WASHOE COUNTY SCHOOL DISTRICT
Risk Management Office

Questions/Answers and Highlights effective 1/01/14 for the District's:

- ***PPO Plans***
- ***EPO Plans***
- ***Dental Plan***
- ***Basic Term Life Insurance***
- ***Vision Plan***
- ***Legal Plan***
- ***Section 125 Program***
- ***Wellness Program***
- ***Submitting Forms to Enroll***

PREFERRED PROVIDER (PPO) PLANS with GAP PLAN

OVERVIEW

What are the PPO Plans offered by the District?
The District offers two PPO Plans. They have the same benefits, deductibles, coinsurance, and co-payments. The difference between the two plans is one plan uses a St. Mary's based provider system and the other plan uses a Renown based provider system. The PPO using the St. Mary's based provider system is called the **Saint Mary's (CDS) PPO**; and the one using the Renown based provider system is called the **Renown (HTH) PPO**.

What type of plans are the PPO Plans?
They are Self-funded Comprehensive Major Medical Plans with a Preferred Provider Organization (PPO) component. See "Highlights" of the PPO Plans on page 8.

Do they cover services worldwide? Yes

Who processes and administers the claims?

- For the **Saint Mary's (CDS) PPO** it is CDS Group Health, PO Box 50190, Sparks, NV 89435-0190, 775/ 352-6900
- For the **Renown (HTH) PPO** it is Hometown Health, 830 Harvard Way, Reno, NV 89502, 775/982-3232

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

PREFERRED PROVIDERS

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

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

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

- If you select the **Saint Mary's (CDS) PPO**, contact *Saint Mary's Preferred Health Care Networ*k at (775)770-3000 or (800)433-3077. You may also visit their web site at www.saintmarysreno.org.

- If you select the **Renown (HTH) PPO**, contact Hometown Health at 775/982-3232 or 800/336-0123; or their web page at www.hometownhealth.com.

What are the PPO Hospitals in Washoe County?

- If you select the **Saint Mary's (CDS) PPO**, it is Saint Mary's Regional Medical Center and Northern Nevada Medical Center.
- If you select the **Renown (HTH) PPO**, it is Renown Regional Medical Center and Renown South Meadows.

What if I need services that cannot be provided by a PPO provider?
You will receive reimbursement at the PPO level of benefit (no reduction in level of benefit).

What if I receive emergency services from a Non-PPO provider?
If it meets the definition of an "Emergency", you will receive reimbursement at the PPO level of benefit (no reduction in level of benefit).

DEDUCTIBLES/CO-INSURANCE/CO-PAYMENTS

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

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

What is co-insurance and co-insurance limit?
Co-insurance is the percentage of the cost both you and the plan share for covered expenses after you have met your deductible. The co-insurance limit is the total amount of eligible billed charges that the co-insurance is applied to before the plan will pay your benefits at 100%. The PPO Plans have an annual out-of-pocket maximum of $3,000 per person and $6,000 per family when you use preferred providers. For non-preferred providers, the annual out-of-pocket maximum is $6,000 per person and $12,000 per family.

Do the PPO Plans have co-payments?
Yes, they have a $25 co-payment for primary care physician office visits, and a $35 co-payment for specialist physician visits. These co-payments are not subject to and do not apply to the $500 deductible. Also, you won't need to complete any claim forms when you make a co-payment.

What are Usual, Customary, and Reasonable Fees (UCR)?
The PPO contracted fees, or when applicable, charges that are within the usual level of charges in your locality for similar medical treatment, services, and supplies as determined by the Plan Administrator.

PRECERTIFICATION

Are there any procedures I must follow to ensure I receive full benefits for certain services?
Yes, you must have all inpatient hospital admissions pre-certified. If it is an elective hospitalization, it must be pre-certified before you're admitted. If it is an emergency, it must be pre-certified within 72 hours of being admitted. You must also have any outpatient procedure over $10,000 pre-certified.

Who pre-certifies these services?

- If you select the **Saint Mary's (CDS) PPO**, your physician needs to contact *Saint Mary's Preferred Health Care Networ*k (PHCN) at 775/352-6939 or 800/455-4236.

- If you select the **Renown (HTH) PPO**, your physician needs to contact *Hometown Health (HTH)* at 775/982-3232 or 800/336-0123.

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.

EXCLUSIVE PROVIDER (EPO) PLANS with GAP PLAN

OVERVIEW

What are the EPO Plans offered by the District?
The District offers two EPO Plans. They have the same benefits and co-payments. The difference between the two plans is one plan uses a St. Mary's based provider system and the other plan uses a Renown based provider system. The EPO using the St. Mary's based provider system is called **Saint Mary's (CDS) EPO**; and the one using the Renown based provider system is called **Renown (HTH) EPO**.

What type of plans are the EPO Plans?
They are self-funded Exclusive Provider Organizations or EPOs. See "Highlights" on page 8 for more information on the EPO Plans.

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

Who processes and administers the claims?
- For the **Saint Mary's (CDS) EPO** it is CDS Group Health, PO Box 50190, Sparks, NV 89435-0190, 775/ 352-6900
- For the **Renown (HTH) EPO** it is Hometown Health, 830 Harvard Way, Reno, NV 89502, 775/982-3232

Are there deductibles or co-insurance requirements and claim forms to complete?
No, you will only need to make a "co-payment" when you receive services except for prescription drugs which have an annual $50 per person deductible. No, there are no claims forms to complete.

For example, the plans have a $25 co-payment for primary care physician office visits, a $30 co-payment for specialist physician visits, a $100 co-payment for emergency services, a $200 co-payment for Same-Day Surgery Facility services, and a $1,250 co-payment per admit for Inpatient Hospital services.

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

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 EPO Plans. It will pay up to $1,000 per inpatient hospital confinement, up to $200 for certain outpatient services, up to $200 for emergency room visits and up to $25/doctor visit/x-ray or lab (limit of $125/family). If you cover your dependents, they will also have the GAP Plan coverage. There are specific exclusions to this plan, so please 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 the EPO Plan administrator with an American Fidelity GAP claim form.

CONTRACTED PROVIDERS

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 EPO Plan you select.

- If you select the **Saint Mary's (CDS) EPO**, you'll need to use their panel of providers.
- If you select the **Renown (HTH) EPO**, you'll need to use their panel of providers.

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

What are the EPO Plans' contracted hospitals?

- If you select the **Saint Mary's (CDS) EPO**, it is Saint Mary's Regional Medical Center and Northern Nevada Medical Center.
- If you select the **Renown (HTH) EPO**, it is Renown Regional Medical Center and Renown South Meadows.

PRIMARY CARE PHYSICIANS/SPECIALISTS

Must I select a Primary Care Physician and what is a Primary Care Physician?
Yes, but only if you select the **Renown (HTH) EPO**. Members on the **Saint Mary's (CDS) EPO** will not need to select a Primary Care Physician but must use a Primary Care Physician from the PHCN Provider Panel. 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?
Your EPO Plan will refer you to the proper specialist who can handle your medical condition.

How do I find out if my doctor is on the EPO Health Maintenance Plan's physician list?

- If you select the **Saint Mary's (CDS) EPO**, 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.org.
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- If you select the **Renown (HTH) EPO**, contact Hometown Health at 775/982-3232 or 800/336-0123; or their web page at www.hometownhealth.com.

OVERVIEW OF PRESCRIPTION DRUG BENEFIT

Do the PPO Plans and the EPO Plans have a prescription drug benefit?
Yes, both plans have the same prescription drug benefit. It is administered by CVS/CAREMARK.

How are prescription drugs covered?
There is a $50 per member annual deductible. Once this is met, generic drugs have a $5 per prescription co-payment, "preferred brand name" drugs have a $25 co-payment and "non-preferred brand name" drugs have a $50 co-payment. (Note: If you prefer 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.)

Does this program have a mail order prescription drug program?
Yes, but only for prescription drugs that have been determined by CVS/CAREMARK to be maintenance prescription drugs. You will receive a 90-day supply through mail order rather than a 30-day supply from your pharmacy. The co-payment amount for the 90-day supply would be twice the applicable co-payment for the 30-day supply and there is no deductible on mail order. See "Highlights" on page 8 for co-payment amounts. (Note: If you prefer 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?
Yes, the list changes every year. So, a preferred-brand name drug not on the list in 2013 could be on the list in 2014. Likewise, a preferred-brand name drug on the list in 2013 may not be on the list for 2014. The formulary may also change during the year if a drug brand name drug goes generic or over-the-counter.

OVERVIEW OF DISTRICT'S DENTAL PLAN

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

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

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

How do I find out if my dentist is on the Dental Plan's dentist list? Contact Guardian Dental at 1-888-600-9200 or visit their web page at www.guardiananytime.com/# and query using Dental Guard Preferred.

Dental Plan Highlights

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

SAINT MARY'S (CDS) PPO/EPO
RENOWN (HTH) PPO/EPO HIGHLIGHTS

Benefits	***EPO Plan***	***PPO Plan***	
GAP Plan	GAP Plan will reimburse up to $1,000/inpatient hospital admit; up to $200 for certain outpatient services; and up to $25 per non-routine doctor's visit, outpatient services, X-ray & Lab services, or urgent care services ($125 maximum for all services/year/ family)		
		PPO PROVIDERS	**NON-PPO PROVIDERS**
Calendar Year Deductible: • Per Member • Per Family	NA	$500 $1,000	$1,500 $3,000
Out-of Pocket Maximum:	$3,000 per member	$3,000 per member $6,000 per family	$6,000 per member $12,000 per family
Inpatient Hospital Services	$1,250 co-payment/admit	80% After Deductible	50% of UCR After Deductible
Outpatient Surgery	$200 co-payment	80% After Deductible	50% of UCR After Deductible
Primary Care Physician Office Visit	$25 co-payment	$25 co-payment	80% of UCR After Deductible
Specialist Physician Office Visit	$30 co-payment	$35 co-payment	80% of UCR After Deductible
Urgent Care Facility	$30 co-payment	$35 co-payment	80% of UCR After Deductible
Chiropractic ($2,500 limit/year)	$30 co-payment	$35 co-payment	80% of UCR After Deductible
Physical Therapy (50 visits/year)	$30 co-payment	$35 co-payment	80% of UCR After Deductible
Ambulance	$100 co-payment	80% After Deductible	80% of UCR After Deductible
Freestanding X-ray & Lab Services	$25 co-payment	80% After Deductible	80% of UCR After Deductible
Home Health Care (100 visits/year)	$25 co-payment	80% After Deductible	80% of UCR After Deductible
Mental Health	$30 co-payment $1,250 co-payment/admit $30 co-payment	Outpatient - $35 co-payment Inpatient - 80% of PPO After Deductible	Outpatient -50% of UCR After Deductible Inpatient - 50% of UCR After Deductible
Emergency Room	$100 co-payment if Emergency $150 co-payment if Non-Emergency	80% After Deductible if Emergency 50% After Deductible if Non-Emergency	80% of UCR After Deductible if Emergency 50% of UCR After Deductible if Non-Emergency
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 $5 $25 $50 $10 $50 $100	

Note: UCR is defined at the PPO Allowable Rate

2014 Premium Schedule for EPO and PPO Plans with Premium Discount*

Saint Mary's (CDS) EPO & Renown (HTH) EPO

Coverage Level	26 Pay Periods 12 Month Classified EEs	18 Pay Periods 9/10/11 Month Classified EEs	Monthly Premium Full-Time Certified & Administrative EEs	Monthly Premium .5 FTE Certified & Administrative EEs
Employee Only	$85.12	$122.95	$184.43	$488.21
Employee + Spouse	$296.31	$428.00	$642.00	$945.78
Employee + 1 Child	$214.33	$309.59	$464.38	$768.16
Employee + 2 Children	$336.79	$486.48	$729.72	$1033.50
Employee + Family	$415.90	$600.75	$901.12	$1204.90

Saint Mary's (CDS) PPO & Renown (HTH) PPO

Coverage Level	26 Pay Periods 12 Month Classified EEs	18 Pay Periods 9/10/11 Month Classified EEs	Monthly Premium Full-Time Certified & Administrative EEs	Monthly Premium .5 FTE Certified & Administrative EEs
Employee Only	$0	$0	$0	$303.70
Employee + Spouse	$160.28	$231.52	$347.28	$650.98
Employee + 1 Child	$100.07	$144.55	$216.82	$520.52
Employee + 2 Children	$192.25	$276.25	$414.38	$718.08
Employee + Family	$254.52	$367.63	$551.45	$855.15

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

***See "Wellness Program" on page 15 for explanation of Premium Discounts. Premiums are increased by $40 per month without Premium Discount.**

BASIC GROUP TERM LIFE OVERVIEW

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

How much coverage do I have?
Certified/Classified: $40,000; Confidential Classified: $50,000; and Administrators: $250,000

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

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

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

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

VISION BENEFITS OVERVIEW

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

Who is covered and do I have to pay any premiums for this coverage?
You and your eligible dependents are covered and the premium is District-paid so there is no cost to you unless you are a part-time contracted teacher in which case your District-paid premiums will be prorated based on FTE. For example, if you are a .5 FTE, your cost would be $6.16/month; or if you are a .8 FTE, your cost would be $2.46/month.

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

How do I find out when I am or my dependents are eligible for exam, lenses and frames?
Please visit the VSP website at www.vsp.com.

What are the benefits?

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

Does the vision plan have a preferred provider list? Yes

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

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

COMPREHENSIVE GROUP LEGAL SERVICES PLAN OVERVIEW

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

What is the cost of the plan?
The cost is $19.80 per month or $9.14 biweekly which is payroll deducted.

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

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

SECTION 125 BENEFIT PROGRAM OVERVIEW

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

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

- **Premium Conversion Plan** – Allows dependent medical/health and cancer insurance premiums to be paid on a pretax basis.
- **Flexible Spending Accounts** – There are two types:
  - Dependent Day Care Expenses – Allows you to set aside up to $5,000 per year on a pretax basis to pay for day care expenses for your children under the age of 13.
  - Non-reimbursed Medical Expenses – Allows you to set aside up to $2,500 per year on a pretax 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**

Pretax Under Section 125 Program

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

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

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

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

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

When does the Section 125 Plan Year start and end?
It runs from January 1 through December 31.

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

Are there any fees for the Premium Conversion Plan? No

Are there any fees for the Flexible Spending Accounts? No

Who administers the Flexible Spending Accounts?
American Fidelity

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

When can I enroll into a Section 125 Benefit Program?
Please contact American Fidelity at 829-1313 for details.

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

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

WELLNESS PROGRAM

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

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

Please note that if your health insurance coverage with the District becomes effective on or after April 1, 2014 you will **NOT** need to complete and submit an annual Health Appraisal and you will automatically receive the premium discount for the remainder of the current year and the following year. However, you will need to complete and submit a form for 2016. When the time comes for you to do your screening, you will receive additional information from the Wellness Office.

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IMPORTANT! 90-DAY WINDOW TO ENROLL

You have 90 days from the date your 90-day waiting period begins to complete and return all forms and add eligible dependents. If Risk Management does not receive your paperwork within this time frame, you will be automatically enrolled into a District PPO Plan and you will not be able to change plans until next year's Open Enrollment with a coverage effective date of January 1. Also, dependents not added during this 90-day time frame cannot be added until the next year's open enrollment with a coverage effective date of January 1. Again, it is very important to remember that it is your responsibility to turn in your forms within the 90-day time frame. If you have any questions, please contact the Risk Management Office at 348-0343.

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

Please note that this information is a summary of the various benefit programs offered to Plan Members. It is not meant as a full explanation of the benefits provided by these programs. Please refer to the plan document or contract for specific benefits and provisions. Copies are available from the Risk Management Office. 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.