Westside Community Schools

2021-22 PRE-65 RETIREE BENEFITS GUIDE

SEPTEMBER 1, 2021 - AUGUST 31, 2022

WELCOME

This guide answers some of the basic questions you may have about your benefits. Please read it carefully, along with any supplemental materials you receive.

Eligibility

A Pre-65 Retiree and/or Dependent of a Retiree must meet ALL of the following criteria:

1. The retiree is between the ages of 50-64;

AND

2. The retiree has worked in the Westside Community School District, or any other school district in Nebraska that is affiliated with the Educators Health Alliance AND covered under the Group Insurance plan for a minimum of 60 continuous months.

3. A dependent of an eligible Pre-65 Retiree that has been covered on the Pre-65 retiree plan for a period of no more than 4 years.

Eligible family members include:

- Your legally married spouse
- Your children who are your natural children, stepchildren, adopted children or children for whom you have legal custody who are under age 26. Disabled children age 26 or older who meet certain criteria may continue on your health coverage.

When Coverage Begins

- **Open Enrollment:** Changes made during Open Enrollment are effective September 1, 2021 - August 31, 2022.

To enroll or make changes to your current elections, you will need to complete the Pre-65 Enrollment/Change Form. Changes include adding/dropping dependents or adding/dropping coverage. The Pre-65 Enrollment/Change Form is attached to the open enrollment email and is included in the open enrollment mailing.

Required Information—*When you enroll, you will be required to enter a Social Security number (SSN) for all covered dependents. The Affordable Care Act (ACA), otherwise known as health care reform, requires the company to report this information to the IRS each year to show that you and your dependents have coverage. This information will be securely submitted to the IRS and will remain confidential.*

Medical

We are proud to offer you a choice of three medical plans through UnitedHealthcare. Following is a high-level overview of the coverage available.

Key Medical Benefits	Pre-65 $1,250 - PPO		Pre-65 $2,500 - PPO	
	In-Network	Out-of-Network[1]	In-Network	Out-of-Network[1]
Deductible (per calendar year)				
Individual / Family	$1,250 / $2,500	$2,500 / $5,000	$2,500 / $5,000	$5,000 / $10,000
Out-of-Pocket Maximum (per calendar year)				
Individual / Family	$5,000 / $10,000	$9,600 / $19,200	$7,350 / $14,700	$14,700 / $29,400
Covered Services				
Office Visits (physician/specialist)	PCP: $35 copay /Specialist: Designated Network: $35 copay/ Network: $55 copay	40%*	PCP: $50 copay / Specialist: Designated Network: $50 copay/ Network: $70 copay	40%*
Routine Preventive Care	No charge	40%*	No charge	40%*
Outpatient Diagnostic (lab/X-ray)	No charge	40%*	No charge	40%*
Complex Imaging	20%*	40%*	30%*	40%*
Chiropractic	$35 copay up to 24 visits per calendar year	40%*, up to 24 visits per calendar year	30%*	40%*
Ambulance	20%*		30%*	
Emergency Room	$150 copay, then 20%		$100 copay, then 30%*	
Urgent Care Facility	$55 copay	40%*	$70 copay, then 30%*	40%*
Inpatient Hospital Stay	20%*	40%*	30%*	40%*
Outpatient Surgery	20%*	40%*	30%*	40%*
Prescription Drugs (Tier 1 / Tier 2 / Tier 3 / Tier 4)				
Retail Pharmacy (30-day supply)	$15 / $60 / $100 / $200		Tier 1: 30% coinsurance ($12 minimum/$45 maximum), Tier 2: 30% coinsurance ($55 minimum/$110 maximum), Tier 3: 30% coinsurance ($75 minimum/$150 maximum), Tier 4: 25% coinsurance ($125 minimum/$250 maximum)	60%*
Mail Order (90-day supply)	$45 / $180 / $300	No benefit	Tier 1: 30% coinsurance ($36 minimum/$135 maximum), Tier 2: 30% coinsurance ($165 minimum/$330 maximum), Tier 3: 50% coinsurance ($225 minimum/$450 maximum)	No benefit

Coinsurance percentages and copay amounts shown in the above chart represent what the member is responsible for paying.
***Benefits with an asterisk (*) require that the deductible be met before the Plan begins to pay.**
1. If you use an out-of-network provider, you will be responsible for any charges above the maximum allowed amount.

Medical (continued)

We are proud to offer you a choice of three medical plans through UnitedHealthcare. Following is a high-level overview of the coverage available.

Key Medical Benefits	Pre-65 $3,600 - HSA	
	In-Network	Out-of-Network[1]
Deductible (per calendar year)		
Individual / Family	$3,600 / $7,050	$7,200 / $14,100
Out-of-Pocket Maximum (per calendar year)		
Individual / Family	$4,250 / $8,150	$12,700 / $25,400
Covered Services		
Office Visits (physician/specialist)	10%*	20%*
Routine Preventive Care	No charge	20%*
Outpatient Diagnostic (lab/X-ray)	10%*	20%*
Complex Imaging	10%*	20%*
Chiropractic	10%*	20%*
Ambulance	10%*	20%*
Emergency Room	10%*	
Urgent Care Facility	10%*	20%*
Inpatient Hospital Stay	10%*	20%*
Outpatient Surgery	10%*	20%*
Prescription Drugs (Tier 1 / Tier 2 / Tier 3 / Tier 4)		
Retail Pharmacy (30-day supply)	10%*	
Mail Order (90-day supply)	10%*	No benefit

Coinsurance percentages and copay amounts shown in the above chart represent what the member is responsible for paying.
***Benefits with an asterisk (*) require that the deductible be met before the Plan begins to pay.**
1. If you use an out-of-network provider, you will be responsible for any charges above the maximum allowed amount.

Dental

We are proud to offer you a dental plan through UnitedHealthcare. Following is a high-level overview of the coverage available.

Key Dental Benefits	Dental Plan - DPPO	
	In-Network	Out-of-Network[1]
Deductible (per calendar year)		
Individual / Family	$25 / $25	$50 / $50
Benefit Maximum (per calendar year; preventive, basic, and major services combined)		
Per Individual	$5,000	
Covered Services		
Preventive Services	0%	30%
Basic Services	20%	30%*
Major Services	50%*	50%*
Orthodontia (Child Only)	$25 deductible, then 50% up to $1,000 Lifetime Maximum	$50 deductible, then 50% up to $1,000 Lifetime Maximum

Coinsurance percentages and copay amounts shown in the above chart represent what the member is responsible for paying.
***Benefits with an asterisk (*) require that the deductible be met before the Plan begins to pay.**
1. If you use an out-of-network provider, you will be responsible for any charges above the maximum allowed amount.

Cost of Benefits

Your contributions toward the cost of benefits are on an after-tax basis. The amount will depend upon the plan you select and if you choose to cover eligible family members. **Please refer to the separate rate sheet for your contributions.**

Contact Information

Coverage	Carrier	Phone #	Website/Email
Medical	UnitedHealthcare	844-234-7921	myuhc.com
Dental	UnitedHealthcare	877-816-3596	www.myuhcdental.com

Questions?

If you have additional questions, you may also contact:

Human Resources
402-390-2144
hrdept@westside66.net

HUB