

Employee Benefit Guide

2025-2026



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Welcome – A Message from HR



Roanoke County Public Schools mission is preparing every student, in every school, and in every classroom to be Opportunity Ready. We accomplish this together through our talented and dedicated workforce. We appreciate and value each of your contributions and are pleased to offer a comprehensive benefits program for you and your families. This guide provides you with details about those benefits so you can make informed decisions.

The HR Department Staff and contact information as well as additional information on our benefits resources, provider information, leave information and more can be found on the RCPS intranet. All of us in HR are here to help. Please do not hesitate to reach out to us with questions.

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Additional Links (To view choose CTRL + Click):

- [Intranet Link](#)
- [Employee Offers](#)
- [RCPS HR Directory](#)

Information contained in this insurance and benefits booklet is not a guarantee of benefits. Our summary plan descriptions and SPD Wrap Document are the guiding legal documents for our plans. If there are any discrepancies between this booklet and the legal summary from the insurance carrier, the carrier's documentation will prevail.

Summary of Open Enrollment

Open Enrollment:

Roanoke County Public Schools holds an Open Enrollment period each year. During Open Enrollment, you may make changes without a Qualifying/Life Event.

The 2025 Open Enrollment period is April 25th – May 9th. Any benefit change must be entered in GHR Employee Space no later than May 9th, 2025. Your changes will be effective July 1, 2025, and any deductions associated with these changes will be reflected on your July 11, 2025, paycheck. If you do not make your 2025 benefit elections, you will automatically be defaulted to your prior year elections, except for the FSA, which will default to zero (\$0) elections. To participate in the FSA program for the upcoming plan year, you must re-enroll during open enrollment.

Important Information: 2025 SUMMARY OF BENEFIT CHANGES:

■ Health, Dental, Vision Insurance Premiums

- We are making some medical plan design changes to our current plans and adding a third High Deductible Health Plan to be paired with a Health Savings Account option!
- As a result of the medical plan design changes, there have been changes to the health premiums.
- There will be no changes to the dental and stand-alone vision premiums.
- New School Couples will need to request a School Couple/Family form from the HR Benefits Manager (ext. 10146) to update their status.

■ Wellness Program

- We are making changes to our Wellness Program for the 2025-2026 plan year. Please review the details in this benefit guide to understand how these changes may affect you.

■ Flexible Spending Plans

- The Healthcare FSA carryover increased from \$640 to \$660 for 2025. This means that funds up to \$660 will carryover at year end (June 30) into the next plan year beginning July 1. Additionally, the annual contribution amount increased from \$3,200 to \$3,300.
- Remember, for the Dependent Care FSA, employees will have until September 15 to submit claims for reimbursement that were incurred through the end of the plan year (June 30).

Eligibility

Eligible Employees:

You may enroll in the Roanoke County Public Schools' Medical, Dental, and Vision programs if you are a full-time or part-time contracted employee.

Eligible Dependents:

If you are eligible for our benefits, then your dependents are too. In general, eligible dependents include your spouse and children up to age 26. If your child is mentally or physically disabled, coverage may continue beyond age 26 once proof of the ongoing disability is provided. Children may include natural, adopted, stepchildren and children obtained through court-appointed legal guardianship.

Please Note:

Employees must show proof of their dependents (i.e., marriage certificates, birth certificates, adoption paperwork, court orders, hospital birth records, custody agreements, qualified medical child support orders, or divorce decrees)

When Coverage Begins:

Insurance for new hire employees on a 230, 240 and 260 contract starting work on the first working day of July will have coverage effective July 1. Insurance for beginning of the school year - new hire employees on a 220 day contract will be effective August 1. Insurance for beginning of the year new hire employees on a 210 and below contract will go into effect September 1. Insurance benefits for all new mid-year hires will be effective the first of the month following the date of hire.

All elections are in effect for the entire plan year and can only be changed during Open Enrollment unless you experience a qualifying life event. Benefit enrollments or changes made during open enrollment become effective on July 1st. The effective date of your benefit enrollments or changes at the time of a life event are dependent upon the date of the event. The plan year begins on July 1st and ends on June 30th.

Changes in Benefit Elections

With few exceptions, Open Enrollment is the only time of year when you can make changes to your benefits plan. All elections and changes take effect on the first day of the plan year, July 1st. During Open Enrollment, you can:

- Enroll, cancel or change the coverage tier on health, dental, and vision insurance plans.
- Add, or drop dependents from coverage. Note: You will be required to show proof of dependent eligibility (i.e., marriage certificates, birth certificates, adoption paperwork, court orders, hospital birth records, custody agreements, qualified medical child support orders, or divorce decrees) if you are adding a new dependent to your coverage.
- Enroll, or re-enroll in dependent or health care flexible spending accounts. *To continue your FSA benefits, you must re-enroll each plan year.*
- Change your insurance deduction from pre-tax status to after-tax status.

Family Status Change:

A life event is a change in your personal life that may impact your eligibility or dependent's eligibility for benefits. Examples of some family status changes include:

- Change of legal marital status (i.e., marriage, divorce, death of spouse, legal separation)
- Change in number of dependents (i.e., birth, adoption, death of dependent, ineligibility due to age)
- Change in employment or job status (spouse loses job, etc.)

If such an event occurs, you must make the change to your benefits for most life events within 30 days of the event date. Documentation may be required to verify your change of status. Failure to request a change of status within 30 days of the event may result in your having to wait until the next open enrollment period to make your change. Please use GHR Employee Space to make these changes. Instructions for GHR can be found on our intranet.

Health Premiums

For the 2025-2026 plan year, Roanoke County Public Schools will now offer three medical and prescription drug plan options through Anthem. The charts shown on the next few pages reflect a brief outline of what is offered, and the premium amounts based on the coverage tier. Please refer to the summary plan description on the intranet for complete plan details. Employees MUST provide documentation to show that their dependents are eligible for the School's health plans.

KeyCare 1000 PPO				
12-Month Full-Time	Monthly Employee	Monthly RCPS	Total Premium	Per Pay Period
Subscriber	\$185.00	\$740.00	\$925.00	\$92.50
Subscriber + 1 Minor	\$499.50	\$888.00	\$1,387.50	\$249.75
Subscriber + Spouse	\$814.00	\$1,036.00	\$1,850.00	\$407.00
Family	\$1,054.50	\$1,258.00	\$2,312.50	\$527.25
Family - School Couple	\$536.50	\$1,776.00	\$2,312.50	\$268.25
11-Month Full-Time	Employee	Monthly RCPS	Total Premium	Per Pay Period
Subscriber	\$201.82	\$807.28	\$1,009.10	\$100.91
Subscriber + 1 Minor	\$544.92	\$968.72	\$1,513.64	\$272.46
Subscriber + Spouse	\$888.00	\$1,130.18	\$2,018.18	\$444.00
Family	\$1,150.36	\$1,372.36	\$2,522.72	\$575.18
Family - School Couple	\$585.26	\$1,937.46	\$2,522.72	\$292.63
10-Month Full-Time	Employee	Monthly RCPS	Total Premium	Per Pay Period
Subscriber	\$222.00	\$888.00	\$1,110.00	\$111.00
Subscriber + 1 Minor	\$599.40	\$1,065.60	\$1,665.00	\$299.70
Subscriber + Spouse	\$976.80	\$1,243.20	\$2,220.00	\$488.40
Family	\$1,265.40	\$1,509.60	\$2,775.00	\$632.70
Family - School Couple	\$643.80	\$2,131.20	\$2,775.00	\$321.90

HealthKeepers 2000 HMO				
<i>*New Plan Network*</i>				
12-Month Full-Time	Monthly Employee	Monthly RCPS	Total Premium	Per Pay Period
Subscriber	\$93.14	\$740.00	\$833.14	\$46.57
Subscriber + 1 Minor	\$361.72	\$888.00	\$1,249.72	\$180.86
Subscriber + Spouse	\$630.28	\$1,036.00	\$1,666.28	\$315.14
Family	\$824.86	\$1,258.00	\$2,082.86	\$412.43
Family - School Couple	\$306.86	\$1,776.00	\$2,082.86	\$153.43
11-Month Full-Time	Monthly Employee	Monthly RCPS	Total Premium	Per Pay Period
Subscriber	\$101.60	\$807.28	\$908.88	\$50.80
Subscriber + 1 Minor	\$394.62	\$968.72	\$1,363.34	\$197.31
Subscriber + Spouse	\$687.58	\$1,130.18	\$1,817.76	\$343.79
Family	\$899.86	\$1,372.36	\$2,272.22	\$449.93
Family - School Couple	\$334.76	\$1,937.46	\$2,272.22	\$167.38
10-Month Full-Time	Monthly Employee	Monthly RCPS	Total Premium	Per Pay Period
Subscriber	\$111.76	\$888.00	\$999.76	\$55.88
Subscriber + 1 Minor	\$434.06	\$1,065.60	\$1,499.66	\$217.03
Subscriber + Spouse	\$756.34	\$1,243.20	\$1,999.54	\$378.17
Family	\$989.84	\$1,509.60	\$2,499.44	\$494.92
Family - School Couple	\$368.24	\$2,131.20	\$2,499.44	\$184.12

*All employees, unless grandfathered in, are on 12 month pay and should refer to the 12-month rate.

Health Premiums Continued

HealthKeepers 3400 HMO				
<i>*New Plan Option*</i>				
12-Month Full-Time	Employee	RCPS	Total Premium	Per Pay Period
Subscriber	\$0.00	\$740.00	\$740.00	\$0.00
Subscriber + 1 Minor	\$222.00	\$888.00	\$1,110.00	\$111.00
Subscriber + Spouse	\$444.00	\$1,036.00	\$1,480.00	\$222.00
Family	\$592.00	\$1,258.00	\$1,850.00	\$296.00
Family - School Couple	\$74.00	\$1,776.00	\$1,850.00	\$37.00
11-Month Full-Time	Employee	RCPS	Total Premium	
Subscriber	\$0.00	\$807.28	\$807.28	\$0.00
Subscriber + 1 Minor	\$242.18	\$968.72	\$1,210.90	\$121.09
Subscriber + Spouse	\$484.36	\$1,130.18	\$1,614.54	\$242.18
Family	\$645.82	\$1,372.36	\$2,018.18	\$322.91
Family - School Couple	\$80.72	\$1,937.46	\$2,018.18	\$40.36
10-Month Full-Time	Employee	RCPS	Total Premium	
Subscriber	\$0.00	\$888.00	\$888.00	\$0.00
Subscriber + 1 Minor	\$266.40	\$1,065.60	\$1,332.00	\$133.20
Subscriber + Spouse	\$532.80	\$1,243.20	\$1,776.00	\$266.40
Family	\$710.40	\$1,509.60	\$2,220.00	\$355.20
Family - School Couple	\$88.80	\$2,131.20	\$2,220.00	\$44.40

*All employees, unless grandfathered in, are on 12 month pay and should refer to the 12-month rate.

Glossary of Health Care Terms

Below is a list of common terms associated with a health insurance plan. Understanding what these terms mean can help you better understand your benefits and what you might owe at the time of service.



Copay

A flat fee you pay for covered services, such as doctor visits.



Deductible

The set amount you pay before your plan begins to share the cost for covered health services.



Your percentage of the costs (coinsurance)

After you pay your deductible, this is your percentage of costs each time you get care.



Out-of-pocket limit

The maximum amount you can pay out of your pocket for covered services each year. Once you reach that limit, your plan covers the rest.

Traditional Medical Plan Summaries

	Anthem KeyCare 1000 PPO	
	In-Network Benefits	Out-of-Network Benefits
Annual Deductible		
Individual (embedded)	\$1,000	\$1,500
Family (embedded)	\$2,000	\$3,000
Coinsurance	80%	60%
Maximum Out-of-Pocket*		
Individual	\$3,500	\$5,250
Family	\$7,000	\$10,500
Physician Office Visit		
Primary Care	20% after deductible	40% after deductible
Specialty Care	20% after deductible	40% after deductible
Preventive Care		
Adult Periodic Exams	100%	40% after deductible
Well-Child Care	100%	40% after deductible
Diagnostic Services		
X-ray and Lab Tests	20% after deductible	40% after deductible
Complex Radiology	20% after deductible	40% after deductible
Urgent Care Facility	20% after deductible	40% after deductible
Emergency Room Facility Charges*	20% after deductible	40% after deductible
Inpatient Facility Charges	20% after deductible	40% after deductible
Outpatient Facility and Surgical Charges	20% after deductible	40% after deductible
Mental Health		
Inpatient	20% after deductible	40% after deductible
Outpatient	20% after deductible	40% after deductible
Substance Abuse		
Inpatient	20% after deductible	40% after deductible
Outpatient	20% after deductible	40% after deductible
Other Services		
Chiropractic	20% after deductible	40% after deductible

- This is a high-level overview of benefits only. For complete Medical Benefit Summary, Summary of Benefit and coverage, and detailed benefits overview, visit our [Intranet Link](#)

Traditional Medical Plan Summaries

	Anthem Blue Cross Blue Shield HealthKeepers 2000 HMO	
	In-Network Benefits	Out-of-Network Benefits
Annual Deductible		
Individual (embedded)	\$2,000	\$3,000
Family (embedded)	\$4,000	\$6,000
Coinsurance	80%	60%
Maximum Out-of-Pocket*		
Individual	\$5,000	\$7,500
Family	\$10,000	\$14,000
Physician Office Visit		
Primary Care	20% after deductible	40% after deductible
Specialty Care	20% after deductible	40% after deductible
Preventive Care		
Adult Periodic Exams	100%	40% after deductible
Well-Child Care	100%	40% after deductible
Diagnostic Services		
X-ray and Lab Tests	20% after deductible	40% after deductible
Complex Radiology	20% after deductible	40% after deductible
Urgent Care Facility	20% after deductible	40% after deductible
Emergency Room Facility Charges*	20% after deductible	40% after deductible
Inpatient Facility Charges	20% after deductible	40% after deductible
Outpatient Facility and Surgical Charges	20% after deductible	40% after deductible
Mental Health		
Inpatient	20% after deductible	40% after deductible
Outpatient	20% after deductible	40% after deductible
Substance Abuse		
Inpatient	20% after deductible	40% after deductible
Outpatient	20% after deductible	40% after deductible
Other Services		
Chiropractic	20% after deductible	40% after deductible

- This is a high-level overview of benefits only. For complete Medical Benefit Summary, Summary of Benefit and coverage, and detailed benefits overview, visit our [Intranet Link](#)

High Deductible Health Plan Medical Plan Summary

	Anthem Blue Cross Blue Shield HealthKeepers 3400 HMO <i>*New Plan*</i>	
	In-Network Benefits	Out-of-Network Benefits
Annual Deductible		
Individual (embedded)	\$3,400	\$4,000
Family (embedded)	\$6,800	\$8,000
Coinsurance	80%	60%
Maximum Out-of-Pocket*		
Individual	\$6,000	\$7,500
Family	\$12,000	\$14,000
Physician Office Visit		
Primary Care	20% after deductible	40% after deductible
Specialty Care	20% after deductible	40% after deductible
Preventive Care		
Adult Periodic Exams	100%	40% after deductible
Well-Child Care	100%	40% after deductible
Diagnostic Services		
X-ray and Lab Tests	20% after deductible	40% after deductible
Complex Radiology	20% after deductible	40% after deductible
Urgent Care Facility	20% after deductible	40% after deductible
Emergency Room Facility Charges*	20% after deductible	40% after deductible
Inpatient Facility Charges	20% after deductible	40% after deductible
Outpatient Facility and Surgical Charges	20% after deductible	40% after deductible
Mental Health		
Inpatient	20% after deductible	40% after deductible
Outpatient	20% after deductible	40% after deductible
Substance Abuse		
Inpatient	20% after deductible	40% after deductible
Outpatient	20% after deductible	40% after deductible
Other Services		
Chiropractic	20% after deductible	40% after deductible

Frequently Asked Questions about the Traditional Medical Plans

KeyCare 1000 PPO

Q: Are there any changes to the KeyCare 1000 health plan structure or to the premiums?

A: There are no changes to the benefit plan this year, but the premiums have increased.

Q: Are there co-pays for doctor visits in the KeyCare 1000 plan?

A: No, the KeyCare 1000 plan does not include co-pays at doctor visits. The employee pays the full amount due (until the deductible amount is satisfied). Your doctor may or may not require this amount to be paid at the time of service. Once the deductible is met, the employee pays the 20% co-insurance. **Note:** You can use your **HRA** dollars to pay for all out-of-pocket medical, deductible and co-insurance expenses.

Q: What is the deductible on the KeyCare 1000 plan?

A: If you have an employee only plan, the deductible is \$1,000. If you have other family members covered on the plan, there is a \$2,000 aggregate family deductible, which means that you, your spouse, and/or covered dependents will all contribute to the family deductible of \$2,000. One family member cannot satisfy the entire family deductible because the maximum one family member can contribute towards deductible is \$1,000.

Q: Is this a calendar year deductible?

A: Yes, it is calendar year, January-December.

Q: What does the deductible mean as far as what I pay?

A: Once you have paid your \$1,000/\$2,000 deductible each year, you will then pay 20% of the cost of future medical claims. (For example: You receive a bill for \$1,050. You will have to pay the first \$1,000 in full, and then you would only pay 20% of the other \$50.)

Q: Is there any type of deductible carry-over?

A: Yes, any deductible amount that is satisfied in the 4th quarter of the calendar year (October-December) will carry over towards the deductible for the next year.

Q: What is my out-of-pocket maximum each calendar year?

A: If you have a single plan, it is \$3,500 January-December. If you have any additional family members on your plan, it is \$7,000 January-December. (There is also a separate drug out-of-pocket maximum each calendar year of \$2,500 per member, January-December.)

Q: Does my deductible count towards my out-of-pocket yearly maximum of \$3,500/\$7,000?

A: Yes, the \$1,000/\$2,000 deductible does count towards this maximum. However, only the portion that is acquired in the new calendar year will be applied to the OOPM limit.

Q: Do we have to pay any emergency room, out-patient hospital, or in-patient hospital co-pays?

A: No, there are no co-pays for those services with the KeyCare 1000 health plan. But there is a 20% coinsurance for covered services.

Q: Is there vision coverage on the KeyCare 1000 plan?

A: Yes, a discount vision program is included with the KeyCare 1000 plan through Blue View Vision at no additional cost to the member.

Q: Am I eligible to participate in the KeyCare 1000 option if I am part-time?

A: Yes, you will be able to participate in the KeyCare 1000 medical plan.

Q: If I do not return for the new school year in August, when does my insurance end?

A: Your insurance will end June 30, 2025.

HealthKeepers 2000 HMO

Q: Are there any changes to the HealthKeepers 2000 health plan structure or to the premiums?

A: Yes, the 2000 plan is moving from the KeyCare PPO network to the HealthKeepers HMO network and the out-of-pocket maximums have increased to \$5,000/\$10,000.

Q: Are there co-pays for doctor visits in the HealthKeepers 2000 plan?

A: No, the HealthKeepers 2000 plan does not include co-pays at doctor visits. The employee pays the full amount due (until the deductible amount is satisfied). Your doctor may or may not require this amount to be paid at the time of service. Once the deductible is met, the employee pays the 20% co-insurance. **Note:** You can use your **HRA** dollars to pay for all out-of-pocket medical, deductible and co-insurance expenses.

Q: What is the deductible on the HealthKeepers 2000 plan?

A: If you have an employee only plan, the deductible is \$2,000. If you have other family members covered on the plan, there is a \$4,000 aggregate family deductible, which means that you, your spouse, and/or covered dependents will all contribute to the family deductible of \$4,000. One family member cannot satisfy the entire family deductible because the maximum one family member can contribute towards deductible is \$2,000.

Q: Is this a calendar year deductible?

A: Yes, it is calendar year, January-December.

Q: What does the deductible mean as far as what I pay?

A: Once you have paid your \$2,000/\$4,000 deductible each year, you will then pay 20% of the cost of future medical claims. (For example: You receive a bill for \$2,050. You will have to pay the first \$2,000 in full, and then you would only pay 20% of the other \$50.)

Q: Is there any type of deductible carry-over?

A: Yes, any deductible amount that is satisfied in the 4th quarter of the calendar year (October-December) will carry over towards the deductible for the next year.

Q: What is my out-of-pocket maximum each calendar year?

A: If you have a single plan, it is \$5,000 January-December. If you have any additional family members on your plan, it is \$10,000 January-December. (There is no separate drug out-of-pocket maximum each calendar year like there is on the KeyCare \$1,000 plan.)

Q: Does my deductible count towards my out-of-pocket yearly maximum of \$5,000/\$10,000?

A: Yes, the \$2,000/\$4,000 deductible does count towards this maximum. However, only the portion that is acquired in the new calendar year will be applied to the OOPM limit.

Q: Do we have to pay any emergency room, out-patient hospital, or in-patient hospital co-pays?

A: No, there are no co-pays for those services with the HealthKeepers 2000 health plan. But there is a 20% coinsurance for covered services.

Q: Is there vision coverage on the HealthKeepers 2000 plan?

A: Yes, a discount vision program is included with the HealthKeepers 2000 plan through Blue View Vision at no additional cost to the member.

Q: Am I eligible to participate in the HealthKeepers 2000 option if I am part-time?

A: Yes, you will be able to participate in the HealthKeepers 2000 medical plan.

Q: If I do not return for the new school year in August, when does my insurance end?

A: Your insurance will end June 30, 2025.

Frequently Asked Questions about the High Deductible Health Plan

HealthKeepers 3400 HMO *New Plan*

Q: What is a High Deductible Health Plan (HDHP)?

A: A High Deductible Health Plan is an IRS approved medical plan that can be paired with a Health Savings Account (**HSA**) that you can contribute pre-tax dollars to, to help offset your out-of-pocket health expenses. This plan is structured this way because there is no “first dollar coverage”, meaning that you must pay the full cost of the negotiated charge that is billed by your provider or pharmacy until you meet your medical deductible before Anthem shares the cost of covered services – even your prescription drugs.

Q: Are there co-pays for doctor visits in the HealthKeepers 3400 plan?

A: No, the HealthKeepers \$3,400 plan does not include co-pays at doctor visits. The employee pays the full amount due (until the deductible amount is satisfied). Your doctor may or may not require this amount to be paid at the time of service. Once the deductible is met, the employee pays the 20% co-insurance. **Note:** You can use your **HSA** dollars to pay for all out-of-pocket medical, deductible and co-insurance expenses. More information on HSA accounts is provided later in this benefit guide.

Q: What is the deductible on the HealthKeepers 3400 plan?

A: If you have an employee only plan, the deductible is \$3,400. If you have other family members covered on the plan, there is a \$6,800 aggregate family deductible, which means that you, your spouse, and/or covered dependents will all contribute to the family deductible of \$6,800. One family member cannot satisfy the entire family deductible because the maximum one family member can contribute towards deductible is \$3,400.

Q: Is this a calendar year deductible?

A: Yes, it is calendar year, January-December.

Q: What does the deductible mean as far as what I pay?

A: Once you have paid your \$3,400/\$6,800 deductible each year, you will then pay 20% of the cost of future medical claims. (For example: You receive a bill for \$3,450. You will have to pay the first \$3,400 in full, and then you would only pay 20% of the remaining \$50.) With this plan, the same structure applies to pharmacy coverage. Once you meet the \$3,400, you will have a copay either \$10, \$40, or \$80 based on the drug tier until you meet your out-of-pocket maximum for the plan year.

Q: Is there any type of deductible carry-over?

A: Yes, any deductible amount that is satisfied in the 4th quarter of the calendar year (October-December) will carry over towards the deductible for the next year.

Q: What is my out-of-pocket maximum each calendar year?

A: If you have a single plan, it is \$6,000 January-December. If you have any additional family members on your plan, it is \$12,000 January-December. (There is no separate drug out-of-pocket maximum each calendar year like there is on the KeyCare \$1,000 plan.)

Q: Does my deductible count towards my out-of-pocket yearly maximum of \$6,000/\$12,000?

A: Yes, the \$3,400/\$6,800 deductible does count towards this maximum. However, only the portion that is acquired in the new calendar year will be applied to the OOPM limit.

Q: Do we have to pay any emergency room, out-patient hospital, or in-patient hospital co-pays?

A: No, there are no co-pays for those services with the HealthKeepers \$3,400 health plan. But there is a 20% coinsurance for all covered services after you’ve met your deductible.

Q: Is there vision coverage on the HealthKeepers 3400 plan?

A: Yes, a discount vision program is included with the HealthKeepers \$3,400 plan through Blue View Vision at no additional cost to the member.

Q: Am I eligible to participate in the HealthKeepers 3400 option if I am part-time?

A: Yes, you will be able to participate in the HealthKeepers \$3,400 medical plan.

Q: If I do not return for the new school year in August, when does my insurance end?

A: Your insurance will end June 30, 2025.

Prescription Benefits

KeyCare 1000 PPO	Anthem Rx (Carelton Rx)	
	Retail Pharmacy 31-Day Supply	Home Delivery 90-Day Supply
Generic Drugs	\$10	\$20
Preferred Brand-Name Drugs	\$25	\$50
Nonpreferred Brand-Name Drugs	Greater of \$40 or 20% coinsurance up to \$100 maximum per prescription	Greater of \$80 or 20% coinsurance up to \$200 maximum per prescription
Maximum Out-of-Pocket		
Individual/ Family	\$2,500/\$10,000	

A 90-day supply of Maintenance Medications ONLY can be filled at participating retail pharmacies for 2-times the applicable retail copay.

HealthKeepers 2000 HMO	Anthem Rx (Carelton Rx)	
	Retail Pharmacy 31-Day Supply	Home Delivery 90-Day Supply
Generic Drugs	\$10	\$20
Preferred Brand-Name Drugs	\$40	\$80
Nonpreferred Brand-Name Drugs	Greater of \$80 or 20% coinsurance up to \$200 maximum per prescription	Greater of \$160 or 20% coinsurance up to \$400 maximum per prescription
Maximum Out-of-Pocket		
Individual/Family	Combined with Medical	

HealthKeepers 3400 HMO	Anthem Rx (Carelton Rx)	
	Retail Pharmacy 31-Day Supply	Home Delivery 90-Day Supply
Generic Drugs	\$10 after deductible	\$20 after deductible
Preferred Brand-Name Drugs	\$40 after deductible	\$80 after deductible
Nonpreferred Brand-Name Drugs	\$80 after deductible	\$160 after deductible
Maximum Out-of-Pocket		
Individual/Family	Combined with Medical	

Prior Authorization: When is a coverage review necessary?

Some medications are not covered unless you first receive approval through a Prior Authorization review. This review uses plan rules based on FDA-approved prescribing and safety information, clinical guidelines and uses that are considered reasonable, safe, and effective.

There are other medications that may be covered, but with limits (for example, only for a certain amount or for certain uses), unless you receive approval through a Prior Authorization review. During this review, Anthem asks your doctor for more information than what is on the prescription before the medication may be covered under your plan. To find out whether a medication requires a Prior Authorization review, your doctor can send a prior authorization form by fax to **1-844-521-6940** or call **1-833-293-0659** to speak to a Prior Authorization Specialist.

Specialty medications: Get individualized service through US Specialty Care

Specialty medications are drugs that are used to treat complex conditions, such as cancer, growth hormone deficiency, hemophilia, hepatitis C, immune deficiency, multiple sclerosis and rheumatoid arthritis.

Whether they're administered by a healthcare professional, self-injected, or taken by mouth, specialty medications require an enhanced level of service. By ordering your specialty medications through Carelon Rx, you can receive:

- Toll-free access to specialty-trained pharmacists and nurses 24 hours a day, 7 days a week;
- Delivery of your medications within the United States, on a scheduled day, Monday through Friday, at no additional charge;
- Most supplies, such as needles and syringes, provided with your medications;
- Safety checks to help prevent potential drug interactions;
- Refill reminders;
- Up to a 30-day supply of your specialty medication for just one copayment.

KEEP THIS INFORMATION:

For more information about your benefit, log in on the Anthem site or call Member Services toll-free at (833) 388-1400.





Skip the pharmacy with home delivery

Have your long-term medications sent to your home with CarelonRx Pharmacy

Set up home delivery through CarelonRx Pharmacy for the prescriptions you take long-term for conditions like high blood pressure, diabetes, heart disease, or asthma. You'll receive your medications at your door and enjoy the convenience of not having to visit the pharmacy.

With home delivery, you can count on:

Convenience. Medications are delivered directly to your home or any location you choose.

- Manage your prescriptions with the Sydney Health app or at [anthem.com](https://www.anthem.com).
- Expect first-time orders to take about five days to process. Refills take two days to process. Standard shipping time varies between 3 to 5 days.
- Track your order.
- Set up reminders and automatic refills, too.

Savings. Many medications cost less when you fill a 90-day supply instead of three 30-day supplies. Standard shipping is always free. With CarelonRx Pharmacy, you can also learn about lower-cost options.

Safety. A licensed pharmacist checks all orders before they ship. Discreet packaging is:

- Tamperproof
- Weatherproof
- Temperature controlled, if needed



Peace of mind. You're less likely to miss a dose and more likely to stay on track with the treatment your doctor prescribed when you switch to home delivery.* You can also talk, text, or chat 24/7 with a trained pharmacist if you have questions or need help.

Hassle-free service. CarelonRx Pharmacy will contact your doctor to order a new, 90-day prescription if you need one. If a medication preapproval is needed, the home delivery team will reach out to you for consent before shipping your medication.

We're here to help

Call the CarelonRx Pharmacy Contact Center at **833-396-0309** or use the live chat feature on Sydney Health or [anthem.com](https://www.anthem.com).



Start home delivery now

1. Log in to [anthem.com](https://www.anthem.com) and go to the **Prescriptions Home** page. You can also log in to your mobile app and select **Pharmacy** or scan the QR code with your phone's camera. Register your member account if you haven't already.
2. Go to **View Prescriptions** and follow the guided steps to switch to CarelonRx Pharmacy.

* National Survey of Pharmacy, National Center for Biotechnology Information, Comparative Database Study Comparing Diabetes-Related Medication Adherence and Health Outcomes to Mail Order versus Community Pharmacy (March 2015), <https://pubmed.ncbi.nlm.nih.gov/25814441/>

Sydney Health is offered through an arrangement with Carelon Digital Platforms, a separate company offering similar application services on behalf of your health plan. Services provided by CarelonRx, Inc. CarelonRx is an independent company providing pharmacy benefit management services on behalf of your health plan.

Anthem Blue Cross and Blue Shield is the trade name of its Colorado, Rocky Mountain Hospital and Health Services, Inc. (HMO products administered by HMO Colorado, Inc. Types of Colorado network access plans are available per group from member selection or can be obtained by going to [anthem.com/healthplans](https://www.anthem.com/healthplans). In Connecticut, Anthem Health Plans, Inc. In Georgia, Blue Cross Blue Shield Health Plan of Georgia, Inc. In Indiana, Anthem Insurance Company, Inc. In Kentucky, Anthem Health Plans of Kentucky, Inc. In Maine, Anthem Health Plans of Maine, Inc. In Missouri, including 30 counties in the Kansas City area, HighMark Managed Care, Inc. (HMO Health Alliance), Anthem Company (HMO), and HMO Missouri, Inc. (HMO) and certain affiliates administered HMO benefits administered by LLC and HMO benefits administered by HMO Missouri, Inc. (HMO) and certain affiliates only provide administrative services, will fund the plan and do not administer benefits. In Nevada, Rocky Mountain Hospital and Health Services, Inc. (HMO products administered by HMO Colorado, Inc.). Blue HMO Nevada in New Hampshire, Anthem Health Plans of New Hampshire, Inc. (HMO plans are administered by Anthem Health Plans of New Hampshire, Inc. and administered by Pharmacy Transition Health Plan, Inc. In Ohio, Community Insurance Company, Inc. (group), Anthem Health Plans of Virginia, Inc. (individual), Anthem Blue Cross and Blue Shield of Virginia, and its service group(s) of Virginia except for the City of Fairfax, the Town of Herndon, and the area west of Fairfax Blvd. In Wisconsin, Blue Cross and Blue Shield of Wisconsin (BCBSWI), and certain affiliates HMO and internally policies and underwritten by out of network benefits in PPO policies offered by Community Health Services Insurance Cooperative Company or Wisconsin Collaborative Insurance Cooperative (WCIC). Companies underwritten or administered HMO or PPO policies, WCIC underwritten or administered HMO (Priority HMO) or PPO policies, independent carriers of the Blue Cross and Blue Shield Association. Anthem is a registered trademark of Anthem Insurance Company, Inc.

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Prescription Benefits Frequently Asked Questions

Q. Where can I get my prescriptions filled?

- A. You can have your prescription filled at one of Anthem's 67,000 retail pharmacies. To find one near you, go to the Pharmacy Locator in the Anthem website.

Q. Do I need to take my ID card with me to the pharmacy every time?

- A. It is a good idea to carry your member ID card with you at all times. When you fill a prescription at a new pharmacy or start a new insurance plan, the pharmacist will need specific information on your member ID card. This information allows the pharmacy to fill your prescription properly, process your claim and tell you what your copay is at the time of purchase. Once you are in the pharmacy's system you should not have to show your ID card again.

Q. Why can't I get my prescription filled?

- A. There are many reasons why your prescription request might not process. Here are some common reasons.
- **Refill too soon** – your prescription can't be refilled before it's expected to run out. Contact your doctor and ask them to call Anthem to inquire about what is needed to request an early refill.
 - **Quantity Limits** – based on your plan, your prescription might not be filled if the quantity requested is too high. Limits are placed for safety and to keep you from being overcharged.

Q. Why should I use Anthem Prescription Delivery Service (mail order)?

- A. The Anthem Prescription Delivery Service is a convenient and cost-effective way for you to order up to a 90-day supply of any medication that you take on a long-term basis, for delivery to your home or business. You will avoid having to visit a local pharmacy each month and save money on your prescriptions.

Q. How do I use the Prescription Delivery Service?

- A. Have your doctor write your prescription for the number of days your plan allows for mail service (for example 90 days).
- **Register Online:** Using the Member Portal, provide your mailing address, phone number, certain health information and payment information to get started with the service.
 - **Mail:** Review and complete the Prescription Delivery Service form and return with a valid prescription.

Q. How long will it take to receive my prescription?

- A. You can expect to receive your prescription approximately 7 to 10 business days after Anthem receives your order. You can check the status of your order by signing into your online account or call Anthem Member Services.

Q. Will Anthem send me a refill reminder?

- A. Anthem will call or email you with a refill reminder, allowing you enough time to order before you finish your current supply. You then need to request a refill online through the Anthem member portal or call the automated phone system to place an order for the medication(s). You will be charged in accordance with the payment information you provided.

Q. What forms of payment does Anthem accept?

- A. Anthem accepts VISA, MasterCard, American Express, Discover, check, check by phone or money order as approved forms of payment. Payment cards for flexible spending accounts are also accepted. For your convenience, your credit card will be maintained on a secure site for future orders.

Q. How are prescriptions sent?

- A. Prescription Delivery Service orders are sent via first class U.S. Postal Service. If you choose to have your medicine rush ordered, additional costs will apply and vary by shipping method. All orders are shipped in unmarked, tamper-proof packaging to ensure security and complete confidentiality.

Q. What is the Retail90 Program?

- A. This is an alternative to the Prescription Delivery Service. Members can receive a 90-day maintenance medication at their local pharmacy at the same copay cost as the mail order program.

Q. How does Anthem protect my health information?

- A. Anthem complies with patient privacy regulations and requirements set by the Health Insurance Portability and Accountability Act (HIPAA). If you would like Anthem Rx to discuss and/or release your protected health information to another person or entity, you must authorize Anthem to do this by completing a Protected Health Information Authorization Form.

Q. Who can I call for help?

- A. If you have questions about your prescription benefit coverage, you can call Anthem Member Services, the phone number, 1-833-419-0530, listed on the back of your ID card.

*Please note that how much your prescription costs out-of-pocket depends on the Anthem plan you're enrolled in, what tier the drug is in, and whether you must meet your entire medical deductible before the copays and/or coinsurance percentages apply (HDHP HealthKeepers 3400 HMO Plan).

Additional Anthem Resources



Use your preventive care benefits

Stay healthy and catch problems early for easier treatment



Our health plans offer all the preventive care services and immunizations below at no cost to you.¹ As long as you use a doctor, pharmacy, or lab in your plan's network, you won't have to pay anything. If you go to doctors or facilities that are not in your plan, you may have to pay out of pocket.

If you are not sure which exams, tests, or shots are right for you, talk to your doctor.

Preventive care vs. diagnostic care: Knowing the difference

Preventive care helps protect you from getting sick. If your doctor recommends services when you have no symptoms, that's preventive care. **Diagnostic care** is when you have symptoms, and your doctor recommends services to determine what's causing those symptoms.

Adult preventive care

General preventive physical exams, screenings, and tests (all adults):

- Alcohol and drug misuse: related screening and behavioral counseling
- Anxiety, depression, and suicide risk screenings
- Aortic aneurysm screening (for men who have smoked)
- Behavioral counseling to promote a healthy diet and physical activity
- High blood pressure (hypertension) screening
- Bone density test to screen for osteoporosis
- Cholesterol and lipid (fat) levels screening
- Colorectal cancer screenings, including fecal occult blood test, barium enema, flexible sigmoidoscopy (exam of the large intestine), screening colonoscopy and related prep kit, and computed tomography (CT) colonography (as appropriate)²
- Diabetes screening (type 2)³
- Exercise interventions to prevent falls in adults over age 65

- Hepatitis B virus (HBV) screening for people at increased risk of infection
- Hepatitis C virus (HCV) screening
- Hearing screening
- Height, weight, and body mass index (BMI) measurements
- Human immunodeficiency virus (HIV): screening and counseling ;
- Interpersonal and domestic violence: screening and counseling

Women's preventive care:

- Breast cancer screenings, including exam, mammogram, and genetic testing for BRCA1 and BRCA2 when certain criteria are met⁵
- Breastfeeding: primary care intervention to promote breastfeeding support, supplies, and counseling^{6,7,8,9}
- Chlamydia and gonorrhea screening
- Contraceptive (birth control) counseling
- Counseling related to chemoprevention for those at high risk for breast cancer
- Counseling related to genetic testing for those with a family history of ovarian or breast cancer

Immunizations:

- Diphtheria, tetanus, and pertussis (whooping cough)
- Hepatitis A and hepatitis B
- Human papillomavirus (HPV)
- Influenza (flu)
- Measles, mumps, and rubella (MMR)
- Meningococcal (meningitis)

- Lung cancer screening for adults aged 50 to 80 years who have a 20 pack-year smoking history and currently smoke or have quit within the past 15 years²
- Obesity: related screening and counseling³
- Sexually transmitted infections: related screening and counseling
- Syphilis infection screening for persons who are at increased risk
- Tobacco use: related screening and behavioral counseling
- Tuberculosis screening

- Food and Drug Administration (FDA)-approved contraceptive medical services, including sterilization, provided by a doctor
- Human papillomavirus (HPV) screening⁷
- Pelvic exam and Pap test, including screening for cervical cancer
- Pregnancy screenings, including gestational diabetes, hepatitis B, asymptomatic bacteriuria, Rh incompatibility, HIV, healthy weight, preeclampsia, and depression⁷
- Urinary incontinence screening
- Well-woman visits

- Monkeypox and/or smallpox (at risk)
- Pneumococcal (pneumonia)
- Respiratory syncytial virus (RSV)
- Severe acute respiratory syndrome coronavirus 2 (SARS CoV 2)(COVID-19)
- Varicella (chickenpox)
- Zoster (shingles)

The preventive care services listed above are recommendations of the U.S. Preventive Services Task Force (USPSTF) and are subject to change. They represent the current best evidence for the prevention of disease and the early detection and treatment of disease. This document is not a contract or policy with Aetna Blue Cross and Blue Shield of Illinois, any other insurance carrier, or any other group policy, association or risk. Please see your contracted evidence of coverage (EOC) and disclosure form or certificate for full terms and conditions.

Child preventive care

Preventive physical exams, screenings, and tests:

- Anemia screening
- Anxiety, depression, and suicide risk screenings
- Autism Spectrum Disorder (ASD) screening
- Blood pressure screening
- Cervical dysplasia (abnormal cell growth on the cervix) screening
- Cholesterol and lipid (fat) levels screening
- Development and behavior screening
- Diabetes screening (type 2)
- Hearing screening
- Height, weight, and BMI measurements
- Hemoglobin or hematocrit (blood count) screening
- Hepatitis B screening
- HIV screening
- Lead testing
- Newborn screening
- Obesity: related screening and counseling
- Ocular prophylaxis for Gonococcal Ophthalmia Neonatorum: Preventive medication: newborns
- Oral (dental health) assessment, when done as part of a preventive care visit
- Sexually transmitted infections: related screening and counseling
- Skin cancer counseling for those ages 6 months to 24 years with fair skin
- Sudden cardiac arrest/death risk assessment
- Tobacco, alcohol, and drug use assessments
- Vision screening for those ages 6 months to 5 years



Immunizations:

- Chickenpox
- Flu
- Haemophilus influenzae type B (HIB)
- Hepatitis A and hepatitis B
- Human papillomavirus (HPV)
- Meningitis
- Measles, mumps, and rubella (MMR)
- Pneumonia
- Polio
- Respiratory syncytial virus (RSV)
- Rotavirus
- Severe acute respiratory syndrome coronavirus 2 (SARS CoV 2)(COVID-19)
- Whooping cough

Coverage for pharmacy items

For 100% coverage of your over-the-counter (OTC) drugs and other pharmacy items listed here, you must:

- Meet certain age requirements and other rules
- Receive and fill prescriptions from doctors, pharmacies, or other healthcare professionals in your plan's network
- Have prescriptions, including for OTC items

Women's preventive drugs and other pharmacy items (age appropriate):

- Breast cancer risk-reducing medications, such as tamoxifen, raloxifene, and aromatase inhibitors, that follow the U.S. Preventive Services Task Force criteria¹
- Contraceptives, including generic prescription drugs and OTC items like female condoms and spermicides²
- Folic acid for women ages 55 or younger who are planning to become pregnant
- Low-dose aspirin (81 mg) for pregnant women who have an increased risk of preeclampsia

Adult preventive drugs and other pharmacy items (age appropriate):

- Colonoscopy prep kit (generic or OTC only) when prescribed for preventive colon screening for members ages 45 to 75
- Generic low-to-moderate dose statins for members ages 40 to 75 who have one or more CVD risk factors (dyslipidemia, diabetes, hypertension, or smoking)
- Preexposure prophylaxis (PrEP) for the prevention of HIV
- Tobacco cessation products, including all FDA-approved brand-name and generic OTC and prescription products, for members ages 18 and older

Child preventive drugs and other pharmacy items (age appropriate):

- Dental fluoride varnish to prevent tooth decay in children ages 5 and younger
- Fluoride supplements for children ages 6 and younger

If you'd like more help understanding your preventive care benefits, call the Member Services number on your health plan ID card. For a complete list of covered preventive drugs under the Affordable Care Act, view the *Preventive ACA Drug List* flyer, available at anthem.com/pharmacyinformation.

¹The range of preventive care services covered under this plan when provided by your doctor or designated provider and related equipment. The Department of Health and Human Services website www.hhs.gov lists services to include for full coverage based on U.S. Preventive Services Task Force (USPSTF) recommendations, the Advisory Commission on Intercountry Relations (ACIR) of the Centers for Disease Control and Prevention (CDC), and other guidelines for tobacco, alcohol, substance, and women supported by health insurance and Behavioral Risk Factor Surveillance System (BRFSS) guidelines. See your plan's additional coverage under your insurance policy. To learn more about what your plan covers, see your certificate of coverage or call the Member Services number on your ID card.

²Use may be required to receive prescription for these services.

³The Centers for Disease Control and Prevention (CDC) research shows prevention programs are available for women aged 45 and older with abnormal blood glucose or who have abnormal LDL cholesterol.

⁴Some plans cover additional over-the-counter (OTC) items. Please see your contract or certificate of coverage for details.

⁵Check your medical policy for details.

⁶Direct purchase and supplies must be purchased from suppliers in-network or your plan's network for 100% coverage. We recommend using your durable medical equipment (DME) supplier.

⁷We do not allow supplies for those younger than age 18.

⁸Not every drug is covered. Prescription contraceptives, based on your drug benefits, may not cover any or several. Your doctor decides that using the medication brand or brand name is medically necessary.

⁹Covering services for non-emergency dental care can be provided or supported by a doctor or facility in your plan's network, such as a dentist, oral health care, or hospital with the member's oral care (dental) policy or component. Contact the provider for any restrictions that apply.

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The Sydney Health mobile app makes healthcare easier

Access personalized health and wellness information wherever you are

Use Sydney™ Health to keep track of your health and benefits — all in one place. With a few taps, you can quickly access your plan details, Member Services, virtual care, and wellness resources. Sydney Health stays one step ahead — moving your health forward by building a world of wellness around you.

Find Care

Search for doctors, hospitals, and other healthcare professionals in your plan's network and compare costs. You can filter providers by what is most important to you, such as gender, languages spoken, or location. You'll be matched with the best results based on your personal needs.

My Health Dashboard

Use My Health Dashboard to find news on health topics that interest you, health and wellness tips, and personalized action plans that can help you reach your goals. It also offers a customized experience just for you, such as syncing your fitness tracker and scanning and tracking your meals.

Chat

If you have questions about your benefits or need information, Sydney Health can help you quickly find what you're looking for and connect you to an Anthem representative.

Virtual Care

Connect directly to care from the convenience of home. Assess your symptoms quickly using the Symptom Checker or talk to a doctor via chat or video session.

Community Resources

This resource center helps you connect with organizations offering no-cost and reduced-cost programs to help with challenges such as food, transportation, and child care.

My Health Records

See a full picture of your family's health in one secure place. Use a single profile to view, download, and share information such as health histories and electronic medical records directly from your smartphone or computer.

¿Prefieres obtener Información en español?

Tienes opciones. Si tu teléfono móvil ya está configurado en español, la aplicación Sydney Health también estará en español. Si no es así, selecciona el menú dentro de la aplicación Sydney Health y elige el idioma de la aplicación. También puedes visitar espanol.anthem.com.



Download the Sydney Health app today

Use the app anytime to:

- Find care and compare costs.
- See what's covered and check claims.
- View and use digital ID cards.
- Check your plan progress.
- Fill prescriptions.



Scan the QR code to download the Sydney Health app.

You can also set up an account at anthem.com/register to access most of the same features from your computer.

In addition to using a telehealth service, you can receive telecare or virtual care from your own doctor or another healthcare provider in your plan's network. If you receive care from a doctor or healthcare provider not in your plan's network, your share of the costs may be higher. You may also receive a bill for any charges not covered by your health plan.

Sydney Health is offered through an arrangement with Carelon Digital Platforms, a separate company offering mobile application services on behalf of your health plan. ©2023 The Virtual Primary Care experience is offered through an arrangement with Hygieia Health.

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Get care from anywhere

Virtual visits on LiveHealth Online are an included benefit for Anthem medical plan members

Get the care you need, virtually.

Looking for a quick and easy way to get care? With LiveHealth Online, you can access telehealth visits from anywhere. All you need is a smartphone, tablet, or computer!

Care options available to you through LiveHealth Online:



Annual Wellness. Visits with primary care providers who can help with preventative screenings, chronic health concerns, follow-up care, and referrals for lab work and specialists as clinically appropriate.



Primary Care. Get regular health visits and checkups with virtual primary care. It's like an office visit with a primary care provider (PCP) — without the office. You can even choose to see a network PCP regularly, so you have the same provider taking care of you over time.



Urgent Care. Get care 24/7 for common health issues, including allergies, COVID-19 symptoms, the flu, sinus infections, and UTIs. Physicians assess your symptoms, provide a treatment plan, and send prescriptions to the pharmacy of your choice when needed.



Therapy and Psychiatry. See a therapist online from the comfort of your couch to get help for anxiety, depression, panic attacks, stress relief, and more. Psychiatrists are also available by appointment and can prescribe medication when talk therapy isn't enough.



Dermatology. Get a treatment plan from a board-certified dermatologist. Receive a diagnosis in under 72 hours. No appointment needed. Just upload pictures of your skin, hair, or nail concern.



Breastfeeding support. Have an online appointment with a lactation consultant who can provide help with common breastfeeding issues.



Sign up for free today! Available through the SydneySM Health app or Anthem.com.

App Store | Google Play

LiveHealth Online is offered through an arrangement with Amwell, a separate company, providing telehealth services on behalf of your health plan.

Vision Exam Insurance for Medical Participants Only

Your Anthem medical plans provide you with an *Exam Only* Vision benefit. For a more comprehensive Vision plan, employees may enroll in the Stand-Alone Vision plan – see stand-alone vision page for more details.

Blue View VisionSM

Roanoke County, Schools
and Jails (WVRJ) Exam
Only A15 Plan



Welcome to your Blue View Vision plan!

You have many choices when it comes to using your benefits. As a Blue View Vision plan member, you have access to one of the nation's largest vision networks. You may choose from many private practice eye care doctors. Our network also has many convenient optical stores, including popular national retail stores LensCrafters®, Target Optical®, and most Pearle Vision® locations. When you receive care from a Blue View Vision participating provider, you can maximize your benefits and money-saving discounts. To locate a participating network eye care doctor or location, log in at anthem.com, or from the home page menu under Care, select **Find a Doctor**. You may also call member services for assistance at the number on the back of your ID card.

YOUR BLUE VIEW VISION PLAN BENEFITS	IN-NETWORK	OUT-OF-NETWORK	FREQUENCY
Routine Eye Exam			
A comprehensive eye examination	\$15 copay	Up to \$30 allowance	Once every calendar year

USING YOUR BLUE VIEW VISION PLAN

When you are ready to schedule your eye exam, just make an appointment with your choice of any of the Blue View Vision participating eye care doctors. Your Blue View Vision plan provides services for routine eye care only. If you need medical treatment for your eyes, visit a participating eye care doctor from your medical network.

ADDITIONAL SAVINGS ON EYEWEAR AND MORE

As a Blue View Vision member, you can take advantage of valuable discounts through our Additional Savings program. See page 2 for further details.

OUT-OF-NETWORK

If you choose to, you may receive covered services outside of the Blue View Vision network. If you choose an out-of-network doctor, you must pay in full at the time of service, obtain an itemized receipt, and file a claim for reimbursement up to your maximum out-of-network allowance. To download a claim form, log in at anthem.com, or from the home page menu locate Support and select Forms, click Change State to choose your state, and then scroll down to Claims and select the Blue View Vision Out-of-Network Claim Form. You may instead call member services at the number on the back of your ID card to request a claim form. To request reimbursement for out-of-network services, complete an out-of-network claim form and submit it along with your itemized receipt to the fax number, email address, or mailing address below.

To Fax: 866-293-7373
To Email: oonclaims@eyewearspecialoffers.com
To Mail: Blue View Vision
Attn: OON Claims
P.O. Box 8504
Mason, OH 45040-7111

This is a primary vision care benefit intended to cover only routine eye examinations. Benefits are payable only for expenses incurred while the group and insured person's coverage is in force. Blue View Vision is for routine eye care only. If you need medical treatment for your eyes, visit a participating eye care physician from your medical network. If you have questions about your benefits or need help finding a provider, visit anthem.com or call us at the number on the back of your ID card.

This information is only a brief outline of coverage and only one piece of your entire enrollment package. All terms and conditions of coverage, including benefits and exclusions, are contained in the member's policy, which shall control in the event of a conflict with this overview.

Anthem Website Login Instructions

1. Go to www.anthem.com
2. To Log In: Click the *Member Log In* box (upper right corner of screen)
 - **If you need to register**, click *Register Now* & follow directions (have insurance card available for ID #).
 - If you are a first-time user, they will guide you through the set-up process as you answer their questions regarding you and your plan.
 - **Once you are registered**, enter your username and password as directed & click the *Member Log In* box each time you access the site.
3. Once you are logged in each time, you can search the website by clicking on the tabs you need, such as the following:
 - Find/Rate a Doctor
 - Request ID Card
 - Print Temporary ID Card
 - Estimate Your Cost
 - Prescription Benefits
 - And many Other Useful Links...

Anthem Customer Service: please call 1-833-388-1400



Dental Insurance

Roanoke County Public Schools offers a dental program through Delta Dental of Virginia.

Dental Premiums

Dental Premiums				
12-Month Full-Time*	Monthly Employee	Monthly RCPS	Total Premium	Per Pay Period
Subscriber	\$8.64	\$25.38	\$34.02	\$4.32
Subscriber + 1 Person	\$22.94	\$32.38	\$55.32	\$11.47
Family	\$47.64	\$48.06	\$95.70	\$23.82
Family School Couple	\$27.82	\$67.86	\$95.68	\$13.91
11-Month Full-Time*	Monthly Employee	Monthly RCPS	Total Premium	Per Pay Period
Subscriber	\$9.44	\$27.70	\$37.14	\$4.72
Subscriber + 1 Person	\$25.02	\$35.32	\$60.34	\$12.51
Family	\$51.96	\$52.44	\$104.40	\$25.98
Family School Couple	\$30.36	\$74.04	\$104.40	\$15.18
10-Month Full-Time*	Monthly Employee	Monthly RCPS	Total Premium	Per Pay Period
Subscriber	\$10.38	\$30.46	\$40.84	\$5.19
Subscriber + 1 Person	\$27.52	\$38.86	\$66.38	\$13.76
Family	\$57.16	\$57.68	\$114.84	\$28.58
Family School Couple	\$33.40	\$81.44	\$114.84	\$16.70

*All employees, unless grandfathered in, are on 12 month pay and should refer to the 12-month rate.

The chart below is a brief outline of the plan. Please refer to the summary plan description on our intranet for complete plan details.

	Delta Dental of Virginia Dental PPO Plus Premier		
	PPO	Premier	Out-Of-Network
Annual Deductible			
Individual	\$50	\$50	\$50
Family	\$150	\$150	\$150
Waived for Preventive Care	Yes	Yes	Yes
Annual Maximum			
Per Person / Family	\$1,500	\$1,500	\$1,500
Preventive <i>Exams, X-Rays</i>	100%	100%	100%
Basic <i>Simple Extractions, Endo/Periodontics</i>	90%	80%	80%
Major <i>Crowns, Bridges, Implants</i>	60%	50%	50%
Orthodontia			
Benefit Percentage	Not covered	Not covered	Not covered

Healthy Smile, Healthy You Program

Your plan provides additional cleanings and/or application of topical fluoride to enrollees with specific health conditions such as pregnancy, diabetes, high-risk cardiac conditions or who are undergoing cancer treatment via chemotherapy and/or radiation. Enrollment in the Healthy Smile, Healthy You Program is simple. Visit www.deltadentalva.com to print an enrollment form.

Employees MUST provide documentation to show that their dependents eligible for the school's dental plans. To search for participating providers, please visit www.deltadentalva.com



are

Healthy Smile, Healthy You[®]

A healthy mouth creates more than just a beautiful smile.

In the past, a trip to the dentist simply ensured a bright, shiny, cavity-free smile. Now, researchers are continuing to find evidence that suggests good oral health can positively impact many medical conditions.¹ This means regular dental checkups can improve whole body health, which can translate into lower, overall medical costs for companies and their employees.

A healthy smile can mean a healthier you.

As part of your dental benefits package, *Healthy Smile, Healthy You* offers additional benefits for four important health conditions connected to oral health:

- Pregnancy
- Diabetes
- Certain High Risk Cardiac Conditions
- Cancer being treated via radiation and/or chemotherapy

Why the program is important

According to the American Academy of Periodontology, pregnant women with periodontal disease may be seven times more likely to have a baby that's born too early or too small. For those with diabetes, research shows that increased sugar levels have a negative impact on oral health, and those with periodontal disease find it far more difficult to control sugar levels.² Individuals with certain heart conditions can be impacted by gum disease and infections, such as oral bacteria infecting their hearts.³ Radiation and/or chemotherapy treatments for cancer patients can have direct effects on salivary glands and oral tissues, which, if not treated, can lead to a higher risk of developing cavities, oral pain and infections.⁴

Who is eligible?

Members who have one of these conditions can enroll in the program to become eligible for one additional

cleaning and exam* beyond the ordinary limit per benefit period. For pregnant members, the additional service will be during the term of their pregnancy. Cancer patients will also be eligible for an additional fluoride application beyond the age limit specified by their group contract.

Get started improving your employees' oral health today.

It's easy to enroll in *Healthy Smile, Healthy You*. Simple, one page enrollment forms can be printed from DeltaDentalVA.com. Once the form is received, enrollment is complete and the enrollee can talk to their dentist about scheduling their additional visit.

To learn more about this program, or other benefits features available from Delta Dental, contact your account representative.

¹Steven L. Bricker, Robert P. Langlais, and Craig S. Miller, *Oral Diagnosis, Oral Medicine and Treatment Planning* (Philadelphia: Lea & Febiger, 1994).

²"Gum Disease and Heart Disease", American Academy of Periodontology, www.perio.org/consumer/heart_disease, accessed 7/2016.

³Oral Health in America: A Report of the Surgeon General. Rockville, MD: U.S. Department of Health and Human Services, National Institute of Dental and Craniofacial Research, National Institutes of Health, 2000

⁴"Oral Cancer Facts", Oral Cancer Foundation, Inc., <http://oralcancerfoundation.org/facts>, accessed 7/2016.

*Members may be eligible for a periodontal maintenance procedure if the employee has a history of definitive periodontal treatment, such as surgery.

NOTE: Healthy Smile, Healthy You is included as a standard feature for all fully insured groups with Delta Dental PPOSM and/or Delta Dental Premier[®] coverage. ASO groups with Delta Dental PPO and/or Premier coverage may choose to include Healthy Smile, Healthy You as an optional feature. DeltaCare[®] enrollees are not eligible for Healthy Smile, Healthy You.

Vision Insurance – Voluntary Stand-Alone Plan

The Roanoke County Public Schools provides an Optional Vision Insurance plan through Anthem. Medical participants receive an Exam Only Vision benefit while the plan below is a more comprehensive Vision plan should employees wish to have coverage for materials (glasses and contacts). An overview of the benefits of this plan is reflected in the chart below. You have many choices when it comes to using your benefits. As an Anthem Vision plan member, you have access to one of the nation’s largest vision networks. You may choose from many private practice doctors, local optical stores, and national retail stores including LensCrafters®, Target Optical®, and most Pearle Vision® locations. You may also use your in-network benefits to order eyewear online at Glasses.com and ContactsDirect.com. To locate a participating network eye care doctor or location, log in at anthem.com, or from the home page, select Find a Doctor.

Vision Premiums

Voluntary Vision Premiums				
12-Month Contracted*	Monthly Employee	Monthly RCPS	Total Premium	Per Pay Period
Subscriber	\$5.94	-	\$5.94	\$2.97
Subscriber + Child(ren)	\$10.70	-	\$10.70	\$5.35
Subscriber + Spouse	\$10.70	-	\$10.70	\$5.35
Family	\$17.20	-	\$17.20	\$8.60
11-Month Contracted*	Monthly Employee	Monthly RCPS	Total Premium	Per Pay Period
Subscriber	\$6.48	-	\$6.48	\$3.24
Subscriber + Child(ren)	\$11.68	-	\$11.68	\$5.84
Subscriber + Spouse	\$11.68	-	\$11.68	\$5.84
Family	\$18.76	-	\$18.76	\$9.38
10-Month Contracted*	Monthly Employee	Monthly RCPS	Total Premium	Per Pay Period
Subscriber	\$7.12	-	\$7.12	\$3.56
Subscriber + Child(ren)	\$12.84	-	\$12.84	\$6.42
Subscriber + Spouse	\$12.84	-	\$12.84	\$6.42
Family	\$20.64	-	\$20.64	\$10.32

*All employees, unless grandfathered in, are on 12 month pay and should refer to the 12-month rate.

Vision Insurance – Voluntary Stand-Alone Plan

YOUR BLUE VIEW VISION PLAN BENEFITS	IN-NETWORK	OUT-OF-NETWORK	FREQUENCY
Routine Eye Exam			
A comprehensive eye examination	\$10 copay	Up to \$30 allowance	Once every 12 months
Eyeglass Frames			
One pair of eyeglass frames	\$150 allowance, then 20% off any remaining balance	Up to \$45 allowance	Once every 12 months
Eyeglass Lenses (instead of contact lenses)			
One pair of standard plastic prescription lenses:			
<ul style="list-style-type: none"> • Single vision lenses • Bifocal lenses • Trifocal lenses • Lenticular lenses 	\$20 copay \$20 copay \$20 copay \$20 copay	Up to \$25 allowance Up to \$40 allowance Up to \$55 allowance Up to \$125 allowance	Once every 12 months
Eyeglass Lens Enhancements			
When obtaining covered eyewear from a Blue View Vision provider, you may choose to add any of the following lens enhancements at no extra cost.			
<ul style="list-style-type: none"> • Transitions Lenses (for a child under age 19) • Standard polycarbonate (for a child under age 19) • Factory scratch coating 	\$0 copay \$0 copay \$0 copay	No allowance when obtained out-of-network	Same as covered eyeglass lenses
Contact Lenses (instead of eyeglass lenses)			
Contact lens allowance will only be applied toward the first purchase of contacts made during a benefit period. Any unused amount remaining cannot be used for subsequent purchases in the same benefit period, nor can any unused amount be carried over to the following benefit period.			
<ul style="list-style-type: none"> • Elective conventional (non-disposable) OR • Elective disposable OR • Non-elective (medically necessary) 	\$150 allowance, then 15% off any remaining balance \$150 allowance (no additional discount) Covered in full	Up to \$105 allowance Up to \$105 allowance Up to \$210 allowance	Once every 12 months
Contact lens fit and follow-up			
A contact lens fitting and up to two follow-up visits are available to you once a comprehensive eye exam has been completed.			
<ul style="list-style-type: none"> • Standard contact lens fitting¹ • Premium contact lens fitting² 	\$55 10% off retail price	N/A N/A	Once every 12 months

¹ Standard fitting includes spherical clear lenses for conventional wear and planned replacement. Examples include but are not limited to disposable and frequent replacement.

² Premium fitting includes all lens designs, materials and specialty fittings other than standard contact lenses. Examples include but are not limited to toric and multifocal.

This is a primary vision care benefit intended to cover only routine eye examinations and corrective eyewear. Blue View Vision is for routine eye care only, if you need medical treatment for your eyes, visit a participating eye care doctor from your medical network. Benefits are payable only for expenses incurred while the group and insured person's coverage is in force. This information is intended to be a brief outline of coverage. All terms and conditions of coverage, including benefits and exclusions, are contained in the member's policy, which shall control in the event of a conflict with this overview. This benefit overview is only one piece of your entire enrollment package.

EXCLUSIONS & LIMITATIONS (not a comprehensive list – please refer to the member Certificate of Coverage for a complete list)

Combined Offers. Not to be combined with any offer, coupon, or in-store advertisement.

Excess Amounts. Amounts in excess of covered vision expense.

Sunglasses. Plano sunglasses and accompanying frames.

Safety Glasses. Safety glasses and accompanying frames.

Not Specifically Listed. Services not specifically listed in this plan as covered services.

Lost or Broken Lenses or Frames. Any lost or broken lenses or frames are not eligible for replacement unless the insured person has reached his or her normal service interval as indicated in the plan design.

Non-Prescription Lenses. Any non-prescription lenses, eyeglasses or contacts. Plano lenses or lenses that have no refractive power.

Orthoptics. Orthoptics or vision training and any associated supplemental testing.

Vision Insurance (Voluntary Stand-Alone)

OPTIONAL SAVINGS AVAILABLE FROM BLUE VIEW VISION IN-NETWORK PROVIDERS ONLY		In-network Member Cost (after any applicable copay)
Retinal Imaging - at member's option can be performed at time of eye exam		Not more than \$39
Eyeglass lens upgrades When obtaining eyewear from a Blue View Vision provider, you may choose to upgrade your new eyeglass lenses at a discounted cost. Eyeglass lens copayment applies.	<ul style="list-style-type: none"> • Transitions lenses (Adults) • Standard Polycarbonate (Adults) • Tint (Solid and Gradient) • UV Coating • Progressive Lenses¹ <ul style="list-style-type: none"> • Standard • Premium Tier 1 • Premium Tier 2 • Premium Tier 3 • Anti-Reflective Coating² <ul style="list-style-type: none"> • Standard • Premium Tier 1 • Premium Tier 2 • Other Add-ons 	\$75 \$40 \$15 \$15 \$65 \$85 \$95 \$110 \$45 \$57 \$68 20% off retail price
Additional Pairs of Eyeglasses Anytime from any Blue View Vision network provider.	<ul style="list-style-type: none"> • Complete Pair • Eyeglass materials purchased separately 	40% off retail price 20% off retail price
Eyewear Accessories	<ul style="list-style-type: none"> • Items such as non-prescription sunglasses, lens cleaning supplies, contact lens solutions, eyeglass cases, etc. 	20% off retail price
Conventional Contact Lenses	<ul style="list-style-type: none"> • Discount applies to materials only 	15% off retail price

¹ Please ask your provider for his/her recommendation as well as the available progressive brands by tier.

² Please ask your provider for his/her recommendation as well as the available coating brands by tier.

Discounts are subject to change without notice. Discounts are not "covered benefits" under your vision plan and will not be listed in your certificate of coverage. Discounts will be offered from in-network providers except where state law prevents discounting of products and services that are not covered benefits under the plan. Discounts on frames will not apply if the manufacturer has imposed a no discount policy on sales at retail and independent provider locations. Some of our in-network providers include:



ADDITIONAL SAVINGS AVAILABLE THROUGH ANTHEM'S SPECIAL OFFERS PROGRAM *

Savings on items like additional eyewear after your benefits have been used, non-prescription sunglasses, hearing aids and even LASIK laser vision correction surgery are available through a variety of vendors. Just log in at anthem.com, select discounts, then Vision, Hearing & Dental.

* Discounts cannot be used in conjunction with your covered benefits.

OUT-OF-NETWORK

If you choose to receive covered services or purchase covered eyewear from an out-of-network provider, network discounts will not apply and you will be responsible for payment of services and/or eyewear materials at the time of service. Please complete an out-of-network claim form and submit it along with your itemized receipt to the fax number, email address, or mailing address below. To download a claim form, log in at anthem.com, or from the home page menu under Support select Forms, click Change State to choose your state, and then scroll down to Claims and select the Blue View Vision Out-of-Network Claim Form. You may instead call member services at the number on the back of your ID card to request a claim form.

To Fax: 866-293-7373
To Email: oonclaims@eyewearspecialoffers.com
To Mail: Blue View Vision, Attn: OON Claims, P.O. Box 8504 Mason, OH 45040-7111

Wellness Program Update

We are making changes to our **Wellness Program** for the **2025-2026** plan year. Please review the details below to understand how these changes may affect you.

What's Changing?

- We will **no longer** be offering separate Wellness and Non-Wellness premium rates.
- The **Wellness incentive** will now determine whether you receive employer funds for your **Health Reimbursement Account (HRA)** or **Health Savings Account (HSA)**.

Who Qualifies for the Wellness Incentive?

- If you are currently receiving the **Wellness rate** for your insurance premiums, you will be **automatically grandfathered** into the **Wellness incentive** for the 2025-2026 plan year.
- **To maintain eligibility for the incentive**, you must complete your **Annual Preventive Exam** with your **Primary Care Physician (PCP)**. **Note: This exam is covered 100% by Anthem and is no cost to you!**
- If you do **not** currently receive the **Wellness rate**, there is still time to complete the necessary wellness steps with the **Marathon Health Clinic** or your **Primary Care Provider** to become eligible. However, please note that the **Marathon Health Clinic will be closing August 27th**. Be sure to schedule your visit before then if you plan to use this option.

How Do We Track Compliance?

- **Anthem** will provide a **monthly report** indicating which employees have completed their **Annual Preventive Care visit** in the previous month **beginning July 1, 2025**.

We encourage all employees to take advantage of this benefit and prioritize their health. If you have any questions or need additional details, please contact **Tracy Bandy, HR Benefits Manager**, at tjbandy@rcps.us.

Your health matters! Stay well, stay informed!



Health Savings Accounts

When you enroll in the new High Deductible Health Plan (HDHP) and meet the eligibility requirements, the IRS allows you to open and contribute to a Health Savings Account (HSA). An HSA is a tax-advantaged bank account that you own for the purpose of paying for eligible out of pocket expenses for you/or your eligible dependents.

The Health Savings Account (HSA) is yours to keep, even if you change jobs or medical plans. There is no “use it or lose it” provision; your balance carries over year to year! You can only contribute when enrolled in the HDHP plan – with RCPS this is the **Anthem HealthKeepers 3400 HMO plan**.

If you choose to participate in the RCPS Wellness Program and complete your free Preventive Annual Physical Exam, RCPS will contribute up to \$1,200 to your HSA as an individual and \$2,400 if you cover dependents!

Tax Advantages

- Money deposited into an HSA is exempt from federal income taxes – this helps to lower your overall taxable income.
- Interest in your account grows tax free.
- You do not pay taxes on withdrawals used to pay for eligible health expenses. (If you withdraw funds for non-eligible expenses, taxes & penalties will apply).
- You also have the choice of investment opportunities which earn competitive interest rates, so your unused funds can grow over time.

Am I Eligible to Contribute to an HSA?

- You must be enrolled in a High Deductible Health Plan (HDHP).
- You cannot be covered under another health insurance plan – including Medicare or Tricare. (Other health insurance does not include dental, vision, or workplace voluntary benefits).
- You cannot be claimed as dependent on someone else’s tax return.
- You are not eligible if you participate in a healthcare Flexible Spending Account.

IRS Annual Limits

Since an HSA is a tax-advantaged account, it is monitored by the IRS, and they set annual contribution limits each calendar year. The 2025 contribution limits are listed below:

- **2025 Calendar Year:**
 - Individual: **\$4,300**
 - Family: **\$8,3550**
 - 55 and older catch-up contribution: additional **\$1,000**

Please note that the IRS Calendar Year contribution limits include the Wellness incentive that RCPS deposits into your HSA!

Visit the HSA Store for more information on eligible expenses for your HSA!

[HSA Store](#)

HSA Frequently Asked Questions

Q: Will the School Board fund this money for the employee?

A: Yes, the School Board funds up to \$1,200 for a single plan and \$2,400 for a plan with any additional family members **if you participate in the Wellness Program and complete your Annual Preventive Exam**. This amount will be pro-rated for mid-year new hires or mid-year qualifying events. You may also choose to contribute pre-tax dollars through payroll deduction to your HSA up to \$4,300 as an individual and \$8,550 if you cover dependents for the 2025 calendar year.

Q: Am I eligible to participate in the HSA option if I am part-time?

A: Yes, all full and part time contracted employees are eligible to participate in the HSA plan option and receive up to \$1,200/\$2,400 contributed to their HSA.

Q: Am I eligible to participate in the HSA option if I am already retired or will retire as of June 30, 2025?

A: Employees participating in this plan will be eligible to retain this plan after retirement, but there will be no further contributions to the HSA account from RCPS.

Q: Can employees contribute additional HSA funds each year, beyond the School Board contribution amounts?

A: Yes, when you choose to enroll in the new HealthKeepers 3400 HMO plan and open an HSA (see that section) you can contribute up to \$4,300 or \$8,550 if you cover dependents to offset out-of-pocket health expenses.

Q: If I elect the new HSA plan, can I also have the HRA and/or FSA?

A: No, you are not eligible to participate in the HRA or the Healthcare FSA (**but you can still participate in the Dependent Care FSA**), if you are enrolled in the new HealthKeepers \$3,400 plan and are contributing to your HSA.

Q: Can I pay for eligible medical/Rx, dental and/or vision expenses for my spouse or dependent(s) who is not covered under my medical plan?

A: Yes, you can pay for out-of-pocket eligible health care expenses for yourself, spouse and all of your dependents for healthcare services incurred year after year.

Q: Will the HSA funds roll over each year if any portion goes unused or is it “use it or lose it”?

A: The full amount of unused funds in the HSA will continue to roll over each year into the next coverage period – there is no “use it or

lose it” provision with an HSA. You can even invest the funds in your HSA and any interest you earn is not taxed.

Q: Will there be a time limit on when I will have to spend the money and/or turn in receipts for reimbursement to my HRA?

A: No, you can continue to build your HSA funds year after year to use on future out-of-pocket health expenses. You just have to be mindful of the IRA Calendar Year contribution limits (these are set by the IRS and change from year to year).

Q: What happens to the funds in my HSA if I terminate my employment?

A: The funds in your HSA (including any contributions made by RCPS when you participate in the Wellness Program) are yours to take with you. If you elect COBRA continuation coverage upon termination, you may use the funds in your HSA for this.

Q: What happens to the funds in my HRA if I retire?

A: You will have continued access to any unused funds remaining in your HSA account at the time of retirement that can be used for qualified medical expenses if you are enrolled in any of the Anthem plans offered by RCPS. If you become Medicare eligible, you can even use your HSA funds towards Medicare premiums and out-of-pocket health expenses. There will be no additional HSA contributions by RCPS after you retire and if you choose to enroll in Medicare when eligible, you can no longer contribute to your HSA.

Q: If I terminate my employment or retire, will I be able to cash out the remaining balance in my HRA and pay the tax penalties to use the funds for expenses other than healthcare?

A: Yes, you can cash out the HSA account. This account is your own personal savings account. You can continue to use to towards out-of-pocket health expenses and pay no penalties or tax. Or, you can withdraw the funds and use them as you wish but pay any penalty and income tax.

Q: If I pass away, what will happen to my funds in the HSA?

A: Since an HSA is your own personal savings account, it will become a part of your estate just like your other personal bank accounts.

Q: Do I need to have receipts for all distributions from my HSA ?

A: Yes, you must keep receipts and accurate records when you use your HSA funds in the unlikely event that you are ever audited. You do not need to send in these receipts/records when you do your taxes, just keep them with your tax files.

Health Reimbursement Accounts

Your Health Reimbursement Account (HRA) is administered through Flexible Benefit Administrators.

What is the Health Reimbursement Arrangement (HRA)?

The Health Reimbursement Arrangement is an account that is funded and owned by RCPS. You may use the funds in the HRA to reimburse you for qualified medical care expenses that have not been reimbursed by the RCPS' health plans.

To be eligible for an HRA, the employee must be enrolled in either the traditional \$1,000 or \$2,000 Traditional medical plans and participate in the Wellness Program. Those enrolled in employee coverage will receive a \$500 contribution to their HRA, while those enrolled in other coverage tiers will receive a \$1,000 contribution. While the HRA funds do rollover from year to year, there is a maximum rollover limit of \$25,000. See the HRA FAQs page for more information.



HRA Frequently Asked Questions

Q: Will the School Board fund this money for the employee?

A: Yes, the School Board funds up to \$500 for a single plan and \$1,000 for a plan with any additional family members **if you participate in the Wellness Program and complete your Annual Preventive Exam.** This amount will be pro-rated for mid-year new hires or mid-year qualifying events.

Q: Am I eligible to participate in the HRA option if I am part-time?

A: Yes, all full and part time contracted employees are eligible to participate in the HRA and receive the Wellness incentive of \$500/\$1,000 to use on medical expenses.

Q: Am I eligible to participate in the HRA option if I am already retired or will retire as of June 30, 2025?

A: Employees participating in this plan will be eligible to retain this plan after retirement, but there will be no further contributions to the HRA account.

Q: Can employees contribute additional HRA funds each year, beyond the School Board contribution amounts?

A: No, the employee cannot contribute additional funds into the HRA. The employee can, however, participate in Flexible Benefits (see that section) and contribute up to \$3,300 for health expenses and \$5,000 for Dependent Care. Or choose to enroll in the new HealthKeepers 3400 HMO plan and open an HSA (see that section) to contribute up to \$4,300 or \$8,550 if you cover dependents to offset out-of-pocket health expenses.

Q: If I elect the HRA plan, and I also have an FSA (Flexible Benefits) plan, from which account will my claims come from first?

A: Money will be taken from your FSA first, then from your HRA.

Q: If I elect the new HSA plan, can I also have the HRA?

A: No, you are not eligible to participate in the HRA or the Healthcare FSA (but you can still participate in the Dependent Care FSA), if you are enrolled in the new HealthKeepers \$3,400 plan and are contributing to your HSA.

Q: Can I pay for eligible medical/Rx, dental and/or vision expenses for my spouse or dependent(s) who is not covered under my medical plan?

A: Yes, you can pay for out-of-pocket eligible health care expenses for yourself, spouse and all of your dependents for healthcare services incurred during the plan year and while you are an active participant.

Q: Will the HRA funds roll over each year if any portion goes unused or is it “use it or lose it”?

A: The full amount of unused funds in the HRA will continue to roll over each year into the next coverage period as long as you are an active employee, enrolled in either the KeyCare \$1,000, or HK \$2,000 plan and do not exceed the maximum amount of \$25,000.

Q: Will there be a time limit on when I will have to spend the money and/or turn in receipts for reimbursement to my HRA?

A: Yes, all receipts must be dated within the plan year dates (July 1-June 30) and submitted for reimbursement within 90 days of the plan year end. Funds not spent during the plan year will rollover to the next coverage period.

Q: What happens to the funds in my HRA if I terminate my employment?

A: You may submit reimbursement requests for any allowable medical expense incurred up to your termination date and be reimbursed from your HRA if you submit reimbursement requests within 90 days of your last day of work. If you elect COBRA continuation coverage upon termination and pay your monthly COBRA premium, you will have continued access to the HRA funds for up to 18 months after termination. Otherwise, the funds revert back to the employer.

Q: What happens to the funds in my HRA if I retire?

A: You will have continued access to any unused funds remaining in your HRA account at the time of retirement that can be used for allowable medical expenses as long as you are on either KeyCare \$1,000 plan or HealthKeepers \$2,000 plan with RCPS. There will be no additional HRA contributions by your employer after you retire.

Q: If I terminate my employment or retire, will I be able to cash out the remaining balance in my HRA and pay the tax penalties to use the funds for expenses other than healthcare?

A: No, you cannot cash out the HRA account. The HRA is employer funded and remains the property of the employer unless you use the funds for allowable medical expenses incurred within the plan year.

Q: If I pass away, what will happen to my funds in the HRA?

A: The funds become available to any surviving spouse and children. They may submit reimbursement requests within 6 months for any allowable medical expense incurred up to your date of death and be reimbursed from the HRA. If they elect COBRA continuation coverage upon your death and pay their monthly COBRA premium, they will have continued access to the HRA funds for up to 36 months after your date of death. Otherwise, the funds revert back to the employer.

Q: Will I have to complete and submit paper claim reimbursements, or will I have a debit card option similar to Flexible Benefits?

A: All new HRA members will be issued a Benefits Card that is good for a three-year period. If you do not want to use the card option, you will have to call Flexible Benefits Administrators and request to “deactivate” the card. You will then be required to provide your personal banking information so you can receive direct deposit of your reimbursements from your HRA account.

(Anyone who participates in both the HRA and the FSA will have the total amount of both accounts loaded on the same card. Example: If you elect the KeyCare 1000 or HK 2000 plan/HRA single plan option, your Benefit Card could have \$3,550 loaded on the card as of July 1. (\$500 HRA contribution from the School Board + \$3,300, the maximum contribution you could choose with Flexible Benefits through the FSA.) **Note: You cannot use your debit card for previous plan year claims/expenses, you must file manual claims but can continue to use your debit card for current year expenses.**

Q: Do I need to have receipts for all claims submitted to the HRA for reimbursement?

A: Yes, you must keep receipts, even if you use the debit card feature, as the third-party administrator routinely requests supporting documentation for medical services charged to your debit card.

Flexible Spending Accounts

The Flexible Spending Account (FSA) plan with Flexible Benefit Administrators, Inc. allows you to set aside **pre-tax dollars to cover qualified expenses you would normally pay out of your pocket with post-tax dollars**. The plan is comprised of a health care spending account and a dependent care account. You pay no federal or state income taxes on the money you place in an FSA.

How an FSA works:

- Choose a specific amount of money to contribute each pay period, **pre-tax**, to one or both accounts during the year.
- The amount is automatically deducted from your pay at the same level each pay period.
- As you incur eligible expenses, you may use your flexible spending debit card to pay at the point of service OR submit the appropriate paperwork to be reimbursed by the plan.

Employees can go to the [FSA Store](#) to obtain a list of eligible expenses and even shop!

Types of FSAs:

HealthCare FSA: As an active participant you can pay for your out-of-pocket healthcare expenses for yourself, your spouse and all of your tax dependents that are incurred during your Plan Year. Eligible expenses are those incurred for the diagnosis, cure, mitigation, treatment, or prevention of disease, or of the purpose of affecting any structure or function for the body.

Dependent Care FSA: This account allows you to pay for day care expenses for your qualified dependent/child with pre-tax dollars. Eligible Day Care/Aged Adult Care expenses are considered care of an eligible dependent so that you and your spouse can go to work or school full-time. Eligible dependents, as revised under Section 152 of the Code by the Working Families Tax Act of 2005, are defined as either dependent children or dependent relatives that you can claim as dependents on your taxes.

Note: You can still participate in the Dependent Care FSA even if you enrolled in the new HealthKeepers 3400 HMO plan with the HSA!

Important rules to keep in mind:

- The IRS has a strict “use it or lose it” rule. Your plan has a \$660 rollover provision. However, if you do not use the full amount in your FSA, you will lose any remaining funds that are in excess of \$660.
- Once you enroll in the FSA, you cannot change your contribution amount during the year unless you experience a qualifying life event.
- You cannot transfer funds from one FSA to another.

Please plan your FSA contributions carefully, as any funds not used by the end of the year will be forfeited. Re-enrollment is required each year.

MAXIMUM CALENDAR YEAR ANNUAL ELECTION	
Health Care FSA	\$3,300
Dependent Care FSA	\$5,000 (\$2,500 if married but filing separately)

Additional Things to Note About the HealthCare FSA:

The HealthCare FSA is a pre-funded account. This means that your full annual election is available on the first day of the Plan Year. You can submit a claim for medical expenses exceeding your current contribution amount and be reimbursed your total eligible expense up to your annual election. The funds that you are pre-funded will be recovered as deductions continue to be deposited into your account throughout the Plan Year.

Obtaining a Reimbursement from your HealthCare Account:

To obtain a reimbursement from your HealthCare Account, you must complete a Claim Form. You must attach a receipt, bill, or an Explanation of Benefits (EOB) from your service provider. Please see the Claims Sections for more information.

NOTE: To be eligible for reimbursement through the HealthCare Account, the medical expense must be incurred during the Plan Year. IRS defines "incurred" as when the medical care is provided (or date of service), not when you are formally billed, charged for, or pay for the care.

How the Flexible Benefit Plan Works

	Without FSA	With FSA
Gross Monthly Income	\$2,500.00	\$2,500.00
Eligible Pre-Tax Employer Medical Insurance	\$0.00	\$200.00
Eligible Pre-Tax Medical Expenses	\$0.00	\$100.00
Taxable Income	\$2,500.00	\$2,200.00
Federal Tax (15%)	\$375.00	\$330.00
State Tax (5.75%)	\$143.75	\$126.50
FICA Tax (7.65%)	\$191.25	\$168.30
After-Tax Employer Medical Insurance	\$200.00	\$0.00
After-Tax Medical Expenses	\$100.00	\$0.00
Monthly Spendable Income	\$1,490.00	\$1,575.20

By taking advantage of the Flexible Benefit Plan, this employee was able to increase his/her spendable income by \$85.20 every month! This means an annual tax savings of \$1,022.40. Remember, with the Flexible Benefit Plan, the better you plan, the more you save!

Additional Things to Note About the Dependent Care FSA:

The Dependent Care Reimbursement Account allows you to pay for day care expenses for your dependents with tax-free dollars. **You are still eligible to participate in this FSA even if you are enrolled in the HDHP HealthKeepers 3400 HMO plan and are contributing to your Health Savings Account!**

Eligible Dependent:

- A child under 13 who qualifies as a dependent on your Federal Income Taxes.
- Any other dependents, including a disabled spouse, disabled children over age 13 and elderly parents, who depend on you for financial support, qualify as dependents for tax purposes, and are incapable of self-care.



The Dependent Care Account is NOT a pre-funded account. This means that you will only be reimbursed up to your account balance at the time you submit your claim. If your claim is for more than your account balance, the unreimbursed portion of your claim will be tracked by Flexible Benefit Administrators, Inc. You will be automatically reimbursed as additional deductions are deposited into your account.

To obtain a reimbursement from your Dependent Care Reimbursement Account you must complete a Claim Form and you must attach a receipt from the service provider.



FSA, HRA, & HSA: How They Work

	Health FSA	HRA	HSA
Description	It is a prefunded account that works like an interest-free, tax-free loan designed to help you pay for covered health care services and eligible medical expenses.	It is a prefunded account owned and funded solely by your employer designed to help you pay for covered healthcare services and medical expenses.	An HSA is a tax-advantaged personal savings account that can be used to pay for medical, dental, vision, and other qualified expenses now or later in life. To contribute to an HSA, you must be enrolled in a high-deductible health plan (HDHP) and your contributions are limited annually. The funds can even be invested, making it a great addition to your retirement portfolio.
Eligibility	You are eligible to participate in the Plan on the first day of the month following your date of hire if you are classified as a full-time employee working 30 hours or more per week.	You are eligible to participate in the Plan on the first day of the month following your date of hire if you are classified as a full-time employee working 30 hours or more per week and be enrolled in the HDHP/HRA Insurance Plan.	In order to contribute, you must be enrolled in a qualified HDHP, not covered under a secondary health insurance plan, not enrolled in Medicare, and not another person's dependent. There are no eligibility requirements to spend previously-contributed HSA funds.
Employer's Medical Insurance Plan Participation	No.	Yes, you have to be enrolled in the HDHP coverage to participate.	Yes, you have to be enrolled in the HDHP coverage to participate.
Funding the Account	Your employer pre-funds the account on day one of the Plan Year. Pre-tax payroll deductions are taken to re-pay your employer over the course of the Plan Year.	Your employer.	Contributions can be made by the eligible employee, their employer, and any other qualified individual.
Maximum Dollars Allowed per Plan Year	Up to \$3,300 for the 2025 Plan Year; Mid-year new hires will receive a pro-rated amount.	Up to \$500 for an employee only policy and \$1,000 for an employee plus dependents.	For 2025, up to \$4,300 for Single Coverage and \$8,550 for Family Coverage. Individuals aged 55 and over may make an additional \$1,000 catch-up contributions.
Expenses Covered	All 213(d) expenses	All 213(d) expenses	All 213(d) expenses
Carryover Funds	Yes, up to \$640 so long as you are an active employee. Any amount over \$640 will be forfeited back to the employer.	Yes, up to \$25,000 for active employees.	HSA money is yours to keep and is not forfeited at the end of the year; it continues to grow, tax-deferred.
FBA Benefit Card - Point of Sale Expenses	Eligible expenses only.	Eligible expenses only.	Eligible expenses only.
Resignation/Termination (Mid-Plan Year)	<p>If you resign/terminate Mid-Plan Year:</p> <ul style="list-style-type: none"> • If there are funds remaining in your FSA, claims can be submitted for expenses incurred prior to your termination; • Claim cannot exceed your annual election amount; • All claims must be submitted before the end of the 90 day grace period. <p>If you have FSA dollars remaining and elect to participate in COBRA, you can continue to set aside dollars on an after-tax basis to be deposited into your FSA account. If you do not elect COBRA, all remaining funds will be forfeited to the County.</p>	<p>Claims can be submitted for allowable medical expenses incurred up to your termination date (last day of coverage). Claims must be submitted by the coverage end date, 90 days from the termination date. If you wish to have continued access to your HRA funds, you must elect COBRA continuation coverage upon termination and pay your monthly COBRA premium. HRA funds will be available for up to 18 months after termination with COBRA election. If COBRA is not elected, all funds will be returned to the County.</p>	<p>HSAs are portable and move with you if you change your employment. Your HSA belongs to you, not your employer, just like your personal checking account.</p>

Continued...

	Health FSA	HRA	HSA
Death	The executor of the estate has 90 days from the date of death to submit any claims in the employee's name that were incurred up to the date of death.	The executor of the estate has 6 months from the date of death to submit any claims in the employee's name that were incurred up to the date of death. If the surviving spouse and/or dependent children elect COBRA continuation coverage and pay the monthly premium, they will have continued access to the HRA fund for up to 36 months. Remaining funds will be returned to the County after the 36 months is up or if COBRA is not elected.	Your HSA funds are typically transferred to your designated beneficiary, either your spouse or another individual. The tax benefits or implications depend on the beneficiary's relationship to you. If you don't name a beneficiary, the HSA funds will go to your estate and be subject to taxes.
Qualifying Event/Change of Status	If you have a qualifying change of status, you can make a new election, change your current election, or revoke your election. A Status Change Form must be filed within 30 days of the qualifying event. FBA or your benefits contact person will determine if your request for an election change meets IRS Regulations.	If you have a qualifying change of status, you can make a new election, change your current election, or revoke your election. A Status Change Form must be filed within 30 days of the qualifying event. FBA or your benefits contact person will determine if your request for an election change meets IRS Regulations.	You are not subject to the change-in-status rules applicable to other benefit accounts when it comes to changing your contributions during the year. You will be able to make changes in your contributions by providing the applicable notice of change provided by your employer.
Incurring Expenses	Expenses must be incurred during the Plan Year to be reimbursed.	Expenses must be incurred during the plan year to be reimbursed.	Expenses can be incurred at any time up to the account's available balance.
Submitting Claims/ Claim Submission Timeline	All documentation must reflect a service date within the Plan Year. Claims can be submitted after the Plan Year ends, during the run-out period. According to your Plan design, the run-out period is 90 days following the end of the Plan Year. All claims must be received in the FBA office by 5:00pm EST on the 90th day. Methods of claim submission: Fax: 757.431.1155 Scan/Email: flexdivision@flex-admin.com Mail: FBA/Flex Division, P.O. Box 8188, Virginia Beach, VA 23450 Online Claim Submission: www.flex-admin.com Mobile App: Flexible Benefit Administrators mobile	All documentation must reflect a service date within the Plan Year. Claims can be submitted after the Plan Year ends, during the run-out period. According to your Plan design, the run-out period is 90 days following the end of the Plan Year. All claims must be received in the FBA office by 5:00pm EST on the 90th day. Methods of claim submission: Fax: 757.431.1155 Scan/Email: flexdivision@flex-admin.com Mail: FBA/Flex Division, P.O. Box 8188, Virginia Beach, VA 23450 Online Claim Submission: www.flex-admin.com Mobile App: Flexible Benefit Administrators mobile	Claims submission does not apply to the HSA.
Manual Claim Reimbursement	Paper check is the default. Direct deposit is available with form completion.	Paper check is the default. Direct deposit is available with form completion. If you have a FSA, HRA reimbursement will default to match it.	Claims submission does not apply to the HSA.
Expense Substantiation	Required.	Required.	The participant is the owner of the account and is responsible for substantiating the expenses.
Processing/Approving Claims	Completed by FBA.	Completed by FBA.	Claims submission does not apply to the HSA.
Dual Plan Participation	Allowed.	Allowed.	Not allowed.
Funds Disbursement	FSA funds will be used until the funds are exhausted. This will prevent any unused funds from being forfeited to your employer.	Once the FSA funds are exhausted, the HRA will be used.	HSA funds can be spent on qualified expenses up to the amount available in the account at time of the transaction.
ERISA Fiduciary Rules	Applicable.	Applicable.	Applicable.

Short-Term and Long-Term Disability Insurance

VRS Hybrid Only

Plan eligibility

If you were hired and a member of the VRS Hybrid Retirement Plan on or after January 1, 2014, and met the disability plan member definition and active work requirement, you are covered under VACORP Hybrid Disability Plan offered by Anthem Life as addressed below. You are a member if you are a U.S. or Canadian citizen or resident and are actively at work at least the minimum hours per week required by your employer for coverage and are an employee of Roanoke County Public Schools. Members exclude a temporary or seasonal employee or a leased employee or independent contractor.

If you were hired before January 1, 2014, and elected to transfer to the VRS Hybrid Retirement Plan from the VRS Plan 1 or the VRS Plan 2, your coverage in the plan and in the hybrid disability plan was effective July 1, 2014, assuming you met the member and active work requirements. If you left employment and took a refund of your Plan 1 or Plan 2 member contributions and interest or withdrew your full account balance from an ORP authorized or administered by VRS, you will be rehired under the Hybrid Retirement Plan if you return to a position covered under the plan.

Short-Term Disability Benefits Overview

Short Term Disability (STD) helps to provide financial protection with a bi-weekly benefit in the event of a covered disability.

- Elimination/Waiting Period before benefits begin:
 - The STD benefit is payable after the employee has been continuously disabled for 7 continuous calendar days.
- Maximum Benefit Period is 125 business days.
- Benefit Amount:
 - The disability benefit is a percentage of pre-disability wages that is determined by the months of continuous service with Roanoke County Public Schools and shown in the charts below.
- The School covers all costs associated with the STD plan.

Non-Occupational

Months of Continuous Service	Workdays at 100% Income Replacement	Workdays at 80% Income Replacement	Workdays at 60% Income Replacement
0-12	0	0	0
13-59	0	0	125
60-119	25	25	75
120-179	25	50	50
180+	25	75	25

Work-Related

Months of Continuous Service	Workdays at 100% Income Replacement	Workdays at 80% Income Replacement	Workdays at 60% Income Replacement
Fewer than 60	0	0	125
120+	85	40	0
120-179	25	50	50
180+	25	75	25

Long-Term Disability Benefits Overview

Long Term Disability (LTD) helps to provide financial protection with a monthly benefit in the event of a covered disability.

- The benefit waiting period is 7 calendar days plus 125 contract workdays.
- Benefits paid under LTD are taxable
- A policy summary is available on our intranet for more detailed information on this plan.

Filing a Disability Claim

In the event that you need to file a disability claim, the first thing you must do is notify RCPS Human Resources Dept. They will provide the steps and contact information to Anthem to file your claim. Please note that if you are approved for a Short-Term Disability claim through Anthem, you will not have to file a Long-Term Disability claim, should this be applicable to your situation.



VRS Retirement

Roanoke County Public Schools provides retirement benefits through the Virginia Retirement System (VRS), offering three plan options: Plan 1, Plan 2, and the Hybrid Plan. The plan you are eligible for is based on your hire date and any previous service under VRS. All employees are required to contribute 5% of their salary to VRS as a mandatory retirement contribution. Additionally, Hybrid Plan members can receive a match of up to 2.5% if they participate in the Hybrid DCP account.

Create a VRS account to explore your plan details and available benefits. Contact Tracey Epperly, HR VRS Manager for more information at tepperly@rcps.us or at 540-562-3900.



Register your online myVRS account today!



- Secure Login
- Retirement Planner
- Benefit Estimator
- Manage Beneficiaries
- Request Refund
(when you leave employment)
- Purchase Prior Service
- Retire Online
 - Set up direct deposit
 - Claim health insurance credit



- Articles, Videos and Webinars
 - Calculators
 - Educational Games
 - Budgeting Tools
- PLUS personalized content exclusive to members through your myVRS account log-in:
- Interactive Courses
 - Action Plans
 - Money Mindfulness

varetire.org/myVRS
HELPING YOU PLAN FOR TOMORROW, TODAY



Basic Group Life Insurance and Optional Group Life Insurance

Basic Group Life Insurance

Full-time employees are enrolled in the Basic Group Life Insurance coverage from their first day of employment. VRS administers the Basic Group Life Insurance coverage which is underwritten by Securian Financial (formerly Minnesota Life Insurance Company). Roanoke County Public Schools pays 100% of the premiums for this benefit.

Your coverage includes a natural death benefit, equal to your compensation, rounded to the next highest thousand and then doubled; an accidental death benefit, double the natural death benefit; an accidental dismemberment benefit; a safety belt benefit; a repatriation benefit; a felonious assault benefit; and an accelerated death benefit. Death benefits are paid to your beneficiary.

After you retire with an unreduced or reduced retirement benefit, you receive some Basic Group Life Insurance coverage at no cost to you, provided you meet the eligibility requirements under your retirement plan. Your coverage begins to reduce on January 1 following one calendar year after your employment ends. Your benefits will begin to reduce 25% each January 1 until the benefit reaches 25% of the total life insurance benefit value at the time your employment ends. If you are eligible for retirement when your employment ends, but defer retirement, and you do not take a refund of your member contributions and interest, some basic life insurance benefits will continue. Your benefits will begin to reduce 25% each January 1 following the same reduction schedule reflected above for someone who retires. If you have at least 30 years of creditable service, your coverage cannot reduce below an \$8,000 minimum established in 2015. This minimum will be increased annually based on the VRS Plan 2 cost-of-living adjustment calculation.

Optional Group Life Insurance

If covered under the Basic Group Life Insurance Program, you may be eligible to purchase additional life insurance for yourself, your spouse and dependent children through the Optional Group Life Insurance Program. You pay the premiums for this additional coverage through payroll deductions. If you are enrolled in this program, you may continue a portion of your coverage into retirement. You, as well as your spouse and dependent children if enrolled, must have been continuously covered during the 60 months preceding your retirement date to continue coverage. Accidental death and dismemberment coverage ends upon retirement. Optional life insurance amounts will reduce by 25% based on your age, beginning with your normal retirement age under your plan; coverage ends at age 80. You must elect to continue your coverage within 31 days of your retirement date; after 31 days, it will not be available.

You, as well as your spouse and dependent children, if enrolled, can convert your coverage to an individual policy without proof of good health within 31 days of the last day of the month in which you leave your position. Proof of good health will be required after 31 days. You will be billed for the premiums.

For more information on your VRS Basic Group Life Insurance and Optional Group Life Insurance benefits go to the VRS website at www.varetire.org



Retirement Savings Plans

Participating in a supplemental retirement savings plan allows employees to set aside additional funds for retirement (eligibility requirements must be met). These contributions are employee-funded and can be made through payroll deductions.

Roanoke County Public Schools offers both a 403(b) and a 457 Retirement Savings Plan through Empower. These plans are separate from your benefits under the Virginia Retirement System, and contributions can be made on either a pretax or post-tax basis. You may enroll, make changes, or discontinue participation at any time throughout the year.

All Roanoke County School employees are eligible to participate in the Empower 403(b) plan, while only contracted employees are eligible for the 457 plan. RCPS provides a match of up to \$600 per year for contracted employees participating in the 403(b) plan. For more information, contact Tracey Epperly, HR VRS Manager at tepperly@rcps.us or at 540-562-3900.

For more information, visit our website or contact our vendor/agent directly:



www.empower.com/participant

Catherine Pfeilsticker
Retirement Plan Advisor
Empower Retirement
Cell: 540-907-2045
catherine.pfeilsticker@empowerretirement.com
Client Services: 1-800-701-8255

**All funds, including target date funds are subject to risk and are not guaranteed.



Top reasons to enroll in your plan

It's easier than you think to start saving for the future you want. Here are 10 reasons to start saving:

1. Starting early can make a big difference

Starting early and making small increases in the amount you contribute could make a real difference when you retire.

The sooner you start saving, the better

Any earnings are reinvested over time, building your savings, and it doesn't take a lot to start. Just \$25 or \$50 can add up to a lot.



FOR ILLUSTRATIVE PURPOSES ONLY. This hypothetical illustration is not intended as a projection or prediction of future investment results, nor is it intended as financial planning or investment advice. It assumes semi-monthly contributions at a 6% annual rate of return and reinvestment of earnings with no withdrawals. Rates of return may vary. The illustration does not reflect any associated charges, expenses or fees. The tax-deferred accumulation shown would be reduced if these fees were deducted.

2. You can reduce your taxable income

With traditional pretax savings, your contributions are deducted from your pay before income taxes. So, whatever amount you decide to contribute may affect your take-home pay less than you think while also reducing your taxable income.

Tax breaks

Pretax contributions reduce your taxable income, so you'll save for tomorrow and also save today.

Here's an example based on \$50,000 income:

	Saving	Not saving
Your contribution	4%	0%
Saved annually for retirement	\$2,000	\$0
Saved on taxes	\$440	\$0

FOR ILLUSTRATIVE PURPOSES ONLY. This is a hypothetical illustration that assumes a 22% federal tax rate. State and local tax not included. Your salary, contribution rate and tax bracket may vary.

3. A focus on monthly retirement income

When you log in to your account, you are able to clearly see your estimated monthly retirement income and the percentage of current income you're on track to replace in retirement. These estimates are based on your total account balance, current contribution amount and other income sources.

Increase your monthly income in retirement



FOR ILLUSTRATIVE PURPOSES ONLY. This hypothetical illustration assumes contributions of \$25/month for 30 years at a 6% annual rate of return and reinvestment of earnings with no withdrawals. This is followed by withdrawals of \$179.92/month for 20 years at a 6% annual rate of return during retirement. These rates of return are not guaranteed. Investing involves risk, including loss of principal. This illustration does not include any taxes due, fees, charges or expenses. These deductions would reduce the tax-deferred amount shown in this illustration.

4. Review your finances in one place

When you log in to your account and link your financial accounts, you unlock helpful resources and tools to help you manage your current finances and view your complete financial picture.

5. Contributions are automatic and controlled by you

You choose the amount you want to save, and contributions are automatically deducted from your paycheck. Plus, you can change, stop or restart your contributions at any time.

6. More ways to save on taxes

You may be eligible for an IRS saver's credit on the first \$2,000 you contribute to your plan based on your adjusted gross income and tax-filing status.

7. Build your investment mix

Select from a variety of investment choices and build the right mix for your personal situation.

8. A partner for your future

Your employer manages and monitors your plan and continually works on your behalf. They carefully selected the investment options and a service provider, Empower, to work directly with you.

9. Stay as long as you like

Even after you change jobs or retire, you can keep your account right where it is so you have access to all the resources your plan has to offer.

10. We're here to help

Representatives are ready to answer your questions and help you plan for the future.

▶ Don't wait. Enroll today. Visit empowermyretirement.com or call **800-701-8255**.

Investing involves risk, including possible loss of principal.

Unless otherwise noted, investments are not deposits, insured by the FDIC or any federal government agency, or bank guaranteed and may lose value.

IMPORTANT: The projections, or other information generated on the website by the investment analysis tool regarding the likelihood of various investment outcomes, are hypothetical in nature, do not reflect actual investment results and are not guarantees of future results. The results may vary with each use and over time.

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Employee Assistance Program (EAP)

EMPLOYEE ASSISTANCE PROGRAM (EAP)

MAINSTREAM MENTAL HEALTH SERVICES



Confidential Mental Health Assistance

Access to guidance and counseling with licensed clinicians to assist with concerns such as stress, anxiety, depression, grief, substance abuse, and relationship conflicts. Support options include in-person and telehealth referrals.



Stress Management & Enhanced Being

Learn to eliminate the chronic negative effects of stress and enhance personal life satisfaction with actionable tools and coaching.

Life Management Solutions

Help explore resources for everyday concerns including child and eldercare, legal, wellness support groups, and transportation.

For more info, contact us:
(540) 966-5808
after hours email:
cthpsimuong@mainstreammh.com
Offices located in:
Roanoke, Dublin, and Blairs

Employee Perks and Local Offers

Please visit the [Employee Offers](#) for additional information (press Ctrl and click the link)!

<u>Vendor</u>	<u>Phone Number</u>	<u>Email or Website</u>
Aflac – Kevin Martin	540-556-9494	Kevin Martin - AFLAC Agent
Atlantic Bay Mortgage	540-354-7957	Atlantic Bay Mortgage
BJ's Wholesale Club	540-597-1994	BJ's Educator Discount
Blue Eagle Credit Union – Teacher Grant Program	540-342-3429	Blue Eagle Credit Union Teacher Grant Program
Complete Dental Care – Salem	540-387-3844	Complete Dental Care - Salem
Public Service Discount		
District Vue Apartments	540-339-7200	District Vue
Employee Discounts for State Employees	N/A	Employee Discounts for State Employees
Green Ridge Rec Center	540-777-6300	Green Ridge Recreation Center
Home Chef	N/A	Home Chef
Member One FCU	540-982-8811	Member One FCU
Planet Fitness	N/A	Planet Fitness
Roanoke Valley Credit Union	540-982-3931	Roanoke Valley Community Credit Union
Sam's Club Teacher Discount	540-563-2620	Sam's Club Teacher Discount
TAP – Tax Assistance	540-283-4804	TAP - Tax Assistance
The Orchards Apartments	540-977-6200	The Orchards - Leasing
YMCA of the Roanoke Valley	540-342-9622	YMCA of Virginia's Blue Ridge
NY Life – The Conner Group	540-767-6669	B. Neil Zimmerman - NY Life Ins Agent - The Conner Group

Contact Information

Vendor Customer Service Contacts

	Carrier	Phone Number	Website
Medical	Anthem Blue Cross and Blue Shield	1-833-388-1400	www.anthem.com
Prescription	Anthem	1-833-419-0530	www.anthem.com
Dental	Delta Dental Insurance Company	1-800-237-6060	www.deltadentalva.com
Vision	Anthem	866-723-0515	www.anthem.com
Short Term Disability (STD)	Anthem Life	Contact HR Dept.	STD Benefits at a Glance
Long Term Disability (LTD)	Anthem Life	Contact HR Dept.	LTD Benefits at a Glance
Health Reimbursement Account Flexible Spending Accounts Health Savings Accounts	Flexible Benefit Administrators, Inc.	1-800-437-3539	www.flex-admin.com/
Employee Assistance Program	Mainstream	1-540-966-5808	www.mainstreammh.com
Long Term Care	Genworth	1-866-859-6060	Group LTC - Login
Deferred Compensation (403(b) and 457)	Empower	1-800-701-8255	www.empower-retirement.com/participant
Retirement	VRS	1-888-827-3847	www.varetire.org
Basic Group Life	Securian	1-800-441-2258	www.varetire.org
Optional Group Life	Securian	1-800-441-2258	www.varetire.org

Please contact Human Resources to complete any changes to your benefits that are not related to your Initial or Annual enrollment.

This brochure summarizes the benefit plans that are available to Roanoke County Public Schools eligible employees and their dependents. Official plan documents, policies and certificates of insurance contain the details, conditions, maximum benefit levels and restrictions on benefits. These documents govern your benefits program. If there is any conflict, the official documents prevail. These documents are available upon request through the Human Resources Department. Information provided in this brochure is not a guarantee of benefits.

Important Legal Notices



If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please see pages starting at 50 for more details.



***IMPORTANT NOTICE:** This document is provided to help employers understand the compliance obligations for Health & Welfare benefit plans, but it may not take into account all the circumstances relevant to a particular plan or situation. It is not exhaustive and is not a substitute for legal advice.*

VIRGINIA VALUES ACT NOTICE

Roanoke County Public Schools does not unlawfully discriminate on the basis of pregnancy, childbirth, or related medical issues. Employees may have a right to reasonable accommodation for known limitations related to pregnancy, childbirth, or related medical issues. Reach out to Human Resources - Benefits if you have limitations related to pregnancy, childbirth, or related medical issues for which you seek an accommodation. You may be entitled to an interactive process to determine whether a specific accommodation is reasonable. Employers are prohibited from taking adverse action against an employee who requests or uses a reasonable accommodation.

CONTINUATION COVERAGE OVER COBRA NOTICE

This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it. When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to Roanoke County Public Schools, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

When is COBRA continuation coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee;
- Commencement of a proceeding in bankruptcy with respect to the employer; or
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 30 days after the qualifying event occurs. You must provide this notice to: Human Resources Department of Roanoke County Public Schools.

How is COBRA continuation coverage provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicare, Medicaid, [Children's Health Insurance Program \(CHIP\)](#), or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period¹ to sign up for Medicare Part A or B, beginning on the earlier of

The month after your employment ends; or

The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the

¹ <https://www.medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b/part-a-part-b-sign-up-periods>.

COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit <https://www.medicare.gov/medicare-and-you>.

If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

Keep your Plan informed of address changes

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan contact information

Roanoke County Public Schools
Tracy Bandy, HR Benefits Manager
5937 Cove Road
Roanoke, VA 24019
540-562-3900 extension 10146

Important Legal Notices Affecting Your Health Plan Coverage

THE WOMEN'S HEALTH CANCER RIGHTS ACT OF 1998 (WHCRA)

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. For further details, please refer to your Summary Plan Description or Summary of Benefits and Coverage (SBC).

NEWBORNS ACT DISCLOSURE - FEDERAL

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

NOTICE OF SPECIAL ENROLLMENT RIGHTS

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Further, if you decline enrollment for yourself or eligible dependents (including your spouse) while Medicaid coverage or coverage under a State CHIP program is in effect, you may be able to enroll yourself and your dependents in this plan if:

- coverage is lost under Medicaid or a State CHIP program; or
- you or your dependents become eligible for a premium assistance subsidy from the State.

In either case, you must request enrollment within 60 days from the loss of coverage or the date you become eligible for premium assistance.

To request special enrollment or obtain more information, contact the person listed at the end of this summary.

NOTICE REGARDING WELLNESS PROGRAMS

The Wellness Program is a voluntary wellness program available to all employees. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. If you choose to participate in the wellness program you will be asked to complete a voluntary health risk assessment or "HRA" that asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (e.g., cancer, diabetes, or heart disease). If you choose to participate in the Wellness Program, you will also be asked to complete an annual physical.

However, employees who choose to participate in the wellness program will receive an incentive of employer contributions to your HRA or HSA for completing an annual physical. Although you are not required to complete your Annual Physical, only employees who do so will receive employer contributions into their HRA or HSA.

Protections from Disclosure of Medical Information

We are required by law to maintain the privacy and security of your personally identifiable health information. Although the wellness program and County of Roanoke may use aggregate information it collects to design a program based on identified health risks in the workplace, Marathon Health and Wellness Program will never disclose any of your personal information either publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements. The only individual(s) who will receive your personally identifiable health information are Health and Wellness Center staff such as, a registered nurse, a doctor, and/or a health coach in order to provide you with services under the wellness program.

In addition, all medical information obtained through the wellness program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the wellness program will be used in making any employment decision. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you immediately.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate.

Your health plan is committed to helping you achieve your best health. Rewards for participating in a wellness program are available to all employees. If you think you might be unable to meet a standard for a reward under this wellness program, you might qualify for an opportunity to earn the same reward by different means.

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact Human Resources at 540-562-3900.

MODEL INDIVIDUAL CREDITABLE COVERAGE DISCLOSURE NOTICE LANGUAGE
FOR USE ON OR AFTER APRIL 1, 2011

If you are receiving this electronically, you are responsible for providing a copy of this notice to any Medicare Part D-eligible dependents who are covered under the group health plan.

Important Notice from Roanoke County Public Schools About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Roanoke County Public Schools and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

- 1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.**
- 2. Roanoke County Public Schools has determined that the prescription drug coverage offered by the Anthem Health Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.**

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current Roanoke County Public Schools coverage will not be affected.

If you do decide to join a Medicare drug plan and drop your current Roanoke County Public Schools coverage, be aware that you and your dependents will be able to get this coverage back.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with Roanoke County Public Schools and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage...

Contact the person listed below for further information. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Roanoke County Public Schools changes. You also may request a copy of this notice at any time.

MODEL INDIVIDUAL CREDITABLE COVERAGE DISCLOSURE NOTICE LANGUAGE
FOR USE ON OR AFTER APRIL 1, 2011

For More Information About Your Options Under Medicare Prescription Drug Coverage...

More detailed information about Medicare plans that offer prescription drug coverage is in the “Medicare & You” handbook. You’ll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the “Medicare & You” handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date:	Effective July 1, 2025
Name of Entity/Sender:	Roanoke County Public Schools
Contact--Position/Office:	Tracy Bandy, HR Benefits Manager
Address:	5937 Cove Road, Roanoke, VA 24019
Phone Number:	540-562-3900 extension 10146

Premium Assistance Under Medicaid and the Children’s Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you’re eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren’t eligible for Medicaid or CHIP, you won’t be eligible for these premium assistance programs, but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren’t already enrolled. This is called a “special enrollment” opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2024. Contact your State for more information on eligibility –

ALABAMA – Medicaid

Website: <http://myalhipp.com/>
Phone: 1-855-692-5447

ALASKA – Medicaid

The AK Health Insurance Premium Payment Program
Website: <http://myakhipp.com/>
Phone: 1-866-251-4861
Email: CustomerService@MyAKHIPP.com
Medicaid Eligibility: <https://health.alaska.gov/dpa/Pages/default.aspx>

ARKANSAS – Medicaid

Website: <http://myarhipp.com/>
Phone: 1-855-MyARHIPP (855-692-7447)

CALIFORNIA – Medicaid

Health Insurance Premium Payment (HIPP) Program Website:
<http://dhcs.ca.gov/hipp>
Phone: 916-445-8322
Fax: 916-440-5676
Email: hipp@dhcs.ca.gov

COLORADO – Health First Colorado (Colorado’s Medicaid Program) & Child Health Plan Plus (CHP+)

Health First Colorado Website: <https://www.healthfirstcolorado.com/>
Health First Colorado Member Contact Center:
1-800-221-3943/State Relay 711
CHP+: <https://hcpf.colorado.gov/child-health-plan-plus>
CHP+ Customer Service: 1-800-359-1991/State Relay 711
Health Insurance Buy-In Program (HIBI): <https://www.mycohibi.com/>
HIBI Customer Service: 1-855-692-6442

FLORIDA – Medicaid

Website: <https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html>
Phone: 1-877-357-3268

GEORGIA – Medicaid

GA HIPP Website: <https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp>
Phone: 678-564-1162, Press 1
GA CHIPRA Website: <https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra>
Phone: 678-564-1162, Press 2

INDIANA – Medicaid

Health Insurance Premium Payment Program
All other Medicaid
Website: <https://www.in.gov/medicaid/>
<http://www.in.gov/fssa/dfr/>
Family and Social Services Administration
Phone: 1-800-403-0864
Member Services Phone: 1-800-457-4584

IOWA – Medicaid and CHIP (Hawki)

Medicaid Website:
[Iowa Medicaid | Health & Human Services](#)
Medicaid Phone: 1-800-338-8366
Hawki Website:
[Hawki - Healthy and Well Kids in Iowa | Health & Human Services](#)
Hawki Phone: 1-800-257-8563
HIPP Website: [Health Insurance Premium Payment \(HIPP\) | Health & Human Services \(iowa.gov\)](#)
HIPP Phone: 1-888-346-9562

KANSAS – Medicaid

Website: <https://www.kancare.ks.gov/>
Phone: 1-800-792-4884
HIPP Phone: 1-800-967-4660

KENTUCKY – Medicaid

Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website:
<https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx>
Phone: 1-855-459-6328
Email: KIHIPP.PROGRAM@ky.gov
KCHIP Website: <https://kynect.ky.gov>
Phone: 1-877-524-4718
Kentucky Medicaid Website: <https://chfs.ky.gov/agencies/dms>

LOUISIANA – Medicaid

Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp
Phone: 1-888-342-6207 (Medicaid hotline) or
1-855-618-5488 (LaHIPP)

MAINE – Medicaid

Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US
Phone: 1-800-442-6003
TTY: Maine relay 711
Private Health Insurance Premium Webpage:
<https://www.maine.gov/dhhs/ofi/applications-forms>
Phone: 1-800-977-6740
TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP

Website: <https://www.mass.gov/masshealth/pa>
Phone: 1-800-862-4840
TTY: 711
Email: masspremassistance@accenture.com

MINNESOTA – Medicaid

Website: <https://mn.gov/dhs/health-care-coverage/>
Phone: 1-800-657-3739

MISSOURI – Medicaid

Website: <http://www.dss.mo.gov/mhd/participants/pages/hipp.htm>
Phone: 573-751-2005

MONTANA – Medicaid

Website: <http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP>
Phone: 1-800-694-3084
Email: HHSHIPProgram@mt.gov

NEBRASKA – Medicaid

Website: <http://www.ACCESSNebraska.ne.gov>
Phone: 1-855-632-7633
Lincoln: 402-473-7000
Omaha: 402-595-1178

NEVADA – Medicaid

Medicaid Website: <http://dhcfp.nv.gov>
Medicaid Phone: 1-800-992-0900

NEW HAMPSHIRE – Medicaid

Website: <https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program>
Phone: 603-271-5218
Toll free number for the HIPP program: 1-800-852-3345, ext. 15218
Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov

NEW JERSEY – Medicaid and CHIP

Medicaid Website: <http://www.state.nj.us/humanservices/dmahs/clients/medicaid/>
Phone: 1-800-356-1561
Medicaid Phone: 609-631-2392
CHIP Website: <http://www.njfamilycare.org/index.html>
CHIP Phone: 1-800-701-0710 (TTY: 711)

NEW YORK – Medicaid

Website: https://www.health.ny.gov/health_care/medicaid/
Phone: 1-800-541-2831

NORTH CAROLINA – Medicaid

Website: <https://medicaid.ncdhhs.gov/>
Phone: 919-855-4100

NORTH DAKOTA – Medicaid

Website: <https://www.hhs.nd.gov/healthcare>
Phone: 1-844-854-4825

OKLAHOMA – Medicaid and CHIP

Website: <http://www.insureoklahoma.org>
Phone: 1-888-365-3742

OREGON – Medicaid and CHIP

Website: <http://healthcare.oregon.gov/Pages/index.aspx>
Phone: 1-800-699-9075

PENNSYLVANIA – Medicaid and CHIP

Website: <https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html>
Phone: 1-800-692-7462
CHIP Website: [Children's Health Insurance Program \(CHIP\) \(pa.gov\)](#)
CHIP Phone: 1-800-986-KIDS (5437)

RHODE ISLAND – Medicaid and CHIP

Website: <http://www.eohhs.ri.gov/>
Phone: 1-855-697-4347, or
401-462-0311 (Direct RIte Share Line)

SOUTH CAROLINA – Medicaid

Website: <https://www.scdhhs.gov>
Phone: 1-888-549-0820

SOUTH DAKOTA – Medicaid

Website: <http://dss.sd.gov>
Phone: 1-888-828-0059

TEXAS – Medicaid

Website: [Health Insurance Premium Payment \(HIPP\) Program | Texas Health and Human Services](#)
Phone: 1-800-440-0493

UTAH – Medicaid and CHIP

Utah's Premium Partnership for Health Insurance (UPP) Website: <https://medicaid.utah.gov/upp/>
Email: upp@utah.gov
Phone: 1-888-222-2542
Adult Expansion Website: <https://medicaid.utah.gov/expansion/>
Utah Medicaid Buyout Program Website: <https://medicaid.utah.gov/buyout-program/>
CHIP Website: <https://chip.utah.gov/>

VERMONT – Medicaid

Website: [Health Insurance Premium Payment \(HIPP\) Program | Department of Vermont Health Access](#)
Phone: 1-800-250-8427

VIRGINIA – Medicaid and CHIP

Website: <https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select>
<https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs>
Medicaid/CHIP Phone: 1-800-432-5924

WASHINGTON – Medicaid

Website: <https://www.hca.wa.gov/>
Phone: 1-800-562-3022

WEST VIRGINIA – Medicaid and CHIP

Website: <https://dhhr.wv.gov/bms/>

<http://mywvhipp.com/>

Medicaid Phone: 304-558-1700

CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)

WISCONSIN – Medicaid and CHIP

Website:

<https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm>

Phone: 1-800-362-3002

WYOMING – Medicaid

Website: <https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/>

Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2024, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub.L.104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C.3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C.3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.



Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 12-31-2026)

PART A: General Information

Even if you are offered health coverage through your employment, you may have other coverage options through the Health Insurance Marketplace (“Marketplace”). To assist you as you evaluate options for you and your family, this notice provides some basic information about the Health Insurance Marketplace and health coverage offered through your employment.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers “one-stop shopping” to find and compare private health insurance options in your geographic area.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium and other out-of-pocket costs, but only if your employer does not offer coverage, or offers coverage that is not considered affordable for you and doesn’t meet certain minimum value standards (discussed below). The savings that you’re eligible for depends on your household income. You may also be eligible for a tax credit that lowers your costs.

Does Employment-Based Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that is considered affordable for you and meets certain minimum value standards, you will not be eligible for a tax credit, or advance payment of the tax credit, for your Marketplace coverage and may wish to enroll in your employment-based health plan. However, you may be eligible for a tax credit, and advance payments of the credit that lowers your monthly premium, or a reduction in certain cost-sharing, if your employer does not offer coverage to you at all or does not offer coverage that is considered affordable for you or meet minimum value standards. If your share of the premium cost of all plans offered to you through your employment is more than 9.12%² of your annual household income, or if the coverage through your employment does not meet the “minimum value” standard set by the Affordable Care Act, you may be eligible for a tax credit, and advance payment of the credit, if you do not enroll in the employment-based health coverage. For family members of the employee, coverage is considered affordable if the employee’s cost of premiums for the lowest-cost plan that would cover all family members does not exceed 9.12% of the employee’s household income.³

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered through your employment, then you may lose access to whatever the employer contributes to the employment-based coverage. Also, this employer contribution – as well as your employee contribution to employment-based coverage – is generally excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis. In addition, note that if the health coverage offered through your employment does not meet the affordability or minimum value standards, but you accept that coverage anyway, you will not be eligible for a tax credit. You should consider all these factors in determining whether to purchase a health plan through the Marketplace.

When Can I Enroll in Health Insurance Coverage through the Marketplace?

You can enroll in a Marketplace health insurance plan during the annual Marketplace Open Enrollment Period. Open Enrollment varies by state but generally starts November 1 and continues through at least December 15.

Outside the annual Open Enrollment Period, you can sign up for health insurance if you qualify for a Special Enrollment Period. In general, you qualify for a Special Enrollment Period if you’ve had certain qualifying life events, such as getting married, having a baby, adopting a child, or losing eligibility for other health coverage. Depending on your Special Enrollment Period type, you may have 60 days before or 60 days following the qualifying life event to enroll in a Marketplace plan.

There is also a Marketplace Special Enrollment Period for individuals and their families who lose eligibility for Medicaid or Children’s Health Insurance Program (CHIP) coverage on or after March 31, 2023, through July 31, 2024. Since the onset of the nationwide COVID-19 public health emergency, state Medicaid and CHIP agencies generally have not terminated the enrollment of any Medicaid or CHIP beneficiary who was enrolled on or after March 18, 2020, through March 31, 2023. As state Medicaid and CHIP agencies resume regular eligibility and enrollment practices, many individuals may no longer be eligible for Medicaid or CHIP

² Indexed annually; see <https://www.irs.gov/pub/irs-drop/rp-22-34.pdf> for 2023.

³ An employer-sponsored or other employment-based health plan meets the “minimum value standard” if the plan’s share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs. For purposes of eligibility for the premium tax credit, to meet the “minimum value standard,” the health plan must also provide substantial coverage of both inpatient hospital services and physician services.

coverage starting as early as March 31, 2023. The U.S. Department of Health and Human Services is offering a temporary Marketplace Special Enrollment period to allow these individuals to enroll in Marketplace coverage.

Marketplace-eligible individuals who live in states served by HealthCare.gov and either- submit a new application or update an existing application on HealthCare.gov between March 31, 2023, and July 31, 2024, and attest to a termination date of Medicaid or CHIP coverage within the same time period, are eligible for a 60-day Special Enrollment Period. That means that if you lose Medicaid or CHIP coverage between March 31, 2023, and July 31, 2024, you may be able to enroll in Marketplace coverage within 60 days of when you lost Medicaid or CHIP coverage. In addition, if you or your family members are enrolled in Medicaid or CHIP coverage, it is important to make sure that your contact information is up to date to make sure you get any information about changes to your eligibility. To learn more, visit HealthCare.gov or call the Marketplace Call Center at 1-800-318-2596. TTY users can call 1-855-889-4325.

What about Alternatives to Marketplace Health Insurance Coverage?

If you or your family are eligible for coverage in an employment-based health plan (such as an employer-sponsored health plan), you or your family may also be eligible for a Special Enrollment Period to enroll in that health plan in certain circumstances, including if you or your dependents were enrolled in Medicaid or CHIP coverage and lost that coverage. Generally, you have 60 days after the loss of Medicaid or CHIP coverage to enroll in an employment-based health plan, but if you and your family lost eligibility for Medicaid or CHIP coverage between March 31, 2023, and July 10, 2023, you can request this special enrollment in the employment-based health plan through September 8, 2023. Confirm the deadline with your employer or your employment-based health plan.

Alternatively, you can enroll in Medicaid or CHIP coverage at any time by filling out an application through the Marketplace or applying directly through your state Medicaid agency. Visit <https://www.healthcare.gov/medicaid-chip/getting-medicaid-chip/> for more details.

How Can I Get More Information?

For more information about your coverage offered through your employment, please check your health plan's summary plan description or contact:

Name of Entity/Sender:	Roanoke County Public Schools
Contact--Position/Office:	Human Resources Department
Address:	5937 Cove Road, Roanoke, VA 24019
Phone Number:	540-562-3900

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

1. Employer Name Roanoke County Public Schools		2. Employer Identification Number (EIN)	
3. Employer address 5937 Cove Road		6. Employer phone number 540-572-2018	
4. City Roanoke	8. State VA	9. ZIP code 24019	
10. Who can we contact about employee health coverage at this job? 540-562-3900 x 10146			
11. Phone number (if different from above)		12. Email address tjbandy@rcps.us	

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:

All employees. Eligible employees are:

Full-time active employees who work on average 30 hours or more per week and retirees.

Some employees. Eligible employees are:

- With respect to dependents:

We do offer coverage. Eligible dependents are:

Spouses and dependents to age 26 years.

We do not offer coverage.

If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, [HealthCare.gov](https://www.healthcare.gov) will guide you through the process. Here's the employer information you'll enter when you visit [HealthCare.gov](https://www.healthcare.gov) to find out if you can get a tax credit to lower your monthly premiums.

The information below corresponds to the Marketplace Employer Coverage Tool. Completing this section is optional for employers but will help ensure employees understand their coverage choices.

13. **Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible in the next 3 months?**

Yes (Continue)

13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage? _____ (mm/dd/yyyy) (Continue)

No (STOP and return this form to employee)

14. Does the employer offer a health plan that meets the minimum value standard*?

Yes (Go to question 15) No (STOP and return form to employee)

15. For the lowest-cost plan that meets the minimum value standard* **offered only to the employee** (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/she received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs.

a. How much would the employee have to pay in premiums for this plan? \$

b. How often? Weekly Every 2 weeks Twice a month Monthly Quarterly Yearly

If the plan year will end soon and you know that the health plans offered will change, go to question 16. If you don't know, STOP and return form to employee.

16. What change will the employer make for the new plan year?

Employer won't offer health coverage

Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)

a. How much would the employee have to pay in premiums for this plan? \$

b. How often? Weekly Every 2 weeks Twice a month Monthly Quarterly Yearly

ROANOKE COUNTY PUBLIC SCHOOLS

IMPORTANT NOTICE

COMPREHENSIVE NOTICE OF PRIVACY POLICY AND PROCEDURES

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.**

This Notice is provided to you on behalf of: Roanoke County Public
School

Roanoke County Public Schools Keycare Medical Plan
Roanoke County Public Schools HealthKeepers Medical Plans
Roanoke County Public Schools Prescription Drug Plan
Roanoke County Public Schools Delta PPO plus Premier Dental Plan
Roanoke County Public Schools Voluntary Vision Plan
Roanoke County Public Schools Employee Assistance Plan
Roanoke County Public Schools Flexible Benefits Plan
Roanoke County Public Schools Health Savings Accounts
Roanoke County Public Schools Health Reimbursement Account Plan

These plans comprise what is called an “Affiliated Covered Entity,” and are treated as a single plan for purposes of this Notice and the privacy rules that require it. For purposes of this Notice, we’ll refer to these plans as a single “Plan.”

The Plan’s Duty to Safeguard Your Protected Health Information.

Individually identifiable information about your past, present, or future health or condition, the provision of health care to you, or payment for the health care is considered “Protected Health Information” (“PHI”). The Plan is required to extend certain protections to your PHI, and to give you this Notice about its privacy practices that explains how, when and why the Plan may use or disclose your PHI. Except in specified circumstances, the Plan may use or disclose only the minimum necessary PHI to accomplish the purpose of the use or disclosure.

The Plan is required to follow the privacy practices described in this Notice, though it reserves the right to change those practices and the terms of this Notice at any time. If it does so, and the change is material, you will receive a revised version of this Notice either by hand delivery, mail delivery to your last known address, or some other fashion. This Notice, and any material revisions of it, will also be provided to you in writing upon your request (ask your Human Resources representative, or contact the Plan’s Privacy Official, described below), and will be posted on any website maintained by Roanoke County Public Schools that describes benefits available to employees and dependents.

You may also receive one or more other privacy notices, from insurance companies that provide benefits under the Plan. Those notices will describe how the insurance companies use and disclose PHI, and your rights with respect to the PHI they maintain.

How the Plan May Use and Disclose Your Protected Health Information.

The Plan uses and discloses PHI for a variety of reasons. For its routine uses and disclosures it does not require your authorization, but for other uses and disclosures, your authorization (or the authorization of your personal representative (e.g., a person who is your custodian, guardian, or has your power-of-attorney) may be required. The following offers more description and examples of the Plan’s uses and disclosures of your PHI.

• **Uses and Disclosures Relating to Treatment, Payment, or Health Care Operations.**

- **Treatment:** Generally, and as you would expect, the Plan is permitted to disclose your PHI for purposes of your medical treatment. Thus, it may disclose your PHI to doctors, nurses, hospitals, emergency medical technicians, pharmacists and other health care professionals where the disclosure is for your medical treatment. For example, if you are injured in an accident, and it’s important for your treatment team to know your blood type, the Plan could disclose that PHI to the team in order to allow it to more effectively provide treatment to you.
- **Payment:** Of course, the Plan’s most important function, as far as you are concerned, is that it *pays for* all or some of the medical care you receive (provided the care is covered by the Plan). In the course of its payment operations, the Plan receives a substantial amount of PHI about you. For example, doctors, hospitals and pharmacies that provide you care send the Plan detailed information about the care they provided, so

that they can be paid for their services. The Plan may also share your PHI with other plans, in certain cases. For example, if you are covered by more than one health care plan (e.g., covered by this Plan, and your spouse’s plan, or covered by the plans covering your father and mother), we may share your PHI with the other plans to coordinate payment of your claims.

- **Health care operations:** The Plan may use and disclose your PHI in the course of its “health care operations.” For example, such activities may include underwriting, premium rating and other activities relating to plan coverage; administering health productivity and care management activities; conducting quality assessment and improvement activities; submitting claims for stop-loss coverage; conducting or arranging for medical review, legal services, audit services and fraud and abuse detection programs and business planning, management and general administration.
- **Other Uses and Disclosures of Your PHI Not Requiring Authorization.** The law provides that the Plan may use and disclose your PHI without authorization in the following circumstances:
 - **To the Plan Sponsor:** The Plan may disclose PHI to the employers (such as Roanoke County Public Schools) who sponsor or maintain the Plan for the benefit of employees and dependents. However, the PHI may only be used for limited purposes, and may not be used for purposes of employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the employers. PHI may be disclosed to: the human resources or employee benefits department for purposes of enrollments and disenrollments, census, claim resolutions, and other matters related to Plan administration; payroll department for purposes of ensuring appropriate payroll deductions and other payments by covered persons for their coverage; information technology department, as needed for preparation of data compilations and reports related to Plan administration; finance department for purposes of reconciling appropriate payments of premium to and benefits from the Plan, and other matters related to Plan administration; internal legal counsel to assist with resolution of claim, coverage and other disputes related to the Plan’s provision of benefits.
 - **Required by law:** The Plan may disclose PHI when a law requires that it report information about suspected abuse, neglect or domestic violence, or relating to suspected criminal activity, or in response to a court order. It must also disclose PHI to authorities that monitor compliance with these privacy requirements.
 - **For public health activities:** The Plan may disclose PHI when required to collect information about disease or injury, or to report vital statistics to the public health authority.
 - **For health oversight activities:** The Plan may disclose PHI to agencies or departments responsible for monitoring the health care system for such purposes as reporting or investigation of unusual incidents.
 - **Relating to decedents:** The Plan may disclose PHI relating to an individual’s death to coroners, medical examiners or funeral directors, and to organ procurement organizations relating to organ, eye, or tissue donations or transplants.
 - **For research purposes:** In certain circumstances, and under strict supervision of a privacy board, the Plan may disclose PHI to assist medical and psychiatric research.
 - **To avert threat to health or safety:** In order to avoid a serious threat to health or safety, the Plan may disclose PHI as necessary to law enforcement or other persons who can reasonably prevent or lessen the threat of harm.

- **For specific government functions:** The Plan may disclose PHI of military personnel and veterans in certain situations, to correctional facilities in certain situations, to government programs relating to eligibility and enrollment, and for national security reasons.
- **Uses and Disclosures Requiring Authorization:** For uses and disclosures beyond treatment, payment and operations purposes, and for reasons not included in one of the exceptions described above, the Plan is required to have your written authorization. Your authorizations can be revoked at any time to stop future uses and disclosures, except to the extent that the Plan has already undertaken an action in reliance upon your authorization.
- **Uses and Disclosures Requiring You to have an Opportunity to Object:** The Plan may share PHI with your family, friend or other person involved in your care, or payment for your care. We may also share PHI with these people to notify them about your location, general condition, or death. However, the Plan may disclose your PHI only if it informs you about the disclosure in advance and you do not object (but if there is an emergency situation and you cannot be given your opportunity to object, disclosure may be made if it is consistent with any prior expressed wishes and disclosure is determined to be in your best interests; you must be informed and given an opportunity to object to further disclosure as soon as you are able to do so).

Your Rights Regarding Your Protected Health Information.

You have the following rights relating to your protected health information:

- **To request restrictions on uses and disclosures:** You have the right to ask that the Plan limit how it uses or discloses your PHI. The Plan will consider your request, but is not legally bound to agree to the restriction. To the extent that it agrees to any restrictions on its use or disclosure of your PHI, it will put the agreement in writing and abide by it except in emergency situations. The Plan cannot agree to limit uses or disclosures that are required by law.
- **To choose how the Plan contacts you:** You have the right to ask that the Plan send you information at an alternative address or by an alternative means. The Plan must agree to your request as long as it is reasonably easy for it to accommodate the request.
- **To inspect and copy your PHI:** Unless your access is restricted for clear and documented treatment reasons, you have a right to see your PHI in the possession of the Plan or its vendors if you put your request in writing. The Plan, or someone on behalf of the Plan, will respond to your request, normally within 30 days. If your request is denied, you will receive written reasons for the denial and an explanation of any right to have the denial reviewed. If you want copies of your PHI, a charge for copying may be imposed but may be waived, depending on your circumstances. You have a right to choose what portions of your information you want copied and to receive, upon request, prior information on the cost of copying.
- **To request amendment of your PHI:** If you believe that there is a mistake or missing information in a record of your PHI held by the Plan or one of its vendors, you may request, in writing, that the record be corrected or supplemented. The Plan or someone on its behalf will respond, normally within 60 days of receiving your request. The Plan may deny the request if it is determined that the PHI is: (i) correct and complete; (ii) not created by the Plan or its vendor and/or not part of the Plan's or vendor's records; or (iii) not permitted to be disclosed. Any denial will state the reasons for denial and explain your rights to have the request and denial, along with any statement in response that you provide, appended to your PHI. If the request for amendment is approved, the Plan or vendor, as the case may be, will change the PHI and so inform

you, and tell others that need to know about the change in the PHI.

- **To find out what disclosures have been made:** You have a right to get a list of when, to whom, for what purpose, and what portion of your PHI has been released by the Plan and its vendors, other than instances of disclosure for which you gave authorization, or instances where the disclosure was made to you or your family. In addition, the disclosure list will not include disclosures for treatment, payment, or health care operations. The list also will not include any disclosures made for national security purposes, to law enforcement officials or correctional facilities, or before the date the federal privacy rules applied to the Plan. You will normally receive a response to your written request for such a list within 60 days after you make the request in writing. Your request can relate to disclosures going as far back as six years. There will be no charge for up to one such list each year. There may be a charge for more frequent requests.

How to Complain about the Plan's Privacy Practices.

If you think the Plan or one of its vendors may have violated your privacy rights, or if you disagree with a decision made by the Plan or a vendor about access to your PHI, you may file a complaint with the person listed in the section immediately below. You also may file a written complaint with the Secretary of the U.S. Department of Health and Human Services. The law does not permit anyone to take retaliatory action against you if you make such complaints.

Contact Person for Information, or to Submit a Complaint.

If you have questions about this Notice please contact the Plan's Privacy Official or Deputy Privacy Official(s) (see below). If you have any complaints about the Plan's privacy practices or handling of your PHI, please contact the Privacy Official or an authorized Deputy Privacy Official.

Privacy Official.

The Plan's Privacy Official, the person responsible for ensuring compliance with this Notice, is:

Dr. Jessica McClung
Assistant Superintendent of Student Services and Human Resources
Telephone Number: (540) 562-3900

The Plan's Deputy Privacy Official(s) is/are:

Jim Bradshaw, Director of Human Resources	(540) 562-3900
Tracy Bandy, HR Benefits Manager	(540) 562-3900
Jodylee Edsall, Associate Director of Human Resources	(540) 562-3900

Organized Health Care Arrangement Designation.

The Plan participates in what the federal privacy rules call an "Organized Health Care Arrangement." The purpose of that participation is that it allows PHI to be shared between the members of the Arrangement, without authorization by the persons whose PHI is shared, for health care operations. Primarily, the designation is useful to the Plan because it allows the insurers who participate in the Arrangement to share PHI with the Plan for purposes such as shopping for other insurance bids.

The members of the Organized Health Care Arrangement are:

Roanoke County Public Schools Keycare Medical Plan
Roanoke County Public Schools HealthKeepers Plans
Roanoke County Public Schools Prescription Drug Plan
Roanoke County Public Schools Delta Dental PPO plus Premier
Roanoke County Public Schools Voluntary Vision Plan
Roanoke County Public Schools Employee Assistance Plan
Roanoke County Public Schools Flexible Benefits Plan
Roanoke County Public Schools Health Savings Account
Roanoke County Public Schools Health Reimbursement Account Plan

The effective date of this Notice is: July 1, 2025.