Agenda Item No: 11.A

STAFF REPORT

Report To: Board of Supervisors **Meeting Date:** April 20, 2023

Staff Contact: Melanie Bruketta, Human Resources Director

Agenda Title: For Possible Action: Discussion and possible action regarding proposed health and vision insurance contracts for Carson City to provide benefits coverage to City employees and retirees with the following providers: (1) health insurance benefits through Anthem as a one-year contract renewal with a 2.0% rate increase for the PPO plan and a 2.0% rate increase for the high deductible plan, with monthly contributions to health savings accounts for employees in the amounts of $199.20 (employee only), $303.81 (employee plus spouse), $290.70 (employee plus children) and $411.70 (employee plus family); and (2) vision insurance benefits through Kansas City Life as a two-year contract with no rate increase over the rates presently charged by Kansas City Life as the City's current provider. (Melanie Bruketta, mbruketta@carson.org)

Staff Summary: This item is for the Board of Supervisors ("Board") to consider the approval of contracts with benefit providers for the provision of health and vision insurance for City employees and retirees.

Agenda Action: Formal Action / Motion **Time Requested:** 10 minutes

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Proposed Motion

I move to approve the benefits contracts as presented.

Board's Strategic Goal

Organizational Culture

Previous Action

May 5, 2022 (Item 16A) – The Board authorized the City to contract with Anthem for health insurance for one year, Renaissance for dental insurance for two years and Kansas City Life for life insurance for two years.

June 17, 2021 (16B) – The Board rescinded its May 20, 2021, approval of a one-year contract with Hometown Health to provide employee and retiree health insurance coverage and approved a one-year contract with Anthem to provide health insurance coverage.

May 20, 2021 (13A) – The Board approved a one-year contract with Anthem for health insurance and a two-year contract with Kansas City Life for vision insurance.

Background/Issues & Analysis

The City's combined medical and prescription paid claims loss ratio was 81% this year as opposed to last year's claims loss ratio of 95%. The loss ratio is driven by overall utilization trends and the presence of large claims. Anthem initially proposed a 9.5% rate increase when approached about renewal, and after negotiations

agreed to reduce the increase to 2.0%. There is no decrease to the current benefits. Staff is recommending approval of the current plans with a 2.0% increase.

Staff is also requesting a change in the contributions currently made by the City to those who elect the high deductible plan. The City has set the funding based on the cost difference between the PPO plan and the high deductible plan. Due to the increase in the plans, this request is also to change the monthly contributions as follows: $195.29 to $199.20 (employee only); $297.85 to $303.81 (employee plus spouse); $285.00 to $290.70 (employee plus children); and $403.62 to $411.70 (employee plus family). The Human Resources Department, in coordination with the City's insurance broker, held Insurance Committee meetings on March 6, 2023.

The City's vision insurance contract is also up for renewal. Kansas City Life, the City's current insurer, quoted a 0% increase for a two-year term.

Applicable Statute, Code, Policy, Rule or Regulation
N/A

Financial Information
Is there a fiscal impact? Yes

If yes, account name/number: 5700706-506301, 5700706-506302, & 5700706-506303 - Health insurance increase and no increase for vision, life insurance or dental insurance.

Is it currently budgeted? Yes

Explanation of Fiscal Impact: If approved, the health insurance premiums will increase by 2.0% for the PPO and the high deductible plan. Due to the increase in the premiums, a recommendation is being made to increase the health savings account contributions. Finance initially budgeted for a 10% increase to benefits in the FY 2024 tentative budget; however, staff reduced the increase to 4% for the final tentative budget. Finance budgeted conservatively due to the fact that employees change their elections and sometimes the annual year-over-year total premium changes equal more than just the rate of 2% increase.

Alternatives
Do not approve one or more of the proposed contracts and/or provide alternative direction to staff.

Attachments:
Carson City Analysis 2023 - Board Materials.xlsb.pdf

SOB Custom BlueSecure PPO 7 $Essential Rx_NV_PPO_Large Group_ 2023(1).pdf

SOB Custom Health Savings Account HSA Compatible PPO Plan $3000_100% 15_45_75_30% Essential Rx_NV_PPO 2023.pdf

Carson City 07-2023 FI Medical Final 02212023 Additional Items.pdf

KCL Signature Page.docx

Carson City 07-2023 FI Medical Final 02212023 CS_Medical_FI - Needs Signature Upon Approval.pdf

Carson City 07-2023 Revised Medicare Final 03032023 CS Needs Signature Upon Approval.pdf

Board Action Taken:

Motion: ___________________ 1) __________________ Aye/Nay

2) __________________ __________

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(Vote Recorded By)

2023 Renewal Presentation

Prepared For:
Carson City

Effective Date:
July 1, 2023

Presented By:

INSURANCE

Carson City
Benefits & Cost Comparison - Medical

		CURRENT & RENEWAL				
Carrier		Anthem Blue Secure PPO 7 Plan			Anthem HSA PPO Plan	
Network		Anthem PPO			Anthem PPO	
		In Network			In Network	
Individual Calendar Year Deductible		$2,500			$3,000	
Family Maximum		$4,500			$6,000	
Individual Calendar Year Out of Pocket Max.		$6,500			$4,000	
Family Maximum		$12,000			$8,000	
Primary Care Physician		$40 copay			0% after deductible	
Specialist Physician		$60 copay			0% after deductible	
Virtual Visit		$5 copay → $0 copay			0% after deductible	
Emergency Room		$150 copay			0% after deductible	
Urgent Care		$50 copay			0% after deductible	
Lab		no charge			0% after deductible	
X-Ray		$60 copay			0% after deductible	
MRI, PET, CT Scans		$100 copay			0% after deductible	
Outpatient Surgery		$500 copay			0% after deductible	
Inpatient Hospitalization		$1500 copay after deductible			0% after deductible	
Prescription Benefit:						
Tier I		$15 copay			$15 after deductible	
Tier II		$40 copay			$45 after deductible	
Tier III		$60 copay			$75 after deductible	
Rates: Actives and Non-Medicare Retirees		Current	Renewal		Current	Renewal
Employee	262	$607.97	$620.13	129	$412.68	$420.93
Employee + Spouse	76	$1,246.50	$1,271.43	27	$846.10	$863.02
Employee + Child/ren	67	$1,166.49	$1,189.82	53	$791.79	$807.63
Family	84	$1,905.10	$1,943.20	73	$1,293.15	$1,319.01
Rates: Retirees with Medicare						
Retiree w/ Medicare (A&B)	34	$442.06	$450.90	0	$306.29	$312.42
Retiree + Spouse, both w/ Medicare (A&B)	7	$938.26	$957.03	0	$650.11	$663.11
Retiree + Spouse, one w/ Medicare (A&B)	1	$1,108.84	$1,131.02	0	$768.27	$783.64
Retiree + Child(ren), w/ Medicare (A&B)	0	$1,144.51	$1,167.40	0	$793.04	$808.90
Retiree + Family, both w/ Medicare (A&B)	0	$1,143.50	$1,166.37	0	$792.29	$808.14
Retiree + Family, one w/ Medicare (A&B)	0	$1,329.33	$1,355.92	0	$921.13	$939.55
	531			282		
Total Monthly Premium		$514,912	$525,210		$212,445	$216,694
Total Annual Premium		$6,178,945	$6,302,524		$2,549,343	$2,600,324
$ over/under current		-	$123,579		-	$50,981
% over/under current		-	2.00%		-	2.00%
		Current - Both Plans			Renewal - Both Plans	
Total Monthly Premium		$727,357			$741,904	
Total Annual Premium		$8,728,288			$8,902,847	
$ over/under current		-			$174,560	
% over/under current		-			2.00%	

Carson City
Benefits & Cost Comparison - Dental

		CURRENT
Carrier		**Renaissance**
Network		DDS
Out-of-Network Reimbursement		MAC
		In Network
Individual Calendar Year Deductible		$50
Family Maximum		$150
Coverage Level:		
Preventive		no charge
Basic		20% after deductible
Major		45% after deductible
Orthodontia (child only/child and adult)		50% after deductible
Coverage Detail:		
Cleaning Frequency		3 per year
Implants		major
Composite Fillings		basic
Composite Placement		anterior and posterior
Crowns		major
Endo and Perio		major
Oral Surgery		major
Calendar Year Maximum		$2,000
Orthodontia Lifetime Maximum		$1,500
Missing Tooth Provision		yes
Roll-Over Benefits		no
Waiting Periods (timely applicants):		
Basic		none
Major		none
Annual Open Enrollment		yes
Rates:		**Current**
Employee	397	$45.70
Employee + Spouse	107	$63.95
Employee + Child/ren	117	$80.86
Family	154	$99.36
	775	
Total Monthly Premium		**$49,748**
Total Annual Premium		**$596,971**
Rate Guarantee:		Renews 7/1/24

Carson City
Benefits & Cost Comparison - Vision

		CURRENT & RENEWAL	
Carrier		**Kansas City Life**	
Network		VSP Network	
		In Network	
Exam		$10 copay	
Materials		$25 copay	
Frequency:			
Eye Exam		Every 12 months	
Lenses		Every 12 months	
Frames		Every 24 months	
Schedule of Benefits:			
Vision Exam		covered in full	
Single Vision Lenses		covered in full	
Bifocal Lenses		covered in full	
Trifocal Lenses		covered in full	
Frames		up to $150	
Contact Lenses - elective		up to $150	
Rates:		**Current**	**Renewal**
Employee	400	$3.85	$3.85
Employee + Spouse	106	$7.33	$7.33
Employee + Child/ren	118	$7.71	$7.71
Family	155	$11.34	$11.34
	779		
Total Monthly Premium		**$4,984**	**$4,984**
Total Annual Premium		**$59,814**	**$59,814**
$ over/under current		-	**$0**
% over/under current		-	**0.00%**
Rate Guarantee:		24 months	

Carson City
Benefits & Cost Comparison - Employer Paid Life/AD&D

	CURRENT
Carrier	**Kansas City Life**
Eligibility	Active and Retired Employees
Benefit Amount:	
Class 1: Unclassified & Elected	$35,000
Class 2: Sheriff Personnel	$50,000
Class 3: Active Fire Members	$50,000
Class 4: All Other Active Members	$20,000
Class 5: Retirees	$10,000
Class 6: Surviving Spouses	$500, no AD&D
Dependents, Class 1-5:	
Spouse	$500
Child	$500
Plan Features:	
Accelerated Death Benefit	included
Conversion	included
Waiver of Premium	included
Travel Assistance	included
Benefit Reduces To:	
at age 65	none
at age 70	65%
at age 75	65%
Rates:	**Current**
Volume	$22,305,000
Life, AD&D per $1,000	$0.205
Total Monthly Premium	**$4,573**
Total Annual Premium	**$54,870**
Rate Guarantee:	**Renews 7/1/24**

Your summary of benefits

Anthem® Blue Cross and Blue Shield

Your Plan: BlueSecure PPO 7 $40/$2500/80% 15/40/60/20% Essential Your

Network: PPO

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Overall Deductible	$2,500 member / $4,500 family	$5,000 member / 15,000 family
Overall Out-of-Pocket Limit	$6,500 member / $12,000 family	$12,000 member / $24,000 family
The family deductible and out-of-pocket limit are embedded, meaning the cost shares of one family member will be applied to the per member deductible and per member out-of-pocket limit; in addition, amounts for all covered family members apply to both the family deductible and family out-of-pocket limit. No one member will pay more than the per member deductible or per member out-of-pocket limit. Your copays, coinsurance and deductible count toward your out of pocket limit(s). In-Network and Non-Network deductibles and out-of-pocket limit amounts are separate and do not accumulate toward each other.		
Doctor Visits (virtual and office) *You are encouraged to select a Primary Care Physician (PCP).*		
Medical Chats and Virtual Visits for Primary Care *from our Online Provider K Health, through its affiliated Provider groups are covered at $0 copay per visit deductible does not apply.*		
Virtual Visits from online provider LiveHealth Online *for urgent/acute medical and mental health and substance abuse care via www.livehealthonline.com are covered at $0 copay per visit deductible does not apply; and $60 copay per visit deductible does not apply for covered Specialist Care.*		
Primary Care (PCP) and Mental Health and Substance Abuse Care *virtual and office*	$40 copay per visit deductible does not apply	50% coinsurance after deductible is met
Specialist Care *virtual and office*	$60 copay per visit deductible does not apply	50% coinsurance after deductible is met
Other Practitioner Visits		
Routine Maternity Care (Prenatal and Postnatal)	$0 copay per pregnancy deductible does not apply	50% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Retail Health Clinic *for routine care and treatment of common illnesses; usually found in major pharmacies or retail stores.*	$40 copay per visit deductible does not apply	50% coinsurance after deductible is met
Spinal Manipulation *Coverage is limited to 20 visits per benefit period.*	$60 copay per visit deductible does not apply	50% coinsurance after deductible is met
Acupuncture *Coverage is limited to 20 visits per benefit period.*	$60 copay per visit deductible does not apply	50% coinsurance after deductible is met
<u>Other Services in an Office</u>		
Allergy Testing	$60 copay per visit deductible does not apply	50% coinsurance after deductible is met
Prescription Drugs *Dispensed in the office*	$60 copay per visit deductible does not apply	50% coinsurance after deductible is met
Surgery	0% coinsurance after deductible is met	50% coinsurance after deductible is met
Preventive care / screenings / immunizations	No charge	50% coinsurance after deductible is met
Preventive Care for Chronic Conditions *per IRS guidelines*	No charge	50% coinsurance after deductible is met
<u>Diagnostic Services</u> **Lab**		
Office	No charge	50% coinsurance after deductible is met
Freestanding Lab/Reference Lab	No charge	50% coinsurance after deductible is met
Outpatient Hospital	No charge	50% coinsurance after deductible is met
X-Ray		
Office	$60 copay per visit deductible does not apply	50% coinsurance after deductible is met
Freestanding Radiology Center	$60 copay per visit deductible does not apply	50% coinsurance after deductible is met
Outpatient Hospital	$60 copay per visit deductible does not apply	50% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Advanced Diagnostic Imaging *for example: MRI, PET and CAT scans*		
Office	$100 copay per visit deductible does not apply	50% coinsurance after deductible is met
Freestanding Radiology Center	$100 copay per visit deductible does not apply	50% coinsurance after deductible is met
Outpatient Hospital	$100 copay per visit deductible does not apply	50% coinsurance after deductible is met
Emergency and Urgent Care		
Urgent Care *includes doctor services. Additional charges may apply depending on the care provided.* *There may be other levels of cost share that are contingent on how services are provided.*	$50 copay per visit deductible does not apply	50% coinsurance after deductible is met
Emergency Room Facility Services *Copay waived if admitted.*	$150 copay per visit deductible does not apply	Covered as In-Network
Emergency Room Doctor and Other Services *There may be other levels of cost share that are contingent on how services are provided.*	0% coinsurance deductible does not apply	Covered as In-Network
Ambulance	$200 copay deductible does not apply	Covered as In-Network
Outpatient Mental Health and Substance Abuse Care at a Facility		
Facility Fees	$1500 copay per admit after deductible is met	50% coinsurance after deductible is met
Doctor Services	$40 copay per visit deductible does not	50% coinsurance after deductible is met
Outpatient Surgery		
Facility Fees		
Hospital	$500 copay per visit deductible does not apply	50% coinsurance after deductible is met
Ambulatory Surgical Center	$500 copay per visit deductible does not apply	50% coinsurance after deductible is met
Doctor and Other Services		
Hospital	0% coinsurance after deductible is met	50% coinsurance after deductible is met
Ambulatory Surgical Center	0% coinsurance after deductible is met	50% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<u>Hospital (Including Maternity, Mental Health and Substance Abuse)</u>		
Facility Fees	$1500 copay per admit after deductible is met	50% coinsurance after deductible is met
Physician and other services *including surgeon fees*	0% coinsurance after deductible is met	50% coinsurance after deductible is met
Home Health Care *Coverage is limited to 60 visits per CYD. Limits are combined for all home health services.*	$60 copay per visit deductible does not apply	50% coinsurance after deductible is met
Rehabilitation and Habilitation services *Coverage for Physical, Occupational, Speech therapy combined is limited to 90 visits per CYD benefit period. Costs may vary by site of service. Office and outpatient visits count towards your rehabilitation limit.*		
Office	$60 copay per visit deductible does not apply	50% coinsurance after deductible is met
Outpatient Hospital	$60 copay per visit deductible does not apply	50% coinsurance after deductible is met
Pulmonary rehabilitation *office and outpatient hospital*	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Cardiac rehabilitation *office and outpatient hospital* *Coverage is limited to 60 CYD benefit period.*	$10 copay per visit deductible does not apply	50% coinsurance after deductible is met
Dialysis/Hemodialysis *office and outpatient hospital*	$60 copay per visit deductible does not apply	50% coinsurance after deductible is met
Chemo/Radiation Therapy *office and outpatient hospital*	$60 copay per visit deductible does not apply	50% coinsurance after deductible is met
Skilled Nursing Care (facility) *Coverage for Inpatient rehabilitation and skilled nursing services is limited to 100 days combined per benefit period.*	$1500 copay per admit after deductible is met	50% coinsurance after deductible is met
Inpatient Hospice	$60 copay per visit deductible does not apply	50% coinsurance after deductible is met
Durable Medical Equipment	$60 copay per visit deductible does not apply	50% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Prosthetic Devices *Coverage for wigs is limited to 1 item after cancer treatment up to a $500 maximum per member.*	$60 copay per visit deductible does not apply	50% coinsurance after deductible is met

Covered Prescription Drug Benefits	Cost if you use a Preferred Network Pharmacy	Cost if you use an In-Network Pharmacy	Cost if you use a Non-Network Pharmacy
Pharmacy Deductible	Not applicable	Not applicable	Not applicable
Pharmacy Out-of-Pocket Limit	Combined with In-Network medical out-of-pocket limit	Combined with In-Network medical out-of-pocket limit	Combined with Non-Network medical out-of-pocket limit
Prescription Drug Coverage **Network: *Rx Choice Tiered Network*** **Drug List: *Essential*** *Drugs not included on the Essential drug list will not be covered.*			
Day Supply Limits: **Retail Pharmacy** *30 day supply (cost shares noted below)* **Retail 90 Pharmacy** *90 day supply (3 times the 30 day supply cost share(s) charged at Preferred Network and In-Network Retail Pharmacies noted below applies).* **Home Delivery Pharmacy** *90 day supply (maximum cost shares noted below) Maintenance medications are available through CarelonRx Mail (IngenioRx will become CarelonRx on January 1, 2023). You may get two 30-day supply fills of the same maintenance medication at a retail pharmacy. Prior to your 3rd fill, you must call us on the number on your ID card and tell us if you would like to keep getting your maintenance medications from a retail pharmacy or if you would like to use home delivery. If you do not contact us, you will pay the full retail cost of any maintenance medication until you inform us of your decision.* **Specialty Pharmacy** *30 day supply (cost shares noted below for retail and home delivery apply). We may require certain drugs with special handling, provider coordination or patient education be filled by our designated specialty pharmacy. Drug cost share assistance programs may be available for certain specialty drugs.*			
Tier 1 - Typically Generic	N/A - See in network	$15 copay per prescription (retail) and $37.50 copay per prescription (home delivery)	50% coinsurance (retail) and Not covered (home delivery)
Tier 2 – Typically Preferred Brand	N/A - See in network	$40 copay per prescription (retail) and $120 copay per prescription (home delivery)	50% coinsurance (retail) and Not covered (home delivery)
Tier 3 - Typically Non-Preferred Brand	N/A - See in network	$60 copay per prescription (retail) and $180 copay per prescription (home delivery)	50% coinsurance (retail) and Not covered (home delivery)

Covered Prescription Drug Benefits	Cost if you use a Preferred Network Pharmacy	Cost if you use an In-Network Pharmacy	Cost if you use a Non-Network Pharmacy
Tier 4 - Typically Specialty (brand and generic)	N/A - See in network	20% coinsurance up to $500 per prescription (retail and home delivery)	50% coinsurance (retail) and Not covered (home delivery)

Notes:

- The Primary Care Physician and Specialist office visit cost share applies to both office and facility based office visits for evaluation and management services only.
- Costs may vary by the site of service. Other cost shares may apply depending on services provided. Check your Certificate of Coverage for details.
- The representations of benefits in this document are subject to Nevada Division of Insurance (NV DOI) approval and are subject to change.

This summary of benefits is a brief outline of coverage, designed to help you with the selection process. This summary does not reflect each and every benefit, exclusion and limitation which may apply to the coverage. For more details, important limitations and exclusions, please review the formal Evidence of Coverage (EOC). If there is a difference between this summary and the Evidence of Coverage (EOC), the Evidence of Coverage (EOC), will prevail.

Your Plan: BlueSecure PPO 7 Custom Essential RX

Your Network: PPO

This summary of benefits is intended to be a brief outline of coverage. The entire provisions of benefits and exclusions are contained in the Group Contract, Certificate, and Schedule of Benefits. In the event of a conflict between the Group Contract and this description, the terms of the Group Contract will prevail.

By signing this Summary of Benefits, I agree to the benefits for the product selected as of the effective date indicated.

Authorized group signature (if applicable)	Date
Underwriting signature (if applicable)	Date

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Language Access Services:

Get help in your language

Curious to know what all this says? We would be too. Here's the English version:
If you have any questions about this document, you have the right to get help and information in your language at no cost. To talk to an interpreter, call (877) 811-3106

Separate from our language assistance program, we make documents available in alternate formats for members with visual impairments. If you need a copy of this document in an alternate format, please call the customer service telephone number on the back of your ID card.

(TTY/TDD: 711)

Arabic (العربية): إذا كان لديك أي استفسارات بشأن هذا المستند، فيحق لك الحصول على المساعدة والمعلومات بلغتك دون مقابل. للتحدث إلى مترجم، اتصل على (877) 811-3106 .

Armenian (հայերեն). Եթե այս փաստաթղթի հետ կապված հարցեր ունեք, դուք իրավունք ունեք անվճար ստանալ օգնություն և տեղեկատվություն ձեր լեզվով: Թարգմանչի հետ խոսելու համար զանգահարեք հետևյալ հեռախոսահամարով՝ (877) 811-3106:

Chinese(中文)：如果您對本文件有任何疑問，您有權使用您的語言免費獲得協助和資訊。如需與譯員通話，請致電(877) 811-3106。

Farsi (فارسی) : در صورتی که سؤالی پیرامون این سند دارید، این حق را دارید که اطلاعات و کمک را بدون هیچ هزینه ای به زبان مادریتان دریافت کنید. برای گفتگو با یک مترجم شفاهی، با شماره (877) 811-3106 تماس بگیرید.

French (Français) : Si vous avez des questions sur ce document, vous avez la possibilité d'accéder gratuitement à ces informations et à une aide dans votre langue. Pour parler à un interprète, appelez le (877) 811-3106.

Haitian Creole (Kreyòl Ayisyen): Si ou gen nenpòt kesyon sou dokiman sa a, ou gen dwa pou jwenn èd ak enfòmasyon nan lang ou gratis. Pou pale ak yon entèprèt, rele (877) 811-3106.

Italian (Italiano): In caso di eventuali domande sul presente documento, ha il diritto di ricevere assistenza e informazioni nella sua lingua senza alcun costo aggiuntivo. Per parlare con un interprete, chiami il numero (877) 811-3106.

Japanese (日本語):この文書についてなにかご不明な点があれば、あなたにはあなたの言語で無料で支援を受け情報を得る権利があります。 通訳と話すには、(877) 811-3106 にお電話ください。

Korean (한국어): 본 문서에 대해 어떠한 문의사항이라도 있을 경우, 귀하에게는 귀하가 사용하는 언어로 무료 도움 및 정보를 얻을 권리가 있습니다. 통역사와 이야기하려면(877) 811-3106로 문의하십시오.

Language Access Services:

Navajo (Diné): Díí naaltsoos biká'ígíí łahgo bína'ídílkidgo ná bohónéedzą́ dóó bee ahóót'i' t'áá ni nizaad k'ehjí bee níł hodoonih t'áadoo bááh ílínígóó. Ata' halne'ígíí ła' bich'į' hadeesdzih nínízingo kojį' hodíílnih (877) 811-3106.

Polish (polski): W przypadku jakichkolwiek pytań związanych z niniejszym dokumentem masz prawo do bezpłatnego uzyskania pomocy oraz informacji w swoim języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer: (877) 811-3106.

Punjabi (ਪੰਜਾਬੀ): ਜੇ ਤੁਹਾਡੇ ਇਸ ਦਸਤਾਵੇਜ਼ ਬਾਰੇ ਕੋਈ ਸਵਾਲ ਹੁੰਦੇ ਹਨ ਤਾਂ ਤੁਹਾਡੇ ਕੋਲ ਮੁਫ਼ਤ ਵਿੱਚ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਮਦਦ ਅਤੇ ਜਾਣਕਾਰੀ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੁੰਦਾ ਹੈ। ਇੱਕ ਦੁਭਾਸ਼ੀਏ ਨਾਲ ਗੱਲ ਕਰਨ ਲਈ, (877) 811-3106 ਤੇ ਕਾਲ ਕਰੋ।

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Vietnamese (Tiếng Việt): Nếu quý vị có bất kỳ thắc mắc nào về tài liệu này, quý vị có quyền nhận sự trợ giúp và thông tin bằng ngôn ngữ của quý vị hoàn toàn miễn phí. Để trao đổi với một thông dịch viên, hãy gọi (877) 811-3106.

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Anthem® Blue Cross and Blue Shield

Your Plan: Custom Health Savings Account HSA Compatible PPO Plan $3000/100% 15/45/75/30% Essential Rx

Your Network: PPO

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Overall Deductible	$3,000 member / $6,000 family	$3,000 member / $6,000 family
Overall Out-of-Pocket Limit	$4,000 member / $8,000 family	$12,000 member / $24,000 family
The family deductible and out-of-pocket limit are embedded, meaning the cost shares of one family member will be applied to the per member deductible and per member out-of-pocket limit; in addition, amounts for all covered family members apply to both the family deductible and family out-of-pocket limit. No one member will pay more than the per member deductible or per member out-of-pocket limit. Your copays, coinsurance and deductible count toward your out of pocket limit(s). In-Network and Non-Network deductibles and out-of-pocket limit amounts are separate and do not accumulate toward each other.		
Doctor Visits (virtual and office) *You are encouraged to select a Primary Care Physician (PCP).*		
Medical Chats and Virtual Visits for Primary Care *from our Online Provider K Health, through its affiliated Provider groups are covered at No charge after deductible is met.*		
Virtual Visits from online provider LiveHealth Online *for urgent/acute medical and mental health and substance abuse care via www.livehealthonline.com are covered at 0% coinsurance after deductible is met; and 0% coinsurance after deductible is met for covered Specialist Care.*		
Primary Care (PCP) and Mental Health and Substance Abuse Care *virtual and office* **Specialist Care** *virtual and office*	0% coinsurance after deductible is met 0% coinsurance after deductible is met	30% coinsurance after deductible is met 30% coinsurance after deductible is met
<u>**Other Practitioner Visits**</u> **Routine Maternity Care** (Prenatal and Postnatal) **Retail Health Clinic** *for routine care and treatment of common illnesses; usually found in major pharmacies or retail stores.*	 0% coinsurance after deductible is met 0% coinsurance after deductible is met	 30% coinsurance after deductible is met 30% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Spinal Manipulation *Coverage is limited to 20 visits per benefit period.*	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Acupuncture *Coverage is limited to 20 visits per benefit period.*	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Other Services in an Office		
Allergy Testing	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Prescription Drugs *Dispensed in the office*	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Surgery	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Preventive care / screenings / immunizations	No charge	30% coinsurance after deductible is met
Preventive Care for Chronic Conditions *per IRS guidelines*	No charge	30% coinsurance after deductible is met
Diagnostic Services **Lab**		
Office	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Freestanding Lab/Reference Lab	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Outpatient Hospital	0% coinsurance after deductible is met	30% coinsurance after deductible is met
X-Ray		
Office	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Freestanding Radiology Center	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Outpatient Hospital	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Advanced Diagnostic Imaging *for example: MRI, PET and CAT scans*		
Office	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Freestanding Radiology Center	0% coinsurance after deductible is met	30% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Outpatient Hospital	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Emergency and Urgent Care		
Urgent Care	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Emergency Room Facility Services	0% coinsurance after deductible is met	Covered as In-Network
Emergency Room Doctor and Other Services	0% coinsurance after deductible is met	Covered as In-Network
Ambulance	0% coinsurance after deductible is met	Covered as In-Network
Outpatient Mental Health and Substance Abuse Care at a Facility		
Facility Fees	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Doctor Services	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Outpatient Surgery		
Facility Fees		
Hospital	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Ambulatory Surgical Center	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Doctor and Other Services		
Hospital	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Ambulatory Surgical Center	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Hospital (Including Maternity, Mental Health and Substance Abuse)		
Facility Fees	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Physician and other services *including surgeon fees*	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Home Health Care *Coverage is limited to 30 visits per benefit period. Limits are combined for all home health services.*	0% coinsurance after deductible is met	30% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Rehabilitation and Habilitation services Coverage for Physical, Speech and Occupational therapy combined is limited to 90 visits per benefit period. Costs may vary by site of service. Office and outpatient visits count towards your rehabilitation limit. Office Outpatient Hospital	 0% coinsurance after deductible is met 0% coinsurance after deductible is met	 30% coinsurance after deductible is met 30% coinsurance after deductible is met
Pulmonary rehabilitation *office and outpatient hospital*	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Cardiac rehabilitation *office and outpatient hospital* *Coverage is limited to 60 visits per benefit period.*	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Dialysis/Hemodialysis *office and outpatient hospital*	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Chemo/Radiation Therapy *office and outpatient hospital*	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Skilled Nursing Care (facility) *Coverage for Inpatient rehabilitation and skilled nursing services is limited to 100 days combined per benefit period.*	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Inpatient Hospice	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Durable Medical Equipment	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Prosthetic Devices *Coverage for wigs is limited to 1 item after cancer treatment up to a $500 maximum per member.*	0% coinsurance after deductible is met	30% coinsurance after deductible is met

Covered Prescription Drug Benefits	Cost if you use an In-Network Pharmacy	Cost if you use a Non-Network Pharmacy
Pharmacy Deductible	Combined with In-Network medical deductible	Combined with Non-Network medical deductible

Covered Prescription Drug Benefits	Cost if you use an In-Network Pharmacy	Cost if you use a Non-Network Pharmacy
Pharmacy Out-of-Pocket Limit	Combined with In-Network medical out-of-pocket limit	Combined with Non-Network medical out-of-pocket limit
Prescription Drug Coverage **Network:** ***Base Network*** **Drug List:** ***Essential*** *Drugs not included on the Essential drug list will not be covered.*		
Day Supply Limits: **Retail Pharmacy** *30 day supply (cost shares noted below)* **Retail 90 Pharmacy** *90 day supply (3 times the 30 day supply cost share(s) charged at In-Network Retail Pharmacies noted below applies).* **Home Delivery Pharmacy** *90 day supply (maximum cost shares noted below) Maintenance medications are available through CarelonRx Mail (IngenioRx will become CarelonRx on January 1, 2023). You will need to call us on the number on your ID card to sign up when you first use the service.* **Specialty Pharmacy** *30 day supply (cost shares noted below for retail and home delivery apply). We may require certain drugs with special handling, provider coordination or patient education be filled by our designated specialty pharmacy. Drug cost share assistance programs may be available for certain specialty drugs.*		
Tier 1 - Typically Generic	$15 copay per prescription after deductible is met (retail) and $37.50 copay per prescription after deductible is met (home delivery is 0% after deductible)	30% coinsurance after deductible is met (retail) and Not covered (home delivery)
Tier 2 – Typically Preferred Brand	$45 copay per prescription after deductible is met (retail) and $135 copay per prescription after deductible is met (home delivery is 0% after deductible)	30% coinsurance after deductible is met (retail) and Not covered (home delivery)
Tier 3 - Typically Non-Preferred Brand	$75 copay per prescription after deductible is met (retail) and $225 copay per prescription after deductible is met (home delivery is 0% after deductible)	30% coinsurance after deductible is met (retail) and Not covered (home delivery)
Tier 4 - Typically Specialty (brand and generic)	30% coinsurance up to $500 per prescription after deductible is met (retail) and (home delivery is 0% after deductible)	30% coinsurance after deductible is met (retail) and Not covered (home delivery)

Notes:

- The Primary Care Physician and Specialist office visit cost share applies to both office and facility based office visits for evaluation and management services only.
- Costs may vary by the site of service. Other cost shares may apply depending on services provided. Check your Certificate of Coverage for details.
- The representations of benefits in this document are subject to Nevada Division of Insurance (NV DOI) approval and are subject to change.

This summary of benefits is a brief outline of coverage, designed to help you with the selection process. This summary does not reflect each and every benefit, exclusion and limitation which may apply to the coverage. For more details, important limitations and exclusions, please review the formal Evidence of Coverage (EOC). If there is a difference between this summary and the Evidence of Coverage (EOC), the Evidence of Coverage (EOC), will prevail.

Your summary of benefits

Your Plan: Health Savings Account HSA Compatible PPO Plan $3000/100% 15/45/75/30% Essential Rx
Your Network: PPO

This summary of benefits is intended to be a brief outline of coverage. The entire provisions of benefits and exclusions are contained in the Group Contract, Certificate, and Schedule of Benefits. In the event of a conflict between the Group Contract and this description, the terms of the Group Contract will prevail.

By signing this Summary of Benefits, I agree to the benefits for the product selected as of the effective date indicated.

Authorized group signature (if applicable)	Date
Underwriting signature (if applicable)	Date

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Get help in your language

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If you have any questions about this document, you have the right to get help and information in your language at no cost. To talk to an interpreter, call (877) 811-3106

Separate from our language assistance program, we make documents available in alternate formats for members with visual impairments. If you need a copy of this document in an alternate format, please call the customer service telephone number on the back of your ID card.

(TTY/TDD: 711)

Arabic (العربية): إذا كان لديك أي استفسارات بشأن هذا المستند، فيحق لك الحصول على المساعدة والمعلومات بلغتك دون مقابل. للتحدث إلى مترجم، اتصل على (877) 811-3106 .

Armenian (հայերեն). Եթե այս փաստաթղթի հետ կապված հարցեր ունեք, դուք իրավունք ունեք անվճար ստանալ օգնություն և տեղեկատվություն ձեր լեզվով: Թարգմանչի հետ խոսելու համար զանգահարեք հետևյալ հեռախոսահամարով՝ (877) 811-3106:

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Services included and buy-up options

CARSON CITY
Group Number: L03291
Effective July 1, 2023 through June 30, 2024

Quote highlights
Funding type: Fully Insured

Included in Premiums
Fully Insured Foundational Program
Smart Shopper
Renewal Wellness Budget- One Time credit in the amount of $5,000.00 will be applied for the purchase of services provided from Anthem, or an outside vendor through June 30, 2024. All applicable invoices must be submitted prior to June 9, 2024. Funds will be forfeited if not used by June 30, 2024.
Renewal Technology Credit- One Time credit in the amount of $3,000.00 will be applied for the purchase of services provided from Anthem, or an outside vendor through June 30, 2024. All applicable invoices must be submitted prior to June 9, 2024. Funds will be forfeited if not used by June 30, 2024.
NOTE: Expenses for items such as programming, personnel expenses, travel and incentives are not reimbursable.
NOTE: The One Time credits are only available in year one and will be forfeited if not used by the end of the year.

Account Administration Buy-Up Options (charged separately)	Fee Billed Per Participant Per Month	Confirm Purchase Here
Anthem Commuter	*$3.40*	
Anthem FSA	*$3.40*	
Anthem HRA with FSA, Dependent FSA, Commuter	*$3.40*	
Anthem Limited Purpose FSA or Dependent FSA or Commuter Add on to Anthem HSA	*$1.15*	
Anthem FSA or Dependent FSA or Commuter add on to Member Pay HRA	*$3.40*	
Anthem FSA or Dependent FSA or Commuter add on to Provider Pay HRA	*$3.40*	

Notes
- **HRA and HSA plan designs include Anthem Account Administration.**
- **Anthem FSA pricing is also applicable to Limited Purpose FSAs and Dependent Care FSAs.**
- **Applicable taxes or assessments are not reflected in the buy-up option pricing.**

Authorized Signature: ______________________

By typing my name I intend for it to serve as my signature, and that I am authorized to sign on behalf of this group.

Title: ______________________

Date: ______________________

0350489-07

Carson City

July 1, 2023

Insurance Coverage Requested:

VSP Vision Plan

Vision Monthly Rates:

Single Employee	$3.85
Employee + Spouse	$7.33
Employee + Child(ren)	$7.71
Employee + Family	$11.34

Rates guaranteed through 6/30/2025.

By signing below, Carson City agrees to the above plan and rates.

____
Signature of Authorized Representative

____
Title of Authorized Representative

____
Printed Name

Anthem

Proposed fully insured benefit rates

CARSON CITY

Final Rate Sheet

Group Number: L03291

Effective July 1, 2023 through June 30, 2024

Quote highlights

Funding type: Fully Insured

Commission level : $0.00 PCPM

Selected Plan

Medical plans include mandatory 2023 ABC changes.

Renewal Plan Designs

	BlueSecure PPO 7 $40/$2500/80% ($15/$40/$60/20% to $500, Tiered) Embedded Essential	Health Savings Account HSA Compatible PPO Plan 22AE $3000/100 ($15/$45/$75/30% to $500) Embedded Essential
	PPO	PPO
	Custom	Custom
Benefits		
Deductible (individual/family)	$2,500 / $4,500	$3,000 / $6,000
Coinsurance	20%	0%
Out-of-pocket maximum (individual/family)	$6,500 / $12,000	$4,000 / $8,000
Office visit (primary care physician/specialist) copay	$40/$60	Ded & Coins/Ded & Coins
Emergency room/urgent care copay	$150/$50	Ded & Coins/Ded & Coins
Prescription drugs – retail	$15/$40/$60/20% to $500	Med Ded $15/$45/$75/30% to $500
Prescription drugs – mail order	$37.50/$120/$180	$38/$135/$225
Commission (PCPM)	$0.00	$0.00

Monthly Rates, Assumed Enrollment and Total Premium

Total	Employees	Current rates	Renewal rates	Employees	Current rates	Renewal rates
Employee	262	$607.97	***$620.13***	129	$412.68	***$420.93***
Employee + Spouse	76	$1,246.50	***$1,271.43***	27	$846.10	***$863.02***
Employee + Children	67	$1,166.49	***$1,189.82***	53	$791.79	***$807.63***
Employee + Family	84	$1,905.10	***$1,943.20***	73	$1,293.15	***$1,319.01***
Total Employees/Monthly Premium	489	$492,205	***$502,049***	282	$212,445	***$216,694***
Annual Premium		$5,905,464	***$6,024,594***		$2,549,343	***$2,600,324***
Premium Action			***2.00%***			***2.00%***

	Current Premium	Renewal Premium
Overall Total Annual Premium	$ 8,455,807	***$ 8,624,917***
Overall Premium Action		***2.00%***

Authorized Signature: ______________________

By typing my name I intend for it to serve as my signature, and that I am authorized to sign on behalf of this group.

Title: ______________________

Date: ______________________

Anthem Blue Cross and Blue Shield is the trade name of Rocky Mountain Hospital and Medical Service, Inc. HMO products underwritten by HMO Colorado, Inc., dba HMO Nevada. Independent licensees of the Blue Cross and Blue Shield Association. ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. - 0350489-07

Carson City

Rates Effective 7/1/23 - 6/30/24

Medicare Rate Calculation

Revised Final Rate Sheet

Medicare rates available to those members with both Part A & B of Medicare.

Benefit:	**Custom BS 7 $2,500**
Single	$620.13
E+SP	$1,271.43
E+Chld(n)	$1,189.82
Family	$1,943.20

	Post 65 Rates	
Description	**Current**	**Renewal**
EE rate	**$442.06**	**$450.90**
EE+ Sp	**$938.26**	**$957.03**
EE + Child	**$1,144.51**	**$1,167.40**
EE + Children	**$1,144.51**	**$1,167.40**
EE + Spouse (Spouse not medicare elig)	**$1,108.84**	**$1,131.02**
EE+ Family (both EE and Sp med elig)	**$1,143.50**	**$1,166.37**
EE+ Family (Spouse not Medicare elig)	**$1,329.33**	**$1,355.92**

Authorized Signature ___________________________

Title ___________________________

Date ___________________________

Carson City

Rates Effective 7/1/23 - 6/30/24

Medicare Rate Calculation

Revised Final Rate Sheet

Medicare rates available to those members with both Part A & B of Medicare.

Benefit:	**Custom H.S.A. 22AE**
Single	$420.93
E+SP	$863.02
E+Chld(n)	$807.63
Family	$1,319.01

	Post 65 Rates	
Description	**Current**	**Renewal**
EE rate	**$306.29**	**$312.42**
EE+ Sp	**$650.11**	**$663.11**
EE + Child	**$793.04**	**$808.90**
EE + Children	**$793.04**	**$808.90**
EE + Spouse (Spouse not medicare elig)	**$768.27**	**$783.64**
EE+ Family (both EE and Sp med elig)	**$792.29**	**$808.14**
EE+ Family (Spouse not Medicare elig)	**$921.13**	**$939.55**

Authorized Signature ____________________________

Title ____________________________

Date ____________________________