CENTRAL WASHINGTON SCHOOL EMPLOYEES BENEFIT TRUST

FREQUENTLY ASKED QUESTIONS

1. **If I have a question about my insurance benefits, whom can I contact?** You can call Angie Guinn, Coordinator of the Central WA School Employees Benefit Trust (CWSEBT) at 573-7250. Angie is your advocate in all aspects of your insurance benefits. She does not work for the insurance companies – she works for you. Other contacts: Regence BlueShield (1-888-367-2112); MetLife Dental (1-800-942-0854); Argus Insurance, Inc. (broker) 248-0161 (ext. 1119 -Dave Hargreaves or ext. 1116 – Cherie Ergeson).

2. **How do I submit a medical claim for processing?** (Contracted providers agree to submit claims for you.) If the provider you see is not contracted with Regence BlueShield and the charges are for medical, prescription or vision services, all you need to do is send an "itemized bill" from the provider directly to: Regence BlueShield, PO Box 21267, Seattle, WA 98111.

3. **How do I submit a dental claim for processing?** (Preferred dental providers agree to submit claims for you.) If the dental provider you see is not preferred with MetLife Dental and does not agree to submit the charges for you, contact the Trust Coordinator at 573-7250 for a claim form or you can also download a copy of the dental claim form from the Trust website under "Forms". Mail completed form to: MetLife Dental Claims, PO Box 981282, El Paso, TX 79998-1282.

4. **What is my prescription drug copayment?** We have a 3-tier copayment plan. When purchasing from a "retail pharmacy": if the medication is "generic" and on the formulary (drug list) the copay is $15; if the medication is a "name brand" on the formulary the copay is $35 and if the medication is not on the formulary the copay is $55. When purchasing medications through our "mail-order" benefit: if the medication is "generic" and on the formulary (drug list) the copay is $30; if the medication is a "name brand" on the formulary the copay is $70 and if the medication is not on the formulary the copay is $110.

5. **When purchasing prescription medications, how many units or tablets can I get filled for one copay?** For most medications being purchased from a retail pharmacy our plans allow for a "34 day supply or 100 tablets or capsules, whichever is greater".

6. **I understand the "mail-order" benefit for prescription drugs allows a "90 day supply". Isn't this a better deal?** Maybe. The mail-order benefit is only a "better deal" if you are taking three or more tablets/capsules per day of the same medication. For example, if you take a "generic formulary" drug at 3 units per day X 90-day supply, you could get a total of 270 units/tablets for $30 copay through mail-order. Using the same scenario but buying from a retail pharmacy, the most you could get would be 102 tablets for $15 copay. (Feel free to contact your Coordinator if you need help in determining what is the most advantageous for you.)

7. **My doctor wrote me a prescription and the pharmacy will only fill it for a 30-day supply. Why is that?** Most physicians and pharmacies believe that all plans will only allow a 30-day supply for medications. Our plan is one of the very few that will allow more than a 30-day supply. As an informed consumer you need to advise your provider that our plans will allow a "34 day supply or 100 tablets or capsules, whichever is greater". It would then be up to your doctor to write the prescription how he/she feels is appropriate for your specific condition. The pharmacist can only fill the prescription according to your doctors' instructions, subject to the plan limitations.

8. **What is my vision benefit?** Each plan allows one routine eye exam per calendar year (Jan. through Dec.) subject to a $20 copay with the balance of the allowed amount payable at 80% on the Traditional Choice, Economy Choice and Select Choice plans. All plans allow a benefit for hardware (lenses, frames and contacts) at 80% to a combined maximum of $200 every calendar year. All or part of the $200 benefit maximum can be used for laser eye surgery. Your vision benefit is not subject to any deductible.

9. **What is my deductible?** This is the cost of **covered** medical expenses that you must incur and are responsible to pay before your benefits are available. On the **Traditional Choice Plan**, your deductible is $250 per person/$750 family maximum. The **Economy Choice Plan** has a $750 deductible per person/$2,250 family maximum that applies to all services. On the **Select Choice Plan**, your deductible is $100 per person for category 1 (preferred); $200 deductible for category 2 (participating) and category 3 (non-participating). (Exception: the deductible is waived on all plans for services billed as Preventive Care.)

10. **What is my copay?** All plans have a $20 copay for each outpatient professional service (except lab and x-ray services) performed in the office, home or hospital outpatient department. All plans have a $100 copay for each visit to a hospital emergency room (waived if directly admitted to the hospital as an inpatient). All plans have a $200 copay for each inpatient admission.

11. **I have lost my ID Card? Can I get another one?** Yes. Contact your Trust Coordinator through the website or call Angie at 573-7250 and she can order you another card.

12. **How do I make a change (ie: name, address or beneficiary)?** For an address change you must first notify your employer and complete the form they require. For a name change or beneficiary change, you can access the necessary form from the website under “Forms” and select “Enrollment and Change Form” or contact the Trust Coordinator and Angie will provide you with the necessary form.

13. **What family members/dependents can I cover under my plan?** Eligible dependents include the subscriber’s lawful spouse, domestic partner, and child/children. An eligible child must be either a natural child, an adopted child, a child legally placed for adoption, a stepchild or a child to whom the subscriber is the legal guardian (court documents required) and under the age of 26. Children who are incapacitated due to a developmental disability or physical handicap and chiefly dependent upon the subscriber, spouse, or non-covered legal parent for support and maintenance are also eligible for benefits, provided the dependent was covered immediately prior to the 26th birthday and the incapacity occurred prior to the 26th birthday. Proof of the incapacity and dependency will be required within 31 days after the child’s 26th birthday and not more frequently than one time per year after the child’s 26th birthday.