THE RESCHINI GROUP

Titusville Area School District

Open Enrollment – 2024

Presented by The Reschini Group

TODAY'S TOPICS

- ✓Open Enrollment
- ✓Vision Benefits
- ✓Health Plan Terminology
- ✓QHDHP Benefit Design
- ✓Health Savings Accounts
- ✓PPO Blue Medical Plan with Deductible and Co-Pays
- ✓Plan Comparison
- ✓Electing the QHDHP
- ✓Both Plans

Open Enrollment

OPEN ENROLLMENT

October 31st through November 10th

- ✓Choose your benefit plan for 2024
- ✓Add/drop eligible dependents
- ✓Enroll in Vision Coverage

Your completed enrollment form must be returned to the business office no later than Friday, November 10th.

Vision Benefits

VISION BENEFITS

- ✓ Vision coverage is new effective January 1, 2024
- ✓ Vision coverage is being offered through VBA
- ✓ Vision benefit is for employees and eligible dependents to age 26
- ✓ Your group number for vision will be: 7489

VISION BENEFITS

- ✓ VBA does not mail ID cards. If you have an appointment with an in-network provider, you can provide the following information:
  - ✓ Member zip code
  - ✓ Member DOB
  - ✓ Last four digits of SSN

- ✓ As of January 1, 2024, members can log into the portal to print a VBA card. The portal can be found at:
  - ✓ VBAplans.com and click “Login” from the menu
  - ✓ Select Vision and Member options to sign in
  - ✓ Enter the policyholder’s birth date, zip code and last four digits of SSN
  - ✓ Along with printing a card, you will be able to access benefits and claim information, chat with customer service, and find a provider.

- ✓ Customer service is available Monday through Friday 8:30 am – 6:00 pm at 1-800-432-4966

VISION BENEFITS

Effective 1.1.24
$10 Exam / $25 Materials Copay
Dependent Age: 26 (EOBM)

Frequency Type: Last Date of Service	Employee	Spouse	Children
Vision Exam	12 Months	12 Months	12 Months
Lenses	12 Months	12 Months	12 Months
Frames	24 Months	24 Months	24 Months

Benefits: Employee Can Select Either	VBA Participating Provider Amount Covered/Benefit (After Applicable Copay)*	Out-of-Network Max Reimbursement (Zero Copay)
Vision Exam (Glasses or Contacts)	Covered in Full	$40
Retinal Screening with Exam	Copay not to exceed $39	N/A
Clear Standard Lenses (Pair):		
Single Vision	Covered in Full	$40
Bifocal	Covered in Full	$60
Blended Bifocal	Covered in Full	$60
Trifocal	Covered in Full	$80
Progressives	Partially-Covered	$80
Lenticular	Covered in Full	$120
Polycarbonate	Covered in Full for Persons Up to Age 19	N/A
Basic Scratch Coating	Covered in Full	N/A
Frame	Up to $125	$50
-OR-		
Elective Contacts (in lieu of eyeglass benefits)		
Material Allowance	Up to $125[A]	$125
Elective Fitting Fee and Evaluation	15% off UCR	N/A
-OR-		
Medically Necessary Contacts	Covered in Full[B]	$450
-AND-		
Lasik Surgery (once every 8 years)	N/A	$125

Health Plan Terminology

HEALTH PLAN TERMINOLOGY

- ✓ **Deductible** – The amount you owe during a coverage period for covered health care services before your plan begins to pay.
- ✓ **Network** – a group of providers who have contractually agreed to provide services under your health plan.
- ✓ **In-Network Provider** – A provider that has contracted with your health plan's network to provide services at an agreed upon rate to be paid by the plan.
- ✓ **Out-of-Network Provider** – A provider who doesn't have a contract with your health plan's network to provide services.

HEALTH PLAN TERMINOLOGY

- ✓ **Allowed Amount** – This is the maximum payment the plan will pay for a covered health service. In-network providers agree to take this amount as payment in full; Out-of-network providers have not agreed to accept this as payment in full.

- ✓ **Balance Billing** – When an out-of-network provider bills you for the balance remaining on the bill that your plan doesn't cover.

- ✓ **Total Maximum Out-of-Pocket Limit** – Sometimes referred to as TMOOP, this is the annual cap on the amount of money an individual or family will pay for out-of-network services.

- ✓ **Copayment** - A fixed amount you pay for a covered health care service, usually paid when you receive the service. Copayments are paid each time you receive a service subject to a copayment.

Qualified High Deductible Health Plan (QHDHP)

QHDHP PLAN DESIGN

- ✓ The QHDHP and the PPO are on the same Highmark broad-based network. Under both plans, you will have access to the same doctors and pharmacies.

- ✓ Preventive care is covered at 100% before the deductible is satisfied and does not apply to the deductible. Preventive care is identified on the carrier's preventive care schedule which is updated periodically.

QHDHP PLAN DESIGN

- ✓ The QHDHP has a first dollar deductible that must be satisfied before the plan starts paying claims.

- ✓ Until your deductible is satisfied, you will be responsible for the negotiated rate for non-preventive care services and prescriptions you and your covered family members receive from providers and pharmacies.
  - For example: instead of a copay at the time of service at your PCP, the negotiated rate may be $80 - $120.

- ✓ At providers, you will pay nothing at the time of service. Instead, the provider will process the claim with Highmark, and send you a bill once the claim processes for the negotiated rate.

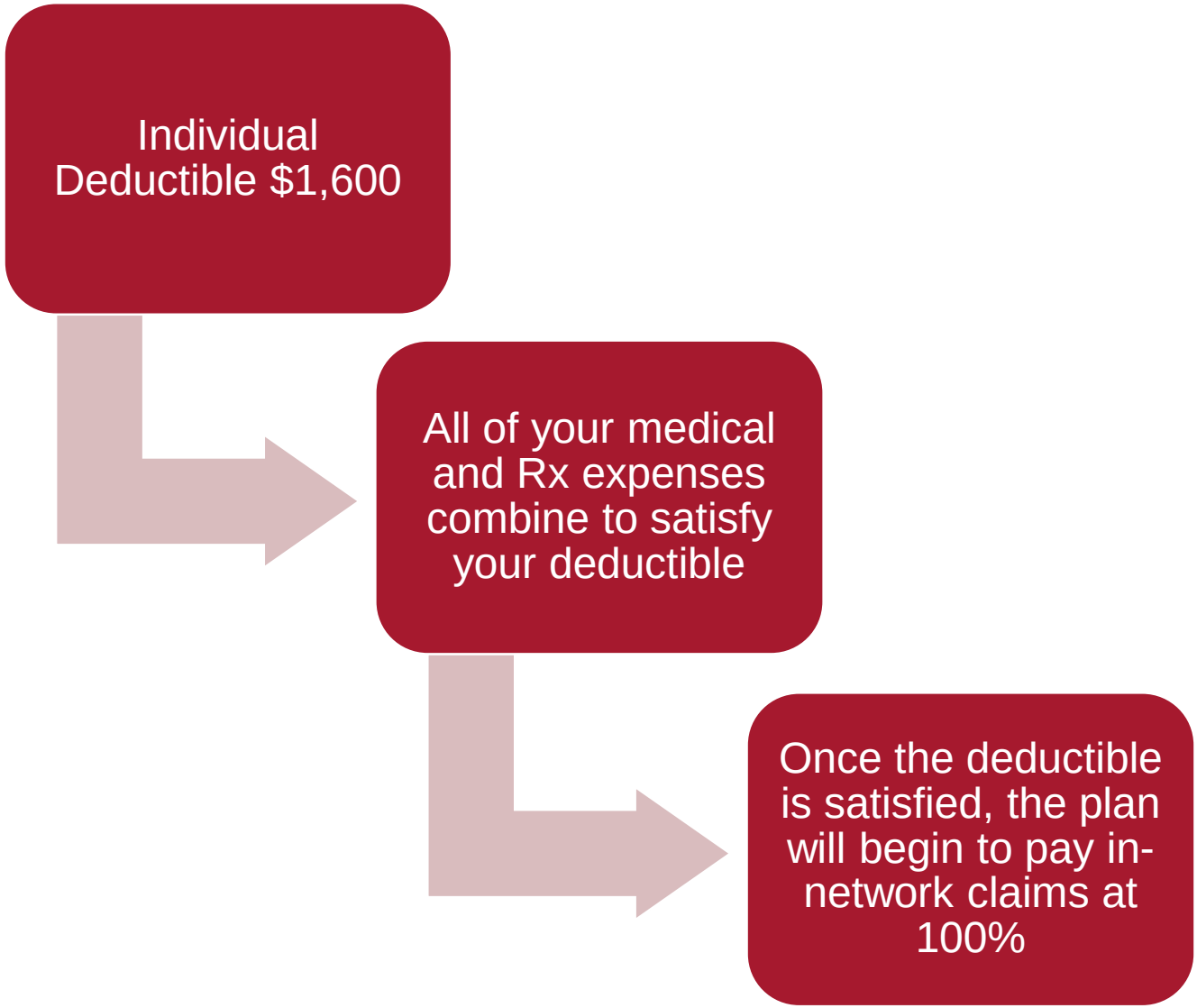
QHDHP PLAN DESIGN

- ✓ At the pharmacy, you will pay the negotiated rate at the time of service.
- ✓ The QHDHP follows the IRS minimum deductible. The minimum deductible for 2024 is $1,600/$3,200. This may increase in future years.
- ✓ The annual deductible for your plan is:

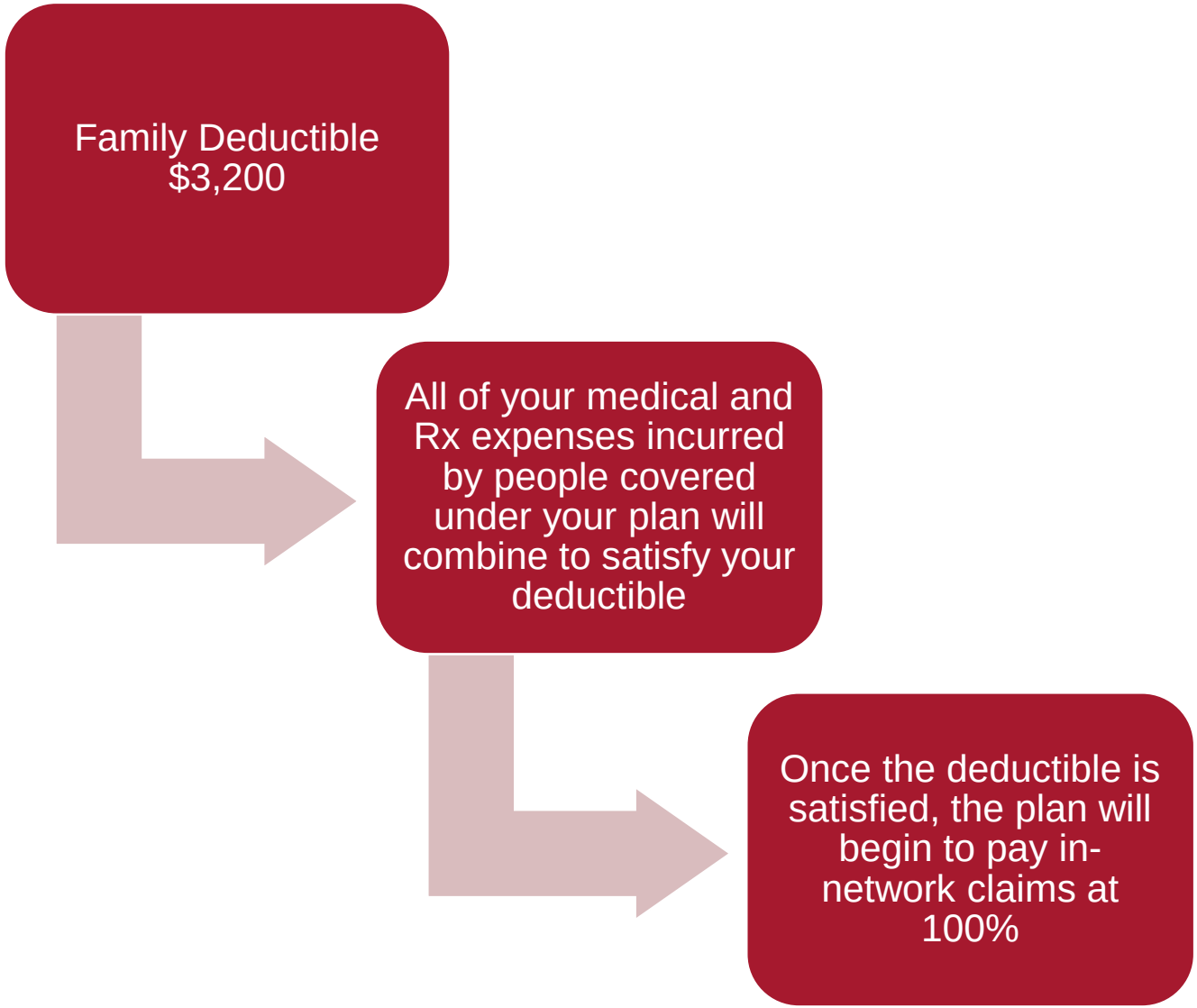
Coverage Type	Deductible Amount
Individual	$1,600
Family (all other tiers)	$3,200

- ✓ The deductible schedule for the QHDHP is January 1 – December 31.
- ✓ Once the deductible is satisfied, all in-network care and all prescriptions are covered 100% (i.e., no out-of-pocket expense for you).

SATISFYING THE INDIVIDUAL DEDUCTIBLE



SATISFYING THE FAMILY DEDUCTIBLE



Health Savings Account (HSA)

HEALTH SAVINGS ACCOUNT (HSA)

- ✓ A Health Savings Account (HSA) is an IRS regulated bank account; it is not your health plan.
- ✓ The HSA can *only* be tied to a QHDHP and is set up so both the employer and employee can contribute money into the account.
- ✓ Once the employer makes a contribution into the HSA, it becomes your money, and generally, the employer is not allowed to recoup that money.
- ✓ The HSA is your account and is portable, meaning that the account and all the money in the account will remain with you even after you leave employment.

TITUSVILLE AREA SCHOOL DISTRICT – HSA CONTRIBUTION

	Individual	Family
QHDHP Deductible	$1,600	$3,200
District HSA Contribution	$750	$1,500
Your OOP Maximum (in-network services)	$850	$1,700

HEALTH SAVINGS ACCOUNT TAX SAVINGS

- ✓ The HSA has preferential tax treatment so that the account holder can save for eligible medical expenses.
  - Contributions to an HSA are tax deductible.
  - Interest earned or investment gains in an HSA are not taxable.
  - Withdrawals from an HSA for eligible expenses are not taxable.
- ✓ *Withdrawals for non-medical expenses are subject to income taxes and an additional penalty if age 65 or under.*

HEALTH SAVINGS ACCOUNT TAX SAVINGS

✓ Tax Savings Example – Employee at 20% Federal Tax Rate

Employee Annual Contribution	$1,000.00
Federal tax savings @ 20%	$200.00
FICA tax savings @ 7.65%	$76.50
State tax savings @ 3.07%	$30.70
Local tax savings @ 1.00%	$10.00
Total tax savings	**$317.20**

HEALTH SAVINGS ACCOUNT LIMITS

- ✓ The IRS sets limits for the maximum annual contribution:

Coverage Type	2023	2024
Individual	$3,850	$4,150
Family	$7,750	$8,300

- ✓ Individuals 55 or older are eligible to make an additional catch-up contribution of $1,000 per year.

- ✓ The contribution limit applies to the sum of employer and employee contributions.

HEALTH SAVINGS ACCOUNT ELIGIBILITY RULES

- ✓ The account holder must be enrolled in a QHDHP.
- ✓ The account holder cannot be covered by any other type of medical or prescription drug coverage that is not a QHDHP (for example, cannot be covered under a spouse’s plan that is not a QHDHP).
- ✓ The account holder cannot be enrolled in Medicare or TRICARE.
- ✓ The account holder cannot be claimed as a dependent on someone else's most recent tax return.

HEALTH SAVINGS ACCOUNT ELIGIBILITY RULES

Not Permitted	✓ General purpose FSA ✓ General purpose HRA ✓ Spouse's general purpose FSA or HRA that pays for or reimburses eligible medical expenses which would cover your expenses as an eligible dependent.
Permitted	✓ Limited purpose FSA (for example, reimburses dental, vision only) ✓ Limited purpose HRA (for example, premium only) ✓ Dependent care FSA

HEALTH SAVINGS ACCOUNT (HSA)

- ✓ You can use money from your HSA for qualified medical expenses.

- ✓ Qualified medical expenses are those incurred by the following persons:
  - You and your spouse.
  - All dependents you claim on your tax return.
  - Any person you could have claimed as a dependent on your return except that:
    - The person filed a joint return,
    - The person had gross income of $4,300 or more, or
    - You, or your spouse if filing jointly, could be claimed as a dependent on someone else's tax return.

HEALTH SAVINGS ACCOUNT AND FLEXIBILITY

- ✓ The HSA is your bank account. The money that you and/or your employer place into the HSA stays with you until you decide to spend it. Unlike a FSA, you do not need to spend it down before the end of the calendar or benefit year.

- ✓ The HSA stays with you in retirement or if you change employers.

- ✓ You can continue to use HSA funds even if you are no longer covered by a QHDHP or otherwise become ineligible for the HSA. Ineligibility only means that you are no longer permitted to contribute to your HSA.

- ✓ You can use the funds to pay for eligible medical expenses that are not covered under your medical and prescription plan (for example: dental and vision expenses).

HEALTH SAVINGS ACCOUNT (HSA) ELIGIBLE EXPENSES

Eligible Expenses*	Not Eligible Expenses*
✓ Claims that hit your deductible by you, your spouse, or any person you could claim as a tax dependent ✓ OTC Medicine ✓ Lasik Surgery ✓ Eyeglasses/contacts ✓ Braces ✓ Medicare and Medicare Advantage premiums ✓ COBRA premiums (up to 18 months)	✓ Health club fees ✓ Special food and beverages ✓ Cosmetic surgery ✓ Spa treatments ✓ Gym equipment ✓ Herbal supplements ✓ Medigap premiums ✓ Marijuana
*See IRS Publication 502 for a complete list of eligible expenses	

HEALTH SAVINGS ACCOUNT (HSA) ELIGIBLE EXPENSES

- ✓ The only qualified medical expenses that will count towards your deductible will be those expenses covered by your QHDHP.

- ✓ You can use the funds to pay for eligible medical expenses that are not covered under your medical and prescription plan, however, they do not apply to your deductible. For example, contact lenses are considered a qualified medical expense, but the cost for those contacts will not be applied to your deductible.

HEALTH SAVINGS ACCOUNT AND RETIREMENT PLANNING

- ✓ It is estimated that the average couple will need at least $280,000 in today's dollars for medical expenses in retirement, including long-term care.

- ✓ Knowing that medical and prescription drug expenses are going to play a large role in retirement, an account holder may elect to maximize HSA contributions prior to saving in traditional retirement vehicles such as 403(b) plans, IRAs, 401(k) plans, etc. If the account holder spends the HSA funds on eligible medical expenses, the money is never taxed.

- ✓ The account holder can also withdraw the HSA funds after reaching age 65 and pay income tax on the withdrawals, just like some of the above retirement accounts.

- ✓ Medicare Premiums – HSA funds may be used for certain Medicare premiums for the account holder and the account holder's spouse, but only if the account holder is over the age of 65. Eligible Medicare premiums include Part B premiums for medical insurance, Medicare Advantage Plan premiums, and Part D premiums for prescription drug. HSA funds cannot be used for premiums for a Medicare supplement policy such as Medigap.

- ✓ COBRA Premiums – An employee planning to retire could start to save money on a pretax basis to cover up to eighteen (18) months of COBRA premium once they leave employment.

PPO Blue

PPOBLUE PLAN

Plan Provisions	Cost
In-Network Individual Deductible	$1,500 - Employee responsibility -$800
In-Network Family Deductible	$3,000 - Employee responsibility - $1,600
Out-of-Network Individual Deductible	$3,000 - Employee responsibility - $1,600
Out-of-Network Family Deductible	$6,000 - Employee responsibility - $3,200
Preventive Care	Covered at 100%
Physician Office Visit	$20 copay/visit
Specialist Office Visit	$20 copay/visit
Diagnostic Services	$10 copay per date of service per provider
Allergy Extracts	$15 copay

PPOBLUE PLAN

Plan Provisions	Cost
Emergency Room	$75 copay per visit (waived if admitted)
Spinal Manipulation	$15 copay/visit
Physical Therapy Services	$15 copay/visit
Speech and Occupational Therapy	$15 copay/visit
Rx Retail – Up to 30 Day Supply	$0 generic / $30 brand copay
Rx Mail Order – Up to 90 Day Supply	$0 generic / $30 brand copay

PPOBLUE PLAN

- How does the family deductible work?
  - ✓ One family member must meet the $1,500 deductible. The remaining family members combined make up the remaining $1,500 deductible.
  - ✓ Deductible schedule for the PPOBlue Plan is January 1 – December 31.
  - ✓ All preventive services listed on the Highmark Preventive Schedule are paid at 100% and do not apply to the annual deductible.

Plan Comparison

FAMILY COVERAGE WITH LOW UTILIZATION

Service	QHDHP*	PPO Plan
Preventive Service	$0	$0
Office Visits (3)	$240	$60
Specialist Visit (1)	$120	$20
Diagnostic Test (1)	$135	$10
Generic Rx (1)	$5	$0
Brand Rx (1)	$115	$30
Total OOP	$615	$120
District HSA Contribution	$1,500	N/A
Balance in HSA	$885	
** HSA costs are estimated*		

FAMILY COVERAGE WITH HIGH UTILIZATION

Service	QHDHP*	PPO Plan
Preventive Service		$0
Office Visits (14)		$280
Specialist Visit (7)		$140
Diagnostic Test (1)		$10
Generic Rx (1)		$0
Brand Rx (16)		$480
Family Meets PPO Deductible	N/A	$1,600
Spinal Manipulation (12)		$180
Total OOP	$3,200	$2,690
District HSA Contribution	$1,500	N/A
Total OOP	$1,700	$2,690
** HSA costs are estimated*		

Flexible Spending Account (FSA)

HEALTH FSA

- ✓ *A health FSA can only be elected if you select the PPOBlue Health Plan.*

- ✓ A Health FSA is a voluntary account in your name that you can use to reimburse yourself for eligible medical expenses, up to the amount contributed for the plan year.

- ✓ Contributions to the Health FSA are made through payroll deductions on a pre-tax basis.

- ✓ The plan year for the Health FSA is January 1, 2024, to December 31, 2024.

HEALTH FSA

- ✓ The maximum contribution for 2023 was $3,050. The projected 2024 contribution limit is $3,200.
- ✓ FSAs have a “use it or lose it” provision meaning that any unused funds at the end of the plan year, including the two and one-half month grace period, will be forfeited.
- ✓ To avoid forfeiture, your Health FSA funds must be used by March 15, 2025.
- ✓ *You are not permitted to have a Health FSA and a HSA at the same time*.

DEPENDENT CARE FSA

- ✓ A Dependent Care FSA is a voluntary account in your name that you can use to reimburse yourself for eligible dependent care expenses, up to the amount contributed for the plan year.
- ✓ Contributions to the Dependent Care FSA are made through payroll deductions on a pre-tax basis.
- ✓ The plan year for the Dependent Care FSA is January 1, 2024, to December 31, 2024.
- ✓ The maximum contribution for 2024 is $5,000.
- ✓ Dependent Care FSAs also have a “use it or lose it” provision meaning that any unused funds at the end of the plan year, including the two and one-half month grace period will be forfeited.
- ✓ To avoid forfeiture, your Dependent Care FSA funds must be used by March 15, 2025.
- ✓ *You are permitted to have a Dependent Care FSA and HSA or Health FSA at the same time.*

HSA, HRA, & Health FSA: What is the Difference?

COMPARISON OF HSA, HRA, & HEALTH FSA

	HSA	HRA	Health FSA
Name of Account	Health Savings Account	Health Reimbursement Arrangement	Health Flexible Spending Account
Who owns the account?	Individual/Employee District contribution is owned by the employee	District	District
Who may fund the account?	District and employee.	District	Employee
What is the district contribution in 2024?	Individual coverage - $750 Family coverage - $1,500	Individual coverage - $700 Family coverage - $1,400 Individuals are responsible for the first $800 of the deductible and families are responsible for the first $1,600. The HRA will pay the remainder of the deductible.	N/A
Is there a limit on the amount that can be contributed each year?	The limit is set annually by the IRS, for 2024: Individual coverage - $4,150 Family coverage - $8,300 This is the total of the district and employee contribution. Plus, catch-up contribution of an additional $1,000 per year age 55 and over.	Yes, limited to the district contribution above.	Determined by the IRS - for 2024 it is projected employees may contribute up to $3,200. The 2023 contribution limit was $3,050.

COMPARISON OF HSA, HRA, & HEALTH FSA

	HSA	HRA	Health FSA
Can unused funds be rolled over from year to year?	Yes	No	No, however, the Titusville Area SD plan allows a grace period of 2 ½ months up to March 15th.
Is there a limit to the amount that can accumulate in my account?	No	Funds do not rollover from year to year and do not accumulate.	Funds do not rollover from year to year and do not accumulate.
What expenses are eligible for reimbursement?	Section 213 (d) medical expenses, COBRA premium, If Medicare eligible due to age, health insurance premiums except medical supplement policies.	Limited to health plan deductible.	Section 213(d) medical expenses.
Must claims be submitted for reimbursement?	No	Yes	Yes
Is interest earned on the account?	Yes, accrues tax free. Investment options are available.	No	No
May account reimburse non-medical expenses?	Yes, but taxed as income and 20% penalty (no penalty if distributed after death, disability, or age 65)	No	No

Making a Decision

MAKING A DECISION

- Multiple Plan Options
  - ✓ Multiple plan offerings establish different point of service cost sharing, so that employees are able to take the following into consideration when choosing a plan.
  - ✓ Point of Service Costs – This is the amount you pay for healthcare when you use the health plan. These costs are the deductibles, copayments, and coinsurance under the health plan.
  - ✓ Utilization – You should consider how much you and your dependents use healthcare services, and where you are receiving those services. Utilization directly impacts your Point of Service Costs.

MAKING A DECISION

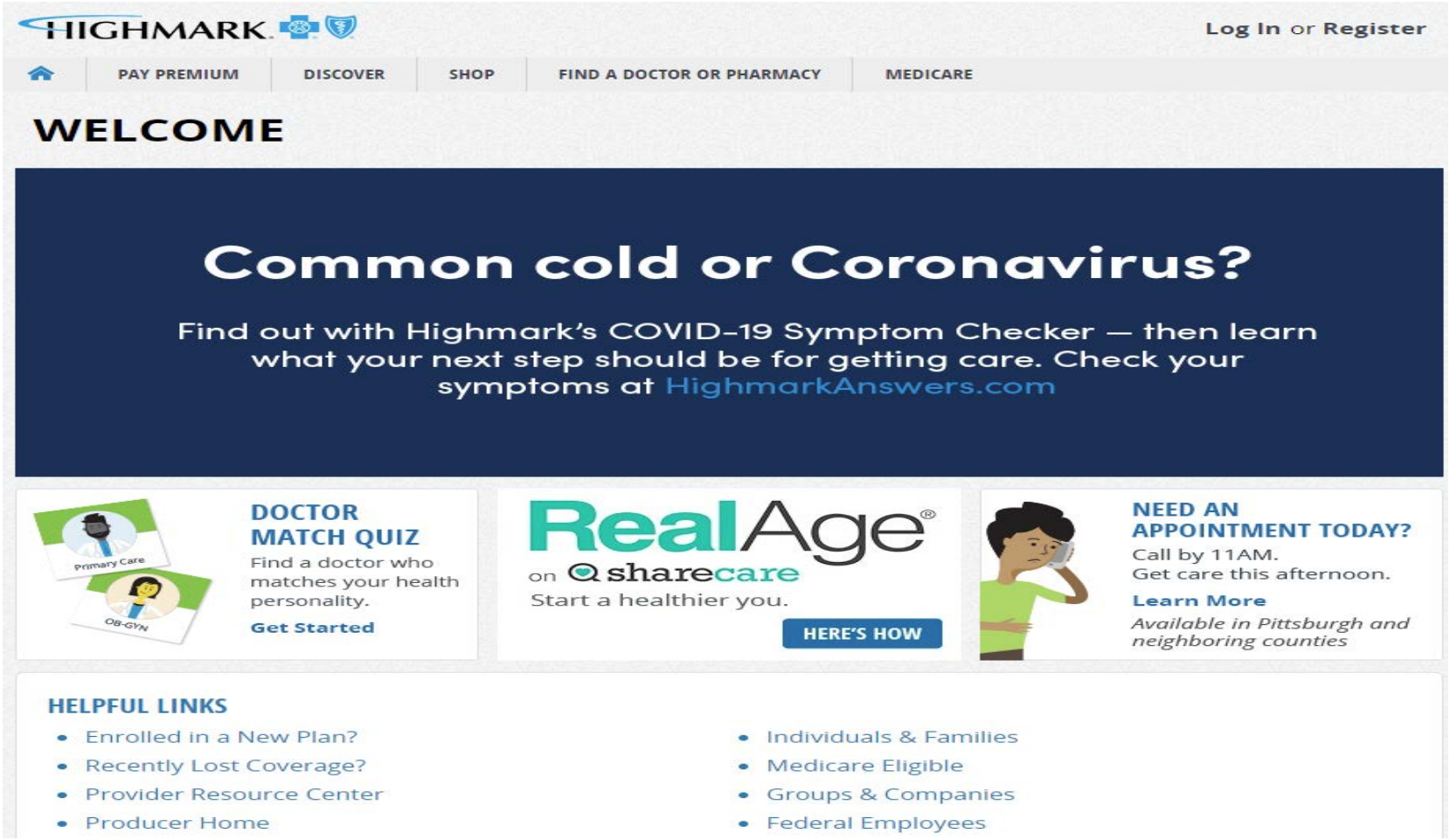
- Utilization
  - ✓ Review your regular health care utilization and make use of the tools on the Highmark website at https://www.highmarkbcbs.com
  - ✓ On the website you have access to several services, including:
    - ✓ Ability to view and access plan documents.
    - ✓ Access to Explanation of Benefits (“EOB”) statements and video tutorials to help you read and understand your EOB.
    - ✓ Medical cost estimator to get an idea of roughly what you can expect to pay out of pocket for certain procedures.
    - ✓ Ability to search for a medical provider or pharmacy.

MAKING A DECISION

- Utilization
  - ✓ Breaking down a Claim:
    - ✓ **Amount Charged** – This amount is what the provider is charging for the services or supplies that you received.
    - ✓ **Highmark Network Discount** – This is the amount that an in-network provider has agreed to accept as payment in full for the services or supplies that you received.
    - ✓ **Plan's Share** – This is the amount paid to the provider through the health plan. You will also be able to see the date that payment was released to the provider.
    - ✓ **Your Share** – This is the amount that you owe depending on whether the services or supplies are subject to the deductible or a copayment under your health care plan design. If there were multiple services or suppliers provided, there will be a Total Cost line as well.

HIGHMARK WEBSITE

- www.highmarkbcbs.com



Electing the QHDHP

QHDHP AND HSA

- What can you expect next?
  - ✓ You will get new ID card(s) in the mail from Highmark Blue Cross Blue Shield
  - ✓ HSA account opens automatically
  - ✓ OFAC check takes place
  - ✓ An HSA Welcome Kit and Debit Card will be mailed to your house.
  - ✓ HSA funding may take a week
  - ✓ Visit the Highmark Blue Cross Blue Shield website
  - ✓ Investment options are available if your HSA balance exceeds $500

QHDHP AND HSA

- What you need to do once your account is established:

  - ✓ Add a beneficiary to your HSA
  - ✓ Sign up for direct deposit from your HSA
  - ✓ Sign up for paperless statements to avoid a fee
  - ✓ Determine how you want to pay deductible claims
    - ✓ Debit card
    - ✓ Direct payment to provider from your HSA
    - ✓ You pay and get reimbursed from your HSA via check or direct deposit

Both Plans

PREVENTIVE SERVICES

- ✓ Preventive Care is covered at 100% on both plans

- ✓ You should use your preventive benefits to ensure you are preventing conditions from becoming more chronic and developing into more serious conditions.

MAIL ORDER – EXPRESS SCRIPTS

- If you are using a mail order drug, it's easy to get a 90-day supply delivered by Express Scripts

  - ✓ Ask your doctor to write a new prescription for up to a 90-day supply plus refills for up to one year.

  - ✓ You can either complete the Home Delivery Mail Order Form or give your doctor's office your Member ID Number and ask the office to call 1-877-327-9791 for fax instructions.

  - ✓ You will receive your 90-day supply within 3-7 days after the order is received. Shipping is free.

KNOW WHERE TO GO

- Where you get your healthcare can make a big difference in how much you pay for services

Type	Cost
Virtual Visit	$
Primary Care Physician	$
Urgent Care Center	$$
Emergency Room	$$$$

THE RESCHINI GROUP

If you need assistance or have any questions regarding your benefit coverages or claims, please contact:

The Reschini Group

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Questions on the Health Plan

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