TechLance Health Insurance Policy

Introduction

TechLance is committed to supporting the health and well-being of our employees and their families through comprehensive health insurance coverage. We believe that access to quality healthcare is fundamental to employee satisfaction and productivity, which is why we contribute significantly to premium costs and offer multiple plan options to meet diverse needs and budgets.

Our health insurance program includes three distinct plan types designed to accommodate different healthcare preferences and financial situations. Whether you prefer the flexibility of a PPO, the coordinated care of an HMO, or the cost savings and tax advantages of a high-deductible health plan paired with a Health Savings Account, we have options that can work for you and your family.

All eligible employees can enroll in health insurance coverage, with TechLance contributing 75% of the premium cost for employee-only coverage and 65% for family coverage. Coverage begins on the first day of the month following 30 days of employment for new hires, and we hold an annual open enrollment period each November for changes that become effective January 1st.

Available Health Plans

Our PPO plan offers the greatest flexibility in choosing healthcare providers and doesn't require referrals to see specialists. This plan works well for employees who want the freedom to visit any doctor or specialist without coordinating through a primary care physician, though you'll pay less when you use providers within our extensive nationwide network. The PPO includes a moderate deductible and copays for most services, making it predictable for budgeting healthcare costs.

The HMO plan provides comprehensive coverage through a more structured approach that emphasizes coordinated care and preventive services. With this plan, you'll choose a primary care physician who will coordinate your healthcare and provide referrals when specialist care is needed. The HMO typically offers the lowest out-of-pocket costs for employees, with minimal deductibles and low copays for covered services. However, except for emergency care, services are only covered when you use providers within the HMO network.

Our High Deductible Health Plan (HDHP) is designed for employees who want to take a more active role in managing their healthcare costs while building tax-advantaged savings for future medical expenses. This plan has a higher deductible than our other options, but it's paired with a Health Savings Account that allows you to set aside pre-tax dollars for healthcare expenses. The HDHP uses the same provider network as our PPO plan, giving you flexibility in choosing providers once you meet the deductible.

Premium Costs and Coverage Details

Employee-only coverage costs range from $32 per month for the HDHP to $89 per month for the PPO plan, with the HMO falling in between at $45 monthly. Family coverage varies significantly depending on the plan you choose and whether you're covering a spouse, children, or a full family. The PPO family coverage costs $245 monthly, while HMO family coverage is $189, and HDHP family coverage is just $134 per month.

These employee contributions represent only a portion of the actual premium costs, with TechLance subsidizing the majority of your health insurance expenses. We review our contribution levels annually to ensure they remain competitive and sustainable while providing maximum value to our employees.

All plans include comprehensive preventive care at no cost to you when you use in-network providers. This includes annual physical exams, routine immunizations, cancer screenings like mammograms and colonoscopies, women's health exams, well-child visits, and annual vision and hearing tests. Preventive care coverage helps you stay healthy and catch potential health issues early when they're most treatable.

The prescription drug coverage varies by plan but generally includes four tiers of medications with different cost-sharing levels. Generic medications (Tier 1) have the lowest copays, typically around $10 for a 30-day supply, while brand-name and specialty medications have higher copays or coinsurance requirements. You can save money by using mail-order pharmacy services for 90-day supplies of maintenance medications.

Understanding Your Benefits

Each plan has different cost-sharing structures that determine how much you'll pay for various services. Copays are fixed amounts you pay for specific services, like $25 for a primary care visit, while coinsurance means you pay a percentage of the total cost after meeting your deductible. For example, if your plan has 20% coinsurance for hospital stays, you would pay 20% of the hospital bill after your deductible is met, up to your annual out-of-pocket maximum.

The annual deductible is the amount you must pay out-of-pocket before your insurance begins paying for most services. However, preventive care and some other services are covered even before you meet your deductible. Once you reach your annual out-of-pocket maximum, your insurance covers 100% of covered services for the rest of the year.

In-network providers have contracts with our insurance company that result in lower costs for both you and the insurance plan. Out-of-network providers don't have these contracts, which typically means higher costs and more paperwork for you. While our PPO and HDHP plans provide some coverage for out-of-network care, the HMO plan only covers out-of-network care in emergency situations.

Finding Providers and Managing Care

To find in-network providers, you can use the insurance company's online directory, download their mobile app, or call the customer service number on your insurance card. It's important to verify that providers are still in-network before scheduling appointments, as networks can change periodically.

Some services require prior authorization from the insurance company before they'll be covered. This typically includes expensive procedures like MRIs and CT scans, specialist surgeries, durable medical equipment over $500, and extended physical therapy. Your doctor's office usually handles prior authorization requests, but it's important to verify coverage before receiving these services to avoid unexpected costs.

For most services with in-network providers, you'll simply pay your copay or coinsurance at the time of service, and the provider will handle billing the insurance company directly. If you use out-of-network providers, you may need to pay the full amount upfront and then submit claims to the insurance company for reimbursement.

Special Programs and Additional Benefits

TechLance employees enrolled in the HDHP are eligible to contribute to a Health Savings Account, which offers significant tax advantages. You can contribute up to $4,150 annually for individual coverage or $8,300 for family coverage in 2024, with an additional $1,000 catch-up contribution allowed if you're 55 or older. TechLance contributes $750 annually for individual HDHP coverage and $1,500 for family coverage, deposited quarterly into your HSA.

HSA funds can be used to pay for qualified medical expenses tax-free, and any unused money rolls over from year to year. After age 65, you can withdraw HSA funds for any purpose without penalty, though non-medical withdrawals will be subject to income tax. This makes the HSA not just a healthcare benefit but also a valuable retirement savings tool.

Our wellness program offers opportunities to earn up to $300 annually in HSA contributions or health insurance premium credits. You can earn $100 for completing an annual biometric screening, $50 for finishing a health assessment, and up to $150 for participating in various wellness challenges throughout the year. These programs are designed to help you stay healthy while reducing your healthcare costs.

All employees have access to telemedicine services at no cost, regardless of which health plan they choose. These virtual consultations are available 24/7 for non-emergency medical issues and can often provide convenient care without the need to visit a doctor's office. The telemedicine

platform can also prescribe medications when appropriate and is particularly useful for minor illnesses, follow-up care, and urgent medical questions.

Mental Health and Employee Assistance

Mental health coverage is integrated into all our health plans with the same copays and coverage levels as other medical care. This includes therapy sessions, psychiatrist visits, inpatient mental health treatment, and substance abuse programs. We believe that mental health is just as important as physical health and ensure that employees have access to the care they need.

In addition to insurance coverage, all TechLance employees have access to our Employee Assistance Program (EAP), which provides confidential support services at no cost. The EAP includes six free counseling sessions per issue per year, 30 minutes of free legal consultation, financial counseling, and work-life balance resources. These services are available 24/7 and can be accessed by calling the number provided in your benefits materials or through the EAP website.

The EAP also provides childcare and eldercare referrals, which can be particularly valuable for employees balancing work with family responsibilities. All EAP services are completely confidential, and TechLance doesn't receive any information about who uses these services or what assistance is provided.

Enrollment and Life Changes

New employees must enroll in health insurance within 30 days of their hire date. If you don't enroll during this initial period, you'll have to wait until the next annual open enrollment unless you experience a qualifying life event such as marriage, birth or adoption of a child, divorce, or loss of other health coverage.

During open enrollment each November, you can change your health plan selection, add or remove dependents, or adjust your coverage for the following year. This is also the time to review

your coverage and consider whether your current plan still meets your needs, especially if your family situation or health status has changed.

Qualifying life events allow you to make changes to your health insurance outside of the open enrollment period, but you must notify HR within 30 days of the event and provide appropriate documentation. Changes due to qualifying life events are effective immediately and don't require waiting until the next plan year.

Coverage Continuation and Appeals

If you go on unpaid leave, you can continue your health insurance coverage through COBRA by paying the full premium plus a 2% administrative fee. COBRA coverage can last up to 18 months in most cases, though some circumstances may allow for longer continuation periods.

If the insurance company denies a claim you believe should be covered, you have the right to appeal the decision. The appeals process typically involves submitting additional documentation or medical records to support your case. HR can help you understand the appeals process and connect you with insurance company advocates who can assist with complex situations.

Most appeals are resolved within 30 days, and if your initial appeal is denied, you have the right to request an independent external review. It's important to file appeals promptly, as there are time limits for challenging claim denials.

This health insurance policy reflects our commitment to providing comprehensive, affordable healthcare coverage for our employees and their families. We regularly review our offerings to ensure they remain competitive and meet the evolving needs of our workforce, and we encourage employees to take an active role in understanding and managing their healthcare benefits.

Frequently Asked Questions

When can I change my health insurance plan? You can change plans during the annual open enrollment period in November, or within 30 days of experiencing a qualifying life event such as marriage, birth of a child, or loss of other coverage.

What's the difference between a copay and coinsurance? A copay is a fixed dollar amount you pay for a service (like $25 for a doctor visit), while coinsurance is a percentage of the total cost (like paying 20% of a $1,000 procedure, which would be $200).

Do I need a referral to see a specialist with the PPO plan? No, the PPO plan allows you to see specialists directly without a referral from your primary care doctor, though you'll save money by staying in-network.

Are prescription drugs covered? Yes, all plans include prescription coverage with different copays based on whether the medication is generic, brand-name, or specialty. Mail-order options are available for 90-day supplies at reduced costs.

What happens if I use an out-of-network provider? With PPO and HDHP plans, you'll have coverage but pay higher costs and may need to submit claims yourself. The HMO plan only covers out-of-network care for emergencies.

Can I add my domestic partner to my health insurance? Yes, domestic partners are eligible for coverage with proper documentation of the domestic partnership relationship.

How do I find out if a procedure requires prior authorization? You can check with your doctor's office or call the insurance company directly. It's important to get prior authorization when required to ensure coverage.

What if I disagree with a claim denial? You have the right to appeal claim denials. Contact HR for assistance with the appeals process, and we can help connect you with insurance company resources to support your appeal.

This policy is effective immediately and may be updated to reflect changes in insurance offerings, legal requirements, or business needs. Employees will receive advance notice of any significant changes. For questions about your specific coverage or benefits, contact HR or call the customer service number on your insurance card.