards your Co-insurance Limit.

Who processes and administers the claims?
CDS Group Health, PO Box 50190, Sparks, NV 89435-0190, (775) 352-6900

Does this program have a prescription drug benefit?
Yes. It is administered by Catalyst RX – 888/869-4600.

Are prescription drugs covered differently under the *"Low Deductible" Plan* and the *"High Deductible" Plan*?
No, both plans have a $50 per member annual deductible. Once this is met, generics have a $10 per prescription co-payment, "preferred brand name" drugs have a $20 co-payment and "non-preferred brand name" drugs have a $40 co-payment. (Note: If a generic is available and your doctor does not specifically request a brand name, you would pay the difference between the brand name drug and its generic equivalent in addition to the applicable co-payment.)

Do both options have a mail order prescription drug program?
Yes. You will receive a 90-day supply through mail order rather than a 30-day supply from your pharmacy. The co-payment amount would be twice the applicable co-payment for the 30-day supply and there is no deductible on mail order prescriptions. (Note: If a generic is available and your doctor does not specifically request a brand name, you would pay the difference between the brand name drug and its generic equivalent in addition to the applicable co-payment.)

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

Can the list of "preferred-brand" name drugs change?
Yes, the list changes every year. So, a preferred-brand name drug not on the list in 2005 could be on the list in 2006. Likewise, a preferred-brand name drug on the list in 2005 may not be on the list for 2006. The formulary may also change during the year if a drug brand name drug goes generic or over-the-counter.

HEALTH MAINTENANCE/GAP PLAN OVERVIEW

What type of plan is the Health Maintenance Plan?
It's a self-funded Exclusive Provider Organization or EPO.

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

Is there a lifetime maximum benefit amount?
Yes, it's $2 million.

Do I need to live in a certain service area to elect this plan?
Yes, you must reside in the Northern Nevada Service Area (or North Lake Tahoe area).

Are there deductibles or co-insurance requirements and claim forms to complete?
No, you will only need to make a "copayment" when you receive services except for prescription drugs. This program has a $50/member deductible. No, there are no claims forms to complete.

Must I receive my care from only contracted providers?
Yes, you must receive your care from only the physicians, hospitals, and other health care providers that have contracted to provide services for the plan.

What happens if I don't use a contracted provider?
No benefits will be paid.

Must I select a Primary Care Physician and what is a Primary Care Physician?
Yes, you must select a Primary Care Physician (PCP) from the plan's list of physicians. Primary Care Physicians include General Practitioners, Internists, and Pediatricians. OB/GYNs are not PCPs and do not direct medical care, however, they fall under the PCP co-payment amount.

Who directs my medical care?
Your Primary Care Physician.

How do I see a medical specialist?
Again, your Primary Care Physician will direct all of your medical care including referrals to specialists. If your Primary Care Physician feels you need to see a specialist, he/she will refer you to the appropriate doctor for your condition.

What happens if I see a specialist without a referral from my Primary Care Physician?
No benefits will be paid even if a contracted specialist performs the services.

What if I need to see a specialist that is not available in the service area?
The plan will refer you to the proper specialist who can handle your medical condition.

What if I travel outside the plan's service area?
The plan will cover emergency and urgent care services only.

How do I find out if my doctor is on the plan's physician list?
Contact Hometown Health Partners at 775/982-3232 or 800/336-0123; or their web page at www.hometownhealth.com or the Risk Management web page at www.washoe.k12.nv.us/risk.

What is the plan's contracted hospital?
In the Reno/Sparks area it is Washoe Medical Center.

Who processes the claims and administers the plan?
Hometown Health Partners - 830 Harvard Way, Reno, NV 89502; 775/982-3232; 800/336-0123

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 January 1, 2006?
Yes, the list changes every year. So, a preferred-brand name drug not on the list in 2005 could be on the list in 2006. Likewise, a preferred-brand name drug on the list in 2005 may not be on the list for 2006. The formulary may also change during the year if a drug brand name drug goes generic or over-the-counter.

Does this plan have a mail order prescription drug program?
Yes. You will receive a 90-day supply through mail order rather than a 30-day supply from your pharmacy. The co-payment amount would be twice the applicable co-payment for the 30-day supply and there is no deductible on mail order prescriptions. (Note: If a generic is available and your doctor does not specifically request a brand name, you would pay the difference between the brand name drug and its generic equivalent in addition to the applicable co-payment.)

DENTAL PLAN OVERVIEW

What type of plan is the Dental Plan and who processes the claims?
It's a Self-funded Dental Plan with a Preferred Provider Dentist component and CDS Group Health, PO Box 50190, Sparks, NV 89435-0190, (775) 352-6900 processes the claims.

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

How do I find out if my dentist is on the plan's dentist list?
Contact Mastercare DENTS at 775/359-3732, their web page at www.dentsppo.com or the Risk Management web page at www.washoe.k12.nv.us/risk.

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

What dental plan do I have?
The *Standard Dental Plan.*

What is the deductible and coinsurance for the *Standard Dental Plan*?

- $50/member deductible
- Covers preventive care at 100% with no deductible
- Covers restorative care at 80% (including crowns)
- Covers major care at 50%

Is orthodontia covered?
No

Group Health Plan (PPO)

Benefits	*Low Deductible Plan*		*High Deductible/GAP Plan*	
GAP Plan	Not Provided		*GAP Plan will reimburse up to $1,000 per inpatient hospital admit; up to $200 for certain outpatient services; and up to $25 per doctor's office visit, outpatient services, X-ray & Lab services, or urgent care services ($125 maximum for all services per year per family)	
Maximum Lifetime Amount	$2,000,000		$2,000,000	
Calendar Year Deductible: • Per Member • Per Family	**PPO** $250 $500	**Non-PPO** $500 $1,000	**PPO** $700 $1,400	**Non-PPO** $1,400 $2,800
Member Co-Insurance Amt: (Based on UCR)	$3,000 per member $6,000 per family		$4,500 per member $9,000 per family	
Hospital Services • Inpatient • Outpatient	**PPO** 70% After Deductible 70% After Deductible	**Non-PPO** 50% After Deductible 50% After Deductible	**PPO** 70% After Deductible 70% After Deductible	**Non-PPO** 50% After Deductible 50% After Deductible
Physician Services	70% of UCR After Deductible		70% of UCR After Deductible	
Physical Therapy ($2,500/yr)	70% of UCR After Deductible		70% of UCR After Deductible	
Chiropractic ($2,000/yr)	70% of UCR After Deductible		70% of UCR After Deductible	
Ambulance	70% of UCR After Deductible		70% of UCR After Deductible	
X-ray and Lab Services	70% of UCR After Deductible		70% of UCR After Deductible	
Urgent Care Facility	70% of UCR After Deductible		70% of UCR After Deductible	
Home Health Care (100 visits/year)	70% of UCR After Deductible		70% of UCR After Deductible	
Mental Health Services -Outpatient (15visits/yr-general; 40 visits/yr-severe) -Inpatient (40 days/yr-severe only)	**PPO** 50% of UCR After Deductible 70% After Deductible	**Non-PPO** 50% of UCR After Deductible 50% After Deductible	**PPO** 50% of UCR After Deductible 70% After Deductible	**Non-PPO** 50% of UCR After Deductible 50% After Deductible
Substance Abuse Care -$39,000 Lifetime -Withdrawal ($1,500/year max) -Inpatient ($10,000/year max) -Outpatient (($2,500/year max)	**PPO** Outpatient - 70% of UCR After Deductible Inpatient - 70% After Deductible	**Non-PPO** Outpatient - 70% of UCR After Deductible Inpatient - 50% After Deductible	**PPO** Outpatient - 70% of UCR After Deductible Inpatient - 70% After Deductible	**Non-PPO** Outpatient - 70% of UCR After Deductible Inpatient - 50% After Deductible
Emergency Room (Deductible Applies)	70% of UCR if Emergency 50% of UCR If Non-Emergency		70% of UCR If Emergency 50% of UCR If Non-Emergency	
Prescription Drugs -Deductible -Copay: Generic -Copay: Preferred Brand -Copay: Non-Preferred -Mail Order Copay: (90-day supply)	$50 per member $10 $20 $40 $20 generic; $40 preferred brand; $80 non-preferred brand			
Standard Dental Plan	**Calendar Year Deductible** • Per Member - $50 • Per Family - $100 **Annual Maximum Benefit -** $1,500 **Percentage Payable:** • Preventative 100% No deductible • Restorative 80% (includes crowns) • Major 50%			

***GAP Plan** - **Outpatient benefits** are payable for the difference between the actual Outpatient expenses you incur and the amount paid by the Group Health Plan, for the out-of pocket covered charges, up to a maximum outpatient benefit of $200 for services in a Hospital Emergency Room, outpatient surgery in a Hospital Outpatient Facility or Free-Standing Outpatient Surgery Center, and diagnostic testing in a Hospital Outpatient Facility or MRI Facility. All benefits for the same or related conditions will be subject to the maximum benefit, unless such conditions are separated by 90 consecutive days, then a new maximum outpatient benefit will apply. **Doctor bill benefits** are payable for doctor visits up to $25 a visit, for up to 5 visits ($125) per family per calendar year for treatment received outside of a Hospital as an Outpatient. Includes treatment at your doctor's office, Outpatient treatment, Emergency Room, Clinic.

Health Maintenance/GAP Plan (EPO)

Benefits	*Co-payment/Limits*
GAP Plan	GAP Plan will reimburse up to $1,000 per inpatient hospital admit; up to $200 for certain outpatient services; and up to $25 per doctor's office visit, outpatient services, X-ray & Lab services, or urgent care services ($125 maximum for all services per year per family)
Maximum Lifetime Benefit Amount	$2,000,000
Inpatient Hospital Services	$1,250 per admit
Outpatient Services	$30 Co-payment
Same Day Surgery (Outpatient Surgical Facility)	$200 Co-payment
Medical Office Visits • Primary Care Physician; OB/GYN • Specialist	 $25 Co-payment $30 Co-payment
X-ray and Laboratory Services	$25 Co-payment
Preventative Health Care	$25 Co-payment
Home Health Care (Limited to 100 visits per year)	$25 Co-payment
Mental Health Services -Outpatient (15 visits/yr-general mental health; 40 visits/yr-severe) -Inpatient (40 days/year-severe mental health only)	 $30 Co-payment $1,250 per admit
Alcohol & Drug Abuse ($39,000 lifetime) -Withdrawal Treatment ($1,500/year max) -Inpatient ($10,000/year maximum) -Outpatient Counseling ($2,500/year max)	 $30 Co-payment $1,250 per admit $30 Co-payment
Ambulance	$100 Co-payment
Emergency Services	$100 Co-payment
Urgent Care Services -At Urgent Care Center -At Hospital Emergency Room	 $30 Co-payment $150 Co-payment
Chiropractic Type Care ($2,000 Annual Limit)	$30 Co-payment
Physical Therapy ($2,500 Annual Limit)	$30 Co-payment
Prescription Drugs • Deductible • Co-payment Generic • Co-payment Preferred Brand • Co-payment Non-Preferred Brand • Mail Order Co-pay (90-day supply)	 $50 per member $10 $20 $40 $20 generic; $40 preferred brand $80 non-preferred brand
Standard Dental Plan	**Calendar Year Deductible** • Per Member - $50 • Per Family - $100 **Annual Maximum Benefit -** $1,500 **Percentage Payable:** • Preventative 100% (No deductible) • Restorative 80% (includes crowns) • Major 50%

GAP Plan - Outpatient benefits are payable for the difference between the actual Outpatient expenses you incur and the amount paid by the Health Maintenance Plan, for the out-of pocket covered charges, up to a maximum outpatient benefit of $200 for services in a Hospital Emergency Room, outpatient surgery in a Hospital Outpatient Facility or Free-Standing Outpatient Surgery Center, and diagnostic testing in a Hospital Outpatient Facility or MRI Facility. All benefits for the same or related conditions will be subject to the maximum benefit, unless such conditions are separated by 90 consecutive days, then a new maximum outpatient benefit will apply. **Doctor bill benefits** are payable for doctor visits up to $25 a visit, for up to 5 visits ($125) per family per calendar year for treatment received outside of a Hospital as an Outpatient. Includes treatment at your doctor's office, Outpatient treatment, Emergency Room, Clinic.

Premium Schedule
Effective January 1, 2006

CLASSIFIED EMPLOYEES

"Low Deductible" PPO Plan

Coverage Level	26 Pay Periods 12 Month Employees	18 Pay Periods 9/10/11 Month Employees
Employee Only	$14.22	$20.54
Employee + Spouse	$178.94	$258.47
Employee + 1 Child	$121.58	$175.62
Employee + 2 Children	$219.62	$317.23
Employee + Family	$269.54	$389.34

"High Deductible" PPO Plan

Coverage Level	26 Pay Periods 12 Month Employees	18 Pay Periods 9/10/11 Month Employees
Employee Only	$0.00	$0.00
Employee + Spouse	$141.19	$203.94
Employee + 1 Child	$90.76	$131.10
Employee + 2 Children	$175.70	$253.79
Employee + Family	$225.36	$325.52

Health Maintenance (EPO) Plan

Coverage Level	26 Pay Periods 12 Month Employees	18 Pay Periods 9/10/11 Month Employees
Employee Only	$0.00	$0.00
Employee + Spouse	$140.54	$203.01
Employee + 1 Child	$98.73	$142.61
Employee + 2 Children	$186.46	$269.33
Employee + Family	$235.65	$340.38

Premium Schedule
Effective January 1, 2006

CERTIFIED/ADMINISTRATIVE EMPLOYEES

"Low Deductible" PPO Plan

Coverage Level	Monthly Premium Full-Time Employee	Monthly Premium .5 FTE	Monthly Premium .8 FTE
Employee Only	$30.81	$253.00	$119.69
Employee + Spouse	$387.71	$609.90	$476.59
Employee + 1 Child	$263.43	$485.62	$352.31
Employee + 2 Children	$475.84	$698.03	$564.72
Employee + Family	$584.01	$806.20	$672.89

"High Deductible" PPO Plan

Coverage Level	Monthly Premium Full-Time Employee	Monthly Premium .5 FTE	Monthly Premium .8 FTE
Employee Only	$0.00	$222.19	$88.88
Employee + Spouse	$305.91	$528.10	$394.79
Employee + 1 Child	$196.65	$418.84	$285.53
Employee + 2 Children	$380.69	$602.88	$469.57
Employee + Family	$488.28	$710.47	$577.16

Health Maintenance (EPO) Plan

Coverage Level	Monthly Premium Full-Time Employee	Monthly Premium .5 FTE	Monthly Premium .8 FTE
Employee Only	$0.00	$222.19	$88.88
Employee + Spouse	$304.51	$526.70	$393.39
Employee + 1 Child	$213.92	$436.11	$302.80
Employee + 2 Children	$403.99	$626.18	$492.87
Employee + Family	$510.57	$732.76	$599.45

NOTES:

The Monthly Premiums for certified employees are for full-time employees only. Certified employees on part-time contracts will have their District-paid premiums prorated based on FTE.

BASIC GROUP TERM LIFE OVERVIEW

What type of life insurance coverage is it?
It's Group Term Life Insurance with Accidental Death & Dismemberment Coverage. It does not build "cash value".

How much coverage do I have?
Certified/Classified: $40,000 Term Life; Administrators: $250,000 Term Life

How much does this coverage cost me?
Your life insurance and AD&D coverage is District-paid so there is no cost to you unless you are a part-time contracted teacher in which case your District-paid premiums will be prorated based on FTE. For example, if you are a .5 FTE, your cost would be $4.80/month; or if you are a .8 FTE, your cost would be $1.92/month.

Can I continue this coverage when I retire?
Yes, up to a maximum of $200,000 but certain restrictions and limitations on coverage amounts will apply.

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

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

SUPPLEMENTAL GROUP TERM LIFE OVERVIEW

What type of life insurance coverage is it?
It is Supplemental Group Term Life Insurance only and it does not build "cash value".

How much will this coverage cost me?
Premiums are **age rated**. Below are the current monthly rates per $1,000 of coverage by age band.

Age				
	< 29	$0.05	30-34	$0.08
	35-39	$0.09	40-44	$0.10
	45-49	$0.18	50-54	$0.28
	55-59	$0.50	60-64	$0.77
	65-69	$1.11	70-72	$1.32
	73-74	$1.57	75-76	$1.66
	77-78	$1.78	79-80	$2.40
	81-82	$3.42	83-84	$3.81
	85-86	$4.23	87-88	$5.89
	89-90	$6.35	91-92	$7.10
	93-94	$9.58	95-96	$11.05
	97-98	$13.15	99+	$25.00

To calculate your premium: 1. Find the rate for your age band. (Use the age you will be turning next year. For example, if you are now 39 and will turn age 40 on or after January 1, 2006, use the 40-44 age band.); 2. Multiply your current supplemental term life limits by this rate; 3. Divide the total by $1,000.

Will my limits ever change?
At age 70, limits reduce by 50%, e.g., if you have $50,000 of term life and you turn 70, the amount will reduce to $25,000.

How much may I purchase?
You may purchase limits in increments of $25,000 up to a maximum of $250,000 but you must do so within 30 days of your eligibility date. Also, all amounts over $150,000 ($100,000 if age 60 or older) are subject to acceptable evidence of insurability.

May I purchase coverage for my spouse?
Yes, so long as you have or are purchasing supplemental life for yourself, you may purchase up to 50% of your supplemental life limit not exceed $25,000.

How much will my spouse's coverage cost me?
Premiums are **age rated**. Below are the current monthly rates per $1,000 of coverage by age band.

Age	< 29	$0.05	30-34	$0.08
	35-39	$0.09	40-44	$0.10
	45-49	$0.18	50-54	$0.28
	55-60	$0.50	60-64	$0.77
	65-70	$1.11	70-72	$1.32
	73-75	$1.57	75-76	$1.66
	77-79	$1.78	79-80	$2.40
	81-83	$3.42	83-84	$3.81
	85-87	$4.23	87-88	$5.89
	89-91	$6.35	91-92	$7.10
	93-95	$9.58	95-96	$11.05
	97-98	$13.15	99+	$25.00

To calculate the premium: 1. Find the rate for your spouse's age band. (Use the age your spouse will be turning next year. For example, if your spouse is now 39 and will turn age 40 on or after January 1, 2006, use the 40-44 age band.); 2. Multiply your current supplemental term life limits by this rate; 3. Divide the total by $1,000.

Will my spouse's limits ever change?
Yes, at age 65 they will reduce by 35% and will terminate the earlier of age 70 or when the employee ceases to be eligible.

May I purchase coverage for my child(ren)?
Yes, you may purchase coverage for your child(ren) who are of the age of 6 months to age 19 (25 if full-time student) with a choice of limits of $5,000 or $10,000 per child.

How much will this coverage cost me?
The premium is $.86/month for the $5,000 limit and $1.72/month for the $10,000 limit. These premiums are per family unit (if you have one child or five children, the premium is the same - $.86/month for the $5,000 limit and $1.72/month for the $10,000 limit.)

VISION BENEFITS OVERVIEW

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

Who is covered and do I have to pay any premiums for this coverage?
You and your eligible dependents are covered and the premium is District-paid so there is no cost to you unless you are a part-time contracted teacher in which case your District-paid premiums will be prorated based on FTE. For example, if you are a .5 FTE, your cost would be $5.60/month; or if you are a .8 FTE, your cost would be $2.24/month.

Do I have to have my dependents covered by District medical coverage to have vision coverage?
No

How do I find out when I am or my dependents are eligible for exam, lenses and frames?
Please visit our website at www.washoe.k12.nv.us/risk and click on "Vision - Benefits" or the VSP website at www.vsp.com.

What are the benefits?

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

Does the vision plan have a preferred provider list?
Yes

Do I have to use a preferred provider?
No, but benefits will be paid at a reduced reimbursement schedule if you use a non-panel provider.

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

COMPREHENSIVE GROUP LEGAL SERVICES PLAN OVERVIEW

What is the Comprehensive Group Legal Services Plan?
It's a voluntary benefit through Hyatt Legal Plans and it covers certain legal services for you.

What is the cost of the plan?
The cost is $15.00/month or $6.92 biweekly which is payroll deducted.

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

How can I get more information about the plan?
If you have questions or would like to see the list of attorneys, call Hyatt's Client Service Center at (800) 821-6400.

SECTION 125 BENEFIT PROGRAM OVERVIEW

- **Does the District offer a Section 125 Benefit Program to its employees?**
  Yes

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

- **What kind of deductions can I make under the Section 125 Benefit Program?**
  The program consists of two parts that include:
  - **Premium Conversion Plan** – Allows dependent medical/health and cancer insurance premiums to be paid on a pre-tax basis.
  - **Flexible Spending Accounts** – There are two types:
    - Dependent Day Care Expenses – Allows you to set aside up to $5,000 per year on a pre-tax basis to pay for day care expenses for your children under the age of 13
    - Non-reimbursed Medical Expenses – Allows you to set aside up to $3,600 per year on a pre-tax basis to pay for expenses not covered by insurance such as deductibles, co-payments, and orthodontia.

- **How does the Premium Conversion Plan work?**

Example:

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

Pre-Tax Under Section 125 Program	
Monthly Salary	$2,000
Monthly Insurance Premium	$ 200
Income Before Tax	$1,800
Tax – 25%	$ 450
Final Net Income	**$1,350**

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

- **How does a Flexible Spending Account work?**
  Example: Assume you have a dependent in braces and you pay your dentist $100 per month for this service, the program would work as follows:

After-Tax	
Monthly Salary	$2,000
Tax – 25%	$ 500
Net Income Before Deductions	$1,500
Monthly Dentist Payment	$ 100
Final Net Income	**$1,400**

Pre-Tax Under Section 125 Program

Monthly Salary	$2,000
Monthly Dentist Payment	$ 100
Income Before Tax	$1,900
Tax – 25%	$ 475
Final Net Income	**$1,425**

As you can see, you would have an extra $25 in your take-home pay under the Section 125 Program.

- **Are there any fees for the Premium Conversion Plan?**
  No

- **Are there any fees for the Flexible Spending Accounts?**
  No

- **Who administers the Flexible Spending Accounts?**
  A firm called American Fidelity.

- **How do I get reimbursed if I sign up for a Flexible Spending Account?**
  You would simply submit a receipt and voucher to American Fidelity. You will receive additional information and vouchers from American Fidelity when you enroll.

- **When can I enroll into a Section 125 Benefit Program?**
  During "open enrollment", which usually begins in October for an effective date of January 1.

- **What happens if I don't use all the money set aside in my Flexible Spending Account by the end of December?**
  IMPORTANT! You will forfeit any unused moneys.

- **Can I stop my Section 125 Benefit Program deductions at anytime?**
  IMPORTANT! No, you cannot stop your deductions until the beginning of the next plan year. Plan years run from January 1 through December 31.

EMPLOYEE ASSISTANCE PROGRAM

- **What is an Employee Assistance Program?**
  A confidential, licensed counseling service that is available to you and your immediate family members.

- **Is there any cost for this service?**
  The District offers an Employee Assistance Program at no cost to you.

- **How many EAP visits are allowed?**
  One counseling session per problem per year is allowed. You may request an additional five visits with an EAP counselor subject to your group medical plan benefits:
  1. **EPO Plan:** No referral required. Subject to applicable copayment.
  2. **PPO Plan:** Subject to deductible and mental/nervous limitations.

- **Who provides this service?**
  This service is provided through Mountain EAP. The brochure in your packet provides more information.

WELLNESS PROGRAM - www.washoe.k12.nv.us/wellness

- **What is the Wellness Program?**
  The Wellness Program's mission is simple – GET Activity, GET Nutrition, GET Screened, GET Life, and GET Involved! Regardless of health status or risk factors, daily health behavior adherence will extend life by 10 to 20 years and compress the time spent in pain, disability, and suffering before death by as much as 75%. Wellness is worth your every effort today!

  As a major part of the Wellness Program, the district put into effect the "Good Health Incentive Program." All District employees, retirees and spouses enrolled in District health insurance have a $40 per month Good Health Incentive Contribution. Since its implementation in 1994, the Good Health Incentive Program has created an incentive to take responsible preventive actions.

- **Who is included in the Wellness Program?** All District personnel, retirees and spouses covered by District medical insurance are included in the Wellness Program.

- **What are the Good Health Incentive Program's incentives for taking responsible preventive actions?**

  1. Screening Form Completion
  Complete the Good Health Incentive Program Screening Form and return it to the WCSD Wellness Office by December 1 each year. If your insurance effective date is during this calendar year, you will need to participate in this year's screening. A Good Health Incentive Program Packet is mailed during the first quarter of each plan year to all District personnel, retirees and spouses covered by District medical insurance. Forms can be requested at anytime online. It is recommended that you complete this screening as part of your annual physical with your physician. **If screening form is completed, the contribution is reduced $10 per month**.

  2. Blood Pressure Measurement
  'At Risk' status is determined if either systolic blood pressure is above 139mmHg and/or diastolic blood pressure is above 89mmHg. If 'At Risk', a responsible preventive action is to have a current blood pressure prescription or have a doctor complete the exemption part of screening form. **If "Not At Risk" or a responsible action is taken, the contribution is reduced $10 per month.**

  3. Tobacco Product Use
  'At Risk' status is determined if any tobacco products are used. If 'At Risk', a responsible preventive action is to stop tobacco use for 90 days and be re-screened, complete a smoking cessation class or have a physician complete the exemption part of the screening form. **If "Not At Risk" or a responsible action is taken, the contribution is reduced $10 per month.**

  4. Body Mass Index Measurement
  'At Risk' status is determined if body mass index is 30 or greater. If 'At Risk, a responsible preventive action is to lose weight and be re-screened, complete one an approved weight-loss programs, or have a physician complete exemption part of the screening form. **If "Not At Risk" or a responsible action is taken, the contribution is reduced $10 per month.**

- **Who makes contributions into the Wellness Program?** Only District personnel, retirees or covered spouses that refuse to take needed responsible preventive health actions, make contributions into the Wellness Program.

- **How do I get more information on the Wellness Program?** For complete information about fun programs and important services, please visit the website.