

2024 - 2025 BENEFITS



Classified Post Eligible



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MEDICARE PART D NOTICE

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a federal law gives you more choices about your prescription drug coverage. Please see the Important Plan Information section for more details.



GETTING STARTED

2024 - 2025 BENEFITS

July 1, 2024
through
June 30, 2025

Whether you're enrolling in benefits for the first time, nearing retirement, or somewhere in between, Santa Ana Unified School District supports you with benefit programs and resources to help you thrive today and prepare for tomorrow.

This guide provides an overview of your healthcare coverage, life, disability, and more.

You'll find tips to help you understand your medical coverage, save time and money on healthcare, reduce taxes, and balance your work and home life. Review the coverage and tools available to you to make the most of your benefits package.

WHO'S ELIGIBLE FOR BENEFITS?



When you become eligible for **Medicare** (usually at age 65) you and/or your spouse must enroll in Part A and B through the Social Security Administration. You must also provide our office with a copy of your Medicare card before the end of your 65th birthday month. The lower “with Medicare” rates will be applied beginning the first day of your 65th birthday month of the first day of the following month from which we receive your card.

Failure to enroll in Medicare Parts A and B or provide our office with a copy of your Medicare card will result in the termination of your benefits.

You are eligible to participate in our post eligible benefits program immediately after your retirement benefits expire. You have a 60-day window to enroll and may remain enrolled indefinitely or until you obtain other coverage. You and your dependents have your own individual election rights to SAUSD’s post eligible program.

Eligible dependents

- Legally married spouse.
- Domestic Partner with proof of a Declaration of Domestic Partnership filed with the California State Secretary. Any premiums paid for by SAUSD for your domestic partner will be deducted on an after-tax basis.
- Natural, adopted or stepchildren, or children of a domestic partner up to age 26.
- Children over age 26 who are disabled and depend on you for support.
- Children named in a Qualified Medical Child Support Order (QMCSO).

You can cover any eligible dependent as long as you enroll them during your initial enrollment period.

Who is not eligible

Members who are not eligible for coverage include (but are not limited to):

- Parents, grandparents, and siblings.

When you can enroll

You can only enroll in the post eligible benefits program during your initial enrollment period only. You have 60 days after your retirement benefits expire to enroll in coverage.

If you fail to enroll during your initial election period, you will not be able to enroll in the future.

OPEN ENROLLMENT



Open Enrollment is a once-a-year opportunity to review your benefit choices, change plans, add or drop dependents, and enroll or re-enroll in Flexible Spending Accounts. After Open Enrollment ends, you cannot change your benefit elections until the next Open Enrollment in 2025, unless you experience an eligible life event.

Open Enrollment begins:

May 13, 2024 through May 24, 2024.

Any changes made during OE will be effective on July 1, 2024.

Do I need to enroll?

If you do not have any changes to make to your 2024 -2025 benefits, **no action is required**. You only need to fill out a form for Open Enrollment, if you would like to change your benefits.

What's new or changing

Our current benefit program will continue into the 2024 – 2025 school year with no changes to benefits. While your benefits aren't changing, you may have had some major life changes. Do your current choices still meet your needs? Review this benefits guide to understand your coverage options. Include your spouse or partner in the review if they have input into your family's benefits decisions.

These changes will be effective on July 1, 2024.

CHANGING YOUR BENEFITS

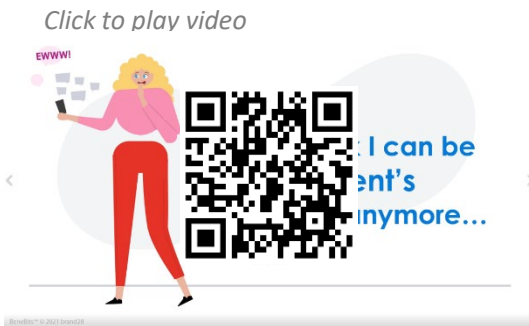
Outside of open enrollment, you may be able to enroll or make changes to your benefit elections if you have a big change in your life, including:

- Change in legal marital status
- Change in number of dependents or dependent eligibility status
- Change in employment status that affects eligibility for you, your spouse, or dependent child(ren)
- Change in residence that affects access to network providers
- Change in your health coverage or your spouse's coverage due to your spouse's employment
- Change in an individual's eligibility for Medicare or Medicaid
- Court order requiring coverage for your child
- "Special enrollment event" under the Health Insurance Portability and Accountability Act (HIPAA), including a new dependent by marriage, birth or adoption, or loss of coverage under another health insurance plan
- Event allowed under the Children's Health Insurance Program (CHIP) Reauthorization Act (you have 60 days to request enrollment due to events allowed under CHIP)

You must submit your change within 30 days after the event.

THREE RULES APPLY TO MAKING CHANGES TO YOUR BENEFITS DURING THE YEAR:

1. Any change you make must be consistent with the change in status.
2. You must make the change within 30 days of the date the event occurs.
3. All proper documentation is required to cover dependents (marriage certificates, birth certificates, etc.).



LIFE HAPPENS

A change in your life may allow you to update your benefit choices. Watch the video for a quick take on your options.



HEALTHCARE

MAKE TIME FOR HEALTH

OUR COMMITMENT

We believe that our employees should have access to healthcare coverage that promotes preventive care and helps cover the cost of illness.

Eligible employees and their eligible dependents can enroll in medical, dental, and vision coverage through the SAUSD benefits program.

Medical

We offer 4 medical plans. Preventive care is fully covered under all plans if obtained in-network. Your costs for other services will depend on which plan you choose. Review the network provider information and out-of-pocket costs such as deductible, coinsurance and prescription drugs so you can choose the best fit for your health concerns and budget.

Dental

Some people don't like going to the dentist, but no one likes big dental bills. Regular checkups and cleanings are fully covered and can identify issues before they become serious. And if you do need dental services, insurance helps cover the cost for fillings, gum disease, orthodontia, and more.

Vision

An eye exam can uncover health conditions you may not know you have, such as glaucoma, or even high blood pressure. Our vision plan help cover the cost of eye exams, eyeglasses, and contact lenses to ensure you're seeing and feeling your best.

MEDICAL HMO COVERAGE WITH MEDICARE

The following chart shows the two plans available to post eligible subscribers who have Medicare Parts A and B. Once you are eligible for Medicare Parts A and B (usually at age 65), you and/or your spouse must enroll in those parts with the Social Security Administration and provide our office with a copy of the Medicare card before the end of your or your spouse's 65th birthday month.

All post eligible subscribers who are Kaiser members and enrolled in Medicare Parts A and B are required to enroll in the Kaiser Senior Advantage plan (additional form required).

Blue Shield members who are enrolled in Medicare Parts A and B have the option to enroll in the Blue Shield 65 Plus plan (additional form required).

Failure to enroll in Medicare Parts A and B or provide our office with a copy of your Medicare card will result in the termination of your benefits.

	Blue Shield 65 Plus HMO	Kaiser Senior Advantage HMO
Calendar Year Deductible¹	None	None
Calendar Year Out-of-Pocket Maximum¹	\$6,700 per person	\$1,000 per person
Office Visit Primary Care Specialist	\$20 copay \$20 copay	\$20 copay \$20 copay
Preventive Services	Plan pays 100%	Plan pays 100%
Chiropractic	\$20 copay (through Medicare) \$15 copay (through American specialty Health / 20 visits per year)	Not Covered
Lab and X-ray	\$20 copay	Plan pays 100%
Urgent Care	\$25 copay	\$20 copay
Emergency Room	\$50 copay (waived if admitted)	\$50 copay (waived if admitted)
Inpatient Hospitalization	\$250 copay (per admission)	\$250 copay (per admission)
Outpatient Surgery	Plan pays 100%	\$20 copay (per procedure)
Gym Membership	Silver Sneakers	Choose Healthy
PRESCRIPTION DRUGS	Express Scripts	Kaiser Pharmacy
Calendar Year Deductible	None	None
Out-of-Pocket Maximum Individual Family	\$5,000	Combined with Medical \$1,500 \$3,000
Retail Generic Preferred Brand Name Non-Preferred Brand Name Supply limit	\$10 copay \$20 copay \$40 copay 30 days	\$10 copay \$20 copay Not Applicable 100 days
Mail Order Generic Preferred Brand Name Non-Preferred Brand Name Supply limit	\$20 copay \$40 copay \$80 copay 90 days	\$10 copay \$20 copay Not Applicable 100 days

¹Deductibles and out-of-pocket maximums accumulate on a calendar year from January 1 – December 31.

MEDICAL HMO COVERAGE WITH OR WITHOUT MEDICARE

The following chart shows the HMO plans available to post eligible subscribers who have or do not have Medicare Parts A and B. Once you are eligible for Medicare Parts A and B (usually at age 65), you and/or your spouse must enroll in those parts with the Social Security Administration and provide our office with a copy of the Medicare card before the end of your or your spouse's 65th birthday month.

All post eligible subscribers who are Kaiser members and enrolled in Medicare Parts A and B are **required** to enroll in the Kaiser Senior Advantage plan (additional form required).

Blue Shield members who are enrolled in Medicare Parts A and B have the option to enroll in the Blue Shield 65 Plus plan (additional form required).

Failure to enroll in Medicare Parts A and B or provide our office with a copy of your Medicare card will result in the termination of your benefits

	HMO Plans		
	Blue Shield Trio ACO HMO	Blue Shield Access+ HMO	Kaiser Permanente HMO
Calendar Year Deductible¹	None	None	None
Calendar Year Out-of-Pocket Maximum¹			
Individual	\$1,000	\$1,000	\$1,500
Family	\$3,000	\$3,000	\$3,000
Office Visit			
Primary Care	\$20 copay	\$20 copay	\$20 copay
Specialist	\$20 copay	\$20 copay (\$30 copay self-referral)	\$20 copay
Preventive Services	No Charge	No Charge	No Charge
Chiropractic	\$10 copay (up to 30 visits per year)	\$10 copay (up to 30 visits per year)	Not Covered
Lab and X-ray	No Charge	No Charge	No Charge
Urgent Care	\$20 copay	\$20 copay	\$20 copay
Emergency Room	\$100 copay (waived if admitted)	\$100 copay (waived if admitted)	\$100 copay (waived if admitted)
Inpatient Hospitalization	\$250 copay per admission	\$250 copay per admission	\$250 copay per admission
Outpatient Surgery	No charge	No Charge	\$20 copay per admission
PRESCRIPTION DRUGS	Express Scripts		Kaiser Pharmacy
Calendar Year Deductible	\$150 per person (for brand name Rx)	\$150 per person (for brand name Rx)	None
Out-of-Pocket Maximum			
Individual	\$5,300	\$5,300	Combined with Medical
Family	\$10,600	\$10,600	
Pharmacy			
Generic	\$15 copay	\$15 copay	\$10 copay
Preferred Brand Name	\$30 copay ²	\$30 copay ²	\$20 copay
Non-Preferred Brand Name	\$50 copay ²	\$50 copay ²	Not Covered
Specialty	20% (\$100 max)	20% (\$100 max)	\$20 copay
Supply Limit	30 days	30 days	30 days
Mail Order			
Generic	\$30 copay	\$30 copay	\$20 copay
Preferred Brand Name	\$60 copay (after Rx deductible)	\$60 copay (after Rx deductible)	\$40 copay
Non-Preferred Brand Name	\$100 copay (after Rx deductible)	\$100 copay (after Rx deductible)	Not Covered
Supply Limit	90 days	90 days	100 Days

¹Deductibles and out-of-pocket maximums accumulate on a calendar year from January 1 – December 31.

² After Rx deductible.

MEDICAL PPO COVERAGE WITH OR WITHOUT MEDICARE

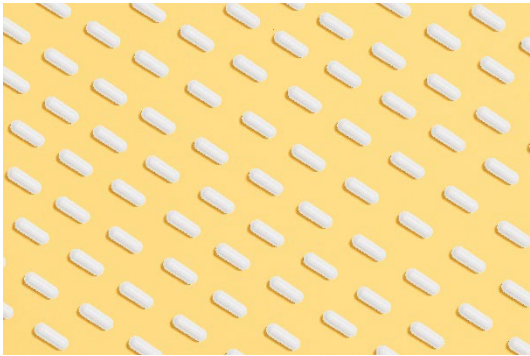
Medical coverage provides you with benefits that keep you healthy like Preventive care screenings and access to urgent care. It also provides important financial protection if you have a serious medical condition. The following chart shows the medical PPO plan offered to SAUSD employees. You always pay the deductible and copayment (\$). The coinsurance (%) shows what the plan pays after the deductible.

	Blue Shield PPO	
	In-Network	Out-of-Network
Calendar Year Deductible¹		
Individual	\$300	\$600
Family	\$600	\$1,200
Calendar Year Out-of-Pocket Maximum¹		
Individual	\$1,300	\$2,600
Family	\$2,600	\$5,200
Office Visit		
Primary Care	\$20 copay	Plan pays 70% ²
Specialist	\$20 copay	Plan pays 70% ²
Preventive Services	Plan pays 100%	Not Covered
Chiropractic (up to 50 visits/year)	Plan pays 80% ²	Plan pays 70% ²
Lab and X-ray	Plan pays 80% ²	Plan pays 70% ²
Urgent Care	\$20 copay	Plan pays 70% ²
Emergency Room	\$100 copay (waived if admitted) +10% physician services fee ⁴	\$100 copay (waived if admitted) +10% physician services fee ⁴
Inpatient Hospitalization	Plan pays 90% ²	Plan pays 70% ² up to \$1,500
Outpatient Surgery	Plan pays 90% ²	Plan pays 70% ² up to \$1,500
PRESCRIPTION DRUGS (Express Scripts)		
Calendar Year Deductible	\$150 per person	Combined with in-network
Out-of-Pocket Maximum		
Individual	\$5,300	Not Applicable
Family	\$10,600	Not Applicable
Retail- 30 Day Supply		
Generic	\$15 copay	\$15 copay +25% coinsurance
Preferred Brand Name	\$30 copay ²	\$30 copay ² +25% coinsurance
Non-Preferred Brand Name	\$50 copay ²	\$50 copay ² +25% coinsurance
Mail Order- 90 Day Supply		
Generic	\$30 copay	Not Covered
Preferred Brand Name	\$60 copay ²	Not Covered
Non-Preferred Brand Name	\$100 copay ²	Not Covered

¹Deductibles and out-of-pocket maximums accumulate on a calendar year from January 1 – December 31.

²After deductible.

PRESCRIPTION DRUGS – Express Scripts (Blue Shield Only)



EXPRESS SCRIPTS APP

You can also use the Express Scripts pharmacy mobile app to search for providers. Download from the App Store or Google Play.

Blue Shield members have access to prescription drug coverage through Express Scripts. Below is some information to keep in mind regarding this coverage:

Advantage Plus Utilization Management Program

Express Scripts uses these strategies to help manage the high-cost and high-utilization of specialty and non-specialty medications. Employees may be required to participate in the following programs when filling their prescriptions.

Drug Quantity Management

Drug quantity management is required medications prescribed “as needed” for which the days of supply cannot be inferred from the prescription (migraine medications, inhalers, creams, and ointments).

Step-Therapy






Step-therapy is required for most non-specialty drugs, including therapies for diabetes, high-blood pressure, depression and ulcers.

Prior Authorization

Prior authorization is required for most specialty drugs. To ensure safe and appropriate use of medications, prior authorization may apply for certain medications. For definitions on what each of these mean, please refer to the Glossary section.

KNOW WHERE TO GO

Where you get medical care can have a significant impact on the cost. Here's a quick guide to help you know where to go, based on your condition, budget, and time.

Type	Appropriate for	Examples	Access	Cost
Nurseline 	Quick answers from a trained nurse	<ul style="list-style-type: none"> Identifying symptoms Decide if immediate care is needed Home treatment options and advice 	24/7	\$
Online visit 	Many non-emergency health conditions	<ul style="list-style-type: none"> Cold, flu, allergies Headache, migraine Skin conditions, rashes Minor injuries Mental health concerns 	24/7	\$
Office visit 	Routine medical care and overall health management	<ul style="list-style-type: none"> Preventive care Illnesses, injuries Managing existing conditions 	Office Hours	\$\$
Urgent care, walk-in clinic 	Non-life-threatening conditions requiring prompt attention	<ul style="list-style-type: none"> Stitches Sprains Animal bites Ear-nose-throat infections 	Office Hours, or up to 24/7	\$\$\$
Emergency room 	Life-threatening conditions requiring immediate medical expertise	<ul style="list-style-type: none"> Suspected heart attack or stroke Major bone breaks Excessive bleeding Severe pain Difficulty breathing 	24/7	\$\$\$\$\$

DENTAL PPO COVERAGE

SAUSD gives you a choice of two dental PPO plans. When you enroll in a Delta Dental DPPO plan, you have the choice of visiting any dentist you choose, including in-network preferred providers and non-network premier providers. Members receive the highest level of benefits when they visit an in-network preferred provider.

Contact Delta Dental at (866) 499-3001 or visit their website at www.deltadentalins.com to find to provider near you.

	Delta Dental Incentive DPPO		Delta Dental Network DPPO	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Annual Deductible	None	\$25 per person \$75 per family (waived for diagnostic and preventative)	None	None
Annual Plan Maximum	\$2,000 per person	\$1,500 per person	\$2,000 per person	\$1,200 per person
Waiting Period	None	None	None	None
Diagnostic & Preventive	Plan pays 70-100%	Plan pays 70-100%	Plan pays 100%	Plan pays 50%
Basic Services Fillings Root Canals	Plan pays 70-100%	Plan pays 70-100%	Plan pays 100%	Plan pays 50%
Major Services Prosthodontics Other Major Services	Plan pays 50% Plan pays 70-100%	Plan pays 50% Plan pays 70-100%	Plan pays 50% Plan pays 100%	Plan pays 50% Plan pays 50%
Orthodontia Adults and Dependent Children	Plan pays 50%	Plan pays 50%	Plan pays 50%	Plan pays 50%
Ortho Lifetime Max	\$500	\$500	\$1,000	\$1,000

Rates For Classified Post Eligible Subscribers

	Incentive DPPO	Network DPPO
Single Cost for Employee only	\$53.65 Per month	\$42.91 Per month
Two-Party Cost for Employee +1 dependent	\$149.12 Per month	\$119.29 Per month
Family Cost for Employee +2 or more dependents	\$202.84 Per month	\$162.24 Per month

DENTAL HMO COVERAGE

Delta Care is a dental HMO plan and automatically assigns you and your dependents a dentist when you enroll. You can always change your dentist by calling Delta Care at (800) 422-4234 and letting them know the office you prefer within their DHMO network.

	Delta Care USA DHMO
Annual Deductible	None
Annual Plan Maximum	Unlimited
Waiting Period	None
Diagnostic & Preventive	\$0 - \$45 copay
Basic Services Fillings Root Canals	Plan pays 100% \$45 - \$205 copay
Prosthodontics	\$0 - \$195 copay
Major Services	\$0 - \$195 copay
Orthodontia Child – up to age 19 Adult – over 19	\$1,700 \$1,900 copay*
Ortho Lifetime Max	Unlimited

*copay covers up to 24 months of active treatment

Copays vary by the type of services you receive. To receive a list of Delta Care's fee schedule, you can contact Delta Care at (800) 422-4234 and request a copy of the plans schedule of benefits.

Rates For Classified Post Eligible Subscriber Employees

Single Cost for Employee only	\$18.08 Per month
Two-Party Cost for Employee +1 dependent	\$29.84 Per month
Family Cost for Employee +2 or more dependents	\$44.11 Per month

VISION

All SAUSD post eligible subscribers and family members enrolled in our medical plans, including Kaiser members, will receive vision benefits from Vision Service Plans (VSP). Routine vision exams are important, not only for correcting vision but because they can detect other serious health conditions.

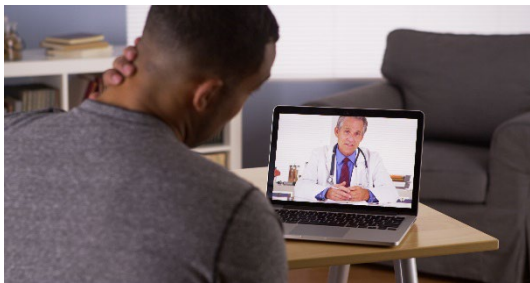
VSP has a large network of optometrist you can choose from for your vision needs. Visit www.vsp.com to find a VSP provider near you.

	VSP Vision Plan	
	In-Network	Out-of-Network
Exams Benefit Frequency	\$15 copay Once every 12 months	\$45 copay Once every 12 months
Eyeglass Lenses Single Vision Lens Bifocal Lens Trifocal Lens Frequency	Plan pays 100% Plan pays 100% Plan pays 100% Once every 12 months	Plan pays up to \$30 Plan pays up to \$50 Plan pays up to \$65 Once every 12 months
Lenses Enhancements Standard Progressive Premium Progressive Custom Progressive Frequency	Plan pays 100% \$95 - \$105 copay \$150 - \$175 Once every 12 months	Plan pays up to \$50 Not Covered Not Covered Once every 12 months
Frames VSP Select frames VSP featured frames Costco frames Frequency	Plan pays up to \$150* Plan pays up to \$170* Plan pays up to \$80 Once every 24 months	Plan pays up to \$70 Not Applicable Not Applicable Once every 24 months
Contacts (Elective) Contact Allowance Fitting and Evaluation Frequency	Plan pays up to \$150 \$0 - \$60 copay Once every 12 months	Plan pays up to \$105 Not Applicable Once every 12 months

*20% savings on amount over allowance



WHEN YOU NEED CARE NOW



GET THE CARE YOU NEED

Teladoc Health doctors can treat many medical conditions, including:

- Cold & flu symptoms
- Allergies
- Sinus problems
- Urinary tract infection
- Respiratory infection
- Skin problems
- And more!

Blue Shield Members - Teladoc

Talk to a doctor anytime

Teladoc Health gives you 24/7/365 access to U.S. board-certified doctors through the convenience of phone, video or mobile app visits. It's an affordable alternative to costly urgent care and ER visits when you need care now.

Meet our doctors

Teladoc Health is simply a new way to access qualified doctors. All Teladoc Health doctors:

- Are practicing PCPs, pediatricians, and family medicine physicians
- Average 20 years' experience
- Are U.S. board-certified and licensed in your state
- Are credentialed every three years, meeting NCQA standards

When should you use Teladoc Health?

Teladoc Health does not replace your primary physician. It is a convenient and affordable option for quality care.

- When you need care now
- If you're considering the ER or urgent care for a non-emergency
- When on vacation, a business trip or away from home
- For short-term prescription refills

Teladoc Health

[Teladoc.com/bsc](https://www.teladoc.com/bsc)

800-Teladoc

Kaiser Permanente Members

Get care from a doctor where they are. If you have a minor health condition or need a follow-up, you may be able to talk to a doctor by video or phone.

You need an in-person appointment and need to register on kp.org before you can receive a video or phone appointment.

Kaiser Member Services

Monday through Friday

7am to 7pm

833-574-2273

EMPLOYEE ASSISTANCE PROGRAM (EAP)



CONTACT THE EAP

Blue Shield Life Referrals 24/7
800-985-2405

**Kaiser Behavioral Health
Hotline**
800-900-3277

Kaiser Wellness Coaching
866-862-4295

Wellness Resources & Discounts

Throughout the years, SAUSD collaborates with various wellness vendors such as Gemini Timing for the 5k walk/run, Feet First and their Amazing Race, and HealthyWage with their team challenges. Visit the employee wellness website at www.sausd.us/ahealthieru for more resources and event information.

Blue Shield Life Referrals 24/7

Because we want our employees to have a well-balanced life, Blue Shield members will receive EAP benefits through Blue Shield's Life Referrals 24/7 program. This program provides referrals to professional counselors for up to 3 free face-to-face confidential visits every 6-months and live 60-minutes telephone consultations.

You can access this program 24 hours, 365 days to help you resolve emotional, health, family and work issues.

This benefit is included in your Blue Shield medical plan and is available to all household members

Best of all, contacting the EAP is completely confidential, free and available to any member of your immediate household.

Kaiser Behavioral Health

Kaiser takes care of the whole you. Your personal physician coordinates your care with a mental health specialist, or team, that can diagnose mental health issues that affect your health and well-being.

Depending on your needs, you can choose from a wide range of services:

- Call or email your doctor
- Make non-urgent appointments
- Make therapy appointments
- Make counseling appointments
- Talk to an advice nurse
- Speak with a wellness coach
- Enroll to take a class

Blue Shield Perks

Visit www.blueshieldca.com/sausd to access a hospital comparison tool, symptom checker, condition management information and resources, along with information specific to your health. Blue shield also offers various discounts including gym memberships. Register with Blue Shield online for additional wellness resources.

Kaiser Perks

Visit kp.org to access information on living healthy, managing conditions and diseases, and to obtain information about natural medicines and remedies. Kaiser also offers customized plans for healthier living, classes, and various specialty health services. Visit www.kp.org/choosehealthy for more information about available services including various discounts.

TURNING 65? UNDERSTAND YOUR MEDICARE OPTIONS



Alliant Medicare Solutions is a no cost service available to you, your family members, and friends nearing age 65.

Alliant Medicare Solutions is provided by Insuractive LLC, a Nebraska resident insurance agency. Insuractive LLC is wholly owned by Alliant Insurance Services, Inc.

Whether you retire or continue to work, choosing the right healthcare option is an important decision when you reach age 65

Most people become eligible for Medicare at age 65. When that happens, you'll probably have some time-sensitive decisions to make, based on your individual situation.

Introducing Alliant Medicare Solutions

Medicare can be complicated. Figuring out the rules—not to mention how Medicare works with or compares to your employer-provided medical coverage—can be a headache. That's why we are offering Alliant Medicare Solutions. The licensed insurance agents at AMS can help you understand Medicare, what is and isn't covered, and how to choose the best coverage for your situation.

How does it work?

1. Call Alliant Medicare Solutions at **(877) 888-0165** to speak to a licensed insurance agent. Have your current medical coverage information available when you call.
2. Discuss with Alliant Medicare Solutions your existing insurance coverage, your Medicare options, and which of those plans might work the best for you.
3. If Medicare is the best option, Alliant Medicare Solutions helps you enroll immediately or emails policy materials for you to review and enroll at a later date.



In this section, you'll find important plan information, including:

- Your benefit contributions
- Contact information for our benefit carriers and vendors
- A Benefits Glossary to help you understand important insurance terms
- A summary of the health plan notices you are entitled to receive annually, and where to find them

RATES SUMMARY

All SAUSD employees pay for their medical insurance coverage. Be sure to look at the appropriate chart for your specific rates.

Your contributions are to be paid on a month-to-month basis.

Rates are effective July 1, 2024 through June 30, 2025

Monthly Rates for Classified Post Eligible Employees

	Blue Shield 65 Plus	Blue Shield Access + HMO		Blue shield Trio ACO HMO		Blue Shield PPO		Kaiser HMO	Kaiser Senior advantage
	With Medicare	Without Medicare	With Medicare	Without Medicare	With Medicare	Without Medicare	With Medicare	Without Medicare	With Medicare
Single (Cost for Retiree only coverage)									
Employee Pays	\$436.65	\$940.24	\$822.45	\$659.36	\$583.72	\$1,116.23	\$976.20	\$758.81	\$166.82
Two Party (Cost for employee + 1 Dependent Coverage)									
Employee Pays	\$869.79	\$1,930.57	\$1,702.42	\$1,363.98	\$1,207.07	\$2,320.02	\$2,028.47	\$1,514.11	\$333.64
Two-Party One with and One without Medicare (Cost for Employee +1 Dependent Coverage)									
Employee Pays	\$1,096.01	Does Not Apply	\$1,828.94	Does Not Apply	\$1,288.35	Does Not Apply	\$2,169.60	Does Not Apply	\$925.63
	1 on Access+								
Employee Pays	\$1,376.88								
Family (Cost for employee + 2 or more dependents Coverage)									
Employee Pays	Does Not Apply	\$2,779.17	\$2,451.07	\$1,964.44	\$1,738.85	\$3,330.71	\$2,912.55	\$2,145.96	\$974.72

In order to qualify for the Two-Party One with One Without Medicare rate you must be enrolled in a Two-Party plan and one person must be enrolled in Medicare Parts A and B.

In order to qualify for the Family with Medicare rate you must be enroll in a Family plan and two or more persons must be enrolled in Medicare Parts A and B.

Blue Shield rates include medical coverage, Express Scripts pharmacy coverage, and VSP vision coverage, except Blue Shield 65 Plus members. 65 Plus member receive pharmacy coverage through Blue Shield.
 Kaiser rates include medical coverage, Kaiser pharmacy coverage, and VSP vision coverage, except Kaiser Senior Advantage members. Senior Advantage members receive vision coverage through Kaiser.

	Delta Care USA DHMO	Delta Dental Incentive DPPO	Delta Dental Network DPPO
Single (Cost for Employee only coverage)			
Employee Pays	\$18.08	\$53.65	\$42.91
Two Party (Cost for employee + 1 Dependent Coverage)			
Employee Pays	\$29.84	\$149.12	\$119.29
Family (Cost for employee + 2 or more dependents Coverage)			
Employee Pays	\$44.11	\$202.84	\$162.24

PLAN CONTACTS

If you need to reach our plan providers, here is their contact information:

Plan Type	Provider	Phone Number	Website	Group #
Medical	Blue Shield of California	Trio members 855-747-5800 Access+ & PPO members 800-393-6130	www.blueshieldca.com/sausd	W0051532
Medical	Kaiser Permanente	833-574-2273	www.kp.org	132731
Dental	Delta Dental	866-499-3001 – DPPO 800-422-4234 - DHMO	Deltadentalins.com	06637
Vision	VSP	800-877-7195	www.vsp.com	30098994
Pharmacy	Express Scripts – BS members only	877-474-1136	www.express-scripts.com	4117379
Voluntary Benefits	American Fidelity	800-365-9180	www.americanfidelity.com	
Supplemental Cancer Insurance	Washington National (American Fidelity)	888-754-3406	www.washingtonnational.com	
Wellness - Blue Shield members only	Blue Shield Heal	844-644-4325	Getheal.com	W0051532
Wellness – Kaiser members only	Kaiser Wellness Coaching	866-862-4295	www.kp.org/coaching	132731
EAP- Blue Shield members only	Blue Shield Life Referrals 24/7	800-985-2405	www.blueshieldca.com/sausd	W0051532
EAP– Kaiser members only	Kaiser Behavioral Health	800-900-3277	www.kp.org	132731
Telemedicine - Blue Shield members only	Teladoc	800-835-2362	Member.Teladoc.com/bsc	W0051532
Medicare Services	Alliant Medicare Solutions	877- 888-0165	N/A	N/A
Employee Union for eligible Classified personnel	C.S.E.A	714-532-3766	www.csea.com/web	
Employee Union for eligible Certificated personnel	S.A.E.A	714-542-6758	www.santaanaeducators.com	
Employee retirement system for Certificated personnel	S.T.R.S	800-228-5453	www.calstrs.com	
Third party administrator of additional retirement accounts	Schools First	714-258-4000	www.schoolsfirst.org	

GLOSSARY

-A-

AD&D Insurance

An insurance plan that pays a benefit to you or your beneficiary if you suffer from loss of a limb, speech, sight, or hearing, or if you have a fatal accident.

Allowed Amount

The maximum amount your plan will pay for a covered healthcare service.

Ambulatory Surgery Center (ASC)

A healthcare facility that specializes in same-day surgical procedures such as cataracts, colonoscopies, upper GI endoscopy, orthopedic surgery, and more.

Annual Limit

A cap on the benefits your plan will pay in a year. Limits may be placed on particular services such as prescriptions or hospitalizations. Annual limits may be placed on the dollar amount of covered services or on the number of visits that will be covered for a particular service. After an annual limit is reached, you must pay all associated health care costs for the rest of the plan year.

-B-

Beneficiary

The person (or persons) that you name to be paid a benefit should you die. Beneficiaries are requested for life, AD&D, and retirement plans. You must name your beneficiary in advance.

Brand Name Drug

A drug sold under its trademarked name. For example, Lipitor is the brand name of a common cholesterol medicine.

-C-

COBRA

A federal law that may allow you to temporarily continue healthcare coverage after your employment ends, based on certain qualifying events. If you elect COBRA (Consolidated Omnibus Budget Reconciliation Act) coverage, you pay 100% of the premiums, including any share your employer used to pay, plus a small administrative fee.

Claim

A request for payment that you or your health care provider submits to your healthcare plan after you receive services that may be covered.

Coinsurance

Your share of the cost of a healthcare visit or service. Coinsurance is expressed as a percentage and always adds up to 100%. For example, if the plan pays 70%, your coinsurance responsibility is 30% of the cost. If your plan has a deductible, you pay 100% of the cost until you meet your deductible amount.

Copayment

A flat fee you pay for some healthcare services, for example, a doctor's office visit. You pay the copayment (sometimes called a copay) at the time you receive care. In most cases, copays do not count toward the deductible.

-D-

Deductible

The amount of healthcare expenses you have to pay for with your own money before your health plan will pay. The deductible does not apply to preventive care and certain other services.

Family coverage may have an **aggregate** or **embedded** deductible. Aggregate means your family must meet the entire family deductible before any individual expenses are covered. Embedded means the plan begins to make payments for an individual member as soon as they reach their individual deductible.

Dental Basic Services

Services such as fillings, routine extractions and some oral surgery procedures.

Dental Diagnostic & Preventive Generally includes routine cleanings, oral exams, x-rays, and fluoride treatments. Most plans limit preventive exams and cleanings to two times a year.

Dental Major Services

Complex or restorative dental work such as crowns, bridges, dentures, inlays and onlays.

Dependent Care Flexible Spending Account (FSA)

An arrangement through your employer that lets you pay for eligible child and elder care expenses with tax-free dollars. Eligible expenses include day care, before and after-school programs, preschool, and summer day camp for children under age 13. Also included is care for a spouse or other dependent who lives with you and is physically incapable of self-care.

-E-

Eligible Expense

A service or product that is covered by your plan. Your plan will not cover any of the cost if the expense is not eligible.

Excluded Service

A service that your health plan doesn't pay for or cover.

-F-

Formulary

A list of prescription drugs covered by your medical plan or prescription drug plan. Also called a drug list.

-G-

Generic Drug

A drug that has the same active ingredients as a brand name drug but is sold under a different name. For example, Atorvastatin is the generic name for medicines with the same formula as Lipitor.

-H-

Healthcare Flexible Spending Account (FSA)

A health account through your employer that lets you pay for many out-of-pocket medical expenses with tax-free dollars. Eligible expenses include insurance copayments and deductibles, qualified prescription drugs, insulin, and medical devices, and some over-the-counter items.

GLOSSARY

-I-

In-Network

In-network providers and services contract with your healthcare plan and will usually be the lowest cost option. Check your plan's website to find doctors, hospitals, labs, and pharmacies. Out-of-network services will cost more or may not be covered.

-L-

Life Insurance

An insurance plan that pays your beneficiary a lump sum if you die.

Long Term Disability Insurance

Insurance that replaces a portion of your income if you are unable to work due to a debilitating illness, serious injury, or mental disorder. Long term disability generally starts after a 90-day waiting period.

-M-

Mail Order

A feature of a medical or prescription drug plan where medicines you take routinely can be delivered by mail in a 90-day supply.

-O-

Open Enrollment

The time of year when you can change the benefit plans you are enrolled in and the dependents you cover. Open enrollment is held one time each year. Outside of open enrollment, you can only make changes if you have certain events in your life, like getting married or adding a new baby or child in the family.

Out-of-Network

Out-of-network providers (doctors, hospitals, labs, etc.) cost you more because they are not contracted with your plan and are not obligated to limit their maximum fees. Some plans, such as HMOs and EPOs, do not cover out-of-network services at all.

Out-of-Pocket Cost

A healthcare expense you are responsible for paying with your own money, whether from your bank account, credit card, or from a health account such as an HSA, FSA or HRA.

Out-of-Pocket Maximum

Protects you from big medical bills. Once costs "out of your own pocket" reach this amount, the plan pays 100% of most remaining eligible expenses for the rest of the plan year.

Family coverage may have an *aggregate* or *embedded* maximum. Aggregate means your family must meet the entire family out-of-pocket maximum before the plan pays 100% for any member. Embedded means the plan will cover 100% for an individual member as soon as they reach their individual maximum.

Outpatient Care

Care from a hospital that doesn't require you to stay overnight.

-P-

Participating Pharmacy

A pharmacy that contracts with your medical or drug plan and will usually result in the lowest cost for prescription medications.

Plan Year

A 12-month period of benefits coverage. The 12-month period may or may not be the same as the calendar year.

Preferred Drug

Each health plan has a preferred drug list that includes prescription medicines based on an evaluation of effectiveness and cost. Another name for this list is a "formulary." The plan may charge more for non-preferred drugs or for brand name drugs that have generic versions. Drugs that are not on the preferred drug list may not be covered.

Preventive Care Services

Routine healthcare visits that may include screenings, tests, check-ups, immunizations, and patient counseling to prevent illnesses, disease, or other health problems. Many preventive care services are fully covered. Check with your health plan in advance if you have questions about whether a preventive service is covered.

Primary Care Provider (PCP)

The main doctor you consult for healthcare issues. Some medical plans require members to name a specific doctor as their PCP and require care and referrals to be directed or approved by that provider.

-S-

Short Term Disability Insurance

Insurance that replaces a portion of your income if you are temporarily unable to work due to surgery and recovery time, a prolonged illness or injury, or pregnancy issues and childbirth recovery.

-T-

Telehealth / Telemedicine / Teledoc

A virtual visit to a doctor using video chat on a computer, tablet or smartphone. Telehealth visits can be used for many common, non-serious illnesses and injuries and are available 24/7. Many health plans and medical groups provide telehealth services at no cost or for much less than an office visit.

-U-

UCR (Usual, Customary, and Reasonable)

The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service. The UCR amount sometimes is used to determine the allowed amount.

Urgent Care

Care for an illness, injury or condition serious enough that care is needed right away, but not so severe it requires emergency room care. Treatment at an urgent care center generally costs much less than an emergency room visit.

-V-

Vaccinations

Treatment to prevent common illnesses such as flu, pneumonia, measles, polio, meningitis, shingles, and other diseases. Also called immunizations.

Voluntary Benefit

An optional benefit plan offered by your employer for which you pay the entire premium, usually through payroll deduction.

IMPORTANT PLAN INFORMATION

HEALTH PLAN NOTICES

These notices must be provided to plan participants on an annual basis and are available in the Annual Notices document, located at www.sausd.us/benefits

- **Medicare Part D Notice:** Describes options to access prescription drug coverage for Medicare eligible individuals
- **Women's Health and Cancer Rights Act:** Describes benefits available to those that will or have undergone a mastectomy
- **Newborns' and Mothers' Health Protection Act:** Describes the rights of mother and newborn to stay in the hospital 48-96 hours after delivery
- **HIPAA Notice of Special Enrollment Rights:** Describes when you can enroll yourself and/or dependents in health coverage outside of open enrollment
- **HIPAA Notice of Privacy Practices:** Describes how health information about you may be used and disclosed
- **Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP):** Describes availability of premium assistance for Medicaid eligible dependents.
- **Notice of Choice of Providers:** Notifies you that your plan requires you to name a Primary Care Physician (PCP) or provides for you to select one
- **Michelle's Law:** Describes right to extend dependent medical coverage during student leaves

PLAN DOCUMENTS

Important documents for our health plan and retirement plan are available www.sausd.us/benefits. Paper copies of these documents and notices are available if requested. If you would like a paper copy, please contact the Plan Administrator.

SUMMARY PLAN DESCRIPTIONS (SPD)

The legal document for describing benefits provided under the plan as well as plan rights and obligations to participants and beneficiaries.

SUMMARY OF BENEFITS AND COVERAGE (SBC)

A document required by the Affordable Care Act (ACA) that presents benefit plan features in a standardized format. SBC documents are www.sausd.us/benefits

- Blue Shield Access+ HMO
- Blue Shield PPO
- Blue Shield Trio ACO HMO
- Kaiser Permanente HMO

STATEMENT OF MATERIAL MODIFICATIONS

This enrollment guide constitutes a Summary of Material Modifications (SMM) to the Santa Ana Unified School District. It is meant to supplement and/or replace certain information in the SPD, so retain it for future reference along with your SPD. Please share these materials with your covered family members.

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