

Your 2014 Benefits

Berkeley Unified School District

Active Employees

Effective January 1, 2014 -
December 31, 2014

Open Enrollment: October 1, 2013 -
October 31, 2013

Health Benefits & FSA/ Parking & Transit Open Enrollment

IN THIS GUIDE YOU'LL FIND:

- Information about your 2014 benefit plans
- How to enroll or make changes to your benefits
- Your resources and where to go for more information including SBCs
- MEDICARE PART D ANNUAL NOTICE ATTACHED
- NEW! BUSD Step Up to Wellness Program - Details Inside

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.

Portability: The Health Insurance Portability and Accountability Act (HIPAA) includes provisions limiting how a group health plan imposes pre-existing condition exclusions. Other provisions offer special enrollment rights under the District's group health plans following certain events. Provisions are explained in the summary plan descriptions (SPD) and this Guide. The plan also provides Certificates of Creditable Coverage that may assist you in obtaining other health coverage if your coverage from the District ends.

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 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 the 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 25 for more details.

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.

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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

Wellness Activities - Fall 2013

NEW! Introducing the District's ***BUSD Step Up*** To Wellness Program!

In conjunction with Kaiser Permanente Healthy Works, the District has designed a wellness program. The program is called "**BUSD Step Up**". Several wellness activities are scheduled for Fall 2013. These activities will be made available to ALL employees of the District. Your participation in these programs is voluntary and results are strictly confidential.

The wellness program is designed around activities to help you stay healthy and make good lifestyle choices. All participants who have a biometric screening done will receive a gift for participating.

Biometric Screenings:

September 24, 2013

11:30am - 4:00pm

Berkeley High School - West Gallery - Theater Lobby
1920 Allston Way

September 30, 2013

12:00pm - 6:00pm

District Office Room 126
2020 Bonar Street

October 8, 2013

11:30am - 4:30pm

King Middle School - Staff Lounge
1781 Rose Street

October 17, 2013

12:00pm - 5:30pm

Berkeley Adult School - Multipurpose Room
1700 San Pablo Avenue

Total Health Assessment:

September 24, 2013 - November 26, 2013

Take a Total Health Assessment - confidential online health assessment to learn about your health status and what steps you can take to improve and maintain your health. Employees who complete the assessment will be entered into a raffle to receive a prize.

Thrive Across America:

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. Employees sign up online to go on a virtual tour of some of our nation's most interesting places—national parks, famous recreation areas, wildlife preserves, cultural attractions and historic landmarks—logging physical activity during the duration of the campaign. Employees who participate and complete the course will be included in a raffle for various prizes.

Registration Dates:

October 1, 2013 - October 15, 2013

Campaign starts and finishes:

October 15, 2013 - December 9, 2013

Health Educational Classes

Please watch for upcoming communications about various health educational classes.

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 2014 Benefit Offerings & Increases

2014 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 Program face the following increases in our 2014 Plan Year premiums. **(Please refer to the enclosed employee contribution pages to see the contributions for the new plan year).**

Health Net		Delta Dental	
HMO High Option:	14.51%	DeltaCare DHMO:	0%
HMO Low Option:	14.51%	Dental PPO Plan:	0%
PPO Plan:	19.05%		
POS Plan:	7.15%		
Kaiser		VSP	
HMO Plan:	0%	Voluntary Vision:	0%

2014 Plan Updates

General

- **Definition of a spouse has changed** - With the decision to overturn the Defense of Marriage Act (DOMA) earlier this year, we want to remind employees that in California, both same and opposite sex spouses are eligible dependents and there is no longer imputed income for same-sex spouses. The change in DOMA does not impact domestic partner relationships or civil unions. It is important to inform the Office of Risk Management/Benefits Department of your marital status to ensure proper taxation. Please see page 6 for additional information regarding DOMA.

Kaiser/Health Net

- **Transgender Services** - Due to regulatory developments in California, transgender services are now being covered. Coverage is now available for procedures or treatment related to changing a member's physical characteristics to those of the opposite sex. Cost sharing is the same as cost sharing for other medical services (i.e inpatient hospitalization copay, office visit copays).
- **Over-the-counter Prescription Coverage** - Certain over-the-counter drugs and items covered at \$0 cost sharing when prescribed by a plan physician (may require a written prescription). These include aspirin to reduce the risk of heart attack and stroke, oral fluoride for children to reduce the risk of tooth decay, folic acid for women to reduce the risk of birth defects, iron supplements for children to reduce the risk of anemia, and female contraceptives that don't require a prescription by law.
- **BRCA Counseling and Testing** - In accordance with guidelines issued by HHS regarding preventive services covered under the Affordable Care Act (ACA), the plans will cover genetic counseling and testing for mutations in BCRA's, the breast cancer susceptibility genes, with no cost sharing.

Health Net

- **PPO, POS, FlexNet** - many out-of-network maximums and other plan limitations have been removed - thereby generally improving the benefits. Below are a few examples of these changes. (Please refer to the new benefit summaries located on the MyBenefits website. See page 3 for login information.)
 - PPO/POS - Durable Medical Equipment (DME) - annual maximum is being removed
 - PPO - Other mental illnesses - Out-of-network maximum allowable amount of \$600 per day is being removed
 - FlexNet - Air ambulance maximum of \$750 each incident is being removed

2014 Plan Updates

Delta Dental PPO - Effective January 1, 2014, diagnostic and preventive services (both in and out-of-network) will not require payment of the deductible, and the cost of these services will not be deducted from the calendar year maximum available for each member (either \$1,600 in-network or \$1,500 out-of-network).

Delta Dental DHMO - no benefit changes

Vision Service Plan (VSP) - no benefit changes

Flex Spending - Election maximums are provided below. For additional information on benefits please refer to page 19 through 21.

- Health Care Spending - \$2,500
- Dependent Care - \$5,000
- Parking - \$245
- Transit - \$245

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.

Defense of Marriage Act of 1996 (DOMA) - CHANGE IN DEFINITION OF SPOUSE

As of June 26, 2013, newly married same-sex spouses are to be treated the same as opposite-sex spouses-no federal or state imputed income tax, pre-tax contributions for benefits and use of Flexible Spending Accounts (FSA). Same-sex couples who are legally married in any state or other jurisdiction that recognizes same-sex marriages (including the District of Columbia, a U.S. territory or a foreign country) will be treated as married for all federal tax purposes even if the couple lives in a jurisdiction that does not recognize same-sex marriages. Employees may file amended tax returns to recover income taxes paid on premiums that were paid on an after-tax basis for the health coverage of the employee's same-sex spouse if within statute of limitations.

Further guidance is expected from the regulatory agencies regarding currently married same-sex spouses and mid-year elections.

Additional information can be found on the District's MyBenefits website (see page 3 for login instructions).

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 Additional 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 2014 plan year. Your current election will not carry forward.
- Parking & Transit Account

All forms are due to the Office of Risk Management/Benefits Department no later than 5:00 pm on Thursday, October 31, 2013. 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, and currently enrolled in a medical plan, (check your bargaining unit language) you will need to make a decision about applying for cash in lieu if you don't want to continue your 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 contract. See page 10 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, 2014 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
- How to submit completed enrollment/change form
- 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 19-21 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 Web site (contact details are on page 23 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 13 of this Guide.
 - b. You move out of your 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> 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
 - e. **Estimate Your Life Insurance Coverage Needs** — Estimate the level of life insurance coverage you may want to select for yourself and your family
 - f. **Learn about a Flexible Spending Account (FSA)** — Estimate the amount you can save on taxes when you use a Flexible Spending Account and estimate your out-of-pocket health care, dependent care and parking transit 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 10).
 - **Employees can walk-in completed forms until 5:00 pm on October 31st.**
2. Mail: Employees may submit the completed form(s) through **Postal Mail**. Forms must be received no later than **5:00 pm on October 31, 2013**. Postmarked submittals received after this date will not be accepted.
3. Wellness Fair: Office of Risk Management/Benefits Department staff will be accepting completed forms at the Wellness Fair on October 17, 2013 from 12:00 pm to 5:30 pm.

Forms must be received no later than **5:00 pm on October 31, 2013**. Completed forms will not be accepted after this date.

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 selected 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 4 (Tuesday through Friday) 8:30 am—4:00 pm
- October 7 - October 10 (Monday through Thursday) 8:30 am—4:00 pm
- **October 10 - Retiree Health Fair (Thursday) 12:00 pm—3:00 pm**
- October 14 - October 16 (Monday through Wednesday) 8:30 am—4:00 pm
- **October 17 - Health Fair (Thursday) 12:00 pm—5:30 pm**
- October 21 - October 24 (Monday through Thursday) 8:30 am—5:00 pm
- October 28 - October 31 (Monday through Thursday) 7:30 am—5:00 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, 2013 - October 31, 2013.**

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 enroll 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, 2014 **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 Kaiser HMO or Health Net 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 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 occur 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, 2014.

Your Dependents

Your eligible dependents include:

- Your spouse (as defined by applicable state law; 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 for whom 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.

(Please see recent legislative changes regarding same-sex marriages on page 6)

Domestic Partner 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 Contributions Insurance 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 or same-sex spouse, and their children, employees are strongly encouraged to consult with a tax advisor.

Please Note: The change in DOMA 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. Please see page 6 for additional information regarding DOMA.

Making Changes

You can enroll in benefits as a new hire or during open enrollment. When you elect coverage under the medical, dental and vision plans, coverage stays in effect for the entire plan year (January 1, 2014 - December 31, 2014). 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 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 HMO area)
- Other changes may qualify. Contact the Office of Risk Management/Benefit 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 listed above. 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 the 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 you 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 15. Employee contribution charts are provide 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)
- Health Net POS (closed to new hires and new membership)

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 (please see page 8)

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 Web site 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 always have the lowest copays, and non-formulary brand name drugs always 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 your plan’s Web site.

Note: *Formularies are updated regularly. Please refer to your plan’s Web site to see any updates. Contact information is on page 23 of this Guide. It is a good idea to keep checking back to determine if your prescriptions are a part of the formulary.*

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!

Comparing Your Medical Plan Options

Closed to new hires and membership

	Health Net POS			Health Net PPO			Health Net PPO	
	HMO	In-Network PPO	Out-of-Network	In-Network PPO	Out-of-Network	In-Network	Out-of-Network	
Annual Deductible (individual/family)	N/A	N/A	N/A	N/A	\$200 / \$600	\$1,000 / \$3,000	Out-of-Net-work	
Annual Out-of-Pocket Limit (individual / family)	\$1,500 / \$3,000	\$1,500 / \$3,000 / \$4,500	\$1,500 / \$3,000 / \$4,500	\$2,000 / \$4,000 / \$6,000	\$3,000 / \$6,000 / \$9,000	\$3,000 / \$9,000	\$6,000 / \$18,000	
Lifetime Maximum	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	
Office Visits	\$15 copay	\$25 copay	\$25 copay	\$20 copay	30%	\$20 copay	40%	
Preventive Care	No charge	No charge	No charge	No charge	Not covered	No charge	Not covered	
Well Baby Care	No charge	No charge	No charge	No charge	30%	No charge	Not covered	
Specialist Consultations	\$15 copay	\$25 copay	\$25 copay	\$20 copay	30%	\$20 copay	40%	
Room & Board Hospital Inpatient (semi-private)	\$250 copay	\$250 copay	\$250 copay	10%	30%	20%	\$500 + 40%	
Outpatient Surgery	\$50 copay per procedure	\$50 copay per procedure	\$250 copay	10%	30%	20%	\$500 + 40%	
Emergency Room Services (copay waived if admitted)	\$50 copay	\$50 copay	\$100 copay	\$50 copay	30%	\$100 + 20%	\$100 + 40%	
Urgent Care Services	\$15 copay	\$25 copay	\$50 copay	\$50 copay	30%	\$20 copay	40%	
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; \$20 G / \$50 B - 31-60 day supply; \$30 G / \$75 B - 61-100 day supply	\$100 Brand Name Deductible \$10 G / \$25 B / \$50 NF up to a 30 day supply	\$10 G / \$20 B / \$35 NF up to a 30 day supply	\$10 G / \$20 B / \$35 NF up to a 30 day supply	\$15 G / \$30 B / 50% (\$30 minimum)NF up to a 30 day supply	\$15 + 50% AWP G / \$30 + 50% AWP 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	\$10 G / \$25 B - up to a 30 day supply; \$20 G / \$50 B - 31-100 day supply	\$100 Brand Name Deductible \$20 G / \$50 B / \$100 NF up to a 90 day supply	\$20 G / \$40 B / \$70 NF up to a 90 day supply	Not covered	\$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	30%	\$20 copay	40% (up to \$25 per visit)	

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
 - Covered expenses incurred for outpatient prescription drugs, and 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 and POS Plans provide 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.

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

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. PPO dentists agree to accept a reduced fee for PPO patients.	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-of-pocket costs when you visit a non-Delta Dental dentist. 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.

	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/Preventative	Various copays apply	100% <small>(Not subject to deductible or calendar year max)</small>	100% <small>(Not subject to deductible or calendar year max)</small>
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 network 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	VSP	
Exam	\$10 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 \$45
Single Lens	Covered in full	Up to \$45
Bi-Focal Lenses	Covered in full	Up to \$65
Tri-Focal Lenses	Covered in full	Up to \$85
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	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 - Plastic	N/A	\$60

**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.*

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 percent off regularly priced services or procedures or 5 percent 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.

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

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 **5:00 pm on Thursday, October 31, 2013**.

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. The balances in your Health Care and Dependent Care accounts are "use it or lose it." What you don't use each year must be forfeited.

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 \$2,500 each year.

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

- Deductibles, copays and coinsurance
- Dental and orthodontia expenses
- Prescription glasses, contact lenses and lens cleaning solution
- Laser vision correction
- 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.

Reminder: Over-the-Counter Medications Change—Effective January 1, 2011, there was a change to how over-the-counter medications are handled. Over-the-Counter drugs and medications, with the exception of insulin, are not reimbursed from a Health Care Spending Account unless the participant has a prescription.

Dependent Care Spending Account

You may use the Dependent Care Spending Account to pay for the day care 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.

If you have not spent all of the amounts in your Health Care Spending Account or Dependent Care Spending Account by the end of the Plan Year, 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, during which time you can continue to incur claims and use up all amounts remaining in your Health Care Spending Account and Dependent Care Spending Account.

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 reimbursement.

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.

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

MAXIMUM AMOUNT THAT CAN BE CONTRIBUTED EACH MONTH:

Parking Spending Account: \$245 (subject to change by IRS)

Transit & Van Pooling Spending Account: \$245 (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. As an eligible employee, 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. 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 or 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 or \$100,000
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 or \$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 65-69	\$1.09	Spouse Life 65-69	\$1.09
Employee Life 70+	\$1.85	Dependent Child Life	\$0.20

Employee Assistance Program (EAP) - ComPsych

By accessing ComPsych’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
- Stress Management
- Alcohol/Drug Dependency
- Childcare & Eldercare Assistance

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

Contacts

If you have questions you can contact the District’s Office of Risk Management/Benefit 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
POS		(800) 676-6976	40616
Flex Net		(800) 638-3678	10235
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)—ComPsych			
EAP	www.guidanceresources.com	(800) 342-8111	
Web ID: COM589			

Annual Notices

Special Enrollment Notice

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.

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.

Women's Health and Cancer Rights Act Annual Notice

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.

Patient Protection Annual Notice

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.

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 at the end of this notice 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:	September 23, 2013
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)

Notice of Privacy Practice: New Rule

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

This Notice of Privacy Practices (the “Notice”) describes the legal obligations of the self-funded health plan(s) (the “Plan”) sponsored by Berkeley Unified School District and your legal rights regarding your protected health information held by the Plan under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Health Information Technology for Economic and Clinical Health Act (HITECH Act) and subsequent amending regulations (“HIPAA Privacy Rule”). Among other things, this Notice describes how your protected health information may be used or disclosed to carry out treatment, payment, or health care operations, or for any other purposes that are permitted or required by law. We are required to provide this HIPAA Privacy Notice to you pursuant to HIPAA.

The HIPAA Privacy Rule protects only certain medical information known as “protected health information.” Generally, protected health information is health information, including demographic information, collected from you or created or received by a health care provider, a health care clearinghouse, a health plan, or your employer on behalf of a group health plan, from which it is possible to individually identify you and that relates to:

- Your past, present, or future physical or mental health or condition;
- The provision of health care to you; or
- The past, present, or future payment for the provision of health care to you.

If you have any questions about this Notice or about our privacy practices, please contact the individual listed at the end of this notice.

Our Responsibilities

Berkeley Unified School District is required by law to:

- Maintain the privacy of your protected health information;
- Provide you with certain rights with respect to your protected health information;
- Provide you with a copy of this Notice of our legal duties and privacy practices with respect to your Protected health information; and
- Follow the terms of the Notice that is currently in effect.

We reserve the right to change the terms of this Notice and to make new provisions regarding your protected health information that we maintain, as allowed or required by law. If we make any material change to this Notice, we will provide you with a copy of our revised HIPAA Privacy Notice electronically or by first class mail to the last known address on file.

How We May Use and Disclose Your Protected Health Information

Under the law, we may use or disclose your protected health information under certain circumstances without your permission.

The following categories describe the different ways that we may use and disclose your protected health information. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

For Payment. We may use or disclose your protected health information to determine your eligibility for Plan benefits, to facilitate payment for the treatment and services you receive from health care providers, to determine benefit responsibility under the Plan, or to coordinate Plan coverage. For example, we may tell your health care provider about your medical history to determine whether a particular treatment is experimental, investigational, or medically necessary, or to determine whether the Plan will cover the treatment. We may also share your protected health information with a utilization review or precertification service provider. Likewise, we may share your protected health information with another entity to assist with the adjudication or subrogation of health claims or to another health plan to coordinate benefit payments.

For Health Care Operations. We may use and disclose your protected health information for other Plan operations. These uses and disclosures are necessary to run the Plan. For example, we may use medical information in connection with conducting quality assessment and improvement activities; underwriting, premium rating, and other activities relating to Plan coverage; submitting claims for stop-loss (or excess-loss) coverage; conducting or arranging for medical review, legal services, audit services, and fraud and abuse detection programs; business planning and development such as cost management; and business management and general Plan administrative activities. However, we will not use your genetic information for underwriting purposes.

Treatment Alternatives or Health-Related Benefits and Services. We may use and disclose your protected health information to send you information about treatment alternatives or other health-related benefits and services that might be of interest to you.

To Business Associates. We may contract with individuals or entities known as Business Associates to perform various functions on our behalf or to provide certain types of services. In order to perform these functions or to provide these services, Business Associates will receive, create, maintain, transmit, use, and/or disclose your protected health information, but only after they agree in writing with us to implement appropriate safeguards regarding your protected health information. For example, we may disclose your protected health information to a Business Associate to process your claims for Plan benefits or to provide support services, such as utilization management, pharmacy benefit management, or subrogation, but only after the Business Associate enters into a Business Associate contract with us.

As Required by Law. We will disclose your protected health information when required to do so by federal, state, or local law. For example, we may disclose your protected health information when required by national security laws or public health disclosure laws.

To Avert a Serious Threat to Health or Safety. We may use and disclose your protected health information when necessary to prevent a serious threat to your health and safety, or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat. For example, we may disclose your protected health information in a proceeding regarding the licensure of a physician.

To Plan Sponsors. For the purpose of administering the plan, we may disclose to certain employees of the Employer protected health information. However, those employees will only use or disclose that information as necessary to perform plan administration functions or as otherwise required by HIPAA, unless you have authorized further disclosures. Your protected health information cannot be used for employment purposes without your specific authorization.

Special Situations

In addition to the above, the following categories describe other possible ways that we may use and disclose your protected health information without your specific authorization. For each category of uses or disclosures, we will explain what we mean and present some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

Organ and Tissue Donation. If you are an organ donor, we may release your protected health information after your death to organizations that handle organ procurement or organ, eye, or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

Military. If you are a member of the armed forces, we may release your protected health information as required by military command authorities. We may also release protected health information about foreign military personnel to the appropriate foreign military authority.

Workers' Compensation. We may release your protected health information for workers' compensation or similar programs, but only as authorized by, and to the extent necessary to comply with, laws relating to workers' compensation and similar programs that provide benefits for work-related injuries or illness.

Public Health Risks. We may disclose your protected health information for public health activities. These activities generally include the following:

- to prevent or control disease, injury, or disability;

- to report births and deaths;
- to report child abuse or neglect;
- to report reactions to medications or problems with products;
- to notify people of recalls of products they may be using;
- to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
- to notify the appropriate government authority if we believe that a patient has been the victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree, or when required or authorized by law.

Health Oversight Activities. We may disclose your protected health information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose your protected health information in response to a court or administrative order. We may also disclose your protected health information in response to a subpoena, discovery request, or other lawful process by someone involved in a legal dispute, but only if efforts have been made to tell you about the request or to obtain a court or administrative order protecting the information requested.

Law Enforcement. We may disclose your protected health information if asked to do so by a law-enforcement official:

- in response to a court order, subpoena, warrant, summons, or similar process;
- to identify or locate a suspect, fugitive, material witness, or missing person;
- about the victim of a crime if, under certain limited circumstances, we are unable to obtain the victim's agreement;
- about a death that we believe may be the result of criminal conduct; and
- about criminal conduct.

Coroners, Medical Examiners, and Funeral Directors. We may release protected health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about patients to funeral directors, as necessary to carry out their duties.

National Security and Intelligence Activities. We may release your protected health information to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

Inmates. If you are an inmate of a correctional institution or are in the custody of a law-enforcement official, we may disclose your protected health information to the correctional institution or law-enforcement official if necessary : (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

Research. We may disclose your protected health information to researchers when:

- the individual identifiers have been removed; or
- when an institutional review board or privacy board has reviewed the research proposal and established protocols to ensure the privacy of the requested information, and approves the research.

Required Disclosures

The following is a description of disclosures of your protected health information we are required to make.

Government Audits. We are required to disclose your protected health information to the Secretary of the United States Department of Health and Human Services when the Secretary is investigating or determining our compliance with the HIPAA privacy rule.

Disclosures to You. When you request, we are required to disclose to you the portion of your protected health information that contains medical records, billing records, and any other records used to make decisions regarding your health care benefits. We are also required, when requested, to provide you with an accounting of most disclosures of your protected health information if the disclosure was for reasons other than for payment, treatment, or health care operations, and if the protected health information was not disclosed pursuant to your individual authorization.

Other Disclosures

Personal Representatives. We will disclose your protected health information to individuals authorized by you, or to an individual designated as your personal representative, attorney-in-fact, etc., so long as you provide us with a written notice/authorization and any supporting documents (i.e., power of attorney). Note: Under the HIPAA privacy rule, we do not have to disclose information to a personal representative if we have a reasonable belief that:

- you have been, or may be, subjected to domestic violence, abuse, or neglect by such person; or
- treating such person as your personal representative could endanger you; and
- in the exercise of professional judgment, it is not in your best interest to treat the person as your personal representative.

Spouses and Other Family Members. With only limited exceptions, we will send all mail to the employee. This includes mail relating to the employee’s spouse and other family members who are covered under the Plan, and includes mail with information on the use of Plan benefits by the employee’s spouse and other family members and information on the denial of any Plan benefits to the employee’s spouse and other family members. If a person covered under the Plan has requested Restrictions or Confidential Communications (see below under “Your Rights”), and if we have agreed to the request, we will send mail as provided by the request for Restrictions or Confidential Communications.

Authorizations. Other uses or disclosures of your protected health information not described above will only be made with your written authorization. For example, in general and subject to specific conditions, we will not use or disclose your psychiatric notes; we will not use or disclose your protected health information for marketing; and we will not sell your protected health information, unless you give us a written authorization. You may revoke written authorizations at any time, so long as the revocation is in writing. Once we receive your written revocation, it will only be effective for future uses and disclosures. It will not be effective for any information that may have been used or disclosed in reliance upon the written authorization and prior to receiving your written revocation.

Your Rights

You have the following rights with respect to your protected health information:

Right to Inspect and Copy. You have the right to inspect and copy certain protected health information that may be used to make decisions about your Plan benefits. If the information you request is maintained electronically, and you request an electronic copy, we will provide a copy in the electronic form and format you request, if the information can be readily produced in that form and format; if the information cannot be readily produced in that form and format, we will work with you to come to an agreement on form and format. If we cannot agree on an electronic form and format, we will provide you with a paper copy.

To inspect and copy your protected health information, you must submit your request in writing to the individual listed at the end of this Notice. If you request a copy of the information, we may charge a reasonable fee for the costs of copying, mailing, or other supplies associated with your request. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to your medical information, you may request that the denial be reviewed by submitting a written request to the individual listed at the end of this Notice.

Right to Amend. If you feel that the protected health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the Plan. To request an amendment, your request must be made in writing and submitted to the individual listed at the end of this Notice. You must provide a reason that supports your request.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- is not part of the medical information kept by or for the Plan;
- was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- is not part of the information that you would be permitted to inspect and copy; or
- is already accurate and complete.

If we deny your request, you have the right to file a statement of disagreement with us and any future disclosures of the disputed information will include your statement.

Right to an Accounting of Disclosures. You have the right to request an “accounting” of certain disclosures of your protected health information. The accounting will not include (1) disclosures for purposes of treatment, payment, or health care operations; (2) disclosures made to you; (3) disclosures made pursuant to your authorization; (4) disclosures made to friends or family in your presence or because of an emergency; (5) disclosures for national security purposes; and (6) disclosures incidental to otherwise permissible disclosures.

To request this list or accounting of disclosures, you must submit it in writing to the individual listed at the end of this Notice. Your request must state the time period you want the accounting to cover, which may not be longer than six years before the date of the request. Your request should indicate in what form you want the list (for example, paper or electronic). The first list you request within a 12-month period will be provided free of charge. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions. You have the right to request a restriction or limitation on your protected health information that we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on your protected health information that we disclose to someone who is involved in your care or the payment for your care, such as a family member or friend. For example, you could ask that we not use or disclose information about a surgery that you had. Except as provided in the next paragraph, we are not required to agree to your request. However, if we do agree to the request, we will honor the restriction until you revoke it or we notify you.

We will comply with any restriction request if (1) except as otherwise required by law, the disclosure is to a health plan for purposes of carrying out payment or health care operations (and is not for purposes of carrying out treatment); and (2) the protected health information pertains solely to a health care item or service for which the health care provider involved has been paid in full by you or another person.

To request restrictions, you must send your request in writing the individual listed at the end of this notice. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure, or both; and (3) to whom you want the limits to apply—for example, disclosures to your spouse.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. To request confidential communications, you must make your request in writing the individual listed at the end of this notice. We will not ask you the reason for your request. Your request must specify how or where you wish to be contacted. We will accommodate all reasonable requests.

Right to Be Notified of a Breach. You have the right to be notified in the event that we (or a Business Associate) discover a breach of unsecured protected health information.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice.

You may obtain a copy of this notice at our website which is listed at the end of this notice. To obtain a paper copy of this notice, contact the individual listed at the end of this notice.

Complaints

If you believe that your privacy rights have been violated, you may file a complaint with the Plan or with the Office for Civil Rights of the United States Department of Health and Human Services. To file a complaint with the Plan, contact to the individual listed below. All complaints must be submitted in writing.

You will not be penalized, or in any other way retaliated against, for filing a complaint with the Office for Civil Rights or with us.

HIPAA Contact

Name: Lolita Coleman/Belinda Stuckey
Title: Administrative Assistant
Address: 2020 Bonar Street Berkeley, CA 94702
Phone: (510) 644-6666
Website: <https://pcms.plansource.com>
Username: BUSDEmployee
Password: benefits