Benefits Open Enrollment 2018

Open Enrollment: May 7 – May 22, 2018
Coverage period: July 1, 2018 - June 30, 2019

Open enrollment time for benefits is once again upon us. This is the only time during the coverage period that you can add, change, or cancel coverage for you or your eligible dependents unless you experience a qualifying event, also known as a family status change. Experiencing a qualifying event allows you to make a change outside of the open enrollment time period within 31 days of the event. By law we are not permitted to allow exceptions to these rules, so please make your choices for benefits for the July 1, 2018 – June 30, 2019 plan year carefully.

DUE TO AFFORDABLE CARE ACT REPORTING REQUIREMENTS, ALL BENEFIT ELIGIBLE EMPLOYEES SHOULD TAKE ACTION IN EMPLOYEE SELF SERVICE OPEN ENROLLMENT TO CONFIRM, DECLINE, OR CHANGE THEIR BENEFITS FOR THE UPCOMING COVERAGE PERIOD!

What should you do during open enrollment

- Log on to the ESS site to review your current benefits, covered dependents, and make your 2018-2019 selections.
    - Contact the Help Desk at ext. 68911 if you have problems logging on. You will use the same login that you use for your email.
    - You are encouraged to review the tutorial guide for assistance on viewing current benefit information and making changes through open enrollment on ESS.
    - Contact the Benefits Department if you experience problems making your selections.

- If you are adding dependents, you are required to provide documentation to prove their eligibility to be on the plan(s). If you are adding a spouse, you will need to provide a copy of a marriage certificate. If you are adding children, you will need to provide copies of their certified birth certificates. You may email, fax, or interoffice mail those documents to the Benefits Office. Coverage on newly added dependents will be canceled if documentation is not provided prior to July 1.

- If you are enrolling for LTD or supplemental life insurance, or increasing your supplemental life insurance amount, you will have to complete an Evidence of Insurability (EOI) and be approved by the insurance company before coverage can take effect. Those forms are available on ESS as a download when choosing that particular coverage.

Cigna Representative on Site

A Cigna representative will be available at the Center for Educational Services to answer individual questions about claims and the medical and prescription plan. During those same time periods, Benefits

Department staff will also be available to answer questions about all offered benefits and provide assistance with the ESS process.

Cigna and Benefits staff will be at CES on Tuesday, May 15 from 9:00 am-1:00 pm, and Monday, May 21 from 12:00 pm-5:00 pm on a walk-in basis.

As always, please contact the Benefits Department with any questions at 301-766-2810 or WCPS_benefits@wcps.k12.md.us.

Insurance Premiums for Fiscal Year 2019

WCPS continues to strive to offer a robust benefits package to meet your needs. Throughout this school year, the health care committee analyzed various cost control measures in light of increasing medical and prescription costs. As a result, the medical and prescription plan will experience some plan updates effective July 1, 2018. A summary of the plan updates follows. While the WCPS self-insurance fund has rebounded some from our past few years of higher claim costs, premium rates will change as follows for fiscal year 2019.

Medical/prescription Insurance: Premiums will increase 5%.

Dental Insurance: Premiums will remain the same.

Vision Insurance: Premiums will remain the same.

Life Insurance and Long Term Disability: Premiums will remain the same.

New payroll contribution rate sheets and other plan information can be found in the 2018-19 Benefits Guide and also on the Benefits Office web page at www.wcpsmd.com/benefits.

Medical Plan Updates

A. Medical plan copayments

To promote the use of convenient, low-cost care where it is appropriate, copayments on using Cigna's telehealth partners is being reduced from $20 to $0. Telehealth provides access to physicians either via web conference or on the telephone to diagnose routine illnesses and provide prescriptions for those illnesses when necessary. Covered employees and family members can establish an account with MDLive or AMWell (Cigna's telehealth partners) and receive services 24 hours a day, 7 days a week for no out-of-pocket cost to the member.

Copayments for using emergency room services are increasing from $50 to $100. **Because of this change, members will be receiving new Cigna cards the week prior to July 1**.

In-Network Service	Prior to 7/1/18	7/1/18 and after
Telehealth copayment	$20	$0
Physician's office copayment	$20	$20
Urgent care copayment	$20	$20
Emergency room copayment	$50	$100

B. Medical and prescription plan out-of-pocket maximum change

The out-of-pocket maximum is the most a member could pay in a plan year (July 1-June 30) for covered services such as copayments and deductibles. Once the out-of-pocket maximum is reached, the plan (WCPS self-insurance fund) picks up covered services at 100% through the end of the plan year. If other family members are on this plan, they have to meet their own out-of-pocket maximums until the overall family out-of-pocket maximum has been met.

Prior to 7/1/18 – Combined medical and prescription (Rx) out-of-pocket maximum

	Limited Plan	Standard Plan		Premium Plan	
	In-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
One person Medical/Rx	$1,000	$1,500	$3,000	$1,000	$1,000
More than one person Medical/Rx	$2,000	$3,000	$6,000	$2,000	$2,000

7/1/18 and after – Separate medical and prescription (Rx) out-of-pocket maximum

	Limited Plan	Standard Plan		Premium Plan	
	In-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
One person Medical Rx	 $1,000 $4,500	 $1,500 $4,000	 $3,000 N/A	 $1,000 $4,500	 $2,000 N/A
More than one person Medical Rx	 $2,000 $9,000	 $3,000 $8,200	 $6,000 N/A	 $2,000 $9,000	 $4,000 N/A

Prescription Plan Updates

Efforts are being made nationwide to combat the growing opioid abuse problem. WCPS will be joining those efforts by implementing some additional oversight on some prescription drugs. Other measures are also being implemented in an attempt to constrain pharmacy costs. The updates to the prescription plan are outlined below.

C. Participation in the Cigna 90 Now Network

To receive a 90 day supply of a prescription at a retail pharmacy, members must begin to use a pharmacy that participates in the Cigna 90 Now network. This network is more limited than the regular participating pharmacy network. This change does not impact where members can receive 30 day prescriptions.

As a compromise to using a more limited network for 90 day prescriptions, all members will now be able to fill a 90 day prescription at a Cigna 90 pharmacy for **two** copayments instead of **three**.

Prior to 7/1/18

- Members can fill a 90 day prescription at any in-network pharmacy for three copayments.
- Members can fill a 90 day prescription through home delivery for two copayments.
- Members can fill a 30 day prescription at any in-network pharmacy for one copayment.

7/1/18 and after

- Limit 90 day prescription fills to pharmacies participating in Cigna 90 network.
- Members can fill a 90 day prescription through a Cigna 90 pharmacy or through home delivery for two copayments.
- Members can fill a 30 day prescription at any in-network pharmacy for one copay. (no change)

The most popular Cigna 90 Now participating pharmacies are CVS, Wal-Mart, Sam's Club, Target, Martin's, and Weis. Walgreens is a major pharmacy that is not participating in the Cigna 90 Now network. For a full list of Cigna 90 Now participating pharmacies, log into your myCigna.com account.

D. Prescribing of Specialty Drugs

Prior to 7/1/18

Specialty drugs paid for under the pharmacy plan can be filled at any in-network pharmacy.

7/1/18 and after

Specialty drugs paid for under the pharmacy plan must be filled by Cigna home delivery. Members will receive a letter at their home address after the first pharmacy fill of a specialty drug to notify them of the steps to move to Cigna home delivery. After the second fill at an in-network retail pharmacy, the specialty drug must be filled through Cigna home delivery in order to be covered.

This change in availability provides additional oversight of drug adherence and increases engagement with the member by providing a concierge service for members to contact with questions about their drug.

*Note – this does not change the availability of specialty drugs being administered and paid for under the medical plan.

E. Non-Preferred Brand Name Diabetes Medications

This change puts non-preferred brand name diabetes medications back into line with how the WCPS plan regards non-preferred drugs for other chronic conditions.

Prior to 7/1/18

Zero copayment on all non-preferred ($50 copayment level) brand diabetes medications.

7/1/18 and after

Charge regular copayment ($50) on all non-preferred brand diabetes medications.

Please log into your myCigna.com account to see which diabetic medications are generic, brand preferred, and brand non-preferred.

F. Dispense as Written Modification

This change is being implemented strictly as a cost control measure to steer members to lower cost drugs where appropriate.

Prior to 7/1/18

Member pays applicable copayment for the generic or brand drug of their choice, if covered.

7/1/18 and after

If a brand drug has a generic equivalent available, member must receive the generic unless prescription reflects "dispense as written". Member will be charged the generic copayment plus the difference in cost between the generic drug and brand drug if member elects to receive brand with no "dispense as written" notation from the physician.

G. Clinical Drug Management

In response to the growing opioid problem nationwide and to combat rising drug costs, tighter management of some drugs will be implemented. These management techniques include:

a. Quantity Over Time Limits
Example: A member has oral surgery and is prescribed a 30 day supply of OxyContin for pain. This prescription will only be filled for a limited amount of days (less than 30). If additional medicine is needed the member can follow up with their physician.

b. Dose consolidation, where appropriate
Example: A member is taking a prescription that calls for 10 milligrams, 2 times per day. If suitable, the prescription may be changed to 20 milligrams, 1 time per day.

c. Prior Authorization on certain non-specialty drugs
Example: A new, high cost drug is prescribed. The prescribing physician will have to provide support and documentation that all other lower cost alternatives were tried first.