



# 2020

## EMPLOYEE BENEFITS HANDBOOK

MEDICAL • DENTAL • VISION • LIFE • AD&D • EAP • LTD • FSA • VOLUNTARY





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**If you and/or your dependents have Medicare or you will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please see pages 27-28 for more details.**

*The information in this brochure is a general outline of the benefits offered under Fallbrook Union High School District's benefits program. Specific details and plan limitations are provided in the Summary Plan Descriptions (SPD), which is based on the official Plan Documents that may include policies, contacts and plan procedures. The SPD and Plan Documents contain all the specific provisions of the plans. In the event that the information in this brochure differs from the Plan Documents, the Plan Documents will prevail.*

# ABOUT THIS GUIDE

There is no question, benefits make our lives richer. The benefit choices we make can help protect the quality of our lives and the lives of our families.

Making enrollment decisions that best serve your family is one of your most important responsibilities. As an employee of the District, it's time to decide which benefit plans are best for you and your family and how you can make the most of your benefits for the upcoming year.

The District's goal is to provide you with the resources you need to make informed decisions about your benefits. Use this guide to learn about your plan options for the new benefit year. The guide also has the information you need to complete a successful enrollment.

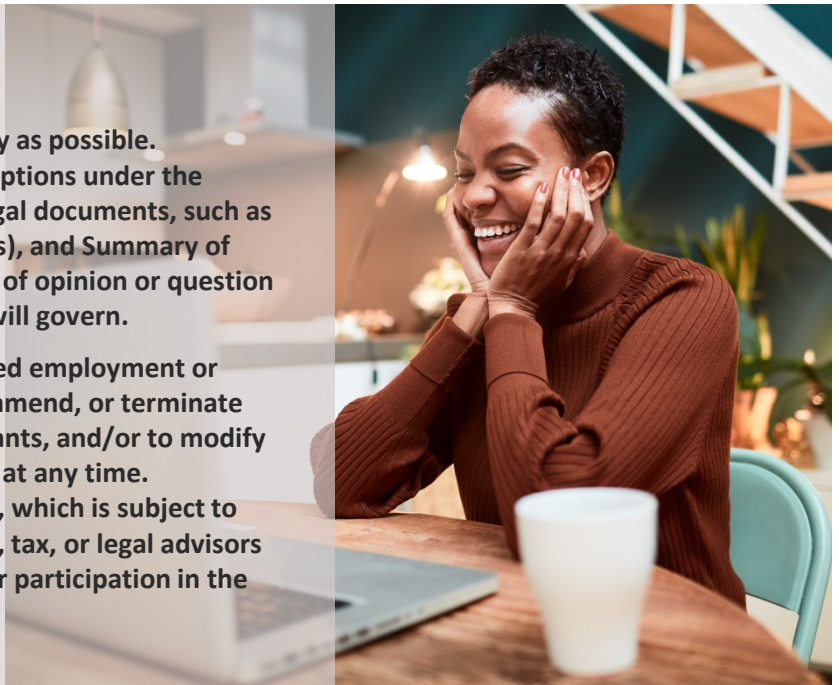
Take time to study your benefits information carefully so you can make wise benefit decisions.

## IMPORTANT LEGAL INFORMATION

This guide has been written as clearly and accurately as possible. However, it contains only brief summaries of your options under the District's benefit plans. Each plan is governed by legal documents, such as policies, contracts, summary plan descriptions (SPDs), and Summary of Benefits Coverage (SBC's). If there is any difference of opinion or question about benefit determination, the legal documents will govern.

This guide does not serve as a guarantee of continued employment or benefits. The District reserves the right to change, amend, or terminate any of the plans or benefits for any class of participants, and/or to modify the classes of participants eligible for such benefits, at any time.

All information in this guide is based on current law, which is subject to change. Please consult with your personal financial, tax, or legal advisors regarding tax matters and other implications of your participation in the plans.



## YOUR RESPONSIBILITIES

### Continuing Employees

Be sure to read the relevant sections of this guide before making your final elections.

### Newly Eligible Employees

You may elect coverage for yourself and any eligible dependents.

Certain plan rules apply at open enrollment that are not applicable to newly eligible employees. Therefore, be sure you read and understand how the benefit plans work before making your enrollment decisions.

The last page of this guide contains a list of contacts available to answer your questions about the benefits package. You can also call Payroll/Benefits during business hours.

Fallbrook Union High School District provides a health and welfare benefits program that allows you to select the benefits that best meet your needs. Health and welfare benefits currently offered through the District include:

- Medical
- Employee Assistance Program (EAP)
- Dental
- Vision
- Life and Accidental Death & Dismemberment Insurance
- Disability
- Long Term Care
- Voluntary Cancer Insurance
- Voluntary Life Insurance
- Voluntary Accident Insurance
- Voluntary Disability Insurance
- Voluntary Critical Choice
- Voluntary Auto and Home Insurance
- Section 125 Flexible Spending Account (Reimbursement Account)
- Voluntary Legal Assistance

While the District provides a broad range of benefit options, you are not required to enroll in all of them. However, some benefits are mandated and your enrollment is not optional.

Each benefit is governed by rules established by law, by the insurance carrier contract, and by the District. While some of the rules are discussed within this guide, please review the Summary of Benefits and Coverage (SBCs) for each plan for an expanded description of the rules that apply.

## ELIGIBILITY

### Eligible Employees

You are eligible for the benefits program if you meet the minimum eligible employee guidelines as defined by the District. Your benefits become effective on the 1st of the month following your date of hire.



### Eligible Dependents

You can enroll eligible dependents on any plan that covers dependents such as medical and dental. Eligible dependents are defined as:

- Legally married spouses
- Children to age 26
- Stepchildren
- Legally adopted children
- Children or grandchildren for whom the member has been awarded court appointed guardianship
- Disabled children (Social Security determination required /no age maximum)
- Children of qualified Domestic Partnerships
- Effective August 10, 1993, any child for whom a Qualified Medical Child Support order that complies with all applicable laws has been issued.

# ELIGIBILITY

## Ineligible Dependents

The following individuals are not eligible dependents, even if they rely on you for support:

- Grandchildren\*, unless legal guardianship has been awarded
- Foster children
- Parents or grandparents
- Ex-spouses once a final decree has been issued or legal separation has been obtained
- Children who have coverage available through their own employment
- Non-registered Domestic Partners (details outlined below)
- Former Spouses and their children\*
- Any person who is an active member of the armed services, except as applicable under USERRA rules

*\*These children are not eligible unless you have legally adopted the child, have been assigned legal guardianship, or are legally required to provide medical coverage under a Qualified Medical Child Support Order (QMCSO).*

## DOMESTIC PARTNERS

To qualify as a dependent under the definition of “qualifying relative,” the domestic partner must meet the following criteria:

- Be Registered as the employee’s domestic partner either with Certificate of Registered Domestic Partnership issued by State of California or SISC Affidavit of Domestic Partnership;
- Have the same primary address as the employee/taxpayer for the year;
- Be a member of the employee/taxpayer’s household;
- Receive more than half of his or her support for the year from the employee/taxpayer;
- Not be anyone’s “qualifying child” for tax purposes; and
- Be a citizen or national of the United States, or a resident of the United States or a country contiguous to the United States.

If a domestic partner does not qualify as a tax dependent of the employee, employers are required to report and withhold taxes on the value of employer-provided health coverage for the domestic partner.

## DEPENDENT VERIFICATION

Enrolling an ineligible person as your dependent is a serious offense that will result in disciplinary action, which may include termination of employment. It is mandatory that all employees submit documentation verifying that the individuals enrolled in benefits meet the eligibility requirements. Accepted documents are:

- **Spouse** – Prior year’s Federal Tax Form that shows the couple was married (financial information may be blocked out) or Marriage Certificate for newly married couple where tax return is not available.
- **Domestic Partner** – Certificate of Registered Domestic Partnership issued by State of California or SISC Affidavit of Domestic Partnership.
- **Children** (stepchildren, adopted and/or under legal guardianship to age 26) – Legal Birth Certificate (or hospital birth certificate if adding a newborn) to include full name of child, parent(s) name & child’s DOB, Legal Adoption Documentation or Court Documentation establishing Guardianship.
- **Disabled Dependents** (over age 26) – Legal Birth Certificate or Hospital Birth Certificate to include full name of child, parent(s) name & child’s DOB, Prior year’s Federal Tax Form that shows child is claimed as an IRS dependent, Proof of 6 months prior creditable coverage and Anthem Disabled Dependent Certification Form or Kaiser Disabled Dependent Enrollment Application. All items listed above are required.



## BENEFITS COST

The District has developed a benefit plan that allows you to create your own benefits package in order to meet your individual needs. It's up to you to evaluate each benefit offered and choose the coverage that works best for you. The cost of your benefits depends on the options you elect.

**Voluntary Benefits** give you the option of purchasing additional coverages such as higher amounts of life or disability insurance, cancer insurance, and long term care coverage based on your particular insurance needs. You pay the cost of voluntary benefits through the convenience of payroll deduction.

**Contributions** for coverage (if any) are deducted from your paycheck. Premiums for most benefits – medical, dental, and vision coverage; the first \$50,000 of life insurance for yourself; and health and dependent care reimbursement accounts – can be deducted before taxes are calculated (see Section 125 information). Because these amounts are deducted before taxes are calculated, your taxable income is reduced. Other premiums may be deducted from your paycheck after taxes are calculated. These deductions will appear on your paycheck stub.



## ENROLLING IN BENEFITS

You can enroll for coverage during your initial eligibility period or during the annual Open Enrollment period. You may enroll your eligible dependents (as described in “Eligibility”) in the same plans you choose for yourself.

If you do not wish to elect medical coverage for yourself, You may decline medical coverage if you provide proof of other qualified coverage under another group medical plan.

## MAKING CHANGES TO YOUR BENEFITS

**During Open Enrollment:** You may change your elections **before the enrollment deadline**, but you may not make any changes after the deadline unless you have a qualifying status change. You must make corrections before the close of the Open Enrollment period.

**During the Year:** Due to IRS rules and the District’s policy, you may not make any changes during the year unless you have a qualifying status change. **Any qualifying event change (as listed below) must be made within 30 days of the event. You will need to submit appropriate documentation and complete any necessary change forms in Payroll/Benefits.**

Changes in family status are defined by the Internal Revenue Code (IRC). You have family status change if:

- Change in marital status;
- Change in number of dependents (birth, adoption, death);
- Change in spouse or dependent’s eligibility under an employer’s plan
- Change in employment status that changes eligibility status (change in work schedule such as termination, a decrease in hours worked, strike, change in residency that affects accessibility to current plan);
- Change in cost or coverage (significant cost increase, open enrollment of spouse under other employer’s plan).

If you make an incorrect entry or change your mind about a plan you have elected, you must contact Payroll/Benefits.

## CONFIRMATION OF BENEFIT ELECTIONS

Please retain copies of your Employee Benefit Selection Form and Section 125 Premium Election Form as a record of your selections and keep them with your important papers. You may need to refer to them during the year.

***If you do not receive a Confirmation Statement as described above, call Payroll/Benefits.***

# ABOUT YOUR MEDICAL PLANS

## SELECTING A DOCTOR

Review the provider listings for each plan/network to determine which plans your doctor participates in. It is a good idea to double-check with your doctor's office, as these arrangements are subject to change. You will want to consider only those plans that include your doctor(s).

HMO enrollees must designate a your Primary Care Physician (PCP) or you will be assigned one. Each family member can choose their own PCP and you may change your PCP once per month by contacting the insurance carrier (some restrictions may apply).

## YOUR MEDICAL PLAN OPTIONS

Since health costs are often unpredictable, it is difficult to estimate how much you will pay for services during the year with any plan. It is helpful to consider the predictable expenses of both the premiums you pay each pay period and what the your cost for medical care might be over the course of the year.

Because employees have different needs, the District offers a total of six different medical plan options. Review the benefit chart for highlights of key features available under each of your plan options. This is a brief summary only. It does not fully describe the coverage. For greater detail, please refer to the health plan's Evidence of Coverage (EOC).

### Health Maintenance Organization (HMO) Health Plans

If you visit the doctor frequently, you usually will pay less under a traditional HMO because the HMO agrees to provide all covered services for a fixed price. To receive benefits, you must use providers within the HMO network. When you do, typically flat dollar copays for most services will apply, per visit, rather than a percentage of the total charges.

You have the following "traditional" HMO options:

- **Kaiser Traditional HMO 20**
- **Anthem Value HMO (Select Network)**
- **Anthem Value HMO (Full Network)**

### Health Savings Account (HSA) Compatible Health Plans

An HSA compatible health plan is an IRS qualified High-Deductible Health Plan or (HDHP) that allows you to set money aside on a tax-free basis to pay for your out-of-pocket expenses. Because of the high deductible, these plans have lower premiums and therefore, lower payroll deductions affording you the option of depositing money into your HSA. If you don't use the money that you put into your HSA, you can save it to pay for future medical expenses and even earn interest. More information can

be found in the HSA section of this handbook. You have the following HSA compatible HMO options:

- **Kaiser HSA Compatible Plan**
- **Anthem HSA Compatible Plan**

### Preferred Provider Organization (PPO) Health Plan

This is a deductible PPO plan and has a higher premium than the HMO plans because members have the ability to seek services from any provider, in-network (contracted) or out-of-network (non-contracted). Your out-of-pocket costs are lower when you see an in-network provider because they have agreed to accept discounted fees as payment in full.

After the annual deductible has been met, the PPO plan includes coinsurance. However, some services such as preventive care visits are covered 100% and other services like office visits and prescription drugs have set copays and you do not need to satisfy your deductible. You have the following PPO option:

- **Anthem PPO**

### Out-of-Area PPO (*retirees living outside of California*)

This plan is for retirees or dependents who reside outside of the HMO. PPO plans are generally priced higher than HMO plans because they offer members the ability to seek services from any provider. PPO plans offer the flexibility to utilize both in-network (contracted) and out-of-network (non-contracted) providers. Because in-network providers contract with the insurance carrier at a discount, participants receive the benefit of lower out-of-pocket costs. PPO plans usually include deductibles and coinsurance. You have the following PPO as an option:

- **Anthem Blue Card PPO**

### Guest Membership (*traveling/living outside California*)

Anthem HMO: When you're a "guest" in another state, you're still covered for many services, including routine and preventive care. Before seeking care in another state, contact Guest Membership at 800-827-6422.

Kaiser: If you are traveling to another Kaiser service area and need care, call the Away from Home Travel Line at 951-268-3900. You're also covered for urgent and emergency care anywhere in the world. Routine services aren't covered, so make sure to get them before your trip if you're traveling elsewhere.

**Opt out:** You may decline medical coverage if you provide proof of other qualified coverage under another group medical plan, and complete the Opt out form that is available in Business Services. Opt out status must be updated annually.

# MEDICAL: Traditional HMO Plan Options

Health Plan Member Benefits...	KAISER Traditional HMO \$20		ANTHEM Value 30/40/500x3 day		ANTHEM Value 30/40/500x3 day	
	Kaiser Facilities		Full-Network		Select-Network	
<b>Deductible</b> (individual/family)	None		None		None	
<b>Out-of-Pocket (OOP) Maximum</b> (individual/family)	\$1,500/\$3,000		\$2,500/\$5,000		\$2,500/\$5,000	
<b>Office Visits</b> (Primary Care Physician/Specialist)	\$20 copay		\$30/\$40 copay		\$30/\$40 copay	
<b>Urgent Care Visits</b>	\$20 copay		\$30 copay		\$30 copay	
<b>Preventive Care</b> (includes physical exams & screenings)	No charge		No charge		No charge	
<b>Prenatal/Postnatal Office Visits</b>	No charge		\$30 copay		\$30 copay	
<b>Diagnostic Laboratory Procedures &amp; Routine X-Rays</b>	No charge		No charge		No charge	
<b>CT, CAT, MRI, PET Scans</b>	No charge		\$100 copay		\$100 copay	
<b>Physical/Occupational Therapy</b>	<b>Office Visit:</b>	\$20 copay	\$30 copay	\$30 copay	\$30 copay	\$30 copay
	<b>Hospital:</b>		\$40 copay	\$40 copay	\$40 copay	\$40 copay
<b>Chiropractic &amp; Acupuncture Visits</b>	<b>Visits/Year:</b>	\$10 copay 30 combined	\$10 copay 30 combined	\$10 copay 30 combined	\$10 copay 30 combined	\$10 copay 30 combined
<b>Emergency Room Visits</b> (waived if admitted)	\$100 copay		\$150 copay		\$150 copay	
<b>Ambulance</b> (ground or air)	\$50 copay		\$100 copay		\$100 copay	
<b>Inpatient Hospital</b> (includes mental health & substance abuse)	No charge		\$500/day (3 day max)		\$500/day (3 day max)	
<b>Outpatient Surgery</b>	\$20 copay		\$250 copay		\$250 copay	
<b>Outpatient Mental Health/Substance Abuse Facility</b>	\$20 copay		No charge		No charge	
<b>Durable Medical Equipment (DME)</b>	no charge		50%		50%	
<b>Infertility</b> (diagnosis and treatment of causes of infertility)	Office visit or hospital benefits apply		50%		50%	
<i>The Navitus/Costco pharmacy benefits below apply to both Anthem Traditional HMO plans...</i>						
Pharmacy Plan Member Benefits...	Retail	Mail Order	Navitus		Costco	
<b>Brand &amp; Specialty Rx Deductible</b> (individual/family)	none		\$200/\$500			
<b>Out-of-Pocket (OOP) Maximum</b> (individual/family)	included in the health plan maximum		\$2,500/\$3,500			
<b>Days Supply</b>	up to 30	up to 100	<b>Retail</b> up to 30	<b>Mail Order</b> up to 90	<b>Retail or Mail Order</b> up to 30    up to 90	
<b>Generic Drugs</b>	\$10 copay	\$20 copay	\$10 copay	N/A	No charge	No charge
<b>Brand Name Drugs</b>	\$30 copay	\$60 copay	\$35 copay	N/A	\$35 copay	\$90 copay
<b>Specialty Drugs</b>	\$30 copay for up to 30 days		N/A	\$35 copay (30 days)	N/A	

See plan documents for complete description of benefits, exclusions, limitations and conditions of coverage.

# MEDICAL: HSA Compatible Plan Options

Health Plan Member Benefits...	Enrolled as:	KAISER HMO HSA-A \$1,500		ANTHEM Prudent Buyer* PPO HSA-B \$3,000		
		Single	Family	Single	Family	
<b>Deductible</b> (individual/family)		\$1,500/ N/A	\$2,700/\$3,000	\$3,000	\$5,200	
<b>Out-of-Pocket (OOP) Maximum</b> (individual/family)		\$3,000/ N/A	\$3,000/\$6,000	\$5,950	\$11,900	
<b>Office Visits</b> (Primary Care Physician/Specialist)		10% after deductible		10% after deductible		
<b>Urgent Care Visits</b>		10% after deductible		10% after deductible		
<b>Preventive Care</b> (includes physical exams & screenings)		No charge		No charge (in-network ONLY)		
<b>Prenatal/Postnatal Office Visits</b>		No charge		10% after deductible		
<b>Diagnostic Laboratory Procedures &amp; Routine X-Rays</b>		10% after deductible		10% after deductible		
<b>CT, CAT, MRI, PET Scans</b>		10% after deductible		10% after deductible		
<b>Physical/Occupational Therapy</b>		10% after deductible		10% after deductible		
<b>Chiropractic &amp; Acupuncture Visits</b>		Not covered		10% after deductible (Chiro: in-network ONLY. Acupuncture: 12 visits/year)		
<b>Emergency Room Visits</b> (waived if admitted)		10% after deductible		\$100 copay + 10% after deductible		
<b>Ambulance</b> (ground or air)		10% after deductible		\$100 copay + 10% after deductible		
<b>Inpatient Hospital</b> (includes mental health & substance abuse)		10% after deductible		10% after deductible		
<b>Outpatient Surgery</b>		10% after deductible		10% after deductible (50% out-of-network)		
<b>Outpatient Mental Health/Substance Abuse Facility</b>		10% after deductible		10% after deductible (50% out-of-network)		
<b>Durable Medical Equipment (DME)</b>		10% after deductible		10% after deductible (in-network ONLY)		
<b>Infertility</b> (diagnosis and treatment of causes of infertility)		Office visit or hospital benefits apply		Office visit or hospital benefits apply		
<i>Medical plan deductible applies before the prescription drugs copayments for both plans:</i>						
Pharmacy Plan Member Benefits...		Retail	Mail Order	Navitus	Costco	
<b>Brand &amp; Specialty Rx Deductible</b> (individual/family)		included in the medical plan deductible		included in the medical plan deductible		
<b>Out-of-Pocket (OOP) Maximum</b> (individual/family)		included in the medical plan maximum		included in the medical plan maximum		
<b>Days Supply</b>		up to 30	up to 100	<b>Retail</b> up to 30	<b>Mail</b> up to 90	<b>Retail or Mail Order</b> up to 30 up to 90
<b>Generic Drugs</b>		\$10 copay	\$20 copay	\$9 copay	N/A	No charge
<b>Brand Name Drugs</b>		\$30 copay	\$60 copay	\$35 copay	N/A	\$35 copay \$90 copay
<b>Specialty Drugs</b>		\$30 copay (30 days)		N/A	\$35 (30 days)	N/A

\*When using non-Prudent Buyer providers, members are responsible for any difference between the maximum allowed and actual charges, as well as the applicable deductible and percentage coinsurance or copay. See plan documents for complete description of benefits, exclusions, limitations and conditions of coverage.

# HSA: Health Savings Account

## HOW AN HSA WORKS

- 1. Enroll in an HSA Compatible Medical Plan:** You must be covered by the HDHP and you must not be eligible for coverage under any other health plan.
- 2. Enroll in the HSA:** Set up your own HSA bank account with the bank of your choosing.
- 3. Contribute:** You, your spouse and family (if any family members are enrolled in the HDHP) may contribute up to the yearly limit set by the IRS.

2020 Plan Year	
Contribution Limit	Self-only: \$3,550 Family: \$7,100
"Catch-up" Contribution Limit (age 55+)	\$1,000

- 4. Know how much you have:** You may use the money in your HSA to pay for qualified medical expenses.
- 5. Use your benefits:** Visit the doctor, hospital and other health care providers.
- 6. Pay for services until you meet your deductible:** Pay for your health care expenses with your account. Or pay out of your own pocket and save your account. Either way, pay until you reach your yearly deductible.
- 7. Pay a copay or coinsurance after each visit:** Use your HSA if you want or pay out of your own pocket. Again, either way, you will pay until you reach the plan's payment limit.
- 8. Pay until you reach the plan's Payment Limit:** Then your health plan pays for 100% of covered services.

## SAVE YOUR HSA: Your contributions are tax free.

Add money to your HSA and when it's time to file taxes, claim any of your contributions made by check or electronic funds transfer as a deduction. Your HSA can also earn tax-free interest. Save the money in your HSA and pay any medical expenses out of pocket. There's no "use it or lose it" rule so you can roll over the money in your account from year to year. Your HSA grows. Once your account reaches a minimum balance, you may have the HSA investment service available. Your HSA can grow even more. As your HSA continues to grow you may use it for future and retiree health-related costs. And if you leave your job or move, you take the account with you.

## HSA ADVANTAGES

**You own it.** You decide whether to spend or save the funds in your health savings account. If you decide to change employers or health plans, the account is yours to keep.

**You don't lose it.** Any money not used at the end of the plan year rolls over to the next year.

**It can grow.** Your HSA is a savings account that earns interest. You can save the money in your account and let it grow, to pay health care costs down the road, even during retirement. And after you build up a certain amount, you may have investment options.

## TAX BENEFITS OF AN HSA

With an HSA, you also get:

- Tax savings.** Money you put in to the account can reduce your taxable income. For example, a \$2,500 annual HSA contribution could lower your annual taxes significantly:

EXAMPLE: \$2,500 annual HSA contribution			
Federal tax rate	State tax rate	Payroll taxes	Estimated annual savings
15%	5%	7.7%	\$691
25%	5%	7.7%	\$941
28%	5%	7.7%	\$1,016

*For illustrative purposes only. Actual savings will vary.*

- Tax-free earnings.** Money you keep in your HSA earns interest tax free.
- Tax-free spending.** Money you take out to pay for qualified health care costs is never taxed.

## SPEND YOUR HSA: Example

- You contributed \$1,000 to your HSA using pretax dollars through payroll deduction.
- You get a \$2,000 bill from your doctor.
- You then decide to deposit an additional \$1,000 in your HSA by electronic funds transfer, and you can claim this \$1,000 as a deduction when you file your taxes.
- Pay the \$2,000 bill from the HSA using your debit card.
- If needed, keep contributing to your HSA during the year, up to the IRS limit, to pay for qualified health care expenses and save on your taxes.

# MEDICAL: PPO Plan Option

Health Plan Member Benefits...	ANTHEM 80-G \$20			
	In-Network		Out-of-Network	
<b>Deductible</b> (individual/family)	\$500/\$1,000 combined			
<b>Out-of-Pocket (OOP) Maximum</b> (individual/family)	\$2,000/\$4,000 combined			
<b>Office Visits</b> (Primary Care Physician/Specialist)	\$20 copay		charges over fee schedule	
<b>Urgent Care Visits</b>	\$20 copay		charges over fee schedule	
<b>Preventive Care</b> (includes physical exams & screenings)	No charge		charges over fee schedule	
<b>Prenatal/Postnatal Office Visits</b>	\$20 copay		charges over fee schedule	
<b>Diagnostic Laboratory Procedures &amp; Routine X-Rays</b>	20% after deductible		charges over fee schedule	
<b>CT, CAT, MRI, PET Scans</b>	20% after deductible		charges over \$800 per test	
<b>Physical/Occupational Therapy</b>	20% after deductible		not covered	
<b>Chiropractic &amp; Acupuncture Visits</b> Visits/Year:	20% after deductible 12 acupuncture		not covered	
<b>Emergency Room Visits</b> (waived if admitted)	\$100 copay + 20% after deductible (limitations may apply)			
<b>Ambulance</b> (ground or air)	\$100 copay + 20% after deductible		\$100 copay + 20% after deductible + charges over fee schedule	
<b>Inpatient Hospital</b> (includes mental health & substance abuse)	20% after deductible		charges over \$600/day	
<b>Outpatient Surgery</b>	20% after deductible		amount over \$600/day charges over fee schedule	
<b>Outpatient Mental Health/Substance Abuse Facility</b>	20% after deductible		charges over fee schedule	
<b>Durable Medical Equipment (DME)</b>	20% after deductible		not covered	
<b>Infertility</b> (diagnosis and treatment of causes of infertility)	not covered			
<i>Pharmacy benefits apply in-network only as follows...</i>				
Pharmacy Plan Member Benefits...	Navitus		Costco	
<b>Brand &amp; Specialty Rx Deductible</b> (individual/family)	\$200/\$500			
<b>Out-of-Pocket (OOP) Maximum</b> (individual/family)	\$2,500/\$3,500			
Days Supply	Retail	Mail Order	Retail or Mail Order	
	up to 30	up to 90	up to 30	up to 90
<b>Generic Drugs</b>	\$10 copay	N/A	No charge	No charge
<b>Brand Name Drugs</b>	\$35 copay	N/A	\$35 copay	\$90 copay
<b>Specialty Drugs</b>	N/A	\$35 copay (30 days)	N/A	

See plan documents for complete description of benefits, exclusions, limitations and conditions of coverage.

# MEDICAL RX: Navitus (Anthem Members Only)

## NAVITUS PLAN RX 200DED/10-35

Members are urged to use generic drugs when available. If you or your physician requests the brand name when a generic equivalent is available, you will pay the generic copay plus the difference in cost between the brand and generic. The difference in cost between the brand and generic will not count toward the Annual Out-of-Pocket Maximum. Monies paid in the 4th quarter (October-December) towards the deductible are carried over to the next calendar year.

\*Members may receive up to 90 day supply of medication at Costco and up to a 30 day supply at all other participating pharmacies. Navitus contracts with most independent and chain pharmacies with the exception of Walgreens.

## FREE GENERIC MEDICATIONS: Costco

HMO and PPO members can get free generic medications at Costco and through Costco Mail Order. Some narcotic pain and cough medications are not included in the Costco Free Generic or 90-day supply programs.

## MAIL ORDER SERVICE

The Mail Order Service allows you to receive a 90-day supply of maintenance medications. This program is part of your pharmacy benefit and is **voluntary**.

## SPECIALTY PHARMACY

Lumicera Specialty Services helps members who are taking medications for certain chronic illnesses or complex diseases by providing services that offer convenience and support. This program is part of your pharmacy benefit and is **mandatory**.

## CUSTOMER CARE

For information regarding the Prescription Drug Program call or visit on-line:

Navitus Customer Care 1-866-333-2757 (toll-free) TTY (toll free) 711 [www.navitus.com](http://www.navitus.com)

Navi-Gate® for Members allows you to access personalized pharmacy benefit information on line at [www.navitus.com](http://www.navitus.com). For information specific to your plan, visit Navi-Gate® for Members. Activate your account online using the Member Login link and an activation email will be sent to you. The site provides access to prescription benefits, pharmacy locator, drug search, drug interaction information, medication history, and mail order information. The site is available 24 hours a day, seven days a week.



# EMPLOYEE ASSISTANCE PROGRAMS (EAP)

## UNDERSTANDING YOUR EAPs

The EAPs are **confidential** counseling and referral services that provide support on a variety of issues, such as:

- **Marital conflicts**
- **Parent/child issues**
- **Alcoholism and other forms of substance abuse**
- **Financial difficulties**
- **Emotional and stress-related problems**
- **Legal matters**
- **Child care and Elder care**
- **Personal Assistance Services**

To assist you and your family with these situations, you have access to 2 EAPs that provide 24-hour access to professional assistance.

**You and each of your family members can utilize up to twelve (12) counseling sessions at no cost to you (6 under each program offered by the district). With the help of the EAP, most employees can resolve their**

problems in just a few sessions. However, each case is unique and the involvement of the EAP depends on your particular needs.

If ongoing assistance is necessary your referral options will be discussed with you. Any referral may involve charges which will be your responsibility.

The EAP only contracts with licensed professionals. What you discuss is held in strictest confidence in accordance with professional ethics and state law.

To access the EAP benefits, you may contact the EAP 24 hours a day, 7 days a week by phone. During the initial telephone call, it is important to give the specialist as much information as possible including any preferences you have regarding a counselor. You will be given the contact information of a counselor(s) in your area that you may contact to schedule an appointment. Counseling sessions are conducted away from work to ensure confidentiality and privacy.



**800-999-7222 or**

**[www.anthem.com/ca/sisc](http://www.anthem.com/ca/sisc)**

company code: SISC



**800-722-EASE (3273) or**

**[www.mhn.advantageengagement.com](http://www.mhn.advantageengagement.com)**

company code: EASE



# STAYING HEALTHY RESOURCES

## Get Started

### Advance Medical

Call 855-201-9925

OR

Go to:

[www.advance-medical.net/sisc](http://www.advance-medical.net/sisc)

### MDLive

Register by calling 888-632-2738

OR

Go to: [www.mdlive.com/sisc](http://www.mdlive.com/sisc)

### Carrum Health

Call 888-855-7806

### Solera4ME

Go to [www.solera4me.com/sisc](http://www.solera4me.com/sisc)

and take a 1-minute quiz to see if you qualify.

### Active & Fit Direct

Anthem members login to

[www.anthem.com/ca/sisc](http://www.anthem.com/ca/sisc),

click "Discounts" then "Special Offers"

Kaiser members go to

[www.kp.org/choosehealthy.com](http://www.kp.org/choosehealthy.com)

then select "Southern California" then "Choose Healthy" then "learn more" near the ASH Active & Fit logo near the bottom.

### TruHearing

Call 866-754-1607

## Program Details

### EXPERT MEDICAL OPINIONS

#### Advance Medical

Get answers to your health care questions and medical opinions from world-leading experts.

### 24/7 PHYSICIAN ACCESS

#### MDLive

Consult with doctors over the phone or using online video for medical conditions such as cold, fever, sore throat, flu, infection, and children's health issues. Physicians can prescribe medication when appropriate. Online behavioral health visits are also available.

### NO COST HIP, KNEE AND SPINE SURGERY

#### Carrum Health

Get access to top-quality surgeons at Scripps with no out-of-pocket cost. All medical bills, including deductibles, coinsurance and even travel expenses are covered.

### DIABETES PREVENTION PROGRAM

#### Solara4ME

If you qualify, you can get access to a 16-week program that helps with weight loss, adopting healthy habits and can significantly reduce your risk of developing diabetes.

### DISCOUNTED GYM MEMBERSHIPS

#### Active & Fit Direct

Choose from over 9,000 participating fitness centers and YMCAs nationwide for a much lower cost than you would pay on your own. Use the online fitness tracking feature, which uses a variety of wearable devices and apps. You pay only \$25 per month plus a \$25 enrollment fee plus taxes.

### DISCOUNTED HEARING AIDS

#### TruHearing

Use your \$700 hearing aid allowance through Anthem to purchase hearing aids. Just go to a TruHearing provider to be fitted and adjusted for a wide variety of the latest digital hearing aids. You will save about \$980 per hearing aid compared to national average prices.

## Who is Eligible?

Anthem and Kaiser  
Members

No Cost

Anthem Members

Low Cost

Anthem PPO  
Members

No Cost

Anthem Members

No Cost

Anthem and  
Kaiser Members

Low Cost

Anthem/VSP  
Members

Low Cost

# DENTAL BENEFITS

## UNDERSTANDING YOUR DENTAL PLAN

The dental plan option available to you is worth smiling about. The District offers you and your family a comprehensive dental plan administered by Delta Dental and encourages good dental health.

**Delta PPO Dental Plan** – a traditional dental plan that allows you to use any dentist you choose. In general, the Delta PPO Dental Plan provides the most flexibility and coverage at any dentist.

## SELECTING A DENTIST

With the Delta Dental PPO Plan, you have the flexibility to visit any dentist, however your out-of-pocket costs are lower when you visit a contracted Delta Dental PPO dentist.

## DENTAL PLAN HIGHLIGHTS

Review the chart below for highlights of key features available under each of your dental plan options. This is a brief summary only. It does not fully describe the coverage.

The Delta Dental incentive plan pays 70% of the PPO contract allowance for covered diagnostic, preventive and basic services and 70% of the PPO contract allowance for major services during the first year of eligibility. The coinsurance percentage will increase by 10% each year (to a maximum of 100%) for each enrollee if that individual visits the dentist at least once during the year. If an enrollee does not use the plan during the calendar year, the percentage remains at the same level attained the previous year. If an enrollee becomes ineligible for benefits and later regains eligibility, the percentage will drop back to 70%.

Health Plan Member Benefits...	In-Network				Out-of-Network			
	Year 1	Year 2	Year 3	Year 4+	Year 1	Year 2	Year 3	Year 4+
<b>Annual Deductible</b>	None							
<b>Annual Benefit Maximum</b>	\$2,000 per person							
<b>Diagnostic &amp; Preventive Services</b> <i>exams, four cleanings &amp; x-rays</i>	plan pays 70%	plan pays 80%	plan pays 90%	plan pays 100%	plan pays 70%	plan pays 80%	plan pays 90%	plan pays 100%
<b>Basic Services</b> <i>fillings, simple extractions &amp;</i>	plan pays 70%	plan pays 80%	plan pays 90%	plan pays 100%	plan pays 70%	plan pays 80%	plan pays 90%	plan pays 100%
<b>Endodontics</b> root canals	plan pays 70%	plan pays 80%	plan pays 90%	plan pays 100%	plan pays 70%	plan pays 80%	plan pays 90%	plan pays 100%
<b>Periodontics</b> gum treatment	plan pays 70%	plan pays 80%	plan pays 90%	plan pays 100%	plan pays 70%	plan pays 80%	plan pays 90%	plan pays 100%
<b>Oral Surgery</b>	plan pays 70%	plan pays 80%	plan pays 90%	plan pays 100%	plan pays 70%	plan pays 80%	plan pays 90%	plan pays 100%
<b>Major Services</b> <i>crowns, inlays &amp; cast restorations</i>	plan pays 70%	plan pays 80%	plan pays 90%	plan pays 100%	plan pays 70%	plan pays 80%	plan pays 90%	plan pays 100%
<b>Prosthodontics</b> <i>bridges, dentures &amp; implants</i>	plan pays 50%				Plan pays 50%			
<b>Dental Accident</b>	Plan pays 100% up to \$1,000 maximum per person, per year							

\*Limitation or waiting periods may apply for some benefits; some services may be excluded.

\*\*Reimbursement is based on PPO contracted fees for in-network dentists and program allowance for out-of-network dentists

*For greater detail, please refer to the dental plan's Evidence of Coverage (EOC).  
If there are any discrepancies between benefits included in this summary, the EOC will prevail.*

## UNDERSTANDING YOUR VISION PLAN

Whether you need prescription eyeglasses or just regular eye examinations, the vision plan will help you meet the cost of vision services. The plan offered by the District is administered by Vision Service Plan (VSP).

Your VSP Vision plan is a Preferred Provider Organization (PPO). If you use a VSP contracted provider, you will receive higher benefits and usually will pay less out of your own pocket for vision care services.

## SELECTING A VISION PROVIDER

To locate a VSP provider, call VSP or visit their website. This information is listed in the Benefit Directory section of this guide. In-network providers will contact VSP to obtain authorization to provide services and eyewear.

VSP has a network of thousands of private-practice doctors throughout the nation. If you choose a VSP network provider, VSP pays allowable expenses directly to your provider.

The services of out-of-network vision providers are covered under the PPO plan, but you typically pay more out of your pocket. If you do not use a network provider, you pay the full fee and must then file a claim for reimbursement. Your benefits are paid according to a reimbursement schedule, which may not cover all of your expenses. You must have an itemized statement that includes the patient's name, address, date of service, charge for each service and the kind of services rendered to file a claim.

## ADDITIONAL DISCOUNTS

As a VSP member, you are eligible for the following discounts on additional items not covered by the plan:

- Laser vision correction is available at a discounted price at specific providers.
- 30% discount on additional pairs glasses, additional glasses from same VSP doctor on the same day as your well vision exam. Or, get 20% off from any VSP doctor within 12 months of your last exam.
- 15% discount on contact lens services.



Review the chart below for highlights of key features available under the vision plan. This is a brief summary only. It does not fully describe the coverage. For greater detail, please refer to the plan's Evidence of Coverage (EOC). Some services, even those provided by an in-network VSP doctor, will have additional charges. The plan limits the amount that will be paid on any particular service. Work with your provider and VSP to maximize the coverage.

Health Plan Member Benefits...	VSP Provider	Out-of-Network
Eye Examination every 12 months	No charge	\$45 allowance
Lenses every 24 months	No charge	Single vision: \$45 allowance; Lined bifocal: \$65 allowance; Lined trifocal: \$85 allowance
Frames every 24 months	\$130 allowance	\$47 allowance
Contact Lenses in lieu of glasses	\$130 allowance	\$105 allowance

# LIFE/AD&D BENEFITS

## BASIC LIFE AND AD&D PLAN OPTIONS

The District provides all benefit-eligible employees with basic term life and accidental death & dismemberment (AD&D) coverage in the amount of \$50,000 through The Hartford. This coverage is part of your benefit package and cannot be declined.

Basic Term Life is also provided to dependents, Spouse – \$5,000, Child, six months to age 21 (age 25 if in school) – \$5,000 Child, 14 days but less than six months – \$500, Child, less than 14 days – \$500.

You will be automatically enrolled in this coverage; however, you must designate a beneficiary.

You may elect to purchase additional coverage for you and your eligible dependents through the optional life and AD&D plans.

### OPTIONAL TERM LIFE INSURANCE

#### Yourself:

- Minimum of \$10,000 with \$10,000 increments not to exceed 5 time earnings or \$300,000.
- \$150,000 is guarantee issue

#### Your Spouse/Domestic Partner:

- Minimum of \$5,000 with \$5,000 increments to \$100,000 not to exceed 50% of the employee elected and approved optional life insurance.
- \$50,000 is guarantee issue.

#### Your Child(ren):

- Minimum of \$2,500 to a maximum of \$10,000 not to exceed 50% of the employee's benefit.
- Guarantee Issue is 50% of the employee's benefit up to \$10,000.

### OPTIONAL AD&D INSURANCE

#### Yourself:

- Times earnings rounded: \$10,000 increments not to exceed 10 times earnings to a maximum of \$300,000, rounded to the next highest \$1,000.
- All guarantee issue

#### Your Spouse/Domestic Partner:

- Family Plan: 60% of employee benefit if no Children, or 50% of employee benefit if Children.
- All guarantee issue

#### Your Child(ren):

- Family Plan: 20% of employee benefit if no spouse, or 10% of employee benefit if spouse
- All guarantee issue

## KNOW MORE ABOUT LIFE INSURANCE

Life insurance policies typically include an age-reduction schedule which limits the amount that will be paid to a beneficiary when the insured reaches a specified age. For example, when you reach age 70, your basic life insurance coverage will reduce to 50% of the face amount.

Similar reductions and sometimes termination of coverage for employees and dependents who reach a certain age are part of the optional coverages as well. When reductions occur, your premium cost will also be reduced to the appropriate premium for the new level of coverage.

You alone have the right to name your beneficiary. The beneficiary is the person or persons to whom the death benefit will be paid. You can change your beneficiary designation(s) at any time by submitting a new written designation to Payroll/Benefits. It is important to carefully consider who you designate on your beneficiary form because the insurance carrier is obligated to pay insurance policy proceeds to the person(s) listed regardless of the current relationship at the time of claim.

The District's life insurance plans provide "term" life insurance; they have no cash value.

*Qualifying domestic partners are eligible for life insurance. See the "Eligibility" section of this guide for more information. Because the terms vary depending on the plan, please refer to the plan's Evidence of Coverage (EOC) for specific details on age-reduction schedules and other plan limitations. If there are any discrepancies between benefits in this summary, the EOC will prevail.*

## APPLYING FOR OPTIONAL LIFE

### Continuing Employees

An application is required for any increase in the amount of coverage. If your coverage remains the same, you will not have to apply – even if your salary increases. For example, if you were covered for three times your salary in 2019, you may automatically elect three times your salary for 2020. If you elect four times your salary for 2020, you must submit an application for the increase in coverage.

### Newly Eligible Employees

If you become eligible during 2020, you will not have to complete a proof of good health statement (Evidence of Insurability or EOI) form if the coverage you elect is \$150,000 or less. You must submit an EOI form for any amount of coverage that exceeds \$150,000 for yourself and \$50,000 for your spouse or domestic partner. You will not have optional coverage while waiting for your application to be approved. Once your coverage is approved, you will pay the appropriate premium.

### Spouse/Domestic Partner Coverage

You must submit an application for any amount of Spouse/Domestic Partner Life Insurance if you are electing this benefit for the first time. Your spouse or

domestic partner must also agree to be covered; his or her signature is required on the application. While waiting for approval of the application, your spouse or domestic partner will not be covered.

Spouse/Domestic Partner Life Insurance covers a specific individual. If you remarry or enter into a new domestic partnership, coverage for a previous spouse or domestic partner does not apply to your new spouse or domestic partner. Your new spouse or domestic partner must apply and be approved for coverage.

### Application Deadlines

To apply for new or increased coverage, you must submit your application as follows:

- **During Open Enrollment** – Complete and return the application to Payroll/Benefits before the deadline.
- **During the Benefit Year** – If you are newly eligible or have a status change, you must complete the application within 30 days of your coverage effective date.

If you do not enroll by these deadlines your coverage will not be approved.

## ADDITIONAL OPTIONAL LIFE

In addition to the Optional Term Life Insurance available through The Hartford, American Fidelity has several life insurance options available that you may take with you after employment. Because the life insurance plans are unique and vary depending on the plan selected, please contact your American Fidelity representative for more information.



# ADDITIONAL SERVICES

Your life insurance from The Hartford can help you protect the financial future of your loved ones. But did you know about the additional services that come with it? These benefits can provide valuable services to you and your family when you need them most. Here's a quick summary:

## **FUNERAL PLANNING & CONCIERGE<sup>(1)</sup>**

**Helps provide peace of mind when it's needed the most.** The Hartford offers a funeral planning and concierge service provided by Everest. It provides a suite of online tools to guide you through key decisions before a loss, including help comparing funeral-related costs. After a loss, this service includes family advocacy and professional negotiation of funeral prices with local providers – often resulting in a significant financial savings.

Find out more: **1-866-854-5429** or visit [www.everestfuneral.com/hartford](http://www.everestfuneral.com/hartford) use code: HFEVLC

## **BENEFICIARY ASSIST® COUNSELING<sup>(2)</sup>**

**Getting through a loss is hard. Getting support to help cope doesn't have to be.** The Hartford offers you Beneficiary Assist counseling services provided by ComPsych®. Compassionate professionals can help you or your beneficiaries (named in your policy) cope with emotional, financial and legal issues that arise after a loss. Includes unlimited phone contact with a counselor, attorney or financial planner for up to a year, and five face-to-face sessions.

Find out more: **1-800-411-7239**

## **ESTATEGUIDANCE® WILL SERVICES<sup>(3)</sup>**

**Create a simple will from the convenience of your desktop.** Whether your assets are few or many, it's important to have a will. Through The Hartford you have access to EstateGuidance® Will Services, provided by ComPsych®. It helps you protect your family's future by creating a will online – backed by online support from licensed attorneys. Your will is customized and legally binding. Access online at: [www.estateguidance.com/wills](http://www.estateguidance.com/wills) use code: WILLHLF

## **TRAVEL ASSISTANCE WITH ID THEFT PROTECTION AND ASSISTANCE**

**Even the best planned trips can be full of surprises.**

Travel Assistance Services with ID Theft Protection and Assistance include pre-trip information to help you feel more secure while traveling. It can also help you access medical professionals across the globe for medical assistance when traveling 100+ miles away from home for 90 days or less when unexpected detours arise. The ID theft services are available to you and your family at home or when you travel.

For more information on Travel Assistance Services or ID Theft Services, call **1-800-243-6108** or collect from other locations: 202-828-5885. Fax: 202-331-1528 or email [idtheft@europassistance-usa.com](mailto:idtheft@europassistance-usa.com). Please provide your employer's name, a phone number where you can be reached, nature of the problem, Travel Assistance Identification Number **GLD-09012**, and your employer policy number.

## **ABILITY ASSIST® COUNSELING SERVICES**

**Disability is a challenge. Getting support doesn't have to be.** Ability Assist Counseling Services, provided through The Hartford by ComPsych®, offers access to Master's- and PhD-degreed clinicians for 24/7 assistance if you're enrolled in our Long-term Disability plan. This includes three face-to-face visits per occurrence per year for emotional concerns and unlimited phone consultations for financial, legal, and work-life concerns.

For access over the phone, call **1-800-96-HELPS (3577)** or visit the website at:

[www.thehartford.com/employeebenefits](http://www.thehartford.com/employeebenefits).

<sup>(1)</sup>Funeral Concierge Services are offered through Everest Funeral Package, LLC (Everest). Everest and the Everest logo are service marks of Everest Funeral Package, LLC. Everest is not affiliated with The Hartford and is not a provider of insurance services. Everest and its affiliates have no affiliation with Everest ReGroup, Ltd., Everest Reinsurance Company or any of their affiliate.

<sup>(2)</sup>Beneficiary Assist® is offered through The Hartford by ComPsych®. ComPsych is not affiliated with The Hartford and is not a provider of insurance services.

<sup>(3)</sup>EstateGuidance® services are provided through The Hartford by ComPsych®. ComPsych is not affiliated with The Hartford and is not a provider of insurance services. A simple will does not cover credit shelter trust, printing or certain other features. These features are available at an additional cost to you.

<sup>(4)</sup>Travel Assistance and ID Theft Protection and Assistance are provided by Europ Assistance USA. Europ Assistance USA is not affiliated with The Hartford and is not a provider of insurance services.

<sup>(5)</sup>Ability Assist® Counseling Services are provided through The Hartford by ComPsych®, the largest provider of employee assistance programs, managed behavioral health, work/life and crisis intervention services. ComPsych is not affiliated with the Hartford and is not a provider of insurance services.

# LONG TERM DISABILITY (LTD) BENEFITS

## UNDERSTANDING YOUR LTD BENEFITS

The District provides disability coverage through The Hartford to protect you against the loss of income that may result if you are ill or injured and unable to work. There is no dependent coverage available under the Long Term Disability program because it is a salary replacement plan. **You are eligible if you are an active full time or permanent part time Certificated employee participating in STRS Plan B or Non-Certified full time or permanent part time employee who works at least 20 hours per week on a regularly scheduled basis.**

The District provides coverage that pays you a benefit of 66.67% of your earnings to a maximum monthly benefit of \$5,000 per month. This plan includes a minimum benefit of the greater of: 10% of the benefit based on monthly income loss before the deduction of other income benefits or \$100 per month. You must be disabled for at least 90 days before you can receive a benefit payment.

Disability payments are based on basic earnings definitions and do not include bonuses, overtime pay, or other extra compensation. If you become disabled prior to age 63, benefits may continue for as long as you remain disabled or until you reach your Social Security normal retirement age. If your disability occurs at age 63 or above, the number of payments may reduce.

The LTD plan includes pre-existing limitations when you first become eligible. You have a pre-existing condition if you received medical treatment, consultation, care or services including diagnostic measures, or took prescribed drugs or medicines in the three (3) months prior to the effective date of coverage; and if the disability begins in the first twelve (12) months of coverage unless you have been treatment free for 12 consecutive months after the effective date.)



# LONG TERM CARE (LTC) BENEFITS

## UNDERSTANDING YOUR LTC OPTIONS

The District offers a voluntary LTC policy through the Fringe Benefits Consortium. The need to plan for LTC is an increasingly important issue facing individuals today. Most people do not think about Long Term Care until it affects someone close to them. If you've cared for an aging parent or close relative, you probably realize the implications of providing and needing this type of care.

The purpose of LTC is to support or protect your assets when you need outside assistance to perform normal, everyday activities.

## YOUR LTC OPTIONS

The following LTC (LTC) plans are available through Unum:

- 2 year, 4 year, or Unlimited benefit duration
- Facility Benefit amount in increments of \$1,000 to a \$6,000 monthly maximum
- \$24,000, \$48,000, or Unlimited Lifetime Maximum
- Nursing Home Facility is the main option within the four plans. Also, the benefit is 50% for Total Home Care/ Professional Home Care.
- Inflation Protection options

**Newly hired employees:** Once eligible for the plan, have 30 days to sign up for guarantee issue coverage.

**All active employees:** If you enroll after the guarantee issue enrollment period or choose benefits over the guarantee issue limits will be required to fill out a medical questionnaire.

LTC policies require underwriting and final policy issue is subject to approval. You will not be charged a premium until your policy is approved.



## KNOW MORE ABOUT LTC

For your protection, LTC coverage is strictly regulated. Therefore, several notices and forms are required to participate. If you are interested in applying for coverage, please contact Payroll/Benefits for a LTC enrollment packet. You must review and sign the notices and forms provided in the UnumProvident LTC packet in order to apply for coverage. If you do not complete the necessary forms, you cannot be enrolled even though the basic plan costs you nothing.

The plan is portable so you can keep the coverage in place even if you leave the District. The plan is also guaranteed renewable which means that once you have been accepted into the program, the policy cannot be cancelled or terminated because you get older.

LTC insurance can be complex and representatives at Unum are prepared to help you in understanding the coverage so you can make an informed enrollment decision. Please refer to the Benefit Directory section of this guide for contact information.

# CANCER PROTECTION POLICY

## VOLUNTARY CANCER PLAN

The District offers a voluntary Cancer Protection Policy through American Fidelity to employees and their dependents as an optional benefit. The purpose of this supplemental coverage is to minimize the financial impact of cancer on the family.

## CANCER PLAN HIGHLIGHTS

American Fidelity's Cancer Policy can help with the indirect costs of cancer. The plans provide wellness benefits to help with the early detection of some cancers as well as the financial aid you may need if diagnosed with cancer. The American Fidelity plans are designed to pay you a specific benefit amount upon the first diagnosis of internal cancer. The plans also pay a per day hospital benefit and may include a Building Benefit Rider and a Specific Disease Benefit Rider.

Coverage for other situations, in or out of the hospital, that may be purchased include:

- Blood
- Second Opinion
- Ambulance
- Family lodging
- Surgery
- Radiation
- Chemotherapy
- Anesthesia

## KNOW MORE ABOUT CANCER INSURANCE

The cost for the American Fidelity plan is based on the coverage level you select along with the premium rate tables for policies within the class. Please request an enrollment packet if you are interested in obtaining the rates and/or applying for coverage. Benefit premiums are Section 125 eligible.

Benefit payments are made directly to you unless you assign them to your doctor or hospital. You will receive American Fidelity benefits regardless of any other insurance you may have. You determine the use of payments as they are available for any financial need.

This coverage does not replace your regular health insurance plan. It is available as a financial support tool if you experience one of the covered events.

The plan is portable so you can continue the plan if you leave the District. Refer to the plan summary for details regarding this option.



# ACCIDENT, DISABILITY, AUTO & HOMEOWNERS

## ACCIDENT ONLY POLICY

Accident Insurance helps protect you and your family against the high cost of accidental injury or death. American Fidelity Assurance helps keep you and your family from financial harm in the future.

The American Fidelity Assurance plans are designed to pay a specific amount for a covered person's death, dismemberment or injury caused by a covered accident. Coverage may be purchased for the following benefits:

- Accident Emergency Treatment Benefit
- Medical Imaging Benefit
- Hospital Confinement Benefits
- Wellness Benefit Ambulance Benefit
- Accidental Death or Dismemberment Benefit

This coverage does not replace your regular health insurance plan. It is available as a financial support tool if you experience one of the covered events. Please request an enrollment packet if you are interested in obtaining the rates and/or applying for coverage. Each plan has unique aspects so please refer to the policy or contact our American Fidelity sales representative for a detailed explanation of the options.

## DISABILITY INCOME INSURANCE

If you are unable to work due to a covered Injury or sickness, with American Fidelity's Disability Income Insurance, you will receive benefits to help pay for life's necessities until you are able to return to work.

Features include:

- Several different benefit plan options available
- Benefit payments can be deposited directly into employee's bank account
- Benefits are payable year-round

Disability Income Insurance contains limitations, exclusions and waiting periods.

## CRITICAL CHOICE

If you or a family member suffered from a critical illness, such as a heart attack or stroke, your medical bills and every day expenses can start adding up quickly.

American Fidelity's Limited Benefit Specified Illness Policy may be able to provide some financial protection so you can focus on your recovery.

Plan Features Include:

- Choose Critical Illness benefit amount: \$15,000, \$20,000 or \$25,000
- Pays 100% of your benefit amount for a Critical Illness
- Cardiac Screening benefit for covered Cardiac Screening tests, which is available without a diagnosis of a Critical Illness and does not reduce your Critical Illness benefit amount.

For more information, please contact your American Fidelity representative.

## AUTO & HOMEOWNERS INSURANCE

You can take advantage of enhanced insurance coverage available through Liberty Mutual that protects you on the road.

- Deductible waived if your car is vandalized on school property or while you're using it for school-related events.
- Deductible waived if your car is damaged from a collision while you're driving it for school business
- You'll be covered to a limit of \$2,500 per occurrence if your personal education materials or school property is stolen or damaged while in your car.

Liberty Mutual's automobile and homeowner programs provide meaningful voluntary benefits to help you save time and money while protecting things you value.

Additional value added services include:

- One-Stop Replacement Shopping
- Handy Home Repair Referral

For more detailed information regarding these voluntary benefits, please contact our Liberty Mutual representative.

# FLEXIBLE SPENDING ACCOUNTS (FSA)

## UNDERSTANDING YOUR SECTION 125 FLEXIBLE SPENDING ACCOUNT OPTIONS

The Section 125 Flexible Spending Accounts (FSA) allow you to use before-tax dollars to pay for health care expenses for you and your family that are not covered or are only partially covered by any health plan, and to pay for dependent day care expenses incurred so that you can be gainfully employed.

When you participate in the FSAs, you can direct a part of your pay, on a pre-tax basis, into a special account that can be used to reimburse yourself tax-free as you incur expenses. You decide whether to participate in one or both of the accounts each year. As you incur eligible expenses throughout the year, you reimburse yourself for those expenses out of the appropriate account with your tax-free dollars.

This plan offers two (2) ways to help you pay for certain, necessary expenses with tax-free dollars:

- 1. Health Care Reimbursement Account (HCRA)** also called Medical Expense Reimbursement
- 2. Dependent Day Care Reimbursement Account (DCRA)**

You may enroll in just one or both plans – it's your choice.

## HEALTH CARE REIMBURSEMENT ACCOUNT

Consider using the HCRA if you have predictable health care expenses for which you must pay some or all of the cost. Predictable expenses may include deductibles, copayments for medical, dental, and vision services, and eligible expenses incurred by you or your eligible dependents that are not covered by any health plan.

The plan allows you to set aside up to \$2,700 per year for eligible expenses. You decide how much to set aside based on the expenses you can reasonably expect to incur within the plan year.

You can be reimbursed at any time, up to your annual contribution amount, even if that amount is not yet in your HFCA. Your contributions for the rest of the year will go toward repaying your account.

Expenses incurred for services must occur during the plan year. These expenses would be for services provided during the plan year without regard to when you were billed or paid for the services.

### Carryover Provision

The IRS gives employers the ability to allow Health FSA participants carry over up to \$500 of unused contributions from one plan year to the next. This carryover amount may be used to reimburse eligible medical expenses incurred anytime during the next plan year. Any carryover amount is in addition to your new Health FSA election and does not increase the election amount or decrease your payroll deductions. Any unused amount over \$500 will be forfeited. It's important to plan conservatively.

## DEPENDENT CARE REIMBURSEMENT ACCOUNT

If you pay for dependent care services so that you can be at work, you will want to consider participating in the DCRA. If you are married, your spouse must be unable to care for your dependent(s) because he or she is employed, is a full-time student, or has a physical or mental disability. You can use this account to pay for expenses for your dependent children under the age of 13 and for any other person living with you whom you claim as a dependent and who is physically or mentally incapable of self-care.

This plan allows you to set aside up to \$5,000 per year for eligible expenses. You decide how much to set aside based on the expenses you can reasonably expect to incur within the plan year.

You may request reimbursement from your DCRA at any time – but you can be reimbursed only up to the amount already in your DCRA. This means that reimbursements will always lag behind your contributions.

To plan your annual expenses, consider amounts you pay for day care and after-school care. Keep in mind that expenses you incur while you are on vacation or on a leave of absence are not eligible for reimbursement. Be thoughtful in your planning of the amount you wish to set aside into the DCRA. The IRS "Use It or Lose It Rule" requires that you forfeit any money left in your account at the end of the plan. You have 90 days after the plan year ends to file claims for expenses incurred during the plan year.

# FSA & LEGAL ASSISTANCE

## FACTS ABOUT FSA

- You may use the money in your accounts only to pay eligible health care or dependent day care expenses.
- You cannot change your elections mid-year unless you have a qualifying status change.
- You may not carry over your account balances from year to year, and you may not transfer funds from one account to the other.
- Except for insulin, over the counter drugs are not reimbursable from a Flexible Spending Account unless you have a prescription .
- The enrollment materials contain examples of tax savings, and lists of eligible and ineligible expenses. Use these materials to plan your savings and maximize your tax saving without risking too much.

## FLEX DEBIT CARD

Your Flex Debit Card allows you to pay for eligible medical expenses directly from your HCRA instead of using out-of-pocket funds. When you incur an allowable medical expense, such as a doctor visit or prescription purchase, you can use the debit card to pay for these expenses. It gives you direct access to your funds, without the need to wait on reimbursement checks.

Other expenses such as vision, dental and recurring medical costs are also eligible, but most of these transactions may require a receipt to be submitted before you are reimbursed.

### Managing your Card:

- Save your receipts
- The card is for medical expenses only; dependent daycare expenses are not eligible
- The card cannot be used for over-the-counter drugs filled with a prescription. You will need to file a paper claim
- If the requested documentation is not provided to the Flex Department within 30 days, the card may be put into a “blocked status” due to the outstanding receipts

For detailed information regarding your Flex Debit Card, please contact your American Fidelity representative.

## LEGAL ASSISTANCE

### Understanding your Legal Assistance Plan

Finding an affordably priced attorney to represent you when you have trouble with creditors, buy or sell your home, or even prepare your last will and testament can be a challenge.

Through Hyatt Legal Plans – MetLaw, you can enroll in a legal services plan that provides legal representation for you, your spouse, and dependents at a price that won't break your budget.

### Your MetLaw Plan Option

If you choose to enroll in the MetLaw plan, you will have a resource for important, everyday legal services for a wide range of matters, including:

- Documentation Review and Preparation (mortgages, deeds, immigration)
- Debt collection defense
- Identity Theft defense
- Wills and Living Trusts
- Real Estate matters

MetLaw provides access to a nationwide network of participating attorneys from which to choose. Attorneys have met stringent selection criteria and have an average of 25 years or more of legal experience.



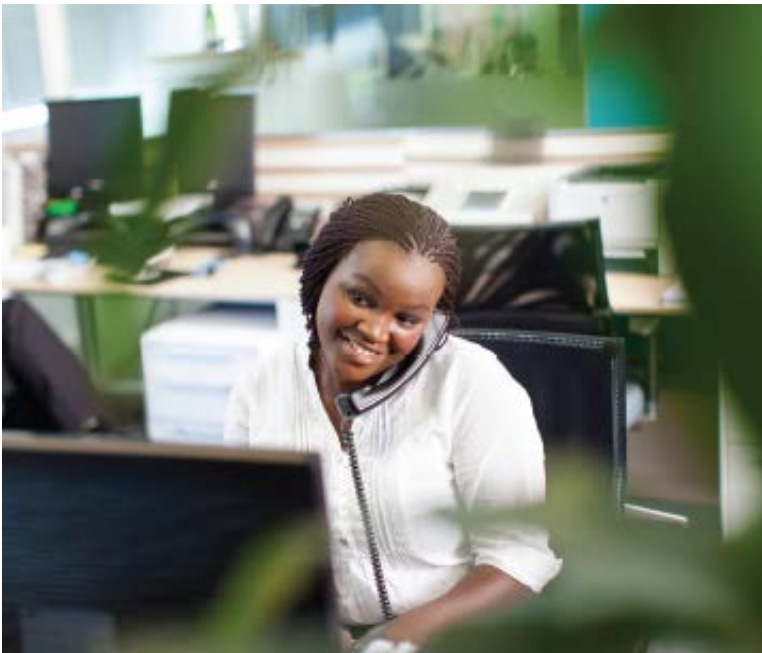
## Need Help with your benefits?

Call or email your Benefits Advocate today!



**Toll Free:** (800) 914-5096

**Email:** [BenefitsAdvocate@mcgriffinsurance.com](mailto:BenefitsAdvocate@mcgriffinsurance.com)



**McGriff** Insurance Services provides Fallbrook Union High School District's valued employees with a unique service. It's your personal **Benefits Advocate!**

When you contact the **Benefits Advocate**, one of FUHSD's dedicated team of benefits professionals who knows our plans is there to help.

Here are just a few of the ways your **Benefits Advocate** can assist you:

- Finding a contracted provider
- Resolving referral problems
- Researching denied claims
- Coverage not shown in provider's system
- Getting a prescription covered
- Coverage while traveling

# HIPAA NOTICE OF PRIVACY PRACTICES

## **Health Insurance Portability and Accountability Act (HIPAA) Notice of Privacy Practices**

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

***Our Pledge to You:*** This notice is intended to inform you of the privacy practices followed by the Benefit Plan (the Plan) and the Plan's legal obligations regarding your protected health information under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The notice also explains the privacy rights you and your family members have as participants of the Plan. It is effective as of July 1, 2009.

The Plan often needs access to your protected health information in order to provide payment for health services and perform plan administrative functions. We want to assure the plan participants covered under the Plan that we comply with federal privacy laws and respect your right to privacy. It is required that all members of our workforce and third parties that are provided access to protected health information to comply with the privacy practices outlined below.

***Protected Health Information:*** Your protected health information is protected by the HIPAA Privacy Rule. Generally, protected health information is information that identifies an individual created or received by a health care provider, health plan or an employer on behalf of a group health plan that relates to physical or mental health conditions, provision of health care, or payment for health care, whether past, present or future.

***How We May Use Your Protected Health Information:*** Under the HIPAA Privacy Rule, we may use or disclose your protected health information for certain purposes without your permission. This section describes the ways we can use and disclose your protected health information.

- ***Payment.*** We use or disclose your protected health information without your written authorization in order to determine eligibility for benefits, seek reimbursement from a third party, or coordinate benefits with another health plan under which you are covered. For example, a health care provider that provided treatment to you will provide us with your health information. We use that information in order to determine whether those services are eligible for payment under our group health plan..
- ***Health Care Operations.*** We use and disclose your protected health information in order to perform plan administration functions such as quality assurance activities, resolution of internal grievances, and evaluating plan performance. For example, we review claims experience in order to understand participant utilization and to make plan design changes that are intended to control health care costs
- ***Treatment.*** Although the law allows use and disclosure of your protected health information for purposes of treatment, as a health plan we generally do not need to disclose your information for treatment purposes. Your physician or health care provider is required to provide you with an explanation of how they use and share your health information for purposes of treatment, payment, and health care operations.
- ***As permitted or required by law.*** We may also use or disclose your protected health information without your written authorization for other reasons as permitted by law. We are permitted by law to share information, subject to certain requirements, in order to communicate information on health-related benefits or services that may be of interest to you, respond to a court order, or provide information to further public health activities (e.g., preventing the spread of disease) without your written authorization. We are also permitted to share protected health information during a corporate restructuring such as a merger, sale, or acquisition. We will also disclose health information about you when required by law, for example, in order to prevent serious harm to you or others.

- *Pursuant to your Authorization.* When required by law, we will ask for your written authorization before using or disclosing your protected health information. If you choose to sign an authorization to disclose information, you can later revoke that authorization to prevent any future uses or disclosures.
- *To Business Associates.* We may enter into contracts with entities known as Business Associates that provide services to or perform functions on behalf of the Plan. We may disclose protected health information to Business Associates once they have agreed in writing to safeguard the protected health information. For example, we may disclose your protected health information to a Business Associate to administer claims. Business Associates are also required by law to protect protected health information.
- *To the Plan Sponsor.* We may disclose protected health information to certain employees for the purpose of administering the Plan. These employees will use or disclose the protected health information only as necessary to perform plan administration functions or as otherwise required by HIPAA, unless you have authorized additional disclosures. Your protected health information cannot be used for employment purposes without your specific authorization.

### **Your Rights:**

- *Right to Inspect and Copy.* In most cases, you have the right to inspect and copy the protected health information we maintain about you. If you request copies, we will charge you a reasonable fee to cover the costs of copying, mailing, or other expenses associated with your request. Your request to inspect or review your health information must be submitted in writing. In some circumstances, we may deny your request to inspect and copy your health information. To the extent your information is held in an electronic health record, you may be able to receive the information in an electronic format.
- *Right to Amend.* If you believe that information within your records is incorrect or if important information is missing, you have the right to request that we correct the existing information or add the missing information. Your request to amend your health information must be submitted in writing to the Risk Management Department. In some circumstances, we may deny your request to amend your health information. If we deny your request, you may file a statement of disagreement with us for inclusion in any future disclosures of the disputed information.
- *Right to an Accounting of Disclosures.* You have the right to receive an accounting of certain disclosures of your protected health information. The accounting will not include disclosures that were made
  - 1) for purposes of treatment, payment or health care operations;
  - 2) to you;
  - 3) pursuant to your authorization;
  - 4) to your friends or family in your presence or because of an emergency;
  - 5) for national security purposes; or
  - 6) incidental to otherwise permissible disclosures.

Your request for an accounting must be submitted in writing to Human Resources. You may request an accounting of disclosures made within the last six years. You may request one accounting free of charge within a 12-month period.

- *Right to Request Restrictions.* You have the right to request that we not use or disclose information for treatment, payment, or other administrative purposes except when specifically authorized by you, when required by law, or in emergency circumstances. You also have the right to request that we limit the protected health information that we disclose to someone involved in your care or the payment for your care, such as a family member or friend.

Your request for restrictions must be submitted in writing to Human Resources. We will consider your request, but in most cases are not legally obligated to agree to those restrictions. However, we will comply with any restriction request if the disclosure is to a health plan for purposes of payment or health care operations (not for treatment) and the protected health information pertains solely to a health care item or service that has been paid for out-of-pocket and in full.

- *Right to Request Confidential Communications.* You have the right to receive confidential communications containing your health information. Your request for confidential communications must be submitted in writing to Human Resources. We are required to accommodate reasonable requests. For example, you may ask that we contact you at your place of employment or send communications regarding treatment to an alternate address.
- *Right to be Notified of a Breach.* You have the right to be notified in the event that we (or one of our Business Associates) discover a breach of your unsecured protected health information. Notice of any such breach will be made in accordance with federal requirements.
- *Right to Receive a Paper Copy of this Notice.* If you have agreed to accept this notice electronically, you also have a right to obtain a paper copy of this notice from us upon request. To obtain a paper copy of this notice, please contact Human Resources.

### ***Our Legal Responsibilities***

We are required by law to protect the privacy of your protected health information, provide you with certain rights with respect to your protected health information, provide you with this notice about our privacy practices, and follow the information practices that are described in this notice.

We may change our policies at any time. In the event that we make a significant change in our policies, we will provide you with a revised copy of this notice. You can also request a copy of our notice at any time from Human Resources. For more information about our privacy practices, if you have any questions or complaints, please contact Human Resources.

### ***Complaints***

If you are concerned that we have violated your privacy rights, or you disagree with a decision we made about access to your records, you may contact Human Resources. You also may send a written complaint to the U.S. Department of Health and Human Services — Office of Civil Rights. Human Resources can provide you with the appropriate address upon request or you may visit [www.hhs.gov/ocr](http://www.hhs.gov/ocr) for further information. You will not be penalized or retaliated against for filing a complaint with the Office of Civil Rights or with us.

# MEDICARE PART D NOTICE

**Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.**

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage: Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

The prescription drug coverage offered by your employer is expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

## **When Can You Join A Medicare Drug Plan?**

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15 through December 7.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

## **When Will You Pay a Higher Premium (Penalty) to Join a Medicare Drug Plan?**

You should also know that if you drop or lose your current coverage under the group health plan and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go 19 months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following November to join.

## **For More Information about This Notice or Your Current Prescription Drug Coverage**

Contact Human Resources for further information. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through IMS changes. You also may request a copy of this notice at any time.

## **For More Information about Your Options under Medicare Prescription Drug Coverage**

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

**For More Information about Medicare Prescription Drug Coverage:**

Visit [www.medicare.gov](http://www.medicare.gov)

Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the “Medicare & You” handbook for their telephone number) for personalized help.

Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at [www.socialsecurity.gov](http://www.socialsecurity.gov) or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

## **Children’s Health Insurance Program (CHIP)**

If you or your children are eligible for Medicaid or CHIP and you’re eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren’t eligible for Medicaid or CHIP, you won’t be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit [www.healthcare.gov](http://www.healthcare.gov).

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial 1-877-KIDS NOW or [www.insurekidsnow.gov](http://www.insurekidsnow.gov) to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren’t already enrolled. This is called a “special enrollment” opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance. If you have questions about enrolling in your employer plan, contact the Department of Labor at [www.askebsa.dol.gov](http://www.askebsa.dol.gov) or call 1-866-444-EBSA (3272).

## **CHIP Reauthorization Act (CHIPRA) of 2009**

Effective April 1, 2009, employees and dependents who are eligible for coverage under the medical plan, but are not enrolled, will be permitted to enroll in the plan if they lose eligibility for Medicaid or CHIP coverage or become eligible for a premium assistance subsidy under Medicaid or CHIP.

Individuals must request coverage under the plan within 60 days of the loss of Medicaid or CHIP coverage or the determination of eligibility for a premium assistance subsidy. CHIPRA allows states to offer eligible low-income children and their families a premium assistance subsidy to help pay for employer-sponsored coverage. Some states offer a premium assistance subsidy. Included with this notice is a list of potential opportunities available for premium assistance. You should contact your State for further information on eligibility.

## **Consolidated Omnibus Budget Reconciliation Act (COBRA) Continuation**

COBRA gives you and your dependents the right to continue health care coverage for a specific time if your employer-sponsored coverage ends. In accordance with COBRA, you (and/or your covered dependents) have a right to continue your health care coverage in the event you (or your dependents) are no longer eligible for coverage through the employee benefits program. There are several instances in which COBRA continuation is available; these instances are referred to as “qualifying events.”

Generally, COBRA coverage is available to you for up to 18 months (an additional 18 months may be available in certain circumstances). To receive this coverage, you must enroll for benefits in a timely manner and pay the required premium. The amount charged can be equal to the full premium plus a 2% administration fee. If a qualifying event occurs and your employer is aware of it or notified, the COBRA administrator will send you the required COBRA enrollment materials. For qualifying events that your employer may not be aware of, such as a divorce or birth of a child, it is your responsibility to report the event within 60 days.

## **Employee Retirement Income Security Act (ERISA) Compliance Statement of Rights**

As a participant in the group insurance plan you are entitled to certain rights and protections under the ERISA of 1974. ERISA provides that all Plan participants shall be entitled to:

### ***Receive Information about You Plan and Benefits***

- Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the Plan administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for copies.
- Receive a summary of the Plan's annual financial report, if the plan administrator is required by law to file a Form 5500. The plan administrator may be required by law to furnish each participant with a copy of this summary annual report.

## **Grandfathered Plan Status Notice**

This group health plan is **NOT** a "grandfathered health plan" under the Patient Protection and Affordable Care Act (PPACA). As permitted by the Affordable Care Act (ACA), a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that the plan may not include certain consumer protections of the ACA that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the ACA, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to Human Resources. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or [www.dol.gov/ebsa/healthreform/](http://www.dol.gov/ebsa/healthreform/). This website has a table summarizing which protections do and do not apply to grandfathered health plans.

## **Health Insurance Marketplace Coverage Options and Your Health Coverage**

When key parts of the health care law took effect in 2014, there was a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the Marketplace.

### ***What is the Health Insurance Marketplace?***

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace began in October 2013 for coverage starting as early as January 1, 2014.

### ***Can I Save Money on my Health Insurance Premiums in the Marketplace?***

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

### ***Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?***

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan.

However, you may be eligible for a tax credit that lowers your monthly premium or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards.

If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5 percent of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit. (An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.)

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution—as well as your employee contribution to employer-offered coverage—is often excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

### ***How Can I Get More Information?***

For more information about your coverage offered by your employer, please check your summary plan description or call your plan administrator.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit [www.HealthCare.gov](http://www.HealthCare.gov) for more information, as well as an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

## **HIPAA Notice of Special Enrollment Rights**

This notice is being provided to make certain that you understand your right to apply for group health insurance coverage. You should read this notice even if you plan to waive health insurance coverage at this time.

### ***Loss of Other Coverage***

If you are declining coverage for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

Example: You waived coverage under this plan because you were covered under a plan offered by your spouse's employer. Your spouse terminates employment. If you notify your employer within 30 days of the date coverage ends, you and your eligible dependents may apply for coverage under this health plan.

### ***Marriage, Birth, or Adoption***

If you have a new dependent as a result of a marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, or placement for adoption.

Example: When you were hired, you were single and chose not to elect health insurance benefits. One year later, you marry. You and your eligible dependents are entitled to enroll in this group health plan. However, you must apply within 30 days from the date of your marriage.

### ***Medicaid or CHIP***

If you or your dependents lose eligibility for coverage under Medicaid or the Children's Health Insurance Program (CHIP) or become eligible for a premium assistance subsidy under Medicaid or CHIP, you may be able to enroll yourself and your dependents. You must request enrollment within 60 days of the loss of Medicaid or CHIP.

Example: When you were hired, your children received health coverage under CHIP and you did not enroll them in this health plan. Because of changes in your income, your children are no longer eligible for CHIP coverage. You may enroll them in this group health plan if you apply within 60 days of the date of their loss of CHIP coverage.

To request special enrollment or obtain more information, please contact Human Resources.

Note: If you or your dependents enroll during a **special enrollment period**, as described above, you will not be considered a late enrollee. Therefore, your group health plan may not impose a preexisting condition exclusion period of more than 12 months. Any preexisting condition exclusion period will be reduced by the amount of your prior creditable health coverage. **Effective for plan years beginning on or after January 1, 2014, health plans may not impose pre-existing condition exclusions on any enrollees.**

### **Newborns' and Mothers' Health Protection Act (NMHPA) Notice**

Group health plans and health insurance issuers generally may not, under Federal Law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal Law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal Law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

### **OTC Drug Reimbursements for FSAs/HSAs**

Under the Health Care Reform law (PPACA), the cost of an over-the-counter medicine or drug cannot be reimbursed from the account unless a prescription is obtained. The change does not affect insulin, even if purchased without a prescription, or other health care expenses such as medical devices, eyeglasses, contact lenses, co-pays and deductibles. The new standard applies only to purchases made on or after January 1, 2011.

A similar rule is in effect for Health Savings Accounts (HSAs).

The IRS has also posted a questions and answers section on its website

<http://www.irs.gov/newsroom/article/0,,id=227308,00.html> concerning these provisions.

### **Patient Protection Notice**

Our plan generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in the network and who is available to accept you or your family members. Until you make this designation, the medical carrier designates one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the medical insurance carrier at the number listed on your identification card.

For children, you may designate a pediatrician as the primary care provider. You do not need prior authorization from the medical insurance carrier or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in the network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the medical insurance carrier at the number listed on your identification card.

## **Qualified Medical Child Support Orders**

A 1993 amendment to the Employee Retirement Income Security Act (ERISA) requires employment-based group health plans to extend health care coverage to the children of a parent-employee who is divorced, separated or never married when ordered to do so by state authorities.

## **Summary of Benefits and Coverage (SBC)**

Under the ACA, health insurers and group health plans provide consumers with a document detailing, in plain language, simple and consistent information about health plan benefits and coverage. This summary document is intended to help consumers better understand the coverage they have and allow them to easily compare different coverage options. SBC's summarize the key features of the plan or coverage, such as the covered benefits, cost-sharing provisions, and coverage limitations and exceptions.

## **Wellness Program Notice of Reasonable Alternative Standard**

Your employer is committed to helping you achieve your best health. Rewards for participating in a wellness program are available to all employees. If you think you might be unable to meet a standard for a reward under a wellness program, you might qualify for an opportunity to earn the same reward by different means. We will work with you (and if you wish, your doctor) to find a wellness program activity with the same reward that is right for you in light of your health status. Contact Human Resources for more information.

## **Women's Health and Cancer Rights Act (WHCRA) of 1998**

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the WHCRA. For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. If you would like more information on WHCRA benefits, call your plan administrator.

# CONTACT INFORMATION

	PHONE NUMBER	E-MAIL/WEBSITE
<b>McGriff Benefits Advocate Hotline</b>	<b>800.914.5096</b>	<a href="mailto:BenefitsAdvocate@McGriffInsurance.com">BenefitsAdvocate@McGriffInsurance.com</a>
<b>Anthem HMO &amp; PPO Medical Plans</b>		
Member Services	<b>800.825.5541</b>	<a href="http://www.anthem.com/ca/sisc">www.anthem.com/ca/sisc</a>
Navitus Prescription Drug Plan	<b>866.333.2757</b>	<a href="http://www.navitus.com">www.navitus.com</a>
24/7 Physician Line – MD Live	<b>888.632.2738</b>	<a href="http://www.mdlive.com/ca/sisc">www.mdlive.com/ca/sisc</a>
Guest Membership (for HMO members)	<b>800.827.6422</b>	<a href="http://www.anthem.com/forms/ca/guest_membership.html">www.anthem.com/forms/ca/guest_membership.html</a>
<b>Kaiser HMO Medical Plan</b>		
Member Services	<b>800.464.4000</b>	<a href="http://www.kp.org">www.kp.org</a>
Away from Home Travel Line	<b>951-268-3900</b>	
<b>Dental PPO</b>		
Delta Dental (FBC)	<b>866.499.3001</b>	<a href="http://www.deltadentalins.com">www.deltadentalins.com</a>
<b>Vision Plan</b>		
VSP Signature Plan (FBC)	<b>800.877.7195</b>	<a href="http://www.vsp.com">www.vsp.com</a>
<b>Term Life AD&amp;D</b>		
The Hartford (FBC)	<b>800.523.2233</b>	<a href="http://www.TheHartfordAtWork.com">www.TheHartfordAtWork.com</a>
<b>Long Term Disability</b>		
The Hartford (FBC)	<b>800.523.2233</b>	<a href="http://www.TheHartfordAtWork.com">www.TheHartfordAtWork.com</a>
<b>Employee Assistance Program (EAP)</b>	<b>Anthem:</b>	<a href="http://www.anthem.com/ca/sisc">www.anthem.com/ca/sisc</a>
Anthem Blue Cross (SISC)	<b>800.999.7222</b>	Company code: SISC
EASE (FBC)	<b>EASE:</b>	<a href="http://www.mhn.advantageengagement.com">www.mhn.advantageengagement.com</a>
	<b>800.722.3273</b>	Company code: EASE
<b>Long Term Care</b>		
Unum (FBC)	<b>800.227.4165</b>	<a href="http://www.unuminfo.com/consortium">www.unuminfo.com/consortium</a>
<b>Flexible Spending Accounts (HCSA/DCSA)</b>		
American Fidelity Assurance	<b>800.654.8569</b>	<a href="http://www.afadvantage.com">www.afadvantage.com</a>
<b>Personal Accident, Cancer, Critical Choice, Disability</b>		
American Fidelity Assurance	<b>800.323.3748</b>	<a href="http://www.afadvantage.com">www.afadvantage.com</a>
Bryan Kraft – Enrollment Specialist	<b>866.523.1857</b> <b>Ext. 405</b>	<a href="mailto:Bryan.Kraft@AmericanFidelity.com">Bryan.Kraft@AmericanFidelity.com</a>
<b>Auto &amp; Home</b>		
Liberty Mutual Insurance	<b>760.930.0841</b>	<a href="http://www.libertymutual.com">www.libertymutual.com</a>
Vineet Tiwary, Personal Market Sales	<b>Ext. 58242</b>	<a href="mailto:Vineet.Tiwary@LibertyMutual.com">Vineet.Tiwary@LibertyMutual.com</a>
<b>Legal Plan</b>		
MetLaw Hyatt Legal (FBC)	<b>800.821.6400</b>	<a href="http://www.Info.legalplans.com">www.Info.legalplans.com</a> code: 1680010 or MetLaw
<b>Fallbrook Union High School District</b>		
Leea Powell, Business Services Technician	<b>760.723.6332</b>	<a href="mailto:leeapowell@fuhsd.net">leeapowell@fuhsd.net</a>
Brenda Mefford, Finance Director		<a href="mailto:bmefford@fuhsd.net">bmefford@fuhsd.net</a>





*The information in this Benefits Summary is presented for illustrative purposes and is based on information provided by the employer. The text contained in this Summary was taken from various summary plan descriptions and benefit information. While every effort was taken to accurately report your benefits, discrepancies or errors are always possible. In case of discrepancy between the Benefits Summary and the actual plan documents the actual plan documents will prevail. All information is confidential, pursuant to the Health Insurance Portability and Accountability Act of 1996. If you have any questions about this summary, contact Human Resources.*