2016

Certificated Benefits Overview

TABLE OF CONTENTS

Who Can You Cover? 3
Rules for Benefit Changes During the Year 4
Making the Most of Your Benefits Program 5
Introducing the Blue Shield Trio ACO HMO Plan 6
Medical - HMO Plans 7
Medical – PPO Plan 8
Prescription Drugs with HMO Plans 9
Prescription Drugs with PPO Plan 10
Dental – PPO Plans 11
Dental – HMO Plan 12
Vision 13
Employee Assistance Programs 14
Basic Life Insurance 14
Wellness Resources - A Healthier U 15
Flexible Spending Accounts 16
Voluntary Benefits 17
Summary of Contributions for Employees hired BEFORE July 1, 2014 18
Summary of Contributions for Employees hired AFTER July 1, 2014 19
Meet Ben-IQ 20
Key Terms 21
Important Plan Notices and Documents 23
For Assistance 24

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 Annual Notices at sausd.us/benefits for more details.

FOCUS ON BENEFITS

At Santa Ana Unified School District, we believe that you, our employees, are our most important asset. Helping you and your families achieve and maintain good health—physical, emotional and financial—is the reason Santa Ana Unified School District offers you this benefits program. We are providing you with this overview to help you understand the benefits that are available to you and how to best use them. Please review it carefully and make sure to ask about any important issues that are not addressed here. A list of plan contacts is provided at the back of this summary.

While we've made every effort to make sure that this guide is comprehensive, it cannot provide a complete description of all benefit provisions. For more detailed information, please refer to your plan benefit booklets or summary plan descriptions (SPDs). The plan benefit booklets determine how all benefits are paid.

The benefits in this summary are effective:

July 1, 2016 - June 30, 2017

Who Can You Cover?

WHO IS ELIGIBLE?

You are eligible to participate in our benefits program if you are an active Certificated employee who is regularly working as a Probationary, Permanent, or Temporary Certificated employee on a contract full-time. Certificated employees voluntarily reducing their contract to less than full-time shall receive benefits only if they pay for the proration of benefit cost equal to the proportion of the reduction of their contract. (See Article 15 of the CBA for more details.)

You can enroll the following family members in our medical, dental and vision plans.

- Your spouse (the person who you are legally married to under state law, including a same-sex spouse.)
- Your domestic partner that has properly filed a Declaration of Domestic Partnership with the California Secretary of State. Note: California state registration is limited to same sex domestic partners and only those opposite sex partners where one partner is at least 62 and eligible for Social Security based on age. Any premiums for your domestic partner paid for by Santa Ana Unified School District are taxable income and will be included on your W-2. Any premiums you pay for your domestic partner will be deducted on an after-tax basis.
- Your children (including your Domestic Partner's Child, Adoptive Child, Stepchild):
    - Under the age of 26 are eligible to enroll in medical coverage. They do not have to live with you or be enrolled in school. They can be married and/or living and working on their own.
    - Over age 26 ONLY if they are mentally or physically handicapped and incapable of self-sustaining employment. Verification of handicapped status will be required before the dependent reaches the limiting age. Contact the Benefits Office for more information.
    - Named in a Qualified Medical Child Support Order (QMCSO) as defined by federal law.

WHO IS NOT ELIGIBLE?

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

- Parents, grandparents, and siblings.

WHEN DOES COVERAGE BEGIN?

The elections you make as a new employee will give you coverage the first day of the month following the month that you were hired. Example: If you were hired on April 10, your coverage will start May 1.

Your Open Enrollment benefit elections are effective July 1.

WHEN CAN I ENROLL?

Open enrollment for current employees is generally held in May. Open enrollment is the one time each year that employees can make changes to their benefit elections without a qualifying life event.

Make sure to notify the Employee Benefits Office right away if you do have a qualifying life event and need to make a change (add or drop) to your coverage election. These changes include (but are not limited to):

- Birth or adoption of a baby or child
- Loss of other healthcare coverage
- Eligibility for new healthcare coverage
- Marriage
- Divorce

You have 30 days to make your change.

This is only a summary of the eligibility requirements and is not intended to modify or supersede the requirements of the plan documents and/or the CSEA contract, and the plan documents/contract will govern in the event of any conflict between this summary and the plan documents/contract.

Rules for Benefit Changes During the Year

Other than annual open enrollment, you may only make changes to your benefit elections if you experience a qualified status change or qualify for a "special enrollment". If you experience a qualified status change that is eligible for a benefit change, you will be required to submit proof of the change or evidence of prior coverage.

Qualified Status Changes Include:

- Change in legal marital status, including marriage, divorce, legal separation, annulment, and death of a spouse.
- Change in number of dependents, including birth, adoption, placement for adoption, or death of a dependent child.
- Change in employment status that affects benefits eligibility, including the start or termination of employment by you, your spouse, or your dependent child.
- Change in work schedule, including an increase or decrease in hours of employment by you, your spouse, or your dependent child, including a switch between part-time and full-time employment that affects eligibility for benefits.
- Change in a child's dependent status, either newly satisfying the requirements for dependent child status or ceasing to satisfy them.
- Change in place of residence or worksite that affects your eligibility for benefits, including the accessibility of network providers.
- Change in your health coverage or your spouse's coverage attributable to your spouse's employment.
- Change in an individual's eligibility for Medicare or Medicaid.
- A court order resulting from a divorce, legal separation, annulment, or change in legal custody (including a Qualified Medical Child Support Order) requiring coverage for your child.
- An event that is a "special enrollment" under the Health Insurance Portability and Accountability Act (HIPAA) including acquisition of a new dependent by marriage, birth or adoption, or loss of coverage under another health insurance plan.
- An event that is allowed under the Children's Health Insurance Program (CHIP) Reauthorization Act. Under provisions of the Act, employees have 60 days after the following events to request enrollment:
    - Employee or dependent loses eligibility for Medicaid (known as Medi-Cal in CA) or CHIP.
    - Employee or dependent becomes eligible to participate in a premium assistance program under Medicaid or CHIP.

Two rules apply to making changes to your benefits during the year:

- Any change you make must be consistent with the change in status, AND
- You must notify the Employee Benefits Office and make the change **within 30 days** of the date the event occurs (unless otherwise noted above)

You are also responsible for notifying the Employee Benefits office of your dependent(s) that become INELIGIBLE as a result of divorce or becoming an overage dependent within 30 days of the event. **Failure to do so may jeopardize your dependent's right to elect COBRA.**

Making the Most of Your Benefits Program

Helping you and your family members stay healthy and making sure you use your benefits program to its best advantage is our goal in offering this program. Here are a few things to keep in mind.

STAY WELL!

Harder than it sounds, of course, but many health problems are avoidable. Take action—from eating well, to getting enough exercise and sleep. Taking care of yourself takes care of a lot of potential problems.

ASK QUESTIONS AND STAY INFORMED

Know and understand your options before you decide on a course of treatment. Informed patients get better care. Ask for a second opinion if you're at all concerned.

GET A PRIMARY CARE PROVIDER

Having a relationship with a PCP gives you a trusted person who knows your unique situation when you're having a health issue. Visit your PCP or clinic for non-emergency healthcare.

GOING TO THE DOCTOR?

To get the most out of your doctor visit, being organized and having a plan helps. Bring the following with you:

- Your plan ID card
- A list of your current medications
- A list of what you want to talk about with your doctor

If you need a medication, you could save money by asking your doctor if there are generics or generic alternatives for your specific medication.

AN APPLE A DAY

Eating moderately and well really does help keep the doctor away. Stay away from fat-heavy, processed foods and instead focus on whole grains, vegetables, and lean meats to be the healthiest you can be.

USING THE EMERGENCY ROOM

Did you know most ER visits are unnecessary? Use them only in a true emergency—like any situation where life, limb, and vision are threatened. Otherwise, call your doctor, your nurse line, or go to an Urgent Care clinic. You'll save a lot of money and time.

BE MED WISE!

Always follow your doctor's and pharmacist's instructions when taking medications. You can worsen your condition(s) by not taking your medication or by skipping doses. If your medication is making you feel worse, contact your doctor.

GOING ABROAD?

When you travel more than 100 miles from home or internationally for up to 180 days for business or pleasure, you can rely on Travel Assistance offered by the Standard Life Insurance Company (UnitedHealthcare Global) to offer aid before, during and after your trip. Contact Travel Assistance at 1-800-527-0218 (U.S, Canada, Puerto Rico, U.S. Virgin Islands and Bermuda) or 1-410-453-6330 (everywhere else). The service is available 24/7/365.

Introducing the Blue Shield Trio ACO HMO Plan

Santa Ana Unified School District is offering a new HMO plan--the **Trio ACO HMO plan**. The Trio ACO HMO is an accountable care organization (ACO), which is a network of doctors and hospitals that share responsibility for providing care to you and your family. The focus of Trio is the patient, who benefits from stronger coordination among doctors, hospitals, and Blue Shield of California. By integrating information, providers are able to manage the "whole patient" through care management, coordination and communication. Blue Shield facilitates the relationship between providers to enable more personalized care through trusted partnerships to manage the member's whole health. If you and your family go to the doctor often, the Trio ACO HMO plan may be the most cost-effective plan for maintaining your family's health. The Trio ACO HMO delivers the same benefits as the Access+ HMO plan along with additional plan features.

Plan features	Blue Shield Access+ HMO	Blue Shield Trio ACO HMO
Employee premium contribution	**$$**	**$**
Medical benefits	Comprehensive benefits	Same as Access+ HMO
Access to top-tier doctors, specialists and hospitals close to your home and workplace	**Full Blue Shield HMO network**	**Quality network of local doctors, specialists and hospitals** If your personal care physician is in the Trio ACO HMO network, you can continue to see your doctor. If your doctor is not in the Trio ACO HMO network, you can search for a new Personal Physician at blueshieldca.com/sausd or call the dedicated Shield Concierge team at (855) 747-5800 for assistance finding a provider.
Self-referral to specialists	**Yes** Members must select a personal physician who is affiliated with a medical group or IPA that is an Access+ provider group which offers the Access+ Specialist feature, and then select a specialist within that medical group or IPA.	**Yes** Members must select a personal physician who is affiliated with a medical group or IPA that is an Access+ provider group which offers the Access+ Specialist feature, and then select a specialist within that medical group or IPA.
Walkadoo,™ a fun and social walking program that tracks your steps and keeps you moving	**No**	**Yes**
Member support and service	**Yes – Member Services** Support for questions on network providers and medical and pharmacy benefits.	**Yes – Shield Concierge** A single toll-free number to help with all of your questions about your medical coverage and care, staffed by a team of experienced health advocates, registered nurses, health coaches, clinical support coordinators, pharmacists, pharmacy technicians and dedicated customer service representatives, with extended customer service hours from 7 a.m. to 7 p.m. Pacific time, Monday through Friday (855) 747-5800.

Lean More at the Trio ACO HMO Webinar

Blue Shield will be hosting several information webinars on the Trio ACO HMO plan. These presentations will provide an overview of this new plan and how it compares to the Access+ HMO plan. You will also have the opportunity to ask any questions you may have. Webinars will be held:

- May 17: 4 p.m. – 5 p.m.
- May 19: 3:30 p.m. – 4:30 pm.
- May 25: 4 p.m. – 5 p.m.

Register to attend by going to **blueshieldca.com/sausd**.

To access details on the Trio ACO HMO plan, including medical and pharmacy benefits: Download the Blue Shield OE mobile app and take OE on the go, or visit the Blue Shield website for SAUSD employees.

Medical - HMO Plans

Medical coverage provides you with benefits that help 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.

	Blue Shield Trio ACO HMO	Blue Shield Access+ HMO	Kaiser HMO
	In-Network	In-Network	In-Network
Annual Deductible	None	None	None
Annual Out-of-Pocket Max	$2,000 individual $4,000 family	$2,000 individual $4,000 family	$1,500 individual $3,000 family
Lifetime Max	Unlimited	Unlimited	Unlimited
Office Visit			
Primary Provider	$20 copay	$20 copay	$20 copay
Specialist	$20 copay (PCP referred) $30 copay (self-referred office visits and consultations within member's Access+ provider group)	$20 copay (PCP referred) $30 copay (self-referred office visits and consultations within member's Access+ provider group)	$20 copay
Preventive Services	Plan pays 100%	Plan pays 100%	Plan pays 100%
Chiropractic Care	$10 (up to 30 visits per year)	$10 (up to 30 visits per year)	Not covered
Lab and X-ray	Plan pays 100%	Plan pays 100%	Plan pays 100%
Inpatient Hospitalization	$250 copay per admission	$250 copay per admission	$250 copay per admission
Outpatient Surgery	Plan pays 100%	Plan pays 100%	$20 copay
Urgent Care	$20 copay	$20 copay	$20 copay
Emergency Room	$150 copay (copay waived if admitted)	$150 copay (copay waived if admitted)	$150 copay (copay waived if admitted)

Medical – PPO Plan

	Blue Shield PPO	
	In-Network	Out-Of-Network
Annual Deductible	$300 individual $600 family	$600 individual $1,200 family
Annual Out-of-Pocket Max	$2,800 individual $5,600 family	$4,600 individual $9,200 family
Lifetime Max	Unlimited	Unlimited
Office Visit		
Primary Provider	$20 copay	Plan pays 60% after deductible
Specialist	$20 copay	Plan pays 60% after deductible
Preventive Services	Plan pays 100%	Not covered
Chiropractic Care	Plan pays 80% after deductible (up to 50 visits per year)	Plan pays 60% after deductible (up to 50 visits per year)
Lab and X-ray	Plan pays 80% after deductible	Plan pays 60% after deductible
Inpatient Hospitalization	Plan pays 80% after deductible	Plan pays 60% after deductible (up to $1,500 per day)
Outpatient Surgery	Plan pays 80% after deductible	Plan pays 60% after deductible (up to $1,500 per day)
Urgent Care	$20 copay	Plan pays 60% after deductible
Emergency Room	$150 copay + 20% (copay waived if admitted)	$150 copay + 20% (copay waived if admitted)

Prescription Drugs with HMO Plans

Prescription drug coverage provides a benefit that is important to your overall health, whether you need a prescription for a short-term health issue like bronchitis or an ongoing condition like high blood pressure.

If you enroll in medical coverage, you will automatically receive coverage for prescription drugs. Here are the prescription drug plans that are offered with our HMO plans.

	Blue Shield Trio ACO HMO	Blue Shield Access+ HMO	Kaiser HMO
	Express Scripts*	Express Scripts*	Kaiser Plan Pharmacy
Prescription Drug Deductible	$150 individual deductible for Brand Name prescriptions	$150 individual deductible for Brand Name prescriptions	None
Annual Out-of-Pocket Limit	$4,600 individual $9,200 family	$4,600 individual $9,200 family	Combined with medical
Pharmacy			
Generic	$10 copay	$10 copay	$10 copay
Preferred Brand	$25 copay after Brand Name prescription drug deductible	$25 copay after Brand Name prescription drug deductible	$20 copay
Non-preferred Brand	$40 copay after Brand Name prescription drug deductible	$40 copay after Brand Name prescription drug deductible	n/a
Supply Limit	30 days	30 days	30 days
Mail Order			
Generic	$20 copay	$20 copay	$20 copay
Preferred Brand	$50 copay after Brand Name prescription drug deductible	$50 copay after Brand Name prescription drug deductible	$40 copay
Non-preferred Brand	$80 copay after Brand Name prescription drug deductible	$80 copay after Brand Name prescription drug deductible	n/a
Supply Limit	90 days	90 days	100 days

*Express Scripts Advantage Plus Advanced Utilization Management Program: The Program utilizes 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:

- Prior Authorization – required for most specialty drugs.
- Step Therapy –for most non-specialty drugs, including therapies for diabetes, high blood pressure, depression and ulcers.
- Drug Quantity Management – for medications prescribed "as needed" for which the days of supply cannot be inferred from the prescription (migraine medications, inhalers, creams, ointments).

Prescription Drugs with PPO Plan

Here is the prescription drug plan that is offered with our Blue Shield PPO plan.

	Blue Shield PPO	
	Express Scripts*	Express Scripts*
	In-Network	Out-Of-Network
Prescription Drug Deductible	$150 individual deductible for Brand Name prescriptions	$150 individual deductible for Brand Name prescriptions
Annual Out-of-Pocket Limit	$3,800 individual $7,600 family	$2,000 individual $4,000 family
Pharmacy		
Generic	$10 copay then plan pays 100%	$10 copay then plan pays 75%
Preferred Brand	$25 copay after Brand Name prescription drug deductible then plan pays 100%	$25 copay after Brand Name prescription drug deductible then plan pays 75%
Non-preferred Brand	$40 copay after Brand Name prescription drug deductible then plan pays 100%	$40 copay after Brand Name prescription drug deductible then plan pays 75%
Supply Limit	30 days	30 days
Mail Order		
Generic	$20 copay	Not covered
Preferred Brand	$50 copay after Brand Name prescription drug deductible then plan pays 100%	Not covered
Non-preferred Brand	$80 copay after Brand Name prescription drug deductible then plan pays 100%	Not covered
Supply Limit	90 days	Not applicable

*Express Scripts Advantage Plus Advanced Utilization Management Program: The Program utilizes 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:

- Prior Authorization – required for most specialty drugs.
- Step Therapy –for most non-specialty drugs, including therapies for diabetes, high blood pressure, depression and ulcers.
- Drug Quantity Management – for medications prescribed "as needed" for which the days of supply cannot be inferred from the prescription (migraine medications, inhalers, creams, ointments).

Dental – PPO Plans

Regular visits to your dentists can protect more than your smile; they can help protect your health. Recent studies have linked gum disease to damage elsewhere in the body and dentists are able to screen for oral symptoms of many other diseases including cancer, diabetes, and heart disease. Santa Ana Unified School District gives you a choice of three dental plans.

When you enroll in one of the Delta Dental DPPO Plans you have the choice of visiting any dentist you chose, including in-network Delta Dental Preferred Providers, non-network Delta Dental Premier Providers and out-of-network providers. Members receive the highest level of benefits when they visit a Delta Dental Preferred provider. Contact Delta Dental to find a Delta Dental Preferred Provider or to see if your dentist is a Delta Dental Preferred Provider or a Delta Dental Premier Provider at 1-866-499-3001.

	Delta Dental DPPO Incentive Plan*		Delta Dental DPPO Delta Network	
	In-Network	Out-Of-Network	In-Network	Out-Of-Network
Calendar Year Deductible	None	$25 individual $75 family (waived for diagnostic and preventive services)	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 and Preventive	Plan pays 70-100%	Plan pays 70-100%	Plan pays 100%	Plan pays 50%
Basic Services				
Fillings	Plan pays 70-100%	Plan pays 70-100% after deductible	Plan pays 100%	Plan pays 50%
Root Canals	Plan pays 70-100%	Plan pays 70-100% after deductible	Plan pays 100%	Plan pays 50%
Periodontics	Plan pays 70-100%	Plan pays 70-100% after deductible	Plan pays 100%	Plan pays 50%
Major Services	Prosthodontics: plan pays 50% All other services: plan pays 70-100%	Prosthodontics: plan pays 50% after deductible All other services: plan pays 70-100% after deductible	Prosthodontics: plan pays 50% All other services: plan pays 100%	Plan pays 50%
Orthodontic Services				
Orthodontia	Plan pays 50%	Plan pays 50%	Plan pays 50%	Plan pays 50%
Lifetime Maximum	$500	$500	$1,000	$1,000
Dependent Children	Covered	Covered	Covered	Covered
Full-time Students	Covered	Covered	Covered	Covered

*The Incentive Plans pays 70% for diagnostics, preventive, basic and major services for the first year. This percentage increases by 10% each year to a max of 100%, as long as the enrollee visits the dentist at least once during the calendar year. If the enrollee does not use the plan at least once during the calendar year, the percentage remains at the level attained the previous year.

Dental – HMO Plan

Our third dental plan is a Dental HMO plan offered through Delta Dental of California. The plan offers the convenience of scheduled copays for specific procedures, and there are no deductibles or annual maximums. When you enroll in the Dental HMO plan, you must select a primary care dentist (PCD) from the DeltaCare USA DHMO network for yourself and any eligible dependents. To receive care you must see your PCD who will take care of your dental care needs. If you require treatment from a specialist, your PCD will refer you to another dentist in the DeltaCare USA DHMO Network.

	Delta Dental DHMO
	In-Network
Calendar Year Deductible	None
Annual Plan Maximum	Unlimited
Waiting Period	None
Diagnostic and Preventive	$0-$45 copay then plan pays 100% (copay varies by services, see contract for fee schedule)
Basic Services	
Fillings	$0-$85 copay then plan pays 100% (copays vary by service, see contract for fee schedule)
Root Canals	$0-$220 copay then plan pays 100% (copays vary by service, see contract for fee schedule)
Periodontics	$0-$195 copay then plan pays 100% (copays vary by service, see contract for fee schedule)
Major Services	$0-$195 copay then plan pays 100% (copays vary by service, see contract for fee schedule)
Orthodontic Services	
Orthodontia	$1,700-$1,900 copay for 24 months of Comprehensive treatment then plan pays 100% (see contract for fee schedule)
Lifetime Maximum	Unlimited
Dependent Children	Covered
Full-time Students	Covered

Vision

Routine vision exams are important, not only for correcting vision but because they can detect other serious health conditions.

If you are a Kaiser member, you will receive your vision benefits from Kaiser. If you are a Blue Shield member, you will receive your vision benefits from VSP.

Kaiser Vision Benefits (Kaiser members only)

Each exam has a $20 copay with no frequency limitation.

Eyewear coverage (frame) is not to exceed $125, at Kaiser medical offices only. The $125 coverage benefit is for every 2 years (24 months).

VSP Vision Benefits (Blue Shield members only)

	VSP Vision (available to Blue Shield Members only)	
	In-Network	Out-Of-Network
Examination		
Benefit	$15 copay then plan pays 100%	Plan pays up to $45
Frequency	Once every 12 months	Once every 12 months
Eyeglass Lenses		
Single Vision Lens	Plan pays 100% of basic lens	Plan pays up to $30
Bifocal Lens	Plan pays 100% of basic lens	Plan pays up to $50
Trifocal Lens	Plan pays 100% of basic lens	Plan pays up to $65
Frequency	Once every 12 months	Once every 12 months
Frames		
Benefit	Plan pays up to $130 allowance (20% discount off amount over your allowance)	Plan pays up to $70
Frequency	Once every 24 months	Once every 24 months
Contacts (Elective)		
Benefit	Plan pays up to $130 for contacts lenses Up to $60 copay for fitting & evaluation	Plan pays up $105
Frequency	Once every 12 months	Once every 12 months

Employee Assistance Programs

Blue Shield LifeReferrals 24/7 - Employee Assistance Program (EAP)

Because we want our employees to have a well-balanced life, Blue Shield members will receive EAP benefits through Blue Shield's LifeReferrals 24/7 program. The program can provide referrals to professional counselors for up to three (3) free face-to-face, confidential visits (per 6 month period) and a live 60 minute telephonic consultation. You can access the program 24 hours/365 days to help you resolve emotional, health, family and work issues. **This benefit is included in your medical plan and is available to all household members**.

Blue Shield LifeReferrals
Confidential Access 24/7
(800) 985-2405

Kaiser Permanente Mental Health Services in Southern California

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 a non-urgent appointment online, call to make an appointment for therapy and other counseling services, talk to an advice nurse (1-888-576-6225), speak with a wellness coach (1-866-402-4320 TOLL FREE) or enroll to take a class.

Behavioral Healthcare Member Hotline
(800) 900-3277

Basic Life Insurance

If you have loved ones who depend on your income for support, having life and accidental death insurance can help protect your family's financial security. District employees are automatically enrolled in the Basic Life Insurance program provided by The Standard.

Basic Life Insurance pays your beneficiary a lump sum if you die. The cost of coverage is paid in full by the District. Coverage is provided by Standard Insurance Group.

Basic Life Amount	$40,000

Beneficiary Reminder: Make sure that you have named a beneficiary for your life insurance benefit.

Wellness Resources - A Healthier U

Take control of your health by accessing the many wellness resources available to Kaiser and Blue Shield members.

Kaiser Members

Visit kp.org to access information on living healthy, managing conditions and diseases, and to obtain information about drugs and natural medicines and remedies. Kaiser also offers customized plans for healthier living, classes, and discounts on Weight Watchers® and more. Register with Kaiser's My Health Manager, and you can schedule appointments, order ID cards, view test results, refill prescriptions and email your doctor.

Blue Shield Members

Visit blueshieldca.com/sausd to access the Hospital Comparison Tool, the Symptom Checker, Condition Management information and resources, along with information specific to women's, men's, children's and senior's health. Blue Shield also offers discounts on Weight Watchers® and 24 Hour Fitness memberships. And with Blue Shield's NurseHelp 24/7, you can speak with a registered nurse any time, day or night, you have health related questions at (800) 304-0504. Register with Blue Shield, and you can check your benefits and claims, order ID cards, and access additional wellness resources.

For more information, please visit sausd.us/ahealthieru

It is the District's goal to offer employees and their families programs, resources and activities that support and encourage healthy lifestyles that include relational, nutritional, physical and emotional wellbeing.

Each SAUSD site was offered the opportunity to have a Wellness Champion establish a wellness program for their site. The site Wellness Champion would create a wellness program, using Wellness Funds, for site personnel. All personnel were encouraged to participate in their site's Wellness Champion's Program regardless of their Benefits eligibility. Please visit our Employee Wellness website, sausd.us/ahealthieru, for more details.

Flexible Spending Accounts

Do you have out-of-pocket expenses for copays, deductibles, dental, and vision care or daycare or eldercare expenses throughout the year?

The District offers its employees a great way to save money over the course of a year through Flexible Spending Accounts (FSAs). These accounts allow you to redirect a portion of your salary, on a pre-tax basis, into reimbursement accounts. Money from these accounts is then used to pay for eligible medical and dependent care expenses. You will need to plan carefully because you will forfeit any money left in your account(s) at the end of each plan year (excludes the $500 Healthcare FSA carry over). If you would like more information, please visit SAUSD's custom American Fidelity website at americanfidelity.com/SantaAnaUSD.

You may enroll in the District's FSA plan even if you receive healthcare insurance through your spouse's employer (as long as it's not and HSA plan). In addition, the FSA can be used for eligible expenses for all your qualified dependents.

Healthcare Spending Account

This account will reimburse you with pre-tax dollars for healthcare expenses not reimbursed under your family's healthcare plans. The maximum you may contribute to your Healthcare Spending Account is $2,550 per plan year (July 1 through June 30).

Dependent Care Spending Account

This account will reimburse you with pre-tax dollars for daycare expenses for your children and other qualifying dependents. The maximum amount you may contribute to a Dependent Care Spending Account is $5,000 per plan year or $2,500 if you are married and file separate tax returns.

Eligible Dependents for the Dependent Care Spending Account include:

- Children under the age of 13 who you have primary custody of; and
- Children or other dependents of any age who are physically or mentally unable to care for themselves and who qualify. You may use the federal childcare tax credit and the Dependent Care Spending Account however; your federal credit will be offset by any amount deferred into the Dependent Care plan.

Flex Debit Card for Unreimbursed Medical Expenses

The Flex Debit Card looks and works just like a credit card. When you incur an allowable medical expense, such as a visit to the doctor or the pharmacy, you can use the debit card and avoid having to wait for reimbursement checks. Contact your American Fidelity Account Representative for details.

FSA Online Store

The FSA store offers a large selection of Flexible Spending Account (FSA) eligible products online. It takes the guesswork out of what is and what is not reimbursable by an FSA.

The FSA Store allows you to:

- Use your Flex Card, or any major credit card, to purchase FSA eligible products
- Purchase over-the-counter products by uploading your prescription, and
- Order FSA eligible products at your convenience and have them shipped straight to your doorstep

If you use your Flex Card, you don't have to submit any receipts to American Fidelity since all of the items on the FSA Store are approved by the IRS. Visit FSAstore.com to start shopping.

Voluntary Benefits

During Open Enrollment, you should also consider the voluntary benefits available and decide if you want to enroll or make changes to your current elections. These benefits include:

SUPPLEMENTAL INSURANCE

You pay the full cost of these benefits and enroll directly through the following insurance providers:

- American Fidelity (Cancer, Disability, Voluntary Life, and Accident)
- Conseco Health Insurance (Cancer)
- The Standard (Life and Disability)

If you want to enroll in any of the District's voluntary benefits, see page 24 for information on how to contact the insurance providers directly. For the supplemental insurance options, you can contact your union for details about how to enroll.

American Fidelity
(800) 325-0654
americanfidelity.com/SantaAnaUSD

Conseco Health Insurance
(800)541-2254
conseco.com

The Standard
(800) 522-0406
CTA.org

Summary of Contributions for Employees hired BEFORE July 1, 2014

The table below summarizes the employee contribution amounts that will be effective July 1, 2016. Remember, your contributions for healthcare coverage are deducted before taxes and are calculated each pay period, effectively lowering your tax liability.

Medical				
	Your contribution Percentage	Single	Two-Party	Family
Kaiser HMO	6.0%	$32.17	$64.34	$91.04
Blue Shield Trio HMO*	2.0%	$12.22	$25.24	$36.38
Blue Shield Access+ HMO*	8.0%	$54.01	$111.62	$160.85
Blue Shield PPO*	15.0%	$145.58	$302.29	$434.23

Dental				
	Your contribution Percentage	Single	Two-Party	Family
DeltaCare USA DHMO	n/a	$0.00	$0.00	$0.00
Delta Dental Network PPO	n/a	$0.00	$97.31	$152.33
Delta Dental Incentive PPO	n/a	$0.00	$129.12	$197.94

*Blue Shield rates include Medical, Prescription and VSP vision benefits.

Summary of Contributions for Employees hired AFTER July 1, 2014

The table below summarizes the employee contribution amounts that will be effective July 1, 2016. Remember, your contributions for healthcare coverage are deducted before taxes and are calculated each pay period, effectively lowering your tax liability.

Medical	Your contribution Percentage	Single	Two-Party	Family
Kaiser HMO	6.0%	$32.17	$64.34	$91.04
Blue Shield Trio HMO*	Difference between lowest cost HMO	$106.87	$253.94	$392.65
Blue Shield Access+ HMO*	Difference between lowest cost HMO	$171.12	$387.20	$584.26
Blue Shield PPO*	Difference between lowest cost HMO	$466.51	$1,007.29	$1,468.55

Dental	Your contribution Percentage	Single	Two-Party	Family
DeltaCare USA DHMO	n/a	$0.00	$0.00	$0.00
Delta Dental Network PPO	n/a	$0.00	$97.31	$152.33
Delta Dental Incentive PPO	n/a	$0.00	$129.12	$197.94

*Blue Shield rates include Medical, Prescription and VSP vision benefits.

Meet Ben-IQ

Ben-IQ is a free app that includes much of the information that's included in this overview, but in a place that's always at your fingertips — your smartphone. Ben-IQ is available for Android and iPhone.

GETTING STARTED WITH BEN-IQ

1. Download and launch the app.
2. Enter your assigned username: SAUCE.
3. Read and agree to the Terms and Conditions.

Take a tour of Ben-IQ and review plan summaries and important contacts like our nurse line and EAP. Store and organize ID cards using your phone's camera, and much more! Be sure to share Ben-IQ with your covered family members too.

INSIDE THE BEN-IQ APP

- 24/7 access to your health plan highlights
- Store and organize your plan ID cards
- Find in-network providers and other care options
- Nurse line numbers and helpful contact information
- Cost of care information at your fingertips
- Access to helpful videos

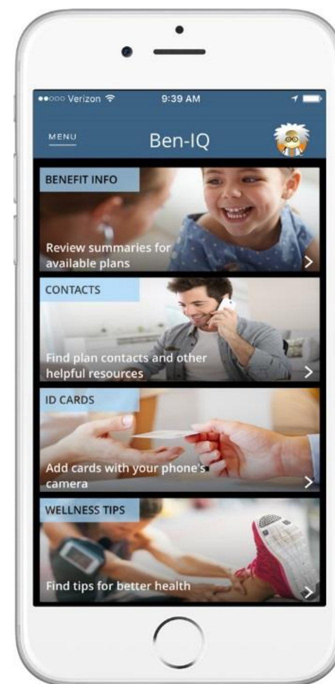
MOBILE APP DOWNLOAD LINKS

iOS (iPhone and iPad) — iTunes App Store

http://itunes.apple.com/us/app/ben-iq/id502985663

Android Devices — Google Play

https://play.google.com/store/apps/details?id=com.Alliant.BenIQ



Key Terms

MEDICAL/GENERAL TERMS

Allowable Charge - The most that an in-network provider can charge you for an office visit or service.

Balance Billing - Non-network providers are allowed to charge you more than the plan's allowable charge. This is called Balance Billing.

Coinsurance - The cost share between you and the insurance company. Coinsurance is always a percentage totaling 100%. For example, if the plan pays 70%, you are responsible for paying the remaining 30% of the cost.

Copay - The fee you pay to a provider at the time of service.

Deductible - The amount you have to pay out-of-pocket for expenses before the insurance company will cover any benefit costs for the year (except for preventive care and other services where the deductible is waived).

Explanation of Benefits (EOB) - The statement you receive from the insurance carrier that explains how much the provider billed, how much the plan paid (if any) and how much you owe (if any). In general, you should not pay a bill from your provider until you have received and reviewed your EOB (except for copays).

Family Deductible - The maximum dollar amount any one family will pay out in individual deductibles in a year.

Individual Deductible - The dollar amount a member must pay each year before the plan will pay benefits for covered services.

In-Network - Services received from providers (doctors, hospitals, etc.) who are a part of your health plan's network. In-network services generally cost you less than out-of-network services.

Out-of-Network - Services received from providers (doctors, hospitals, etc.) who are not a part of your health plan's network. Out-of-network services generally cost you more than in-network services. With some plans, such as HMOs and EPOs, out-of-network services are not covered.

Out-of-Pocket - Healthcare costs you pay using your own money, whether from your bank account, credit card, Health Reimbursement Account (HRA), Health Savings Account (HSA) or Flexible Spending Account (FSA).

Out-of-Pocket Maximum – The most you would pay out-of-pocket for covered services in a year. Once you reach your out-of-pocket maximum, the plan covers 100% of eligible expenses.

Preventive Care – A routine exam, usually yearly, that may include a physical exam, immunizations and tests for certain health conditions.

PRESCRIPTION DRUG TERMS

Brand Name Drug - A drug sold under its trademarked name. A generic version of the drug may be available.

Generic Drug – A drug that has the same active ingredients as a brand name drug, but is sold under a different name. Generics only become available after the patent expires on a brand name drug. For example, Tylenol is a brand name pain reliever commonly sold under its generic name, Acetaminophen.

Dispense as Written (DAW) - A prescription that does not allow for substitution of an equivalent generic or similar brand drug.

Maintenance Medications - Medications taken on a regular basis for an ongoing condition such as high cholesterol, high blood pressure, asthma, etc. Oral contraceptives are also considered a maintenance medication.

Non-Preferred Brand Drug - A brand name drug for which alternatives are available from either the plan's preferred brand drug or generic drug list. There is generally a higher copayment for a non-preferred brand drug.

Preferred Brand Drug - A brand name drug that the plan has selected for its preferred drug list. Preferred drugs are generally chosen based on a combination of clinical effectiveness and cost.

Specialty Pharmacy - Provides special drugs for complex conditions such as multiple sclerosis, cancer and HIV/AIDS.

Step Therapy - The practice of starting to treat a medical condition with the most cost effective and safest drug therapy and progressing to other more costly or risky therapy, only if necessary.

DENTAL TERMS

Basic Services - Generally include coverage for fillings and oral surgery.

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

Endodontics - Commonly known as root canal therapy.

Implants - An artificial tooth root that is surgically placed into your jaw to hold a replacement tooth or bridge. Many dental plans do not cover implants.

Major Services - Generally include restorative dental work such as crowns, bridges, dentures, inlays and onlays.

Orthodontia - Some dental plans offer Orthodontia services for children (and sometimes adults too) to treat alignment of the teeth. Orthodontia services are typically limited to a lifetime maximum.

Periodontics - Diagnosis and treatment of gum disease.

Pre-Treatment Estimate - An estimate of how much the plan will pay for treatment. A pre-treatment estimate is not a guarantee of payment.

Important Plan Notices and Documents

CURRENT HEALTH PLAN NOTICES

Notices that must be provided to plan participants on an annual basis are available on our benefits website at sausd.us/benefits and include:

- 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.
- Notice of Choice of Providers
  Notifies you about the plan's requirement that you name a Primary Care Physician (PCP).
- Children's Health Insurance Program Reauthorization Act (CHIPRA)
  Describes availability of premium assistance for Medicaid eligible dependents.

CURRENT PLAN DOCUMENTS

Important documents for our health plan and retirement plan available our benefits website at sausd.us/benefits and include:

Summary Plan Descriptions (SPDs)

A Summary Plan Description, or SPD, is the legal document for describing benefits provided under the plan as well as plan rights and obligations to participants and beneficiaries. The Summary Plan descriptions for each of the plans outlined in this guide are available at sausd.us/benefits.

Summary of Benefits and Coverage (SBCs)

A Summary of Benefits and Coverage (SBC) is a document required by the Affordable Care Act (ACA) that presents benefit plan features in a standardized format. The following SBCs are available on our benefits website at sausd.us/benefits.

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

Paper copies of these documents and notices are available if requested. If you would like a paper copy, please contact the Benefits Office at (714) 558-5686 or benefits@sausd.us.

Statement of Material Modifications

This enrollment guide constitutes a Summary of Material Modifications (SMM) to the Santa Ana Unified School District Benefits Plan. 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.

For Assistance

American Fidelity
Phone: 1-800-325-0654
Web: https://www.americanfidelity.com/SantaAnaUSD

Assistance with your Flexible Spending Accounts including Dependent Daycare and Healthcare Spending accounts. Also for supplemental insurance including Cancer, Disability, Voluntary Life and Accident.

Blue Shield of California
Phone: 1-855-747-5800 – **TRIO Members**
Phone: 1-800-642-6155 – **Access+ HMO & PPO Members**
Web: https://www.blueshieldca.com/sausd

Medical assistance for all Blue Shield members

CSEA
Phone: 1-714-532-3766
Web: http://www.members.csea.com/memberhome/

California School Employees Association for Classified population.

DeltaCare USA DHMO
Phone: 1-800-422-4234
Web: http://www.deltadentalins.com

Dental services for DeltaCare USA DHMO members.

Kaiser Permanente HMO
Phone: 1-800-646-4000
Web: https://healthy.kaiserpermanente.org

Medical, pharmacy and vision services for Kaiser Permanente members.

Mid America
Phone: 1-800-430-7999
Web: https://www.midamerica.biz

Retirement solutions for Classified population.

SAEA
Phone: 1-714-542-6758
Web: http://santaanaeducators.com

Santa Ana Educators' Association of Certificated population.

STRS
Phone: 1-800-228-5453
Web: http://www.calstrs.com

California State Teachers' Retirement System for Certificated population.

VSP (Blue Shield Vision Services Provider)
Phone: 1-800-877-7195
Web: https://vsp.com

Vision services for all Blue Shield HMO and PPO members.

American Specialty Health (Blue Shield Chiropractic Services)
Phone: 1-877-355-2746
Web: http://ashcompanies.com

Chiropractic services for all Blue Shield HMO and PPO members.

Blue Shield Mental Health Service Providers
Phone: 1-877-263-9952
Web: https://www.blueshieldca.com/sausd

Mental health services for all Blue Shield HMO and PPO members.

Conseco
Phone: 1-800-541-2254
Web: http://conseco.com

Assistance with your supplemental Cancer insurance.

Delta Dental Incentive DPPO & Network DPPO
Phone: 1-866-499-3001
Web: http://www.deltadentalins.com

Dental services for Delta Dental Incentive DPPO & Network DPPO members.

Express Scripts
Phone: 1-877-474-1136
Web: http://express-scripts.com

Pharmacy services for Blue Shield HMO and PPO members.

Life Referrals 24/7 (Blue Shield EAP Services)
Phone: 1-800-985-2405
Web: https://www.blueshieldca.com/sausd

Employee Assistance Program for active employees who are Blue Shield HMO or PPO members.

PERS
Phone: 1-888-225-7377
Web: http://www.calpers.ca.gov/

California Public Employees' Retirement System for Classified population.

Schools First Federal Credit Union
Phone: 1-800-462-8328 or 1-714-258-4000
Web: https://www.schoolsfirstfcu.org

Third party administrator of additional retirement accounts including but not limited to IRA, 403 B, etc.

The Standard (Employee Life Insurance)
Phone: 1-800-522-0406
Web: https://www.standard.com

Assistance with your supplemental Life and Disability insurance.

Notes

Notes

Rev. 5/9/2016