Bethlehem Central School District

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To: Bethlehem CSD Employees Eligible for Health Insurance

From: Amy Baluch, Human Resources

Date: May 1, 2018

Subj: **Open Enrollment for Health Insurance**

OPEN ENROLLMENT runs from May 1 – 31, 2018

This is the only period during which employees may change plans (without a qualifying event).

During the month of May, benefit eligible employees will be able to make changes to health insurance coverage options. These changes include: switching from one plan to another, adding dependents or enrolling in a plan. These plan changes will be effective July 1, 2018. For BCTA members, premium rate changes occur in the two pay periods in June and for BCUEA members, changes occur in the last pay period in May and the two pay periods in June.

The Bethlehem Central School District will provide health insurance benefits in accordance with the appropriate collective bargaining agreements. The employee's contribution rate includes the prescription drug component for all plans which is administered by Blue Shield/Express Scripts. The health insurance contribution rates for 2018-2019 are attached and will also be posted in all buildings and in the staff section of the district website.

If you are not changing your health insurance coverage, adding dependents or enrolling in a health insurance plan, **no action needs to be taken.** Employees who are making changes must return a completed enrollment form to the Human Resource Office before the appropriate change can be made. It is the responsibility of the employee to complete the enrollment form properly and ensure its receipt by the Human Resource Office no later than May 31, 2018.

BUYOUT: Any employee who is eligible for health insurance and wishes to participate in the health insurance buyout must complete a form **EACH** year. Enrollments do not carry over from year to year and verification of other coverage is required annually. **The form to enroll in the buyout for 2018-19 will be included in a separate email and can also be found on the district website.**

A summary comparison of benefits for the $25 copayment plans is also included with this memo to assist you with comparison of the plan offerings.

Additional information and enrollment forms are available upon request to the Human Resource Office by contacting Amy Baluch at 439-7481, ext. 31926 or by email at abaluch@bethlehemschools.org.

Attachments: 2018-2019 Benefit Comparison $25 copay plans
Health Insurance Premium Rates 2018-2019

Bethlehem Central Schools

Please Post

HEALTH INSURANCE PREMIUM ANNOUNCEMENT

Effective July 1, 2018 through June 30, 2019

Monthly Rates for Active BCUEA Employees

For benefit eligible employees hired before 1/23/2014

*** Employees hired after 1/23/2014 and working more than 20, but less than 30 hours will pay an additional percent toward health insurance.**

Capital District Physicians Health Plan	Monthly Premium	Monthly Employer Share	Monthly Employee Share	Bi-Monthly Employee Share
All Support Staff Employees				
Individual Coverage	$765.53	$658.36	$107.17	$53.59
2-Person Plan	$1,525.04	$1,189.53	$335.51	$167.76
Family (more than 2)	$2,016.72	$1,573.04	$443.68	$221.84

EPO-Office Co-Pay: $25
Annual Deductible: None

Blue Shield Secure Blue Preferred (PPO)	Monthly Premium	Monthly Employer Share	Monthly Employee Share	Bi-Monthly Employee Share
All Support Staff Employees				
Individual Coverage	$766.55	$659.23	$107.32	$53.66
2-Person Plan	$1,595.72	$1,244.66	$351.06	$175.53
Family (more than 2)	$2,208.64	$1,722.74	$485.90	$242.95

In-Network: (any participating physician in any location): No Deductible; Co-Pay: $25

Out Of Network: (any physician not participating with Blue Shield);
Annual Deductible: $250 Individual; $500 Family

EXPRESS SCRIPTS DRUG COVERAGE:

(Express Scripts premium is included in each health insurance calculation above.)

ALL PLANS - DRUG COVERAGE:
$5.00-Generic; $15.00-Brand Name Formulary; $30.00-Non Formulary

MAIL ORDER - ALL PLANS - 2 COPAYMENTS FOR A 90 DAY SUPPLY- DRUG COVERAGE:
$10.00-Generic; $30.00-Brand Name Formulary; $60.00-Non Formulary

For additional benefit information, please refer to the benefit comparison worksheet.

	CDPHP EPO $25	BSNENY PPO 815	
	In-Network	In-Network $25	Out-of-Network
TYPE OF PLAN	Exclusive Provider Organization (EPO). You are not required to select a primary care physician (PCP) or obtain referrals, although we encourage you to establish a relationship with a PCP who can help coordinate your care. You have access to a National Network of providers which can be found at findadoc.cdphp.com. Prior approval required for some benefits.	A Preferred Provider Organization (PPO). Coverage varies based on whether services are provided by an in-network or out-of- network provider. No Primary Care Physician, and no specialist referrals required. Prior approval required for some benefits.	
ANNUAL DEDUCTIBLE	None	None	$250 Ind/$500 Family
CO-INSURANCE	N/A	None	20% coinsurance based on schedule of allowances
OUT-OF-POCKET LIMIT	None	None	Coinsurance waived after member has spent $2500 Ind/$5000 Family in a calendar year, excluding payments in excess of the Schedule of Allowances.
MAXIMUM LIFETIME PAYMENTS	None	None	None
DEPENDENT COVERAGE	Dependents have coverage until the end of the month in which they turn 26. Coverage available for eligible domestic partners.	Dependents to age 26. Coverage available for eligible domestic partners.	
WAITING PERIOD	None	None	
HOSPITAL SERVICES			
Inpatient	Covered in full	Covered in full	Deductible and 80% of allowed amount
Outpatient	$15 copay	Covered in full	Deductible and 80% of allowed amount
Emergency Room	$50 copay *(waived if admitted)*	$35 copay *(waived if admitted)*	
MENTAL HEALTH			
In-patient	Covered in full	Covered in full, unlimited days based on medical necessity	Deductible and 80% of allowed amount, unlimited days based on medical necessity
Out-patient	$25 copay	Covered in full, unlimited days based on medical necessity	Deductible and 80% of allowed amount, unlimited days based on medical necessity
SUBSTANCE ABUSE			
In-patient	Covered in full	Covered in full, unlimited detox and rehab days	Deductible and 80% of allowed amount,unlimited detox and rehab days
Out-patient	$25 copay	Covered in full, unlimted based on medical necessity	Deductible and 80% of allowed amount, unlimted based on medical necessity
PHYSICIAN SERVICES			
Office Visits	$25 copay	$25 copay	Deductible and 80% of allowed amount
Hospital Visits	Physician Services during inpatient stay when billed separately from the facility - covered in full	Covered in full - IP only $25 copay outpatient setting	Deductible and 80% of allowed amount
Surgery	Covered in full when inpatient $15 copay when outpatient	Covered in full - IP only $25 copay outpatient setting	Deductible and 80% of allowed amount
	CDPHP EPO $25	BSNENY PPO 815	
Second Opinion	$25 copay	$25 copay	Deductible and 80% of allowed amount
Annual Physical	Covered in full (one per benefit period)	$25 copay	Not covered
OTHER SERVICES			
HOME HEALTH CARE	Covered in full (requires prior authorization)	$25 copay, up to 100-visits per year *(aggregate)*	Deductible and 80% of allowed amount up to 100-visits per year (aggregate)
HOSPICE	Covered in full up to 210 days (IP & OP combined) per lifetime	Covered in full up to 210 days.	Deductible and 80% of allowed amount up to 210 days.
WELL CHILD CARE & IMMUNIZATIONS	Covered in full through age 19 (immunizations covered when preventive)	Covered in full, 0 to age 19 years of age	Deductible and 80% of allowed amount, 0 thru 18 years of age

LAB & X-RAY	$25 copay; waived if preferred free-standing facility; copay always applies to office based lab & x-ray	Covered in full	Deductible and 80% of allowed amount
AMBULANCE	$50 copay	Covered in full	Covered in full
DURABLE MEDICAL EQUIPMENT	20% coinsurance; must use participating vendor; prior authorization required if over $500	Covered in full	Deductible and 50% of allowed amount
PHYSICAL, OCCUPATIONAL & SPEECH THERAPY	$25 copay (Physical/Occupational limited to 120 days each. Speech limited to 60 visits.)	$25 copay; up to 60-visits per year *(aggregate)*	Deductible and 80% of allowed amount, up to 60-visits per year (aggregate)
PRESCRIPTION DRUGS	not administered by CDPHP	Express Scripts, Inc. $5/15/30 Retail $10/30/60 Mail Order	
VISION CARE	$25 copay, 1 routine vision exam every 24 months	$25 copay; one exam annually for children 14 & under; one exam every two years for over age 14	Not covered
PREVENTIVE DENTAL CARE FOR CHILDREN	Not covered	Not covered	Not covered
REWARDS FOR PARTICIPATING IN HEALTHY ACTIVITIES	**LifePoints:** Up to $180 in gift cards per contract per calendar year. **CDPHP Fitness Connect:** 5 free gyms located thoughout Capital Region.		

PLEASE NOTE:

This information is intended only as a summary comparison of benefits and is not intended as a contract. For more detailed info. concerning benefits, limitations, and exclusions, please refer to the actual contract. All visit limits are an aggregate between in and out-of-network services.