Your 2016 Benefits

Berkeley Unified School District

Active Employees

Effective January 1, 2016 — December 31, 2016

Open Enrollment: October 1, 2015— October 30, 2015

Health Benefits & FSA/ Parking & Transit Open Enrollment

IN THIS GUIDE YOU'LL FIND:

- MEDICARE PART D ANNUAL NOTICE ATTACHED (see page 23)
- Information about your 2016 benefit plans
- How to enroll or make changes to your benefits including Cash-In-Lieu (see page 6)
- Your resources and where to go for more information including SBCs
- BUSD Step UP to Wellness Program Details Inside (see page 4)

Office of Risk Management & Benefits Department

IMPORTANT NOTICE: READ CAREFULLY

This Benefits Guide briefly describes your benefit choices and your options to enroll. All benefits, and your eligibility for benefits, are subject to the terms and conditions of the benefit plans, including group insurance contracts. The Guide is not intended to be a complete description of the District's benefit plans and it is not a summary plan description or plan document. In the event of any conflict or discrepancy between this Guide and the plan documents, the plan documents will govern. This Guide is not a guarantee of current or future employment or benefits and you are responsible for knowing and understanding the contents of this Guide. If after review you have any questions, you should contact the Office of Risk Management/Benefits Department immediately.

Understanding Your Rights: Read All Notices

Employees and family members eligible for the District's benefits may have rights under applicable federal or state laws. This Guide does not describe those provisions or rights. If eligible, you will receive separate information and notices explaining those rights, such as:

Privacy Rule: The Health Insurance Portability and Accountability Act (HIPAA) includes provisions to protect the privacy of health information for group health plan participants. Provisions are explained in the District's Privacy Notice.

Health Plan Protections: Health plan benefits must meet the requirements of the Women's Health and Cancer Rights Act and the Mothers' and Newborns' Health Protection Act. These provisions are explained in the summary plan descriptions (SPD) and this Guide.

Coverage Continuation: The Consolidated Omnibus Budget Reconciliation Act (COBRA) offers the opportunity to continue your group health coverage after certain qualifying events (such as leaving the District, or a child reaching the plan's age limit). These provisions are explained in the District's General/Initial COBRA Notice.

"Medicare D" Notice: The District provides Notices to Medicare-eligible beneficiaries explaining whether the group health plan's prescription drug coverage is creditable or non-creditable. This notice is sent annually and is included in this Guide. 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 page 23 for more details.

Summary of Benefits and Coverage (SBC): The SBCs are available on the web at: https::://pcms.plansource.com. See user name and password on page 3. Additional information regarding the SBCs can be found on page 25.

If you do not receive the above information or notices, or if you have any questions about this information, please contact the Office of Risk Management/Benefits Department.

Welcome to Your Benefits Guide

Your benefits are a valuable addition to your overall compensation. Make sure you get the most from them by taking the time to understand your options and by selecting the best coverage for you and your family.

Contents

Where to Obtain Information/Enrollment Forms

In order to enroll or change your benefits, you must submit an enrollment form. This form can be obtained one of the following ways:

- The District's MyBenefits website
  https://pcms.plansource.com
  Username: BUSDEmployee
  Password: benefits
  Click on "Obtain an Enrollment Form"
- The District's Office of Risk Management/Benefits Department
- The Open Enrollment Fair

BUSD Step Up To Wellness - Fall 2015

For the third year, in conjunction with Kaiser Permanente Healthworks, the District's wellness program **"BUSD Step Up"**, has several wellness activities scheduled for Fall 2015, including the Thrive Across America campaign. These activities are available to ALL employees of the District. Your participation in these programs is voluntary and results are strictly confidential.

This year, the District, along with Kaiser will be hosting five (5) **Biometric Screening and Flu Shot Clinics** for BUSD employees at **no cost to you**! Please attend one of the clinics to:

1. Get your blood pressure and pulse rate measured and find out your total cholesterol, HDL, and glucose numbers. Knowing your numbers can help you take control of your health!
2. Find out what you can do to improve your health!
3. Get a Flu Shot! Getting vaccinated is the best way to protect yourself and others from the flu, which can be serious.

Please join us on one of the following dates:

OCTOBER 15, 2015
Health Fair
12:00 pm—5:30 pm
District Office (Board Room—1231 Addison St.)

OCTOBER 22, 2015 9:00 am—1:00 pm Berkeley High School (East Wing—Big Theatre) 1980 Allston Way	**OCTOBER 29, 2015** 9:00 am—1:00 pm District Office (Room 126) 2020 Bonar Street
NOVEMBER 5, 2015 9:00 am—1:00 pm King Middle School (Staff Lounge) 1781 Rose Street	**NOVEMBER 12, 2015** 9:00 am—1:00 pm Transportation (Training Lab) 1314 7th Street

REGISTER & PARTICIPATE

Thrive Across America—Hawaii Route

Research shows that physically active people have fewer doctor visits and hospital stays and use less medication than inactive people—and that can make a big difference in your health care costs. The Thrive Across America campaign encourages employees to get up and move with this fun and easy physical activity program. This year's campaign will take employees on a virtual tour from Kilauea Point National Wildlife Refuge to Hawaii Volcanoes National Park. On the way, employee's will visit Hawaii's most treasured outdoor attractions, brought to life with vivid pictures and detailed descriptions. Sign up online to join the challenger. Employees who participate and complete the course will be included in a raffle for various prizes.

Registration Dates:
STARTS: September 7, 2015
ENDS: October 9, 2015

Campaign starts and finishes:
STARTS: September 21, 2015
ENDS: November 13, 2015

Visit **busd.thriveacrossamerica.com** to register.

As a Reminder:

Get a check-up. Schedule an annual doctor's office visit and any recommended preventive care screenings. Preventive care is covered 100% under all the District's medical plans.
See your dentist. Schedule a check-up with your dentist twice a year. Keeping up with cleanings and X-rays can prevent major dental issues. Diagnostic and preventive services are covered 100% (no deductible) under both District plans.

Important Changes in the 2016 Benefit Offerings & Increases

2016 Plan Increases

Health care continues to be a concern for employers and employees across the nation. For years, costs have increased steadily and employers like Berkeley Unified School District have been challenged to find ways to continue to provide quality health care coverage at affordable prices. Each year the joint labor/management Health Benefits Cost Containment Committee reviews the District's health plan costs and options in the marketplace.

It is the Committee's goal to continue to offer high quality and affordable benefit plans to our employees and retirees. But despite the Committee's best efforts to mitigate cost increases, the **TOTAL RATES** for the District's Health Care Programs face the following increases in our 2016 Plan Year premiums. **(The increase in your employee contribution may be substantially higher). Please refer to the employee contribution pages to determine your contribution for the new plan year).**

Health Net		**Delta Dental**	
HMO High Option:	12.9%	DeltaCare DHMO	0.0%
HMO Low Option:	12.9%	Dental PPO Plan	-3.17%
PPO Plan:	12.9%		
Kaiser		**VSP**	
HMO Plan:	15.0% overall	Voluntary Vision:	0.0%

2016 Plan Updates

Kaiser - Expansion of coverage on some services. Please see below. No other benefit changes reported by the carrier.

- Residential treatment for mental health and chemical dependency
- Contraceptive products and services
  - Expands coverage to include OTC contraceptives when prescribed by a plan provider

Health Net - No benefit changes

Delta Dental PPO - No benefit changes

Delta Dental DHMO - No benefit changes

Vision Service Plan (VSP) - No benefit changes

*****BFT AND UBA ONLY *****

Voluntary Short Term Disability (STD) Coverage—Representatives will be available at the October 15th Health Fair. Additional meetings will be scheduled.

- Added for BFT and UBA members only effective 1/1/16
- Members must work at least 50% of a contract or 17.5 hours per week to be eligible
- 100% employee paid—premiums taken post-tax (benefits are not taxable)
- Provides 60% of replaceable income
- Up to 52 week benefit duration
- Elimination period: 8 days accident / 8 days sickness
- Must be actively at work on the policy effective date
- Pre-existing conditions, such as a current pregnancy, are excluded from benefits :
  - ◊ If you have seen a doctor for a condition during the 3 months prior to 1/1/16 and
  - ◊ You are treated for that condition during the six months following 1/1/16

Note: If you do not enroll for this coverage during this initial offering, and you want to enroll at a later date, you will need to supply evidence of insurability and may not be approved.

Open Enrollment Checklist - IMPORTANT

Review the checklist below to ensure that you have considered all of your options during this open enrollment period as your next opportunity will not be until next year's open enrollment, unless you experience a qualifying event during the year.

- ☐ Medical Plan—adding coverage, changing plans or adding dependents, complete an enrollment/change form
- ☐ Dental Plan—adding coverage, changing plans or adding dependents, complete an enrollment/change form
- ☐ Vision Plan—adding coverage or adding dependents, complete an enrollment/change form
- ☐ MetLife Life Insurance—make sure you have an up-to-date beneficiary form on file
- ☐ Flexible Spending Account/Dependent Care Spending Account—**must complete election form for 2016 plan year. Your current election will not carry forward. Remember to consider any carryover Health Care spending dollars you will have at the end of 2015.**
- ☐ Parking & Transit Account

All forms are due to the Office of Risk Management/Benefits Department no later than 5:30 pm on Friday, October 30, 2015. If you are not making any changes or do not wish to enroll in the Flexible Spending Account or Dependent Care Spending Account, you do not have to complete any paperwork.

If you are eligible for cash in lieu (check your bargaining unit language) and currently enrolled in another employer group medical plan, you will need to make a decision about applying for cash in lieu if you don't want to continue or enroll in the District's medical plan.

Enrollment: What You Need to Do?

You will need to make choices about which benefits you'd like to participate in during "enrollment windows." Enrollment windows are specific times that will require you to take action and select your benefits:

- When you are first eligible to participate in benefits (you have 30 calendar days to enroll). Elections you make generally become effective first of the month following your date of hire with the exception of K-12 teachers, whose benefits are effective the first day of the contract. See page 9 for what happens if you don't enroll in coverage within 30 days.
- **Any changes you make during this Open Enrollment period become effective January 1, 2016 even if you do not receive a new ID card by this date.**
- When you experience a qualified change-in-status event, such as marriage or the birth of a child, or HIPAA special enrollment event; you must report these events within 30 days in order to make any allowable changes to your benefits. See below for more details about reporting qualified change-in-status events and HIPAA special enrollment events.

Each time an enrollment window occurs, use this Guide to familiarize yourself with the most current information on the District's benefit programs and what coverage options are available to you. You can also use this information if:

- You wish to maintain current coverage
- You want to enroll or make a change
- You want to submit completed enrollment/change form(s)
- You want to know what to expect after you enroll
- You want to learn what happens if you don't enroll

You Wish to Maintain Current Coverage

If you are currently enrolled in a medical, dental, and/or vision plan and do not want to make any changes, **NO FURTHER ACTION IS NECESSARY**. Unless you submit an enrollment change form, your current health plan coverage will automatically continue at the same levels. See pages 18-20 about making Flexible Spending Account/Parking & Transit changes.

You Want to Enroll or Make a Change

1. Review your options, ask questions and talk with your family. If you're thinking of changing medical plans or you are choosing for the first time:
    a. Check with your doctors to find out which plans they participate in.
    b. If you take any prescription medications regularly, contact the new plan to find out how these drugs are covered (for example, formulary or non-formulary drugs).

       Call the medical plan's Member Services number or visit its website (contact details are on page 22 of this Guide).
2. Consider not only your current circumstances but also what may be happening in your life in the future. Outside of the Open Enrollment period, you will not be able to make changes to your benefits unless:
    a. You have a qualified change-in-status event or HIPAA special enrollment event (for example, you get married or have a child). HIPAA special enrollment events are explained in more detail on page 12 of this Guide.
    b. You move out of the HMO service area.
3. Review this Guide showing your plan options and costs. Consider the following when choosing a medical plan:
    a. **What the plans cover**. The Medical Plans section of this guide will help explain what each plan covers.
    b. **Your estimated usage**. Does your plan choice adequately cover the services you use most or will need in the future?

c. **Flexibility in choice of doctors, hospitals and how you receive care**. Each plan may include a different set of doctors, hospitals or have different rules for how to receive care.

d. **Verify service areas and provider availability** since all medical plans make ongoing changes during the year.

4. Use available tools to evaluate your needs, compare options and decide what's right for you. Go to **https://pcms.plansource.com/ (Login: BUSDEmployee Password: benefits)** to get started.

   Here's what you can do:

   a. **Compare Your Medical Plan Options** — Review the key features and coverage details for each of your medical plan options;

   b. **Estimate and Compare Medical Expenses by Option** — Estimate what your total annual medical expenses (payroll deductions and out-of-pocket costs) would be under each plan;

   c. **Find a Doctor in Your Medical Plan** — Confirm that your current doctors are preferred network providers in the medical plan options you are considering;

   d. **Estimate Your Life Insurance Coverage Needs** — Estimate the level of life insurance coverage you may want to select for yourself and your family;

   e. **Learn about a Flexible Spending Account** — Estimate the amount you can save on taxes when you use a Flexible Spending Account and estimate your out-of-pocket health care and dependent care expenses to decide how much you want to contribute to each account.

5. **Have the right information handy**. When you start the enrollment process, you'll need:

   a. Your Social Security number;

   b. The names, birth dates, and Social Security numbers of any dependents you wish to enroll, or of any beneficiaries you wish to designate;

   c. Certified marriage license, if from another country translation must be provided, if enrolling a spouse;

   d. Birth certificates (child/children) if enrolling.

How to Submit Completed Enrollment/Change Forms & FSA Election Forms

You may turn in your completed enrollment/change and/or election forms directly to the Office of Risk Management/ Benefits Department by:

1. Walk-in: Employees may submit the completed forms by coming to the Office of Risk Management/ Benefits Department window (See window hours on page 9).

   - **Employees can walk-in completed forms until 5:30 pm on October 30, 2015.**

2. Mail: Employees may submit the completed form(s) through Postal Mail. Forms must be received no later than **5:30 pm on October 30, 2015.** Postmarked submittals received after this date will not be accepted.

3. E-Mail: Employees may submit the completed form(s) through E-mail. Please e-mail to **openenrollment@berkeley.net**. Forms must be received no later than **5:30 pm on October 30, 2015.** E-mailed submittals received after this date will not be accepted.

4. Health Benefits Wellness Fair: Office of Risk Management/Benefits Department staff will be accepting completed forms at the Wellness Fair on **October 15, 2015 from 12:00 pm to 5:30 pm.**

Forms must be received no later than **5:30 pm on October 30, 2015**. Completed forms will not be accepted after this date. **FAXED FORMS WILL NOT BE ACCEPTED.**

Waiving Health Coverage, Cash In Lieu of Medical (Limited Eligibility)

Complete Section III of the BUSD enrollment form. This will acknowledge that you are waiving the District's group health coverages. This waiver will be maintained on file with the District.

Office of Risk Management/Benefits Department Open Enrollment Window Hours

Walk-in submittals will be accepted only during the following Office of Risk Management/Benefits Department window hours:

- October 1 - October 2 (Thursday and Friday) 8:30 am—4:00 pm
- October 5 - October 8 (Monday through Thursday) 8:30 am—4:00 pm
- **October 8 - Retiree Health Fair (Thursday) 1:00 pm—4:00 pm**
- October 12 - October 14 (Monday through Wednesday) 8:30 am—4:00 pm
- **October 15 - Health Fair (Thursday) 12:00 pm—5:30 pm**
- October 19 - October 22 (Monday through Thursday) 8:30 am—5:00 pm
- October 26 - October 29 (Monday through Thursday) 7:30 am—5:00 pm
- **October 30 - Last Day (Friday) 7:30 am—5:30 pm**

You Want to Know What Happens if You Don't Enroll

If You Don't Enroll

If you are an active employee and you don't make any changes during the Open Enrollment period, you will continue to receive your current year's medical, dental, vision and life insurance coverages for yourself and your covered dependents. **You will not participate in any Flexible Spending Accounts (FSA) since you must enroll each year to participate in these plans. You must enroll during the annual Open Enrollment period—October 1, 2015-October 30, 2015.**

If you are not currently enrolled and don't enroll in District-sponsored benefits during the Open Enrollment period, you will not be able to make changes until the next annual Open Enrollment period or until you experience a qualified change-in-status event or HIPAA special enrollment event.

You Want to Know What Happens After Enrollment

ID Cards

After you enroll for the first time, you will receive an ID card from the medical plan you select (Health Net or Kaiser). You will not receive an ID card for dental or vision coverage. Coverage is effective January 1, 2016 **even if you do not receive a new ID card by this date**.

When you receive your ID card, confirm that all information is accurate. If not, contact the Office of Risk Management/ Benefits Department right away.

Selecting Primary Care Physicians

You are not required to select a primary care physician (PCP) if you enroll in a PPO plan. However, most HMOs (medical and dental) require that you and each of your covered dependents select a PCP from the plan's network. Kaiser is the only medical carrier that does not require you to choose a PCP. With Kaiser, you can visit any of the primary care physicians at the facility of your choice. If you enroll in the DeltaCare (dental DHMO) plan, you must select a dental office.

When you first enroll, you'll need to designate your choice of PCP for medical and dental (Health Net and DeltaCare). If you don't designate your preferred PCP, the HMO will assign one for you. To choose a different PCP, call your plan carrier after you receive your ID card and request that your PCP be changed. PCP changes are not effective immediately. Generally, the change will be the first of the following month.

Eligibility and Changes

Eligibility
All full-time and part-time employees who work the minimum specified hours as outlined by contract/agreement can participate in the benefits described in this guide. Coverage begins based on your contract/agreement with the District unless you are applying for coverage during Open Enrollment in which case your effective date will be January 1, 2016.

Your Dependents
Your eligible dependents include:

- Your spouse (includes same and opposite sex spouses)
- Your same-sex or opposite sex domestic partner who meets certain criteria (listed below)
- Your children who are one of the following:
  - under age 26
  - age 26 or older with a physical or mental disability as defined by the Social Security Administration (provided they were on the plan prior to turning age 26)

Your children include:

- You or your domestic partner's natural or adopted children
- Your stepchildren whom you support and who live with you in a parent-child relationship
- Children placed in your home for adoption
- Any other children you support, you are the legal guardian or you are required to provide coverage as the result of a qualified medical child support order

You may be required to provide proof of dependent status. Any falsification of this information could result in disciplinary action.

Domestic Partner Eligibility Criteria
If you are enrolling a domestic partner, you are required to have met all eligibility requirements listed below for the previous 6 months and complete a Domestic Partnership application/affidavit.

A Domestic Partnership shall exist between two persons regardless of gender and each of them shall be the domestic partner of the other if both complete and sign the affidavit and attest to the following:

1. The two parties reside together and share the common necessities of life;
2. The two parties are not married to anyone, not related by blood closer than would bar marriage in the State of California, and are mentally competent to consent to contract;
3. The two parties declare that they are each other's sole domestic partner and they are responsible for their common welfare;
4. The two parties agree to notify the Berkeley Unified School District's Office of Risk Management/Benefits Department if there is a change of circumstances attested to in the affidavit;
5. All dependents under Domestic Partnership coverage shall have permanent residency in the Domestic Partnership household and shall meet all other dependent coverage criteria;
6. It has been at least six months since either of the two parties has filed a statement of termination of a previous Domestic Partnership affidavit with the Office of Risk Management/Benefits Department.

Domestic Partner/Same-Sex Spouse Taxation
The cost to cover a domestic partner and his or her dependent children is the same as the cost to cover all other eligible family members. However, employee contributions for domestic partners and/or their dependent children are made on an after-tax basis for federal tax purposes in compliance with Internal Revenue Service (IRS) regulations.

In addition, the cost of employer paid coverage for domestic partners and their children will result in taxable "imputed" income to the employee for federal tax purposes. This means the District's cost of the coverage is subject to federal income taxes as well as Federal Insurance Contributions Act (FICA). Imputed income will be reflected on the employee's paycheck and year-end W-2 form. The additional taxes will be withheld from pay.

Employee contributions for the domestic partner or his or her children may be deducted on a pre-tax basis if the individual meets the IRS definition of a "dependent." For this purpose, a dependent is defined as a "qualifying relative" of the employee, who is generally someone who resides in, and is a member of, the employee's household and who receives at least half of his or her support from the employee.

In the event your domestic partnership ends, you must notify the Office of Risk Management/Benefits Department within 30 days to discontinue this coverage.

For additional information regarding the tax implications of covering a domestic partner and their children, employees are strongly encouraged to consult with a tax advisor.

Please Note: The change in DOMA (Defense of Marriage Act) and the recent 6/26/15 ruling does not impact domestic partner relationships or civil unions. It is important to inform Office of Risk Management/Benefits Department of your marital status or domestic partnership to ensure proper taxation.

Making Changes

You can enroll in benefits as a new hire or during annual enrollment. When you elect coverage under the medical, dental and vision plans, coverage stays in effect for the entire plan year (January 1, 2016— December 31, 2016). You cannot change your coverage, start or stop coverage, or add or drop any family members to or from your coverage during the plan year unless you have a **qualified change-in-status event** or a **HIPAA special enrollment event**.

Qualified Change-in-Status Events
Examples of qualified change-in-status events include:

- Change in marital status (marriage, divorce or legal separation)
- Change in the number of dependents (birth, adoption or placement for adoption of a child; death of spouse or child)
- Change in dependent eligibility (dependent child loses eligibility due to age)
- Change in other coverage (spouse or child gains or loses eligibility for coverage under another group plan, such as through spouse's employment)
- Change in residence resulting in loss of eligibility (such as moving out of the HMO area)
- Other changes may qualify. Contact the Office of Risk Management/Benefits Department for more information.

If you experience a qualified change-in-status event, you have **30 days** to report the event and request an enrollment change that is consistent with the type of event. For instance, if the event is marriage, you may request an enrollment change to add your new spouse to your coverage. Enrollment changes due to qualified change-in-status events generally are effective the first of the month following the event, provided that you requested the enrollment change by the 30-day deadline. Coverage for a new child due to birth, adoption or placement of adoption generally is effective on the date of the event.

The plan's official documents govern how and when you can make enrollment changes during the plan year and may allow qualified change-in-status events in addition to those previously listed. The District's Office of Risk Management/ Benefits Department can provide complete details.

When you experience any type of family change, you should also consider updating your life insurance and beneficiaries at the same time. In addition, you may need to update your address or update your tax status by completing a new Form W-4. For questions about tax forms or to update your address, contact the District's Office of Risk Management/ Benefits Department.

HIPAA Special Enrollment Rights
Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), if you decline District-sponsored medical, dental or vision coverage for yourself or your dependents because you have other health insurance coverage (for example, through your spouse's employment), you may be able to enroll yourself and your dependents in the District's health care plan during the plan year if:

- You or your dependents lose eligibility for the other group coverage;
- The other employer stops contributing toward the other coverage;
- You or your dependents lose eligibility for Medicaid or Children's Health Insurance Program (CHIP) coverage;
- You or your dependents become eligible for a state's premium assistance program under Medicaid or CHIP.

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents in the District's health care plan during the plan year.

For any HIPAA special enrollment event, you must request enrollment within **30 days** after you or your dependent's other group coverage ends (or after the other employer stops making contributions toward the other coverage) or you acquire a new dependent. If the event is gaining or losing eligibility for coverage or premium assistance under Medicaid or CHIP, you have up to **60 days** to request enrollment.

For more information or to request special enrollment, contact the Office of Risk Management/Benefits Department at (510) 644-6666.

If You Leave Your Job
In most cases, your District-sponsored benefits end on the last day of the month in which you terminate your employment with the District. Depending on your bargaining unit contract/agreement, your coverage may be extended longer. You and the dependents you have covered under your medical, dental and vision coverage have the right to continue participation in group health coverage as allowed under the Consolidated Omnibus Budget Reconciliation Act (commonly referred to as "COBRA"). COBRA generally allows you to continue coverage for up to 18 months by paying the monthly premiums yourself. In some cases, longer extensions may apply. You may request another copy of your COBRA rights notice at any time. For more information, contact the Office of Risk Management/Benefits Department at (510) 644-6666.

You also have the option to continue your District paid Life insurance and/or your Voluntary Life insurance policies. Please note you are not able to continue your AD&D coverage. In addition, you may also continue the group term coverage that you selected for your spouse/domestic partner and dependent child(ren).

It is your responsibility to obtain and make application directly to the insurance carrier if you wish to continue your life insurance policy(ies). **The District cannot do this for you.** You have **31 days** after your termination date to make application directly with the insurance carrier. Failure to submit your application within the **31 day** time limit will result in forfeiture of your rights to continue your insurance. Please contact the District's Office of Risk Management/Benefits Department for an application.

Medical

Your Medical Plans

You have the choice of several medical plans. For your specific plan options, please refer to page 14. Employee contribution charts are provided separately.

- Kaiser High Option HMO—$15 office visit copay
- Kaiser Low Option HMO—$25 office visit copay
- Health Net High Option HMO—$10 office visit copay
- Health Net Low Option HMO—$25 office visit copay
- Health Net PPO ($1,000 deductible single/$3,000 deductible family)

How to Choose the Best Plan for You and Your Family
When choosing a medical plan, it is important to look at your budget, your preferences and the age and health of you and your covered dependents. You should consider the key differences between plan types and choose one that best suits you and your family. The plans differ in the following areas:

- Cost of coverage, including payroll contributions and how you and the plan pay for services throughout the year
- Convenience, covered services, access to providers, ease of use

You Must Enroll

If you want medical coverage, you must enroll during annual enrollment or as a new hire. If you do not elect a medical plan during open enrollment, you will have to wait until the next open enrollment period or have a qualifying event. If you do not elect a medical plan as a new hire, you will not have medical coverage.

Enrolling in an HMO?

Be sure to elect a primary care physician!

Prescription Drugs
Your prescription drug coverage is included as part of the medical plan option you select. You should always use a participating pharmacy (one that is contracted by your medical plan) to get the best price. You can access a list of pharmacies through your plan's website or by calling Member Services. Both Health Net and Kaiser provide prescriptions through their respective mail service programs. If you are taking maintenance medications, this may be a good option as you may be able to get a larger supply for less copayment.

The medical plans have "tiered" copayments for prescription drugs, meaning you pay a different amount for different classes or groups of drugs. The next page provides a comparison of each plan which includes the prescription copays. Generic drugs generally have the lowest copays, and non-formulary brand name drugs generally have the highest copays.

A **formulary** is a list of drugs (both generic and brand name) that are preferred by the health plans. You can learn more about your plan's prescription drug coverage, including what drugs are on the formulary, by visiting the carriers website.

Note: *Formularies are updated regularly. Please refer to carrier's website to see any updates. Contact information is on page 22 of this Guide. It is a good idea to keep checking back to determine if your prescriptions are a part of the formulary*.

Comparing Your Medical Plan Options

	Kaiser HMO High Option	Kaiser HMO Low Option	Health Net HMO High Option	Health Net HMO Low Option	Health Net PPO	
					In-Network	Out-of-Network
Annual Deductible (individual/family)	None	None	None	None	$1,000 / $3,000	
Annual Out-of-Pocket Limit (individual / family)	$1,500 / $3,000	$1,500 / $3,000	$1,500 / $3,000 / $4,500	$1,500 / $3,000 / $4,500	$3,000 / $9,000	$6,000 / $18,000
Lifetime Maximum	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
Office Visits	$15 copay	$25 copay	$10 copay	$25 copay	$20 copay (deductible waived)	40%
Preventive Care	No charge	No charge	No charge	No charge	No charge (deductible waived)	Not covered
Well Baby Care	No charge	No charge	No charge	No charge	No charge (deductible waived)	Not covered
Specialist Cosultations	$15 copay	$25 copay	$10 copay	$25 copay	$20 copay (deductible waived)	40%
Room & Board Hospital Inpatient (semi-private)	$250 copay	$250 copay	No charge	$250 copay	20%	$500 + 40%
Outpatient Surgery	$50 copay per procedure	$50 copay per procedure	No charge	$250 copay	20%	$500 + 40%
Emergency Room Services (copay waived if admitted)	$50 copay	$50 copay	$35 copay	$100 copay	$100 + 20%	$100 + 40%
Urgent Care Services	$15 copay	$25 copay	$35 copay	$50 copay	$20 copay (deductible waived)	40%
Vision Benefit	Exam: No charge; Materials: $175 allowance every 24 months	Exam: No charge; Materials: $175 allowance every 24 months	Exam Only: $10 copay	Exam Only: $25 copay	Exam Only: $20 copay (deductible waived; birth to age 16)	Not covered
Prescription Out of Pocket Max Single/Family	N/A	N/A	$2,000 / $4,000	$2,000 / $4,000	$2,000 / $4,000	$2,000 / $4,000
Brand Name Drug Deductible	None	None	None	$100	None	
Prescription Drugs - Retail (G = Generic, B = Brand, NF = Non-Formulary)	$10 G / $20 B - up to a 100 day supply	$10 G / $25 B - up to a 30 day supply	$10 G / $20 B / $35 NF up to a 30 day supply	$10 G / $25 B / $50 NF up to a 30 day supply after Brand Name Deductible	$15 G / $30 B / 50% ($30 minimum) NF up to a 30 day supply	50% + $15 G / $30 B / 50% ($30 minimum) NF up to a 30 day supply
Prescription Drugs - Mail Order (G = Generic, B = Brand, NF = Non-Formulary)	$10 G / $20 B - up to a 100 day supply	$20 G / $50 B - up to a 100 day supply	$20 G / $40 B / $70 NF up to a 90 day supply	$20 G / $50 B / $100 NF up to a 90 day supply after Brand Name Deductible	$30 G / $60 B / 50% ($60 minimum) NF up to a 90 day supply	Not covered
Chiropractic Care	Not Covered	Not Covered	$10 copay up to 30 visits per calendar year	$10 copay up to 30 visits per calendar year	$20 copay (deductible waived)	40% (up to $25 per visit)
					up to 12 visits per calendar year combined	

The information presented in the chart is a summary only. The information does not include all of the detailed explanation of benefits, exclusions and limitations. Plan participants should refer to the Evidence of Coverage (EOC) document for coverage details. In the event information in this summary differs from the EOC, the EOC will prevail.

Cost of Coverage: How You Pay for Health Care Costs

You share the costs of health care services with the medical plan and the District. As you choose your medical plan, consider the following types of costs:

- **Premium.** A premium is the total cost for your medical insurance. You and the District may share this cost. You pay your portion through payroll deductions. **Amount to be paid will be based on actual FTE. Employee contribution charts represent estimates only;**
- **Deductible**. A deductible is the amount you must pay before the plan begins sharing the cost of services. You pay this full amount, if required by your plan;
- **Shared Expenses**. After you pay the deductible (if required), you and the plan share the cost of health care services. You may pay a copayment (set price for a specific service) or coinsurance (a percentage of the cost of services). Your portion of these expenses is called your "out-of-pocket" costs.
- **Out-of-Pocket Maximum**. The annual out-of-pocket maximum is in place to protect you from major medical expenses. This is the most you would pay for eligible expenses during a calendar year. Once you reach the out-of-pocket maximum, the plan pays 100 percent of negotiated fees in-network and set percentage of negotiated fees out-of-network. The following do not count toward the out-of-pocket maximum:
  - Non-covered services;
  - Coinsurance paid for services that are not certified as required by the plan;
  - Amounts exceeding the usual, customary and reasonable (UCR) charges.

Medical Plan Costs—Who Pays?

Type of Cost	Premium	Deductible	Shared Expenses	Out-of-Pocket Maximum
Who Pays?	You and/or the District	You	You and the plan; you pay through copays and coinsurance	The plan pays for all eligible expenses if you meet the out-of-pocket maximum

The HMO plans strictly limit your coverage to network providers (except in the case of certain emergencies). The PPO plan provides coverage for both in-network and out-of-network services (but you pay less when you use in-network providers). Generally, your premium and ongoing costs will be lower with a more restrictive plan and higher with a plan that has broader coverage and more flexibility. When trying to decide which plan to choose, consider these questions:

- Will network providers meet your needs?
- How convenient are the providers in the plan's network?
- How easy is the plan to understand and use?
- Which services are covered under the plan?
- How much does the plan pay?

Dental

Your Dental Plans

Choosing the right dental plan is as important as choosing your medical insurance plan. After considering your anticipated dental needs for the coming year, you can determine which dental plan will work best for you and your family by reviewing the deductibles, copays, and services covered under each plan. The following are the available plans offered to you:

- **Delta Dental –** DeltaCare DHMO
- **Delta Dental –** PPO (in-network and out-of-network)

DeltaCare DHMO is based on fixed copays for preventive, basic and major care. You must designate a primary care dentist when you enroll in this plan. The plan utilizes a network of dentists, and you must use a dentist who is a part of the DeltaCare network to receive benefits. If you obtain services from a dentist other than your designated primary dentist, you will have no benefits.

Delta Dental PPO gives you the freedom to choose your own dentist and receive coverage from in-network and out-of-network providers. This plan is a preferred provider organization (PPO) made up of general dentists and specialists who have agreed to provide dental care at discounted fees. If you go to a dentist who participates in the PPO, you qualify for in-network coverage, higher calendar year maximum and benefit from discounted rates.

IN - PPO Network Delta Dental PPO Dentist	Out-of-PPO Network Delta Dental Premier Dentists & Non-Delta Dental Dentists
You will usually pay the lowest amount for services when you visit a Delta Dental PPO dentist.	You are responsible for the difference between the amount Delta Dental pays and the amount your non-Delta Dental dentist bills. You will usually have the highest out-ofpocket costs when you visit a non-Delta Dental dentist.
PPO dentists agree to accept a reduced fee for PPO patients.	Delta Premier dentists may not balance bill above Delta Dental's approved amount, so your out-of-pocket costs may be lower than with non-Delta Dental dentists' charges.
You are charged only the patient's share at the time of treatment. Delta Dental pays its portion directly to the dentist.	Non-Delta Dental dentists may require you to pay the entire amount of the bill in advance and wait for reimbursement. Delta Premier dentists charge you only the patient's share at the time of treatment.
PPO dentists will complete claim forms and submit them for you at no charge.	You may have to complete and submit your own claim forms, or pay your non-Delta Dental dentist a service fee to submit them for you. Delta Premier dentists will complete claim forms and submit them for you at no charge.

Below is a quick summary of the key features and costs for both in-network and out-of-network services.

	DeltaCare In Network	Delta Dental In / Out of Network	
Calendar Year Deductible	None	$25 single / $50 Family	
Calendar Year Maximum Benefit	Unlimited	$1,600	$1,500
Diagnostic/Preventive	Various copays apply	100% (Not subject to deductible or calendar year max)	100% (Not subject to deductible or calendar year max)
Basic	Various copays apply	100%	100%
Major	Various copays apply	70%	70%
Orthodontia	Various copays apply	50%	50%
Lifetime Orthodontia Maximum	None	$1,000	
Implants	Not covered	70%	70%
TMJ Treatment	Not covered	Not covered	
Waiting Period	None	None	None

The information presented in the chart is a summary only. The information does not include all of the detailed explanation of benefits, exclusions and limitations. Plan participants should refer to the Evidence of Coverage (EOC) document for coverage details. In the event information in this summary differs from the EOC, the EOC will prevail.

Voluntary Vision

Your Vision Plan

BUSD offers vision coverage through Vision Service Plan (VSP). You, the employee, pay the full premium for this coverage. VSP has one of the most extensive networks of optometrists and ophthalmologists as well as other vision care specialists in the country. Under this plan, you can use a VSP provider or another provider of your choice. However, when you obtain vision care through a non-VSP provider, you will receive a reduced level of benefits.

Here is a summary of covered services and costs:

Copay	Vision Service Plan	
Exam/Glasses	$10 copay	
*Primary Eyecare	$20 copay	
Benefit Frequency		
Exam	Once every 12 months	
Lenses	Once every 12 months	
Frames	Once every 24 months	
Coverage	**In - Network**	**Out-of-Network**
Eye Exam	Covered in Full	up to $50
Single Lens	Covered in Full	up to $50
Bi-Focal Lenses	Covered in Full	up to $75
Tri-Focal Lenses	Covered in Full	up to $100
Lenticular Lenses	Covered in Full	up to $125
Frame Allowance	$140 allowance	up to $47
Contact Lenses		
Medically Necessary	Covered in Full	up to $210
Elective	$140 allowance ($60 copay for contact lens fitting)	up to $105

The information presented in the chart is a summary only. The information does not include all of the detailed explanation of benefits, exclusions and limitations. Plan participants should refer to the Evidence of Coverage (EOC) document for coverage details. In the event information in this summary differs from the EOC, the EOC will prevail.

Solid Tints and dyes (including photochromic lenses)

Patient Option	Single Vision*	Multifocal*
Solid Tints and Dyes (Pink I and II)	$0	$0
Solid Plastic Dye (except Pink I and II)	$13	$13
High Luster Edge Polish	$14	$14
Plastic Gradient Dye	$15	$15
UV Protection	$15	$15
Factory Applied Scratch-resistant Coating	$15	$15
Polycarbonate Lenses Polycarbonate lenses are covered in full for dependent children.	$25	$30
Anti-reflective Coating	$39	$39
Photochromic Lenses - Plastic	$36	$57
Progressive Lenses	N/A	$50 - $160

**Prices shown reflect the standard option price for each respective category. Premium options may vary. Prices are valid only through VSP Preferred Providers and are subject to change without notice.*

***Primary Eyecare** rider is designed for the detection, treatment and management of ocular conditions and/or systemic conditions which produce ocular or visual symptoms. A member can seek care from their vision provider versus their medical primary care physician for -

Symptoms - including but not limited to:

- ocular discomfort
- transient loss of vision
- flashes or floaters
- red eyes
- swollen lids
- pain in or around the eyes
- diplopia
- ocular trauma

Conditions - including but not limited to:

- ocular hypertension
- glaucoma
- cataracts
- pink-eye
- sty
- corneal abrasion
- corneal dystrophy
- macular degeneration
- retinal nevusble
- blepharitis

You are also eligible for certain discounts on non-covered lens options as well as Lasik vision correction surgery at contracted facilities. Discounts include:

- Average 35-40% savings on non-covered lens options and 30% off additional glasses and sunglasses
- Average of 15% off regularly priced services or procedures or 5% off promotionally priced services or procedures
- Discounts on hearing aids

After surgery, you can use your frame allowance (if applicable) to purchase sunglasses from any VSP network provider.

Flexible Spending Accounts (FSA)

Flexible spending accounts (FSAs) help you save money on health care and dependent care expenses by paying for eligible expenses with tax-free dollars. If you are already enrolled, you must re-enroll for the new plan year. If you aren't enrolled and you would like to participate, please complete an enrollment form. Forms must be received no later than **5:30 pm on Friday, October 30, 2015**.

Here's how you save:

- The amount you contribute to either or both FSAs is deducted from your paycheck before federal, state, local, and Social Security taxes are withheld.
- When you have an eligible expense, you are reimbursed from your account(s) and the money isn't taxed.

Important!
Estimate your expenses and make your contribution elections wisely. Some of the funds you elect are subject to forfeiture. Please be sure to review carryover and grace period guidelines. Additional information is available on the District's website or through the District's administrator, CBA. See page 22 for contact info.

Health Care Spending Account

You can use the Health Care Spending Account to pay for out-of-pocket health plan expenses including copays, coinsurance and deductibles. You can contribute up to $2,550 each year. As of 2015, you may carryover up to $500 of unused funds to the next plan year. Amounts in excess of $500 will be forfeited. This carryover provision does not apply to Dependent Care Spending or Parking and Transit Accounts.

Eligible expenses are "medically necessary" expenses not covered by your medical, dental or vision plans, including:

- Deductibles, copays and coinsurance
- Laser vision correction
- Prescription glasses, contact lenses and lens cleaning solution
- Dental and orthodontia expenses
- Prescription drugs and drug copayments
- Much more

Eligible expenses do not include cosmetic procedures, treatments not supervised by a qualified health care professional, premiums for employer-provided health care plans, or other expenses that are not medically necessary.

Dependent Care Spending Account

You may use the Dependent Care Spending Account to pay for the day care expenses of your dependent children under the age of 13, and dependents of any age who are incapable of self-care, live with you at least eight hours per day, and are claimed as dependents on your income tax return. You can contribute up to $5,000 each year. However, if your spouse has access to a Dependent Care Spending Account, your total combined contribution may not exceed $5,000. If you are married and file separate tax returns, each spouse may contribute $2,500.

To be eligible, care must be provided while you (and your spouse, if you are married) work, look for work, or attend school full time. Eligible expenses include care in your home by an eligible provider or at a licensed facility. You will not be reimbursed for residential or "sleep-away" care, nursing home care, or for babysitting when you are not at work.

The Dependent Care Spending Account will not cover services provided by your spouse, a child of yours under age 19, or any dependent you claim as an exemption on your federal income tax.

How to Pay for Eligible Expenses

Health Care Expenses

You'll pay for your eligible out-of-pocket health care expenses using your personal credit card, cash or check. Get a receipt then submit a claim for reimbursement from your Health Care Spending Account.

You may also use your Health Care Spending account debit card to pay for eligible expenses. Be sure to keep the itemized receipt as documentation. A claim is automatically generated when you use your card.

Dependent Care Expenses

You'll pay for your eligible out-of-pocket dependent care expenses using your personal credit card, cash or check. Then, submit a claim for reimbursement from your Dependent Care Spending Account.

Deadline to Submit Claims for Reimbursement

You have 90 days after the end of the plan year to submit claims for reimbursement from your Health Care and Dependent Care Spending Accounts. Reimbursement checks can be mailed to your home or deposited into your bank account if you sign up for direct deposit

Health Care Spending Account— If you have dollars remaining at the end of the Plan year (12/31/16), you may Carryover up to $500 into the next plan year. Any dollars in excess of $500 will be forfeited if not used by the end of the 90-day run-out period (3/31/17).

Dependent Care Spending Account—If you have dollars remaining at the end of the Plan Year (12/31/16), you may continue to incur claims for expenses during the "Grace Period." The Grace Period extends 2 1/2 months after the end of the Plan Year (3/15/17), during which time you can continue to incur claims and use up all amounts remaining in your Dependent Care Spending Account. Any dollars remaining at the end of the Grace Period (3/31/17) will be forfeited.

To submit claims:

1. **Online Claim Filing**: File your claims online via the participant portal website. If new, login to your account at www. cbadministrators.com.
    - After you have logged on click on FILE CLAIMS under Actions next to the appropriate account.
    - You must mark "YES" that you have a valid receipt to continue online filing.
    - A copy of your receipt may be uploaded (must be in PDF, JPG, GIF format and cannot exceed 2 MB) by clicking "Upload Receipt". Use "Browse" to locate and attach the receipt and/or other supporting documentation to your claim.
    - Note: Under "Category" and "Type", if more than one selection from the drop-down list seems right, select the one that best fits the expense.
    - Make sure to click "Add Claim" on the bottom of the screen; this will take you to the next screen.
    - If you have more than one expense/claim, click on "Add Another Claim". Repeat as needed.
    - On the Claims Basket screen, check the box to agree to the Terms & Conditions and click "Submit" (if you need to leave the site for any reason, be sure to click "Submit" first or you will lose everything you have entered).
    - If you uploaded all your receipts and/or supporting documentation, there is nothing more you need to do.
    - If you cannot upload your receipt and/or supporting documentation, click "Print the Claim Confirmation Form" and send the confirmation to CBA with your documentation via e-mail, fax or mail. This confirmation page serves as your claim form and verifies that all claims have been successfully submitted. Your claim is considered "received" by CBA only after CBA receives your supporting documentation.
    - NEVER SUBMIT A "PAPER" CLAIM FOR A CLAIM YOU HAVE ALREADY FILED ONLINE OR FOR AN EXPENSE YOU'VE PAID FOR WITH YOUR CBA DEBIT CARD.
2. **Paper Claim Form Filing**: You may opt to file claims using a paper claim form available on the website under the "Forms" tab.
    - Complete the claim form in full including your "certification" (signature).
    - Do not highlight, alter or write on your documentation.
    - Consider photocopying colored, carbon or thermal-paper receipts, as they may transmit too light to be legible. They may also fade over time, so photocopying may help to preserve the long-term integrity of the document.
    - Retain a complete copy for your records.
    - Submit your completed claim form and required documentation via e-mail (PDF only), fax or mail.
    - NEVER SUBMIT A "PAPER" CLAIM FOR A CLAIM YOU HAVE ALREADY FILED ONLINE OR FOR AN EXPENSE YOU'VE PAID FOR WITH YOUR CBA DEBIT CARD.

More details and eligible expenses

For more information on eligible expenses for the health care or dependent care FSA, refer to IRS guidelines available online at *www.irs.gov.* You can also contact the District's administrator, CBA, by calling (800) 574-5448 or by visiting their website at www.cbadministrators.com.

Parking & Transit Reimbursement Plan

Save money on your parking and transit expenses by utilizing pretax dollars to pay for transit, vanpooling and work-related parking costs. You designate a portion of your salary before taxes (pretax income) to pay for qualified transit, vanpooling or parking expenses. Tax-free benefits are only available through BUSD. You cannot directly take advantage of these tax benefits by taking a tax deduction or credit on your individual tax return.

There are two types of expenses (1) Parking Expenses and (2) Mass Transit Expenses.

Eligible **Parking Expenses** include the costs you incur for parking your car at or near your work premises or at a location that you commute to work to use Mass Transit.

Eligible **Mass Transit** Expenses include your costs for a pass, token, fare card, or voucher used exclusively to pay for mass transportation. The transportation can be on a public or privately owned facility. Vanpools or Commuter Highway Vehicles used for travel to and from your work or to a Mass Transit location that you commute from, are eligible Mass Transit Expenses.

To be eligible, however, a Vanpool must: (a) have a seating capacity of at least six (6) adults excluding the driver; (b) be used 80% for purposes of transporting eligible employees to and from work; and , (c) be used by more than half the riders to commute to and from work.

Toll charges and carpooling expenses do not qualify as a "Mass Transit Expense" and are, therefore, not eligible for re-imbursement.

You are permitted to change your elections on the first day of each calendar month. You may also stop making contributions to your accounts as of the first day of each calendar month. If you have a balance in either of your accounts, you may still access your funds even if you are not currently contributing. Your funds are not forfeited while working.

You may not transfer funds between the Parking and Transit accounts.

MAXIMUM AMOUNT THAT CAN BE CONTRIBUTED EACH MONTH:

Parking Spending Account:	$250 (subject to change by IRS)
Transit & Van Pooling Spending Account:	$130 (subject to change by IRS)

Life Insurance

Basic Life and AD&D Insurance

Life insurance and Accidental Death and Dismemberment (AD&D) insurance provide funds for those who have lost someone or for those who are seriously injured. Life insurance pays funds to your designated beneficiaries after your death, while AD&D pays an additional amount in the event of an accidental death or for certain accidental injuries. Basic Life and AD&D is provided at no cost to employees with FTE's at .50 and greater. You are provided with Life and AD&D Insurance equal to $15,000.

Note: The value of any life insurance coverage in excess of $50,000 may be subject to imputed income taxes.

How to Enroll

You are automatically enrolled when you become an employee of Berkeley Unified School District with a minimum.50 FTE. This benefit is 100% paid by the District.

In addition to the Basic Life insurance plan, you are eligible to purchase additional amounts of individual term life insurance for yourself, your spouse or your domestic partner, and your children. Employees may purchase amounts of voluntary life insurance coverage up to a maximum of $300,000. Dependent spouse or domestic partner life insurance may not exceed $100,000. Voluntary life insurance coverage for your children may be purchased in amounts up to: Birth to 6 Months $100 — 6 Months to 25 Years—$10,000. There are three points to consider when deciding how much life insurance coverage you might need:

- If you have dependents that rely on you, how much will they need to pay off your current debts such as your mortgage, car loans, or credit card balances?

- What will it cost your dependents to maintain their current standard of living?
- What kind of future would you like to provide for your spouse, domestic partner or dependent children or others who rely on you for financial support?

You may enroll in this benefit when you are first hired and receive up to the guarantee issue amount ($100,000) without supplying evidence of insurability. To enroll, you must complete a form that includes the benefit amount you are electing. You can elect up to $300,000; however, any amount above the lesser of three times your salary or $100,000 is subject to evidence of insurability. This means that you must answer questions regarding your health and MetLife is able to approve or deny your request. You will be notified once MetLife has made their decision and the District will deduct the monthly premium amount for the benefit that is approved from your check. If you enroll after you are first eligible, you will need to provide evidence of insurability for any amount elected.

	MetLife
Life/AD&D Benefit Amount	
Employee	$10,000 increments not to exceed $300,000
Dependent Life	
Spouse	$5,000 increments up to the lesser of 50% of the employee's optional amount of $300,000
Child(ren)	Birth to 6 Months: $100; 6 Months to 25 years: $2,500 increments not to exceed $10,000
Guarantee Issue Amount	
Employee	The lesser of 3 times your Basic Annual Earnings not to exceed $100,000
Spouse	$20,000
Benefit Age Reduction Schedule	35% at age 70 and an additional 15% at age 75
Waiver of Premium	Excluded
Accelerated Death Benefit	Up to 80% of optional life amount not to exceed $500,000
Portability	Included
Conversion	Included

Naming Your Beneficiary

You may name anyone you wish as the beneficiary who will receive your Life and AD&D benefits in case of your death. Once you have selected your beneficiary(ies), your designation will remain unchanged until you submit a new beneficiary designation form. You may change your beneficiary(ies) as often as you wish.

Voluntary Life Insurance Monthly Premiums

Voluntary Life Rates Per $1,000 of Benefit			
Employee Life < 35	$0.04	**Spouse Life - <35**	$0.04
Employee Life 35-39	$0.06	**Spouse Life - 35-39**	$0.06
Employee Life 40-44	$0.09	**Spouse Life - 40-44**	$0.09
Employee Life 45-49	$0.16	**Spouse Life - 45-49**	$0.16
Employee Life 50-54	$0.24	**Spouse Life - 50-54**	$0.24
Employee Life 55-59	$0.39	**Spouse Life - 55-59**	$0.39
Employee Life 60-64	$0.65	**Spouse Life - 60-64**	$0.65
Employee Life 66-69	$1.09	**Spouse Life - 65-69**	$1.09
Employee Life 70+	$1.85	**Dependent Child**	$0.20

Employee Assistance Program (EAP) - MHN

By accessing MHN's Employee Assistance Program you can be assessed and referred to Participating Practitioners who can help you and your eligible family members resolve personal problems that can affect your health, family life, abilities, and desire to excel at work. You and your family members are entitled to up to 8 sessions per member per incident per year. The EAP can help you resolve a broad range of personal problems through assessment of issues and referral to Participating Practitioners including:

- Marriage/Family Issues
- Emotional Problems
- Financial & Legal Problems
- Stress Management
- Alcohol/Drug Dependency
- Childcare & Eldercare Assistance

To contact MHN, please see the contact section listed below.

Contacts

If you have questions you can contact the District's Office of Risk Management/Benefits Department or the plan carriers. Use this chart to help guide you to the right resource on the first try.

PLAN INFO	WEBSITE	CONTACT	GROUP #
BUSD Office of Risk Management/Benefits Department			
(510) 644-6666	External: www.berkeley.net (click on "Staff Resources") Internal (Only accessible from a computer within the District): http://intranet.berkeley.net/ (Click on "Risk Management")		
Medical—Health Net			
HMO	www.healthnet.com	(800) 522-0088	5771A
PPO		(800) 676-6976	29410
Medical—Kaiser			
HMO	www.kp.org	(800) 464-4000	260
Dental—Delta Dental			
PPO	www.deltadentalins.com	(866) 499-3001	7069
DeltaCare		(800) 422-4234	5827
Vision—Vision Service Plan (VSP)			
Vision PPO	www.vsp.com	(800) 877-7195	12314888
Flexible Spending Accounts—Custom Benefit Administrators (CBA)			
Administration	www.cbadministrators.com	(800) 574-5448	
Employee Assistance Program (EAP)—MHN			
EAP	www.members.mhn.com Company Code: busd	(800) 535-4985	

Medicare Part D Creditable Coverage Notice

Important Notice from Berkeley Unified School District About Your Prescription Drug Coverage and Medicare

This Notice Applies to You (or Dependent) ONLY if such person is (1) enrolled in a group medical plan offered by Berkeley Unified School District AND (2) eligible for Medicare

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

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. Berkeley Unified School District has determined that the prescription drug coverage offered by Health Net and Kaiser is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

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

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

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current Health Net or Kaiser coverage may be affected. Your current coverage pays for other health expenses in addition to prescription drugs. If you enroll in a Medicare prescription drug plan, you and your eligible dependents may not be eligible to receive all of your current health and prescription drug benefits.

If you do decide to join a Medicare drug plan and drop your current Health Net or Kaiser coverage, be aware that you and your dependents may not be able to get this coverage back. For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information regarding this program is available through the Social Security Administration (SSA). For more information about this extra help, visit SSA online at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

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

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

For More Information About This Notice Or Your Current Prescription Drug Coverage…

Contact the person listed on the following page for further information.

NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Berkeley Unified School District changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage…

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook.

You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

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

Date:	October 1, 2015
Name of Entity/Sender:	Berkeley Unified School District
Contact—Position/Office:	Office of Risk Management/Benefits Department
Address:	2020 Bonar Street Berkeley, CA 94702
Phone Number:	(510) 644-6666 (Option 1 for Actives, Option 2 for Retirees)

Annual Notices

Newborns' and Mothers' Health Protection Act

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

Patient Protection Act

The Health Net HMO Plans generally require the designation of a primary care provider. You have the right to designate any primary care provider who participates in the network and who is available to accept you or your family members. Until you make this designation, Health Net will designate one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact Health Net at the phone number on the back of your ID card. For children, you may designate a pediatrician as the primary care provider.

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

Special Enrollment

If an eligible employee declines enrollment in this group health plan for the employee or the employee's spouse or dependents because of other health insurance or group health plan coverage, the eligible employee may be able to enroll him/herself and eligible dependents in this plan if eligibility is lost for the other coverage (or because the employer stops contributing toward this other coverage). However, the eligible employee must request enrollment within **30 days** after the other coverage ends (or after the employer ceases contributions for the coverage).

In addition, if an eligible employee acquires a new dependent as a result of marriage, birth, adoption or placement for adoption, the eligible employee may be able to enroll him/herself and any eligible dependents, provided that the eligible employee requests enrollment within **30 days** after the marriage, birth, adoption, or placement for adoption. If the eligible employee otherwise declines to enroll, he/she may be required to wait until the group's next open enrollment to do so.

Furthermore, eligible employees and their eligible dependents who are eligible for coverage but not enrolled, shall be eligible to enroll for coverage within 60 days after (a) becoming ineligible for coverage under a Medicaid or Children's Health Insurance Plan (CHIP) plan or (b) being determined to be eligible for financial assistance under a Medicaid, CHIP, or state plan with respect to coverage under the plan.

Women's Health and Cancer Rights Act

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. If you would like more information on WHCRA benefits, call Health Net or Kaiser at the phone number on the back of your ID card.

Summary of Benefits and Coverage (SBC)

As required by the Affordable Care Act (ACA), health plans and employer groups must provide the Summary of Benefits and Coverage (SBC) to eligible employees and family members, who are:

- Currently enrolled in one of the group health plans or
- Eligible to enroll in one of the plans, but not yet enrolled

As such, we are providing you and your covered dependents an SBC for the health plan you are currently enrolled in, if applicable. The SBC provides important information about the Plan's benefits and your rights as a Plan participant.

The Affordable Care Act (ACA) also provides a Uniform Glossary of Insurance and Medical Terms. A paper copy of this Glossary is available upon request. All SBCs and the Glossary can be found on the District's MyBenefits website. Refer to page 3 for login information.