Teachers
HEALTH TRUST
For Teachers. By Teachers.

2024-2025

Benefits Guide

LEARN ABOUT AND NAVIGATE YOUR HEALTH BENEFITS YEAR-ROUND

Get In Touch:

(702) 794-0272
www.ththealth.org
Monday - Friday
8am - 5pm

For Benefits Effective October 1,2024
Through September 30, 2025

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Or, skip the guide and go right to the website! We include the same information and more at ththealth.org.

Eligibility

You are eligible for benefits on the first day of the month following your date of hire* if you are any of the following:

Eligible Employees

- Licensed Clark County School District (CCSD) employees on the teacher's salary schedule who are eligible to be represented by the Clark County Education Association (CCEA). **Note: July new hires are not eligible for health benefits until September 1.*
- Licensed employees teaching at participating charter schools.
- Employees of CCEA or Teachers Health Trust.
- Active community representatives serving as Trustees on the Teachers Health Trust Board.

Eligible Retirees

- Are under 65 years of age.
- Retire from active CCSD employment aged 52 or older on the day of retirement.
- Have been continuously enrolled in a THT medical plan for at least 5 consecutive years prior to retirement.
- Be continuously employed as a CCSD licensed employee since Spring 2014 or earlier (if your employment began after Spring of 2014, you are not eligible for retiree benefits).
- Are eligible for Public Employees' Retirement System (PERS) at the time of retirement.
- Must enroll (or be eligible to postpone enrollment) in the Teachers Health Trust Retiree Plan within 31 calendar days of their loss of active employee coverage.

Eligible Dependents & Required Documents

Teachers Health Trust (THT) requires supporting documentation to establish a dependent's eligibility for coverage. THT has the right to request documentation as often as deemed necessary. Failure to provide requested documentation or respond to the Eligibility & Enrollment department within 31 days of enrolling may result in penalty fees or the dependent's coverage being removed or denied.

Social Security numbers must be provided at the time of enrollment for all family members the employee would like enrolled in THT coverage. Please ensure that all documents from other languages are kindly translated into English.

- **Spouse**: Copy of certified marriage certificate or most recent tax return with a signed affidavit.
- **Registered Domestic Partner**: Copy of a certificate of state registered domestic partnership.
- **Children/Stepchildren up to age 26**: Copy of certified birth certificate which includes one or both of the parents' names, issued by either the state or country of birth. Hospital-issued birth certificates are not accepted. If the dependent is the child of your spouse or domestic partner, you must submit your marriage certificate or registered domestic partnership certificate, respectively.
- **Adopted Children up to age 26**: Copy of legal adoption papers or placement for adoption (signed by a judge), followed by final adoption papers within 60 days of issuance.
- **Children over 26 with a disability**: Certification of Disabled Dependent Child Form (completed by primary participant and child's physician).

Need to make a change? To learn more about making changes to your plan outside of your new hire/retiree or open enrollment period, refer to page 6 or ththealth.org/enrollment.

Read more about the eligibility & enrollment: ththealth.org/enrollment

Annual Open Enrollment

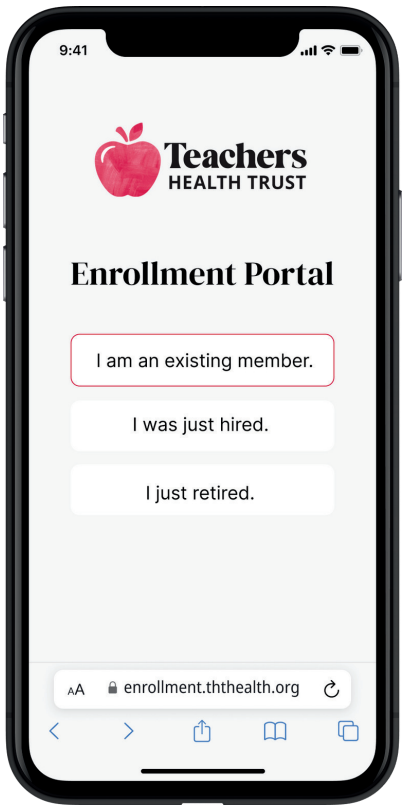
THT holds its annual open enrollment in August. Read about your options carefully before enrolling. After your enrollment period ends, you will not be able change your benefit elections until the next open enrollment period unless you experience a Qualifying Life Event.

2024 Open Enrollment: August 1 - August 25

Enrolling is Easy on Desktop and Mobile!

1. **Enroll online on at enrollment.thhealth.org**
2. **Select the appropriate member type**
3. **Verify your identity and update your info**
4. **Select your plans and add / remove dependents**
5. **Double check your selections and submit**

Upon submitting your selections, you will immediately receive an enrollment summary to the email address on file. Once processed, you will receive a separate confirmation email. Please retain these files for your records and contact us immediately if you have any concerns.



When do my Open Enrollment selections go into effect?

The elections you make during annual Open Enrollment become effective October 1, as long as all enrollment requirements are completed on time. If you are a summer new hire, your new hire enrollment period may overlap with the annual open enrollment period. Refer to the New Hire Enrollment page for more information.

New Hire Enrollment Period

Teachers Health Trust is the health plan for all educators and licensed professionals of Clark County School District. Unlike other employers, whose health benefits are through the HR department, we are your source for any questions/concerns related to your health benefits.

What Benefits Are Available to Me?

- **Medical / Pharmacy** – Signature, Advantage (High-Deductible Plan), Spousal / Domestic Partner Supplement Plan, or Hospital Supplement Plan
- **Dental** – Cigna PPO or Cigna HMO
- **Vision** – VSP Standard Vision or VSP Vision Plus
- **Life** – $50,000 Term Life Benefit
- **Employee Assistance Program** – Additional Behavioral Health Services
- **Wellness & Weight Loss Programs**

Enroll or "Opt Out" within 31 Days of Starting Work

- You can enroll beginning on your first day using the THT enrollment portal to make your selections (or opt out) and designate your life insurance beneficiary(s).
- Failure to enroll or opt-out within 31 days of your hire date will result in your auto enrollment with the following selections: Signature medical plan, Dental HMO, Standard Vision, Employee only / No dependents at $15 per paycheck.
- After your enrollment period, you will be unable to make changes until the next Open Enrollment Period or you experience a qualifying life event.

Which Dependents Are Eligible?

- **Your Spouse or Domestic Partner** (marriage certificate or Domestic Partnership Certificate required)
  - If your spouse or domestic partner also works for CCSD, contact our office to see if you are eligible for a discounted premium!
- **Your Children/Stepchildren up to age 26**, regardless of student, marital, or tax-dependent status (certified birth certificate or adoption papers required).
- **Your Children over age 26 with a disability.**

When Can I Make Future Changes?

- After your initial new hire enrollment, you can make any changes during our Annual Open Enrollment (typically in August) to take effect the following October 1.
- Our plan year begins October 1 and ends September 30. (Your benefit selections will carry over automatically unless you change them; however, your premium may change.)

When Do My Benefits Start?

- **Summer New Hires** (Hired in July/August): Your health benefits will begin on September 1.
- **All Other New Hires**: Your health benefits will begin on the 1st of the following month.

Need More Info or Extra Help?

Visit Our Website: ththealth.org

- Learn more about your benefits options.
- Read step-by-step enrollment instructions.
- Register for a New Hire Benefits Webinar.
- Schedule a call with a THT representative.

Call us: (702) 794-0272. Our team is available Monday-Friday, 8am-5pm.

Ready to Enroll?

Enroll at: enrollment.ththealth.org

Yes, you can enroll from your phone!

Have your dependent documents ready to scan, photograph, or upload.

Enrollment Policies

Auto-Enrollment

If you are newly hired and don't make a health benefits selection or waive them within 31 days of your hire date, you will be automatically enrolled in the Medical Signature plan, Dental HMO plan, and the Vision Standard plan. If you are an existing member and do not go through the annual open enrollment period, your selections will carry over, however, your premium will be updated to the current rate.

Dual District (Married Employees)

THT offers reduced premiums when two active, benefits-eligible, licensed employees from CCSD, participating Charter schools, CCEA, or THT combine health plans. One employee must be designated as the primary policyholder; the other becomes a dependent, enabling both to benefit from the reduced premium. CCSD school administrators, support staff, and police cannot serve as the primary policyholder.

To enroll, complete the Dual District Employees Enrollment Form available at ththealth.org/enrollment. The primary policyholder should then submit the form via the THT Member Portal.

Making Changes Mid-Year

Due to IRS regulations, you can only change your benefits during the annual open enrollment period and when you experience a Qualified Life Event (QLE). Election changes must be completed through the THT Member Portal within 31 days of the life event, including uploading any required supporting documentation.

Qualifying Life Events (QLE) include, but are not limited to:

- Marriage, divorce, legal separation, annulment, death of a spouse.
- Establishing or ending a domestic partnership.
- Birth*, adoption, placement for adoption, legal guardianship, change in legal custody.
- Loss of other group health coverage.
- Change in your spouse's work status that affects his or her benefits.
- Change in your child's eligibility for benefits.
- Qualified Medical Child Support Order.

**Please note newborns are not automatically added to your coverage. You must act by the 31st day from the date of birth to enroll your newborn.*

Out-of-Area Benefits

- The primary network you have access to is determined by the ZIP code we have on file.
- If you have a ZIP code listed in Clark County or Nye County, the network with the best benefit available (Tier I benefits) is the Sierra Healthcare Options (SHO) network. You may utilize the United Healthcare Choice (UHC) Plus network, but it will be subject to Tier II benefits (lower benefits and separate, higher deductibles).
- If you or your dependent resides outside of Clark County, you will have access to the UHC Choice Plus network with the Tier I benefits; however, you must notify THT to request this change in your network status. Fill out this form within 10 business days of your address change. The Out-of-Area Eligibility Form is available at ththealth.org/enrollment.
- Note: UHC Choice Plus providers located in Clark County are not covered unless the service is emergent.

Contact Information

It is important to us that you receive the best service possible and have access to the information you need, when you need it. To enhance your experience, we've established your direct connection to the teams responsible for managing the claims and networks related to each of your benefits.

Teachers Health Trust
www.ththealth.org
702-794-0272 (opt 2)
Mon - Fri, 8am - 5pm
Closed major holidays

- Get help with eligibility, enrollment, & premium questions.
- Have THT advocate for you if you have an issues resolving your concerns with the teams below.

Medical
www.umr.com
1-855-6860
Full service, 24/7
Closed major holidays

- Get help with claims, benefits, or finding a provider.
- Access appointment scheduling assistance.
- Use the UMR portal to access digital ID cards & EOBs.

Behavioral Health
www.bhoptions.com
1-800-878-6266
Mon - Fri, 8am - 5pm
Closed major holidays

- Get help with finding an in-network provider.
- Access free concierge appointment assistance.

Dental
www.cigna.com
1-800-244-6226
Full service, 24/7
Open major holidays

- Get help with claims, benefits, or finding a provider.
- Use the Cigna portal to access digital ID cards &EOBs.

Pharmacy
www.cerpassrx.com
1-844-622-1797
Full service, 24/7
Limited service on major holidays

- Get help with claims, benefits, or finding a pharmacy.
- Use the CerpassRx portal to access EOBs, manage prescriptions, and see which medications are covered.

Vision
www.vsp.com
1-800-877-7195
Mon - Sat, 6am - 5pm
Closed major holidays

- Get help with claims, benefits, or finding a provider.
- Use the VSP portal to access EOBs and digital ID cards.

Why does THT have so many different partners?

One of the benefits of a self-funded plan is the ability to customize the plan design. Since THT is self-funded, we regularly conduct market checks and partner with the organizations that provide the best value for you. We believe in finding partners that specialize in one area, rather than accepting a “one-plan-fits-all” approach. With these partnerships, you have access to larger networks and dedicated service teams for each area of your benefits.

Signature Plan | SUMMARY OF BENEFITS

MEDICAL	In-Area Network	Out-of-Area Network
PLAN YEAR DEDUCTIBLE Individual/Family	$500/$1,500	$1,500/$4,500
OUT-OF-POCKET MAXIMUM Medical & Pharmacy combined Includes deductible, copays, and coinsurance	$7,500/$15,000	$9,200/$18,400
PREVENTIVE CARE	Plan pays 100%	Plan pays 100%
PHYSICIAN SERVICES Primary Care Physician Behavioral Health Office Visits Physical Therapy Telehealth Specialist Urgent Care/CVS Minute Clinic In-Home Urgent Care	 $15 copay $10 copay $10 copay Plan pays 100% $30 copay $30 copay $0 copay	 50% after deductible 50% after deductible 50% after deductible 50% after deductible 50% after deductible $30 copay 50% after deductible
QUEST DIAGNOSTICS Outpatient Clinical Lab Hospital Owned Lab All other lab facilities	 $0 copay 20% after deductible No benefit [1]	 Not Applicable 50% after deductible 50% after deductible
STEINBERG DIAGNOSTIC Diagnostic X-Ray Imaging High Tech Services (CT, MRI, PET) All other imaging facilities	 $0 copay $0 copay No benefit [2]	 Not Applicable Not Applicable 20% after deductible
HOSPITAL SERVICES Inpatient Outpatient	 20% after deductible 20% after deductible	 50% after deductible 50% after deductible
EMERGENCY ROOM [3]	$300 copay for first visit after deductible $750 copay for subsequent visits after deductible	$300 copay for first visit after deductible $750 copay for subsequent visits after deductible

(1) Services not available at Quest Diagnostics will have a $0 copay. (2) Services not available at Steinberg Diagnostics will be 20% after deductible. (3) Copay is waived if admitted to the hospital. Out-of-Network emergency room care is covered as in-area network. Professional provider services (emergency-related or non-emergency) are 20% after deductible.

PHARMACY	Home Delivery Service	Retail Network Pharmacy CVS, Walmart, Sam's Club, Smith's[2]
Tier 1 — Generic	$15 copay per 34-day supply[3] $40 copay per 35+ day supply[3]	
Tier 2 — Preferred Formulary Brand	25% of the cost, copay max of $100 per 34-day supply 25% of the cost, copay max of $300 per 35+ day supply	
Tier 3 — Non-Preferred Formulary Brand	40% of the cost 40% of the cost	
Formulary Diabetic Supplies	$0 copay (includes syringes needles, lancets, and test strips; limited to a quantity of 200 per 30-day supply)	
	Specialty Drugs[4] (Up to a 30-day supply)	
Tier 1 — Generic	25% of the cost, up to $500 max copay	
Tier 2 — Preferred Formulary Brand	25% of the cost, up to $500 max copay	
Tier 3 — Non-Preferred Brand	40% of the cost	

(1) Select products are eligible for a coinsurance assistance program. There is no copay for these products and they do not accumulate toward the out-of-pocket maximum. For more information contact THT at 702-794-0272, Option 1. (2) Prescriptions filled at pharmacies other than THT's Exclusive Network Retail Pharmacies will incur a $10 per prescription choice fee in addition to applicable copays. The pharmacy choice fee does not accumulate toward your out-of-pocket maximum. (3) If the generic cost of the medication is less than the copay, the individual will be responsible for that lesser amount. (4) For more information about this service, please contact CerpassRX at 844-622-1797.

Advantage Plan | SUMMARY OF BENEFITS

MEDICAL	In-Area Network	Out-of-Area Network
PLAN YEAR DEDUCTIBLE Individual/Family	$1,650/$3,300	$3,300/$6,600
OUT-OF-POCKET MAXIMUM Medical & Pharmacy combined Includes deductible, copays, and coinsurance	$7,500/$15,000	$9,200/$18,400
PREVENTIVE CARE	Plan pays 100%	Plan pays 100%
PHYSICIAN SERVICES		
Primary Care Physician	20% after deductible	50% after deductible
Behavioral Health Office Visits	20% after deductible	50% after deductible
Telehealth	20% after deductible	50% after deductible
Specialist	20% after deductible	50% after deductible
Urgent Care	20% after deductible	20% after deductible
CVS Minute Clinic	20% after deductible	20% after deductible
LABWORK		
Outpatient Clinical Lab	20% after deductible	50% after deductible
Hospital Owned Lab	20% after deductible	50% after deductible
All other lab facilities	20% after deductible	50% after deductible
DIAGNOSTIC IMAGING		
Diagnostic X-Ray Imaging	20% after deductible	50% after deductible
High Tech Services (CT, MRI, PET)	20% after deductible	50% after deductible
All other imaging facilities	20% after deductible	50% after deductible
HOSPITAL SERVICES		
Inpatient	20% after deductible	50% after deductible
Outpatient	20% after deductible	50% after deductible
EMERGENCY ROOM	20% after deductible	20% after deductible

PHARMACY	Home Delivery Service	Retail Network Pharmacy CVS, Walmart, Sam's Club, Smith's[2]
Tier 1 — Generic	$15 copay after deductible per 34-day supply[3] $40 copay after deductible per 35+ day supply[3]	
Tier 2 — Preferred Formulary Brand	25% of the cost after deductible, copay max of $100 per 34-day supply 25% of the cost after deductible, copay max of $300 per 35+ day supply	
Tier 3 — Non-Preferred Formulary Brand	40% of the cost after deductible 40% of the cost after deductible	
Formulary Diabetic Supplies	$0 copay after deductible (includes syringes needles, lancets, and test strips; limited to a quantity of 200 per 30-day supply)	
	Specialty Drugs[4] (Up to a 30-day supply)	
Tier 1 — Generic	25% of the cost after deductible, up to $500 max copay	
Tier 2 — Preferred Formulary Brand	25% of the cost after deductible, up to $500 max copay	
Tier 3 — Non-Preferred Brand	40% of the cost after deductible	

(1) Select products are eligible for a coinsurance assistance program. There is no copay for these products and they do not accumulate toward the out-of-pocket maximum. For more information contact THT at 702-794-0272. (2) Prescriptions filled at pharmacies other than THT's Exclusive Network Retail Pharmacies will incur a $10 per prescription choice fee in addition to applicable copays. The pharmacy choice fee does not accumulate toward your out-of-pocket maximum. (3) If the generic cost of the medication is less than the copay, the individual will be responsible for that lesser amount. (4) For more information about this service, please contact CerpassRx at 844-622-1797.

Premiums

Full-Time Licensed Employees | Deducted from 24 payrolls, annually.

Coverage Level	Signature Plan	Advantage Plan	Dental (DHMO / DPPO)	Vision (Standard / Plus)
Subscriber Only*	$15	$7.50	+$0 / +$4.50	+$0 / +$6.50
Subscriber + 1*	$125	$115	+$0 / +$9	+$0 / +$12.50
Subscriber + 2-4*	$368	$247.50	+$0 / +$15	+$0 / +$21.50
Subscriber + 5 or more*	$460.50	$252.50	+$0 / +$15	+$0 / +$21.50
Two Licensed Employees (Couple)^	$0	$0	+$0 / +$9	+$0 / +$12.50
Two Licensed Employees + 1-3^	$61.50	$61.50	+$0 / +$15	+$0 / +$21.50
Two Licensed Employees + 4 or more^	$107.50	$107.50	+$0 / +$15	+$0 / +$21.50

***If you are a Shared Contract Employee:** add $212.08 to Full-time licensed employees per-paycheck rate.

^If one partner and/or the other is not a Full-Time Licensed Employee, find the appropriate combination to the right & add the amount shown to the Dual District rate.

- Licensed & Administrator: + **$0**
- Licensed & Support: + **$17.71**
- Licensed & Police: + **$37.15**
- Licensed & Shared Contract: + **$212.08**
- Shared Contract & Administrator: + **$212.08**
- Shared Contract & Support: + **$229.79**
- Shared Contract & Police: + **$249.23**
- Shared Contract & Shared Contract: + **$424.16**

Use our interactive premium calculator!

ththealth.org/premiums

COBRA Premiums | 12 payments, annually.

Coverage Level	Signature Plan	Advantage Plan	Dental (DHMO / DPPO)	Vision (Standard / Plus)
Subscriber Only*	$784.07	$768.35	+$0 / +$10.83	+$0 / +$13.26
Subscriber + 1*	$1,267.16	$1,246.20	+$0 / +$20	+$0 / +$25.50
Subscriber + 2-4*	$1,736.52	$1,483.95	+$0 / +$35.03	+$0 / +$46.86
Subscriber + 5 or more*	$1,908.85	$1,509.80	+$0 / +$35.03	+$0 / +$46.86

Retiree Premiums

As a retiree, your medical premium is partially subsidized based on your years of service as an active CCSD teacher and the number of unused sick days you had when you retired. Please visit ththealth.org/retirees for more information on retiree plans and premiums.

Which Plan is Right for Me?

The Signature and Advantage Plans have a few things in common.

- **SAME PROVIDER NETWORKS:** Both plans have access to the same provider networks: the Sierra Health-care Options (SHO) Network for local providers, and the UHC Choice Plus Network for members that travel or reside outside of Clark County.
- **TELEHEALTH & PREVENTIVE CARE:** Both plans cover telehealth & preventive care at 100%.
- **NO PROVIDER REFERRALS OR REGISTRATIONS:** Neither plan requires referrals or that you select a primary care provider (PCP).

Signature

PREDICTABLE COSTS
This plan features fixed copayments at the time of service, allowing members to better budget for healthcare expenses.

HIGHER PREMIUMS
Premiums for this plan are higher than the Advantage plan due to having a lower deductible and broader coverage outside of preventive care.

FLEXIBLE SAVINGS ACCOUNT (FSA)
Members of this plan are eligible to open a Flexible Savings Account (FSA), which allows contributing pre-tax money to pay for eligible healthcare costs.

Advantage

HIGHER OUT-OF-POCKET COSTS
Members of this plan must pay for all services until they meet their deductible (except for preventive care).

LOWER PREMIUMS
Premiums for this plan are lower than the Signature plan. For members who seldom use medical services, this plan can result in overall cost savings.

HEALTH SAVINGS ACCOUNT (HSA)
Members can contribute pre-tax money to an HSA to pay for medical expenses, including the deductible, and also benefit from tax advantages.

Read more about the medical plans and benefits: ththealth.org/medical

Pharmacy Information

Exclusive Pharmacies

Fill your prescriptions at any of these pharmacies. To find a location, click on any of the logos below. Prescriptions filled at pharmacies other than THT's Exclusive Network Retail Pharmacies will incur a $10 per prescription choice fee in addition to applicable copays. The pharmacy choice fee does not accumulate toward your out-of-pocket maximum.

Covered Medications

The list of all the medications covered is called the formulary. CerpassRx manages THT's formulary and recommends updates every six months as new medications appear on the market. Use the online formulary to determine which medications are covered and at what tier. **For all non-covered medications, a list of covered alternatives is available.** Consult with your provider to see if these covered alternatives may be right for you.

Generic vs. Brand Medications

You won't find many differences, except for names and prices. The manufacturer assigns a brand name, while a generic drug uses the chemical name; both products have the same active ingredients, strength and dosage form, such as liquid or pill.

Prior Authorizations

Prior Authorization encourages safe, cost-effective medication use by allowing coverage when certain conditions are met. Prior Authorizations in most cases are approved for a specific time period and maybe subject to continuous evaluation. Your doctor can request a Prior Authorization form from CerpassRx by calling the toll-free number (844) 622-1797 to have a form sent by electronic fax. The member and prescriber will receive a letter confirmation of the outcome. If approved, the CerpassRx team will reach out to your pharmacy for reprocessing.

High Cost Medications

THT offers options to lower cost of eligible medications. First, select specialty medications are available with a $0 copay after completing an online questionnaire and a virtual consultation. All other high-cost medications (exceeding $1,000 for a 30-day supply or $2,000 for a 90-day supply) require prior authorization from CerpassRx and routing through the Pharmacy Optimization Program (POP). Prescriptions for high-cost medications are denied unless they are routed through the Pharmacy Optimization Program. If your medication rejects at the pharmacy, we encourage you to call CerpassRx for 24/7 assistance.

Read more about the pharmacy benefits: ththealth.org/pharmacy

Tax-Free Savings Accounts for Healthcare Expenses

Employees enrolled in Signature or a Supplement plan are eligible for a Flexible Savings Account (FSA).

A **Flexible Savings Account (FSA)** is an employer account that allows employees to make pre-tax contributions and reimburse themselves for eligible medical expenses.

Eligible Expenses: FSAs can be used for a variety of medical, dental, and vision expenses as determined by the IRS. This can include deductibles, copayments, prescription medications, and even some over-the-counter products. Please save your receipts and other supporting documentation.

Unused Funds: Depending on your employer's plan, some FSAs allow you to roll over a certain amount of unused funds to the next year.

Employees enrolled in Advantage are eligible for a Health Savings Account (HSA).

A **Healthcare Savings Account (HSA)** is a tax-free, employee-owned savings account meant for covering eligible medical expenses. For the 2024 tax year, individual plans can contribute up to $4,150, and family plans up to $8,300 pre-tax.

Using Your Account: HSA funds should primarily be used for medical expenses but can also cover non-medical expenses. However, using HSA funds for non-medical purposes incurs income tax and a 20% penalty, unless the account holder is 65 or older.

Unused Funds: Unused funds can roll over to the following plan year, with the account potentially earning interest. When the account reaches $2,500, it can be invested in various options.

Contact **American Fidelity** for more information and to open your FSA or HSA at **702-433-5333** or email: **AFES-LasVegas@americanfidelity.com**

Already Have Insurance?

Our supplemental plans enhance your coverage at no extra cost!

If you want to keep your current covered under your spouse's or another plan, our two supplemental plans provide **additional benefits at no extra cost to you.** Supplemental plans are designed to complement your existing health coverage by reimbursing eligible expenses. They are not standalone medical plans or secondary insurance plans, but rather direct reimbursements from THT. Members on these plans can opt out of or select a dental and/or vision plan (additional premium may apply).

Spousal Supplement Plan

THT reimburses all in-network copays, deductibles, and coinsurances for eligible employees covered as dependents on their partner's plan.

Eligibility: All active/suspended employees and COBRA participants (including their dependents) covered as dependents on their partner's insurance (excluding THT or CCSD plans) are eligible. Retirees are not eligible.

Medical Reimbursement Process

1. On your first reimbursement request, submit a copy of the primary's medical ID card.
2. Submit receipt and EOBs in the THT Member Portal message center. Documents must be uploaded within 180 days of the issued date on the EOB.
3. THT will verify and send reimbursement for all in-network copays, coinsurances, and deductibles within 60 days.

Pharmacy Process

You will receive a coordination of benefits card from Teachers Health Trust. Give this card and your primary insurance card to the pharmacy. Your copays for any prescriptions on your primary plan's formulary will be paid by THT.

Hospital Supplement Plan

THT reimburses up to $260 for each day of overnight hospitalization or observation period incurring room and board charges, with a lifetime maximum of 365 days.

Eligibility: All active/suspended employees and COBRA participants are eligible. Dependents and retirees are not eligible.

Hospital Reimbursement process

1. Send itemized hospital bill/EOB & receipt to THT within 12 months of discharge date via the Member Portal message center.
2. THT will verify & send eligible reimbursements within 7-10 business days.

How can I enroll?

If you're not currently covered on your partner's plan, select either supplement plan during Open Enrollment and we will send you necessary documents so that you can enroll with your partner's plan with no gap in coverage. You must enroll with your partner's plan within 30 days of your THT coverage terminating.

Premiums

Employee Type	Spousal	Hospital	Optional Dental	Optional Vision
Active / Suspended Employee	$0	$0	*Waive Dental or select DHMO for $0. Refer to page 7 for DPPO rates.*	*Waive Vision or select Standard for $0. Refer to page 7 for Plus rates.*
COBRA (monthly)	$752	$752		

Preventive Care & Other Programs

Preventive care is covered at 100% for Advantage and Signature plan members when performed by an in-network provider.* Preventive care services vary by age and gender, so we encourage speaking with your provider to determine which are recommended for you and your family. For more information, please call (702) 794-0272 and follow the prompts for UMR medical benefits or visit healthcare.gov/coverage/preventive-care-benefits/.

Annual Preventive Services Covered at 100%

- Physical examinations
- Pelvic examinations and pap smears
- Hearing and vision screenings
- Mammograms
- Cardiovascular screening blood tests
- Colorectal cancer screening tests (Cologuard is currently excluded for Signature members. If opting for a non-invasive screening, Signature members must use Quest to receive the $0 benefit.)
- Vaccinations and immunizations recommended by your physician
- BRCA1 and BRCA2 when medically indicated
- Prostate cancer screening (digital rectal examination)
- Nutritional Counseling

***Note on exclusive providers:** Signature Plan members in Clark County must utilize Quest Diagnostics and Steinberg Diagnostic Medical Imaging for labwork and imaging, respectively, to receive the $0 copay benefit. Any costs incurred by lab work or imaging services performed by providers other than these partners will be the member's full responsibility, even if the services are preventive.*

Health Education & Wellness Programs

We offer health education and wellness programs at no cost to you and your family designed to support and educate our subscribers and their dependents on reducing the risks when managing or preventing chronic diseases. We encourage you to enroll by calling 702-877-5356 or 800-720-7253 (toll free).

- Pre-diabetes
- Diabetes Type 1 & 2
- Heart health
- Kidney health
- Tobacco cessation
- Weight management
- Asthma
- Nutrition

Health Improvement Benefit

THT provides a Health Improvement Benefit to employees enrolled in either medical plan or supplement plans. This benefit covers up to $50 per plan year for specified health improvement programs and activities:

- Health club memberships
- Personal Training
- Tobacco prevention counseling and education
- Weight management support groups

Claims and itemized receipts must be submitted within six (6) months of receipt date. To download the form, visit ththealth.org/forms. The Health Improvement Benefit is not available to dependents unless the dependent is also a benefit eligible employee.

Labwork and Imaging

Quest Diagnostics

For Signature members in Clark and Nye County, Quest Diagnostics is our exclusive partner for lab services. Signature Plan members have a $0 copay for covered lab services provided by Quest Diagnostics.

Please ensure your provider only sends your labs to Quest. Any costs incurred by lab work performed by providers other than Quest will be the member's full responsibility.

Out-of-Area Signature & Advantage Members: Members pay 20% coinsurance (deductible applies for Advantage members) at in-network labs, other than preventive services which are covered at 100%.

Labwork:
Quest Diagnostics
www.questdiagnostics.com

Covered Laboratory Tests (with a referral from your provider):

The following laboratory tests are covered at 100% when ordered by your provider.

- CBC (Complete Blood Count with Differential)
- CMP (Comprehensive Metabolic Panel)
- Lipid panel (Cholesterol/LDL/HDL/Triglycerides)
- TSH (Highly Sensitive Thyroid -Stimulating. Hormone)

The following screenings are allowed one time per year for high-risk individuals:

- Hepatitis B screening
- Hepatitis C screening
- HIV screening
- Syphilis screening

Steinberg Diagnostic Medical Imaging (SDMI)

For Signature members in Clark and Nye County, Steinberg Diagnostic Medical Imaging is our exclusive provider for all imaging services. Signature Plan members have a $0 copay for covered imaging services provided by SDMI.

Out-of-Area Signature & Advantage Members: Members pay 20% coinsurance (deductible applies for Advantage members) at in-network imaging facilities, other than preventive services which are covered at 100%.

Imaging:
Steinberg Medical Diagnostic Imaging
www.sdmi-lv.com

Covered Imaging Services (with a referral from your provider):

- Mammogram: 3D Mammography, Breast Biopsy (including Stereotactic Breast Bx), Breast MRI, Breast Ultrasound
- Fetal MRI, OB Ultrasound
- Dexa Scan
- Fluoroscopy
- LDCT: Screenings for high-risk seniors for lung cancer
- Interventional Radiology:
  - Includes placing chest & arm ports, drainage catheters, needle biopsy/bone biopsy
  - Vertebroplasty & Kyphoplasty (treats compression fractures)
  - IVC Filter placements & removals (prevents blood clots from traveling to heart and lungs)
  - Nephrology image guided procedures
- MRI
- CT
- PET Scan
- Nuclear Medicine
- X-Ray
- Ultrasounds

Seeking Medical Care

When you're feeling under the weather, it can be stressful to choose the right care at the right time. If you are experiencing a true medical emergency, please call 911 or head to the nearest emergency room.

24/7 Nurse Line - (866) 232-4490

$0 copay for Signature and Advantage members.
Call our registered nurse line, free of charge, for medical advice or guidance on if/where to seek medical care.

Find a Provider or Facility

Click the red "Need Care?" button at ththealth.org or call 855-858-6860 any time.

TeleHealth

Signature: $0 copay. Advantage: 20% after deductible.
In addition to virtual urgent care, MDLive offers talk therapy, psychiatry, primary care, and dermatology. Learn more on mdlive.com and download the app to get started.

MDLIVE

Get it On Google Play | Download on the App Store

"Health Investment" Providers

Signature: $0 copay for covered services. Advantage: $0 copay for covered services after deductible.
THT partners with providers dedicated to our teachers' health and well-being, including primary care, specialists, and behavioral health (pediatrics included). They offer expedited appointments for THT members. View the growing provider list at ththealth.org/health-investment.

Primary Care & Specialists

Signature: $10 copay for sick visits, $30 copay for specialist visits. Advantage: 20% after deductible.
Having an established provider allows you the possibility to see a provider within a smaller window of time for any of your acute illnesses. It is recommended for everyone to have a preventative care visit yearly.

Traditional Urgent Care

Signature: $30 copay. Advantage: 20% after deductible.
In-network urgent care facilities provide cost-effective care for most non-life-threatening conditions. Ensure the building's exterior displays "Urgent". If it shows "Emergency", it is likely subject to higher costs.

- **24/7 Urgent Care**: located in the Southwest Medical building at 888 S Rancho Dr, Las Vegas, NV 89106 (Rancho & Charleston) 702-877-5199
- **Orthopedic Urgent Care:** Nevada Orthopedic and Spine Center's Fast Track Clinics treat bone, joint, or muscle injury that occurred in the past few days.

In-Home Urgent Care

Signature: $0 copay. Advantage: $0 copay after deductible. Urgent care that comes right to your home! Same day or next day appointments are available 365 days a year.

DispatchHealth
(702) 329-2093
dispatchhealth.com

Doctoroo
(888) 888-9930
doctoroo.com

IncrediCare Pediatrics
(725) 867-8144
incredicarepediatrics.com

Emergency Room

Signature: 20% of the doctor bill plus copay ($300 copay for first visit, $750 copay for subsequent visits). Advantage: 20% of all bills after deductible.
For life-threatening conditions such as heart attacks, strokes, and accidents, the emergency room can be a lifesaver. Most other less-threatening conditions, however, can be treated quicker and cheaper through other mediums of care. Emergency rooms accept THT, but your costs will be much higher than other modes of care. In 2023, THT members saved an average of $620 out-of-pocket by choosing an urgent care over an emergency room.

Behavioral Health Resources

Seeking behavioral health is just as essential as seeing a provider when you don't feel well. You can utilize mental health for short-term struggles or long-term needs.

Teletherapy

Signature: $0 copay. Advantage: 20% after deductible. MDLive offers traditional therapy and psychiatry via phone call or video call. This is available at no cost for all Signature and Advantage plan members. Simply download the MDLive app or visit mdlive.com to get started.

MDLIVE

Get it On Google Play | Download on the App Store

CCSD Employee Assistance Program (EAP)

Free Behavioral Health Visits (virtual or in-person).
CCSD employees and their family/household members each have a total of 5 free visits per year, even if they are not enrolled dependents on your THT plan. The 5 available visits reset each year on January 1. Open an EAP case by calling (702) 243-4682 or visiting bhoptions.eapintake.com (select "SHO" as the insurance type). After opening your case, you can speak with a trained specialist, and get connected with a local provider that specializes in your needs. The specialist can also schedule your first appointment on your behalf.

More resources online!

Visit our website to learn more about EAP & more Behavioral Health Resources.

ththealth.org/resources/behavioralhealth

Traditional Therapy

Signature: $10 copay. Advantage: 20% after deductible.
The Behavioral Health line can help find an in-network provider that specializes in your needs. There is no online provider directory at this time. Call (800) 878-6266 to speak to a trained specialist. This line is available 24/7 and the specialists can schedule appointments on your behalf.

"Health Investment" Providers

Signature: $0 copay for covered services. Advantage: $0 copay for covered services after deductible.
THT partners with providers dedicated to our teachers' health and well-being. Behavioral health providers, including neuropsychological assessment options*, are offering expedited appointments for THT members. View the growing provider list at ththealth.org/health-investment. **Note: neuropsychological assessments incur a $100 copay (Advantage members must meet deductible).*

Free Concierge Appointment Assistance

Teachers Health Trust members looking for behavioral health services have free, exclusive access to the Concierge Assistance Program. When you call (800) 878-6266, the customer service team will obtain your availability and schedule an appointment with a behavioral health provider who meets your needs.

Behavioral Health Care Management

Our compassionate team of case managers, social workers, and care coordinators are here to provide support and assist members with mental health and substance use issues. These complimentary services are available to improve care communication and promote health. To get started or to find out more, email us at BHCM@uhc.com.

Dental Plans

BENEFITS COMPARISON	Dental HMO*	Dental PPO
DEDUCTIBLE Individual/Family	$0 / $0	$0 / $0
MAXIMUM THT PAYS Per person, per year	*unlimited*	*$1,500*
PREVENTIVE CARE Oral Exams Cleanings X-Rays	 THT pays 100% THT pays 100% THT pays 100%	 THT pays 100% THT pays 100% THT pays 100%
BASIC SERVICES Periodontal Services Endodontic Services (Molar / Other) Oral Surgery Fillings	 THT pays 100% THT pays 60% / 100% THT pays 60% THT pays 100%	 THT pays 80% THT pays 80% THT pays 80% THT pays 80%
MAJOR SERVICES Bridges Crowns (inlays / onlays) Dentures (full / partial)	 THT pays 60% THT pays 60% THT pays 60%	 THT pays 60% THT pays 60% THT pays 60%
TMJ APPLIANCE	THT pays 60%, limit 1 per 24 months, no lifetime maximum benefit	THT pays 100%, up to a $500 liftetime maximumt
ORTHODONTIA SERVICES	Plan pays 60%, no maximum or age limit	Plan pays 100% up to $1,000 lifetime maximum, age 18 and under only
SEALANTS	No age limit	18 and under only (1 treatment per tooth per 24 months)
TEETH WHITENING HOME KITS	$165 per arch, 2 Per Year	No Benefit
ACCESS TO PEDIATRIC & ORTHODONTISTS	Yes	Yes
EMERGENCY CARE COVERAGE	Yes	Yes
OUT-OF-NETWORK COVERAGE	No	Yes
REFERRALS REQUIRED FOR SPECIALISTS	Yes	No
MUST SELECT A GENERAL DENTIST	Yes	No

**The comparison above is only a summary and does not account for all possible procedures and billing codes. For more detailed benefit information, refer to the Patient Charge Schedule (PCS) at www.ththealth.org/dental/pcs or call Cigna 24/7 at (800) 564-7642.*

Dental PPO Premiums

The Dental HMO plan is included for all enrolled members at no additional cost. Members who opt for the Dental PPO plan will pay the rates shown to the right according to their family size.

Coverage Level	Active Employee (per paycheck)	COBRA (per month)	Retirees (per month)
Subscriber Only	$4.50	$10.83	$10.32
Subscriber + 1	$9	$20	$19.60
Subscriber + 2 or more	$15	$35.03	$34.35

Did you know?

Over half of the providers that accept DPPO also accept DHMO. You might be able to lower your premiums and out-of-pocket dental costs by switching to the DHMO while keeping your same provider!

Read more about the dental plans and benefits: ththealth.org/dental

Vision Plans

THT offers two vision plans. The Standard Vision plan is included with all medical and supplement plans at no extra cost. The Vision Plus plan has an additional premium and offers richer benefits.

BENEFITS COMPARISON	Standard Vision	Vision Plus
WELLVISION EXAM Once per Plan Year, Including Routine Retinal Screening	$20 copay, up to $39	$10 copay, up to $39
ESSENTIAL MEDICAL EYE CARE EXAMS [1]	*$20*	*$20*
FRAMES FREQUENCY	Every other plan year	Every plan year
IN-NETWORK FRAMES ALLOWANCE [2] Costco Featured Brands All Other Brands	 $70 allowance $150 allowance $130 allowance	 $80 allowance $170 allowance* $150 allowance
LENSES Once per Plan Year. Single Vision, Lined Bifocal, or Lined Trifocal Lenses. Impact-resistant Lenses for Cildren.	$0 copay	$0 copay
LENS ENHANCEMENTS Standard Progressive Lenses Premium Progressive Lenses Custom Progressive Lenses All Other Enhancements	 $0 copay $95 - $105 copay $150- $175 copay Average savings of 30%	 $0 copay $95 - $105 copay* $150- $175 copay* Average savings of 30%*
CONTACT LENS EXAM	Up to $60 copay	Up to $60 copay
CONTACTS ALLOWANCE (Instead of Glasses)	$120 allowance	$150 allowance*

1 Retinal imaging for members with diabetes covered-in-full. Additional exams and services beyond routine care to treat immediate issues from pink eye to sudden changes in vision or to monitor ongoing conditions such as dry eye, diabetic eye disease, glaucoma, and more. Coordination with your medical coverage may apply. Ask your VSP network doctor for details. Available as needed.

2 Coverage with a retail chain may be different or not apply. Receive 20% savings on the amount over your allowance. The savings is based on doctor's retail price and may vary by plan and purchase selection; average savings determined after benefits are applied. Ask your VSP network doctor for more details.

3 Only available to members with applicable plan benefits. Frame brands and promotions are subject to change.

***VSP EASYOPTIONS:** Vision Plus Members can **choose one** of these upgrades each plan year:

- *Increase frame allowance to $250*
- *Fully covered premium or custom progressive lenses*
- *Fully covered light-reactive lenses*
- *Fully covered anti-glare coating*
- *Increase contact lens allowance to $200*

***VSP LIGHTCARE:** *In place of prescription glasses or contacts, receive a $150 allowance for ready-made non-prescription sunglasses, or ready-made non-prescription blue light filtering glasses.*

Additional Savings:

Check out vsp.com/offers for additional savings on additional pairs of glasses / sunglasses, laser vision correction, contact lens rebates, and digital hearing aids.

Read more about the dental plans and benefits: ththealth.org/vision

Vision Plus Premiums

The Standard Vision plan is included for all enrolled members at no additional cost. Members who opt for the Vision Plus plan will pay the rates shown to the right according to their family size.

Coverage Level	Active Employee (per paycheck)	COBRA (per month)	Retirees (per month)
Subscriber Only	$6.50	$13.26	$13
Subscriber + 1	$12.50	$25.50	$25
Subscriber + 2 or more	$21.50	$46.86	$43

Life Insurance

Teachers Health Trust provides basic life insurance to all benefits-eligible employees and enrolled Retirees at no cost through Lincoln Financial Group. View all benefit information at ththealth.org/life.

What is the Benefit?

Active employees have a $50,000 basic life insurance benefit. Retirees have a $10,000 basic life insurance benefit. There are no exclusions or limitations. Benefits are payable no matter the manner or cause of death. If you leave THT, Lincoln Financial Group will mail out a conversion portability packet and you can apply to convert the coverage within 31 days post-termination of active benefits.

What is a Beneficiary?

A life insurance beneficiary is an individual, entity, trustee, or estate named by the policy owner to collect the death benefit proceeds upon the insured's passing. There are two types of beneficiaries:

- Primary beneficiary: The first one in line to collect the death benefit upon the insured's death.
- Contingent beneficiary: Also known as a secondary beneficiary, is the second one in line to collect the benefit if the primary beneficiary is deceased.

Read more about the life insurance & other benefits from Lincoln Financial Group: ththealth.org/life

Designate, View, & Update Your Beneficiaries

Please be sure to keep your beneficiary designations up to date in the THT member portal.

- Log in at members.ththealth.org and select "Life Insurance".
- To update a current beneficiary's contact information, click "Update Contact Information" for the appropriate beneficiary. Make your necessary changes and click "Update".
- To update a current beneficiary's share or add a new beneficiary, click "Update Beneficiaries".
- To add a new beneficiary, reduce the percentage share(s) of the current beneficiaries so the total is less than 100 and click "Add New Beneficiary".
- Enter the name, personal information, address, phone number, and percentage for each beneficiary.
- Click "Submit"
- Click "Save Changes"

File a Claim

If you are a beneficiary and need to file a claim, submit a Death Certificate to Teachers Health Trust via email or mail, or drop it off at our office.

2950 E Rochelle Ave, Las Vegas, NV 89121

connect@ththealth.org

Additional Benefits | FROM LINCOLN FINANCIAL GROUP

For Beneficiaries:

- **FuneralPrep** offers online resources for both at-need and pre-planning funeral arrangements, reducing stress during emotional times.
- **LifeKeys** provides grief counseling, legal support, financial services, and assistance with everyday life challenges, accessible through various channels such as web, mobile app, or phone.

For Enrollees & Their Dependents:

- **TravelConnect**, a travel assistance program, provides 24/7 support for emergency situations when you are 100 or more miles from home, offering services like medical evacuation, travel arrangements for companions and dependents, and assistance with natural disaster evacuations or security threats.

Glossary of Healthcare Terms

Allowable amount: The dollar amount typically considered payment in full by an insurance company and an associated network of health care providers.

Benefit: The health care items or services covered under a health insurance plan. Covered benefits and excluded services are defined in the health insurance plan's coverage documents.

Beneficiary (Primary): The first one in line to collect the death benefit upon the insured's death.

Beneficiary (Contingent): A contingent beneficiary is a person designated to receive the benefits asset if the primary beneficiary is unable to receive them.

Claim: A request for payment that you or your health care provider submits to your health insurer when you get items or services you think are covered.

COBRA: A federal law that may allow you to temporarily keep health coverage after your employment ends, you lose coverage as a dependent of the covered employee, or another qualifying event. If you elect COBRA (Consolidated Omnibus Budget Reconciliation Act) coverage, you pay 100% of the premiums, including the share the employer used to pay, plus a small administrative fee.

Coinsurance: The amount or percentage that you pay for certain covered health care services under your health plan. This is typically the amount paid after a deductible is met, and can vary based on the plan design.

Copayment: A flat fee that you pay toward the cost of covered medical services.

Coordination of Benefits (COB): If you have more than one health insurance plan, COB determines which plan is primary and which is secondary for covering your healthcare costs. This helps avoid overpayment or duplication of benefits.

Covered Expenses: Health care expenses that are covered under your health plan.

Deductible: A specific dollar amount you pay out of pocket before benefits are available through a health plan. Under some plans, the deductible is waived for certain services.

Dependent: Individuals who meet eligibility requirements under a health plan and are enrolled in the plan as a qualified dependent.

Exclusion: This refers to specific healthcare services, treatments, or conditions that are not covered by your health insurance plan. It's important to be aware of these exclusions so you can plan for potential out-of-pocket expenses.

Formulary: This is a list of prescription drugs covered by your insurance plan. Drugs on the formulary are typically divided into different tiers, with each tier having a different copayment or coinsurance amount.

Formulary Tier: Prescription drug formularies often categorize medications into different tiers, with each tier representing a different level of cost-sharing (e.g., copayment or coinsurance). Drugs in lower tiers typically have lower out-of-pocket costs, while those in higher tiers may require higher cost-sharing.

Generic Drug: A prescription drug that has the same active-ingredient formula as a brand-name drug. Generic drugs usually cost less than brand-name drugs. The Food and Drug Administration (FDA) rates these drugs to be as safe and effective as brand-name drugs.

High Deductible Health Plan (HDHP): A qualified health plan that combines very low monthly premiums in exchange for higher deductibles and out-of-pocket limits. These plans are often coupled with an HSA.

Hospitalization: Care in a hospital that requires admission as an inpatient and usually requires an overnight stay. An overnight stay for observation could be outpatient care.

In-network: Health care received from your primary care physician or from a specialist within an outlined list of health care practitioners.

In-network Coinsurance: The percent (for example, 20%) you pay of the allowed amount for covered health care services to providers who contract with your health insurance or plan. In-network coinsurance usually costs you less than out-of-network coinsurance.

Inpatient: A person who is treated as a registered patient in a hospital or other health care facility.

Medically Necessary: Services or supplies provided by a hospital, health care facility or physician that meet the following criteria: (1) are appropriate for the symptoms and diagnosis and/or treatment of the condition, illness, disease, or injury; (2) serve to provide diagnosis or direct care and/or treatment of the condition, illness, disease or injury; (3) are in accordance with standards of good medical practice; (4) are not primarily serving as a convenience; and (5) are considered the most appropriate care available.

Member: You and those covered become members when you enroll in a health plan. This includes eligible employees, their dependents, COBRA beneficiaries and surviving spouses.

Network: The facilities, providers and suppliers your health insurer or plan has contracted with to provide health care services.

Out-of-network: Health care you receive without a physician referral, or services received by a non-network service provider. Out-of-network health care and plan payments are subject to deductibles and copayments.

Out-of-pocket Expense: Amount that you must pay toward the cost of health care services. This includes deductibles, copayments and coinsurance.

Out-of-pocket Maximum (OOPM): The highest out-of-pocket amount paid for covered services during a benefit period.

Pharmacy Benefit Manager (PBM): Pharmacy Benefit Managers (PBMs) are your advocates in the health care system, working to lower prescription drug costs for patients and health insurance plans across the country.

Premium: The amount you pay for a health plan in exchange for coverage. Health plans with higher deductibles typically have lower premiums.

Preauthorization: A decision by your health insurer or plan that a health care service, treatment plan, prescription drug or durable medical equipment is medically necessary. Sometimes called prior authorization, prior approval or precertification. Your health insurance or plan may require preauthorization for certain services before you receive them, except in an emergency. Preauthorization isn't a promise your health insurance or plan will cover the cost.

Primary Care Physician (PCP): A doctor that is selected to coordinate treatment under your health plan. This generally includes family practice physicians, general practitioners, internists, pediatricians, etc.

Referral: Referrals often involve a primary care physician recommending a patient to see a specialist for further evaluation or treatment. THT medical plans do not require a referral, however, specialists may require a referral to schedule an appointment.

Subscriber: A subscriber is someone who signs up and pays for an insurance plan, often for themselves or their dependents, to get coverage for medical expenses and other services specified in the policy.