CLASSIFIED SELF-PAY BROCHURE

www.sausd.us/benefits

benefits@sausd.us

P (714) 558-5686
F (714) 558-5682

1601 E Chestnut Ave
Santa Ana, CA 92701

CONTENTS

For your convenience, we've provided this table of contents for two purposes:

It provides you an overview of the document's contents and organization and,

It allows readers to go directly to a specific section of the online document.

*

While we have made every effort to make sure that this guide is comprehensive, it cannot provide a complete description of all benefit provisions. For detailed information, you should refer to your plan benefit booklets provided by your insurance provider or summary plan descriptions that are on our website www.sausd.us/benefits. The plan benefits booklets provided by your insurance provider determine how all benefits are paid.

The benefits explained in this summary are effective July 01, 2019 through June 30, 2020.

Plan Changes

Here are some medical and dental plan highlights for the 2019-2020 school year.

01

Medical

Kaiser Senior Advantage HMO

Rate increase*
No changes to medical coverage

Kaiser Permanente HMO

Rate increase*
No changes to medical coverage
Members still receive vision coverage through VSP

Blue Shield 65 Plus HMO

Rate increase*
No changes to medical coverage

Blue Shield Trio ACO HMO

Now the lowest costing HMO plan*
No changes to medical coverage
Members still receive pharmacy coverage through Express Scripts
Members still receive vision coverage through VSP

Blue Shield Access+ HMO

Rate increase*
No changes to medical coverage
Members still receive pharmacy coverage through Express Scripts
Members still receive vision coverage through VSP

Blue Shield Spectrum PPO

Rate increase*
No changes to medical coverage
Members still receive pharmacy coverage through Express Scripts
Members still receive vision coverage through VSP

Refer to your Rates on page 13

Dental

Delta Care USA DHMO

No rate increase and no changes to dental coverage

Delta Dental Incentive DPPO

No rate increase and no changes to dental coverage

Delta Dental Network DPPO

No rate increase and no changes to dental coverage

Here at Santa Ana Unified we believe that you are our most important asset. Helping you and your families achieve and maintain good health - physical, emotional, and financial - is the reason we offer you this program.

This year, we are pleased to announce no changes to our plan coverages and minimal increases to plan cost.

However, even though our plan are not changing significantly, you may have different needs than last year.

Open Enrollment is your once-a-year opportunity to review your existing elections and make any changes to your plans, add or drop dependents, or enroll in the Flexible Spending Account with American Fidelity for the 2019-2020 school year.

FOCUS ON BENEFITS

02

WHO IS ELIGIBILE

Who You Can Cover

You may enroll the following family members in our health insurance plans.

Your Spouse

The person you are legally married to under state law, including a same-sex spouse.

Your Domestic Partner

Only with proof of a Declaration of Domestic Partnership filed with the California State Secretary. California state registration is limited to same sex domestic partners where one is at least 62 and eligible for Social Security based on their age. Any premiums paid for by SAUSD for your domestic partner are taxable and will be included in 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 children, adopted children, and/or stepchildren.

Your children must be under 26 years old. They do not have to live with you or be enrolled in school. They can be married and living on their own.

Any child over the age of 26 only if they are mentally or physically handicapped.

Any children that are named in a Qualified Medical Child Support Order (QMCSO) as defined by federal law.

Who You Cannot Cover

You may not enroll the following family members in our health insurance plans. Family members who are not eligible for coverage include, but are not limited to:

Your Parents

Your Grandparents

Your Siblings

When Coverage Begins

Any changes you make during Open Enrollment begin July 1.

All other changes will go in to effect the first day of the following month you notify our office.

If you add a child, their coverage will being the first day of the following month except for newborn children. Newborn children will be added effective their date of birth.

When You Can Enroll

Open Enrollment

Open enrollment is usually held in late April or early May and is the one time each year you can make changes to your benefits without a qualifying event.

Qualifying Events

Make sure to notify our office right away if you have a qualifying event and need to make a change to your coverage.

These events include, but are not limited to, the birth or adoption of a baby or child, loss of other coverage, your eligibility for new coverage, a marriage, or a divorce. You have 30-days to make your changes.

Rules for Changes

Other than open enrollment, you can only make changes to your benefits if you have a qualified event or a "*special enrollment*". If you have a qualified event and are able to make changes to your benefits, you will be required to submit proof of that change or evidence of prior coverage.

There are four basic types of qualifying events. The following are examples, not a full list:

Loss of Health Coverage

If you lose your current coverage, including job-based, individual, and/or a student plan

If you are no longer eligible for Medicare, Medicaid, or CHIP

When you turn 26 years and lose your coverage through your parent's plan

Changes in Household

Like getting married or a divorce

Having a baby or adoption a child

Experiencing a death in your family

Changes in Residence

If you move to different ZIP code or county that affects your access to network providers

Other Qualifying Events

Changes in your income that affect the coverage you qualify for

A change in eligibility for Medicare or Medicaid

A court order including a Qualified Medical Child Support Order (QMCSO)

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

1. Any change you make must be consistent with the change in status, *AND*
2. You must notify our office and make the change before or within *30-days* of the date the event occurs

You are responsible for notifying our office of your dependent(s) that become INELIGIBLE because of a divorce or becoming an overage dependent before or within 30-days of the event. Failure to do so may jeopardize your dependent's right to COBRA.

Tools and Resources

Before you make any decision about your coverage, there is some important information you need to know about your benefits. Below is a list of tools and resources that will give you the information you need to make informed decisions during this plan year.

Open Enrollment Announcement

This announcement includes information that retirees need to consider when selecting their benefits for 2019-2020 plan year.

Retiree Agreement

The Retiree Agreement you signed when you retired gives you an overview of the benefits you are eligible for and how long.

Medicare

You and/or your spouse must enroll into Medicare parts A and B once you and/or your spouse become eligible for Medicare.

Medicare becomes your primary insurance and the District coverage becomes your secondary coverage. Make sure to tell your doctor's office that Medicare I your primary insurance.

When you visit your doctor's office, tell the Medicare is your primary insurance, give them your Medicare card, and your provider I.D. card; the doctor's office should take care of the rest.

Telephone Appointments

Available to all Blue Shield members, Heal™ and Teladoc™ let you see a doctor at a time and place that is best for you.

Heal™ is only available for Blue Shield PPO members in Los Angeles, Orange County, San Francisco, Oakland, Berkeley, San Diego, and the Peninsula to San Jose.

The cost for Heal™ is the same as your plan's co-pay and Teladoc™ has a $5 co-pay for both HMO and PPO members.

Heal™

8 a.m. to 8 p.m. daily
Phone: 1-844-644-4325
getheal.com

Teladoc™

Phone: 1-800-835-2362
teladoc.com/bsc
Smartphone app also available

Kaiser members can get care from a doctor wherever 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.

Monday - Friday
7 a.m. to 7 p.m.
Phone: 1-800-954-8000

Medical HMO Plans with Medicare

Medical coverage provides you with benefits that keep you healthy like preventative care screenings and access to urgent care. It also provides important financial protection if you have a serious medical condition. The following chart shows two plans available to self-pay subscribers who have Medicare Parts A and B.

	Kaiser Senior Advantage HMO	Blue Shield 65 Plus HMO
Single (Subscriber Only)	$190.70	$292.98
2 Party (Subscriber +1)	$381.40	$581.45
Annual Deductible	None	None
Annual Out-of-Pocket Max	$1,500 per Individual $3,000 per Family	$6,700 per Individual
Lifetime Max	Unlimited	Unlimited
Office Visits		
Primary Provider	$20 Co-pay	$20 Co-pay
Specialist Office Visit	$20 Co-pay	$20 Co-pay
Preventive Services	Plan Pays 100%	Plan Pays 100%
Chiropractic Care	$20 Co-pay	$20 Co-pay *Medicare Covered* $15 Co-pay *American Specialty Health Covered* *(Limit of 20 visits per year)*
Labs and X-Rays	Plan Pays 100%	$20 Co-pay
Hospitalization		
Inpatient Hospitalization	$250 Co-pay *Per admission*	$250 Co-pay *Per admission*
Outpatient Surgery	$20 Co-pay	Plan pays 100%
Emergency Services		
Urgent Care	$20 Co-pay	$25 Co-pay
Emergency Room	$50 Co-pay *Waived if admitted*	$50 Co-pay *Waived if admitted*

If you enroll in medical coverage, you will receive coverage for prescription drugs. The following chart shows the prescription coverage offered to self-pay subscribers who are with Medicare and enrolled in our with Medicare medical HMO plan.

	Kaiser Senior Advantage HMO	Blue Shield 65 Plus HMO
Prescription Drug Deductible	None	None
Annual Out-of-Pocket Limit	$1,500 per Individual $3,000 per Family *Combined with Medical*	N/A
Pharmacy Co-pays		
Generic	$10 Co-pay	$10 Co-pay
Preferred Brand-Name	$20 Co-pay	$20 Co-pay
Non-Preferred Brand-Name	N/A	$40 Co-pay
Supply Limit	30 Days	30 Days
Mail Order Co-pays		
Generic	$20 Co-pay	$20 Co-pay
Preferred Brand-Name	$40 Co-pay	$40 Co-pay
Non-Preferred Brand-Name	N/A	$80 Co-pay
Supply Limit	100 Days	90 days

Medical HMO Plans with or without Medicare

Medical coverage provides you with benefits that keep you healthy like preventative 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 HMO plans available to self-pay subscribers who are with or without Medicare.

	Blue Shield Trio A.C.O. HMO		Blue Shield Access+ HMO		Kaiser Permanente HMO
	w/o Medicare	w/ Medicare	w/o Medicare	w/ Medicare	
Single (Subscriber Only)	$514.14	$457.12	$661.10	$582.02	$678.22
2 Party (Subscriber +1)	$1,062.25	$943.95	$1,356.29	$1,203.11	$1,351.74
Family (Subscriber +2 or more)	$1,597.83	$1,360.91	$1,953.81	$1,733.53	$1,917.40

Refer to the Rates page to view 1 with 1 without Medicare rates

Annual Deductible	None	None	None
Annual Out-of-Pocket Max	$1,000 per Individual $3,000 per Family	$1,000 per Individual $2,000 per Family	$1,500 per Individual $3,000 per Family
Lifetime Max	Unlimited	Unlimited	Unlimited

Office Visits

Primary Provider	$20 Co-pay	$20 Co-pay	$20 Co-pay
Specialist Office Visit	$20 Co-pay *When you are referred by your primary care physician* $20 Co-pay *When you self-refer office visits and consultations within your Trio provider group*	$20 Co-pay *When you are referred by your primary care physician* $30 Co-pay *When you self-refer office visits and consultations within your Access+ provider group*	$20 Co-pay
Preventive Services	Plan Pays 100%	Plan Pays 100%	Plan Pays 100%
Chiropractic Care	$10 Co-pay *Up to 30 visits per year*	$10 Co-pay *Up to 30 visits per year*	Not Covered
Labs and X-Rays	Plan Pays 100%	Plan Pays 100%	Plan Pays 100%

Hospitalization

Inpatient	$250 Co-pay *Per admission*	$250 Co-pay *Per admission*	$250 Co-pay *Per admission*
Outpatient Surgery	Plan pays 100%	Plan pays 100%	$20 Co-pay

Emergency Services

Urgent Care	$20 Co-pay	$20 Co-pay	$20 Co-pay
Emergency Room	$100 Co-pay *Waived if admitted*	$100 Co-pay *Waived if admitted*	$100 Co-pay *Waived if admitted*

If you enroll in medical coverage, you will receive coverage for prescription drugs. The following chart shows the prescription coverage offered to self-pay subscribers who are with or without Medicare and enrolled in one of our medical HMO plans.

	Blue Shield Trio A.C.O. HMO Express Scripts[1]	Blue Shield Access+ HMO Express Scripts[1]	Kaiser Permanente HMO Kaiser Pharmacy
Prescription Drug Deductible	$150 per Individual *For a brand-name Rx*	$150 per Individual *For a brand-name Rx*	None
Annual Out-of-Pocket Limit	$5,600 per Individual $10,200 per Family	$5,600 per Individual $10,200 per Family	Combined with Medical
Pharmacy Co-Pays			
Generic	$10 Co-pay	$10 Co-pay	$10 Co-pay
Preferred Brand-Name	$25 Co-Pay*	$25 Co-Pay*	$20 Co-pay
Non-Preferred Brand-Name	$40 Co-Pay*	$40 Co-Pay*	N/A
Supply Limit	30 Days	30 Days	30 Days
Mail Order Copays			
Generic	$20 Co-pay	$20 Co-pay	$20 Co-pay
Preferred Brand-Name	$50 Co-pay*	$50 Co-pay*	$40 Co-pay
Non-Preferred Brand-Name	$80 Co-pay*	$80 Co-pay*	N/A
Supply Limit	90 Days	90 Days	100 Days

*After Deductible

[1]Express Scripts Advantage Plus Utilization Management Program

This Express Scripts program uses strategies to help manage the high-cost and high-utilization of specialty and non-specialty medications.

Subscribers may be required to participate in the following programs when filling their prescriptions:

Drug Quantity Management

Drug quantity management is required for medications prescribed, "as needed" for which the days of supply cannot be inferred from the prescription (migraine medication, inhalers, creams, 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.

Medical PPO Plan with or without Medicare

Medical coverage provides you with benefits that keep you healthy like preventative 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 available to self-pay subscribers who are with or without Medicare.

Blue Shield Spectrum PPO

	w/o Medicare	w/ Medicare
Single (Subscriber Only)	$987.38	$869.87
2 Party (Subscriber +1)	$2,051.33	$1,806.64
Family (Subscriber +2 or more)	$2,945.72	$2,594.82

Refer to the Rates page to view 1 with 1 without Medicare rates

	In-Network	Out-of-Network
Annual Deductible	$300 per Individual $600 per Family	$600 per Individual $1,200 per Family
Annual Out-of-Pocket Max	$1,300 per Individual $2,600 per Family	$2,600 per Individual $5,200 per Family
Lifetime Max	Unlimited	Unlimited

Office Visits

Primary Provider	$20 Co-pay	Plan pays 70%*
Specialist Office Visit	$20 Co-pay	Plan pays 70%*
Preventive Services	Plan Pays 100%	Plan pays 70%*
Chiropractic Care	Plan pays 80%* *Up to 50 visits per year*	Plan pays 70%* *Up to 50 visits per year*
Labs and X-Rays	Plan pays 80%*	Plan pays 70%*

Hospitalization

Inpatient	Plan pays 90%*	Plan pays 70%* *Up to $1,500 per day*
Outpatient Surgery	Plan pays 90%*	Plan pays 70%* *Up to $1,500 per day*

Emergency Services

Urgent Care	$20 Co-pay	Plan pays 70%*
Emergency Room	$150 Co-pay + 10% *Waived if admitted*	$100 Co-pay + 10% *Waived if admitted*

**After Deductible*

If you enroll in medical coverage, you will receive coverage for prescription drugs. The following chart shows the prescription coverage offered to self-pay subscribers who are with or without Medicare and enrolled in our medical PPO plan.

Blue Shield Spectrum PPO

Express Scripts[1]

	In-Network	Out-of-Network
Prescription Drug Deductible	$150 per Individual *For a brand-name Rx*	$150 per Individual *For a brand-name Rx*
Annual Out-of-Pocket Limit	$5,300 per Individual $10,600 per Family	$4,000 per Individual $8,000 per Family

Pharmacy Co-Pays

Generic	$10 Co-pay	$10 Co-pay *Then plan pays 75%*
Preferred Brand-Name	$25 Co-Pay*	$25 Co-Pay*
Non-Preferred Brand-Name	$40 Co-Pay*	$40 Co-Pay*
Supply Limit	30 Days	30 Days

Mail Order Copays

Generic	$20 Co-pay	Not Covered
Preferred Brand-Name	$50 Co-pay*	Not Covered
Non-Preferred Brand-Name	$80 Co-pay*	Not Covered
Supply Limit	90 Days	Not Applicable

*After Deductible

[1]Express Scripts Advantage Plus Utilization Management Program

This Express Scripts program uses strategies to help manage the high-cost and high-utilization of specialty and non-specialty medications.

Subscribers may be required to participate in the following programs when filling their prescriptions:

Drug Quantity Management

Drug quantity management is required for medications prescribed, "as needed" for which the days of supply cannot be inferred from the prescription (migraine medication, inhalers, creams, 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.

Dental PPO Plans

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

Contact Delta Dental at 1-866-499-3001 or visit their website at www.deltadentalins.com to find a provider near you.

	Delta Dental Network DPPO		Delta Dental Incentive DPPO	
Single (Subscriber Only)	$45.81		$57.27	
2 Party (Subscriber +1)	$127.35		$159.19	
Family (Subscriber +2 or more)	$173.20		$216.54	
	Preferred Provider	Premier Provider	Preferred Provider	Premier Provider
Annual Deductible	None	None	None	$25 per Individual $75 per Family *Waived for diagnostic and preventative services*
Annual Plan Max	$2,000 per Individual	$1,200 per Individual	$2,000 per Individual	$1,500 per Individual
Waiting Period	None	None	None	None
Diagnostic and Preventative	Plan pays 100%	Plan pays 50%	Plan Pays 70-100%	Plan Pays 70-100%
Basic Services				
Fillings	Plan pays 100%	Plan pays 50%	Plan pays 70-100%	Plan pays 70-100% *After deductible*
Root Canals	Plan pays 100%	Plan pays 50%	Plan pays 70-100%	Plan pays 70-100% *After deductible*
Diagnostic and Preventative	Plan pays 100%	Plan pays 50%	Plan pays 70-100%	Plan pays 70-100% *After deductible*
Major Services				
Prosthodontics	Plan pays 50%	Plan pays 50%	Plan pays 50%	Plan pays 50% *After deductible*
Other Major Services	Plan pays 100%	Plan pays 50%	Plan pays 70-100%	Plan pays 70-100% *After deductible*
Orthodontia Services				
Orthodontia	Plan pays 50%	Plan pays 50%	Plan pays 50%	Plan pays 50%
Lifetime Max	$1,000	$1,000	$500	$500
Dependents	Covered	Covered	Covered	Covered

The Incentive plan pays 70% for diagnostics, preventative, basic and major services for the first year. This percentage increases by 10% each year to a max of 100% as long as you use the coverage at least once a year. If you do not use the plan at least once during the year, your percentage will remain at the level attained the previous year.

Delta Care is a dental DHMO plan and automatically assigns you and your dependents a dentist when you enroll. You can always change your dentist by contacting Delta Care and letting them know the office you prefer within the Delta Care network.

Visit www.deltadentalins.com to find a provider near you.

	Delta Care USA D.H.M.O.
Single (Subscriber Only)	$16.76
2 Party (Subscriber +1)	$27.66
Family (Subscriber +2 or more)	$40.88
Annual Deductible	None
Annual Plan Max	Unlimited
Waiting Period	None
Diagnostic and Preventative*	$0-$45 Co-pay then the plan pays 100%
Basic Services	
Fillings*	Plan pays 100%
Root Canals*	Plan pays 100%
Diagnostic and Preventative*	Plan pays 100%
Major Services	
Prosthodontics	N/A
Other Major Services*	$0-$195 Co-pay than the plan pays 100%
Orthodontia Services	
Orthodontia*	$1,700-$1,900 Co-pay
Lifetime Max	Unlimited
Dependents	Covered

*Co-pays vary by the type of services you receive. To receive a list of Delta Care's fee schedule, you should contact Delta Care at 1-800-422-4234 and request a copy of the plan's contract.

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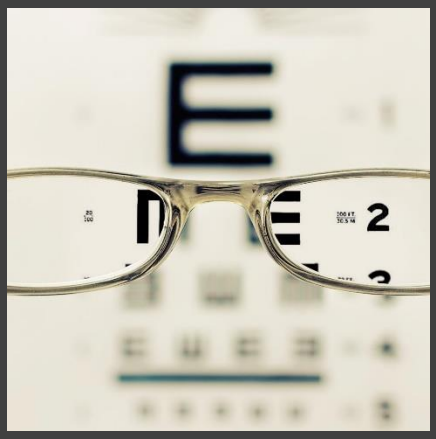
Vision Coverage

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

All SAUSD subscribers and family members enrolled in our medical plans will receive vision benefits from VSP.



V.S.P.

	In-Network Coverage	Out-of-Network Coverage
Office Visit	$15 Co-pay *Then the plan pays 100%*	Plan pays up to $45
Frequency	Event 12 months	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	Every 12 months	Every 12 months
Frames		
Benefit	Plan pays up to $130 *On select frames* Plan pays up to $150 *On featured frames*	Plan pays up to $70
Frequency	Every 24 months	Every 24 months
Contacts		
Benefit	Plan pays up to $130 *With up to $60 co-pay for fitting and evaluation*	Plan pays up to $105
Frequency	Every 12 months	Every 12 months

Visit vsp.com to find a V.S.P. provider near you.

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Employee Assistance Programs (EAP)

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

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 Referral 24/7 program.

This program provides referrals to professional counselors for up to three free face-to-face confidential visits every
6-months and live 60-minute 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.

Life Referrals 24/7

1-800-985-2405

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 online, call to make an appointment for therapy and other counseling services, talk to an advice nurse, speak with a wellness coach or enroll to take a class.

Behavioral Health Hotline

1-800-900-3277

Wellness Coaching

1-866-402-4320

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Rates

The following tables summarize the amounts our self-pay subscribers pay for their health insurance coverage.

Rates are effective July 01, 2019 through June 30, 2020

Subscribers are billed a month in advance, on the third Monday every month, and their payments are due on the second Friday of the following month.

Kaiser rates include medical, pharmacy, and VSP vision coverage.

Blue Shield rates include medical, Express Scripts pharmacy and VSP vision coverage.

Kaiser Sr. Advantage	Single Subscriber Only	2 Party 2 with Medicare	2 Party 1 w/ 1 w/o Medicare
You Pay	$190.70	$381.40	$755.68

Kaiser HMO	Single Subscriber Only	2 Party Subscriber +1	Family Subscriber +2 or more
You Pay	$565.18	$1,126.45	$1,597.83

Blue Shield 65 Plus	Single Subscriber Only	2 Party 2 with Medicare	2 Party 1 w/ 1 w/o Medicare	
			1 on Trio	1 on Access+
You Pay	$292.98	$581.45	$807.12	$954.08

Blue Shield Trio A.C.O.	*Without Medicare* Single Subscriber Only	2 Party Subscriber +1	Family Subscriber +2 or more
You Pay	$514.14	$1,062.25	$1,530.99

Blue Shield Trio A.C.O.	*With Medicare* Single Subscriber Only	2 Party Subscriber +1	2 Party 1 w 1 w/o Medicare	Family Subscriber +2 or more
You Pay	$457.12	$943.95	$1,005.23	$1,360.91

Blue Shield Access+ HMO	*Without Medicare* Single Subscriber Only	2 Party Subscriber +1	Family Subscriber +2 or more
You Pay	$661.10	$1,356.29	$1,953.81

Blue Shield Access+ HMO	*With Medicare* Single Subscriber Only	2 Party Subscriber +1	2 Party 1 w 1 w/o Medicare	Family Subscriber +2 or more
You Pay	$582.02	$1,203.11	$1,288.05	$1,733.53

Blue Shield Spectrum PPO	*Without Medicare* Single Subscriber Only	2 Party Subscriber +1	Family Subscriber +2 or more
You Pay	$987.38	$2,051.33	$2,945.72

Blue Shield Spectrum PPO	*With Medicare* Single Subscriber Only	2 Party Subscriber +1	2 Party 1 w 1 w/o Medicare	Family Subscriber +2 or more
You Pay	$869.87	$1,806.64	$1,933.83	$2,594.82

Dental

Delta Care USA DHMO	Single Subscriber Only	2 Party Subscriber +1	Family Subscriber +2 or more
You Pay	$17.31	$28.48	$42.09

Delta Dental Network DPPO	Single Subscriber Only	2 Party Subscriber +1	Family Subscriber +2 or more
You Pay	$45.81	$127.35	$173.20

Delta Dental Incentive DPPO	Single Subscriber Only	2 Party Subscriber +1	Family Subscriber +2 or more
You Pay	$57.27	$159.19	$216.54

Medical/General Terms

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

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

Coinsurance
The cost between you and the insurance company. Coinsurance is always a percentage totaling 100%. For example, if the plan pays 70%, you are responsible for 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 benefits costs for the year (except for preventative 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 (except copays) until you have received and reviewed your EOB.

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 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 your providers (doctors, hospitals, etc.) who are not a part of your health plan's network. Out-of-network services generally cost 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.

Preventative Care
A routine exam, usually yearly, that may include a physical exam, immunizations, and test for certain health conditions.

Prescription 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 non-preferred brand drugs.

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 billing.

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

Dental Terms

Basic Services
Generally includes coverage for fillings and oral surgery.

Diagnostic and Preventative Services
Generally, includes routine cleanings, oral exams, x-rays, sealants, and fluoride treatments

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, includes 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 alignments 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 payments.

Current Health Plan Notices

We must provide these notices to our plan participants on an annual basis and are available on our website at www.sausd.us/benefits.

These notices include:

Medicare Part D Notice

This notice describes options to access prescription drug coverage for Medicare eligible individuals.

Women's Health and Cancer Rights Act

This notice describes available benefits to those that will or have undergone a mastectomy.

Newborn's and Mother's Health Protection Act

This notice describes the right of mothers and newborns to stay in the hospital 48-96 hours after delivery.

HIPAA Notice of Special Enrollment Rights

This notice describes when you can enroll yourself and/or dependents in health coverage outside of open enrollment.

Notice of Choice of Providers

This notice notifies you about the plan's requirement that you name a primary care physician (PCP).

Children's Health Insurance Program Reauthorization Act (CHIPRA)

This notice describes the availability of premium assistance for Medicaid eligible dependents.

Current Plan Documents

These important documents for our health plans, and retirement plan, are available on our website at www.sausd.us/benefits.

These documents include:

Summary Plan Descriptions (SPD)

This document is the legal document for describing benefits provided under our plan, as well as plan rights and obligations to participants and beneficiaries. The SPD for each of our plans outlined in this brochure are available at www.sausd.us/benefits.

Summary of Benefits and Coverage (SBC)

We are required to provide the following documents by the Affordable Care Act (ACA) it presents benefit plan features in a standardized format. The following SBCs are available on our website at www.sausd.us/benefits.

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

Paper copies of these documents and notices are available as requested. If you would like a paper copy, contact our office at 1-714-558-5686 or benefits@sausd.us.

Statement of Material Modifications

This brochure constitutes a summary of material modifications (SMM) to the Santa Ana Unified School District benefits plan. This brochure does not supplement and/or replace certain information in the SPD. Retain it for future reference along with your SPD. Please share these materials with your covered dependents.

Provider Directory

A

American Fidelity
1-800-365-9180
www.americanfidelity.com
Assistance with your flexible spending accounts.

Also for assistance with your supplemental insurances including accident, cancer, disability, and voluntary life.

American Specialty Health
1-800-848-3555
ashcompanies.com
Chiropractic services for all Blue Shield members.

B

Blue Shield 65 Plus
1-800-393-6130
www.blueshieldca.com/sausd
Medical and pharmacy provider for 65 Plus members.

Blue Shield of California
1-855-747-5800 [Trio]
1-800-393-6130 [Access+ & PPO]
www.blueshieldca.com/sausd
Medical provider for all Blue Shield members.

Blue Shield Heal
1-844-644-4325 [8 a.m. to 8 p.m.]
getheal.com
Telephone appointments for Blue Shield PPO members only.

Blue Shield Mental Health
1-877-263-9952
www.blueshieldca.com/sausd
Mental health services for all Blue Shield members.

Blue Shield Teladoc
1-800-835-2362
member.teladoc.com/bsc
Phone or video consultations for Blue Shield members, except 65 Plus.

C

CSEA
1-714-532-3766
www.csea.com/web
Employee union for eligible Classified personnel.

D

Delta Dental
1-866-499-3001
www.deltadentalins.com
Dental provider for Incentive and Network DPPO members.

Delta Care USA DHMO
1-800-422-4234
www.deltadentalins.com
Dental provider for Delta Care members.

E

Express Scripts
1-877-474-1136
express-scripts.com
Pharmacy provider for Blue Shield members, except 65 Plus.

K

Kaiser Permanente
1-833-KP4CARE (574-2273)
kp.org
Medical, pharmacy, and mental health provider for all Kaiser members.

L

Life Referrals 24/7
1-800-985-2405
www.blueshieldca.com/sausd
Employee assistance program for all Blue Shield members.

P

PERS
1-888-225-7377
www.calpers.ca.gov
Employee retirement system for Classified personnel.

S

SAEA
1-714-542-6758
santaanaeducators.com
Employee union for eligible Certificated personnel.

Schools First Federal Credit Union
1-714-258-4000
www.schoolsfirstfcu.org
Third-party administrator for additional retirement accounts.

STRS
1-800-228-5453
www.calstrs.com
Assistance with your supplemental disability and life insurance.

V

VSP
1-800-877-7195
vsp.com
Vision provider for all SAUSD health plan members.

W

Washington National
1-888-754-3406
www.washingtonnational.com
Assistance with your supplemental cancer insurance.