Your 2014 Benefits

Berkeley Unified School District

Retirees - Early and Self-Pay

Effective January 1, 2014 - December 31, 2014

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

Health Benefit 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
- MEDICARE PART D ANNUAL NOTICE ATTACHED - Page 20

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 benefits.

Understanding Your Rights: Read All Notices

Retirees and their 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:

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.

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.

Premium Assistance: Assistance to pay health plan premiums may be available under your state's Medicaid program or Children's Health Insurance Program (CHIP). These provisions are explained in the District's CHIP Notice.

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

If you 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 valuable. 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.

As a retiree, you are entitled to some of the same Open Enrollment rights as an active employee. You can switch medical or dental plans offered by the District. **However, once you terminate a benefit or are terminated for non-payment, the benefit cannot be reinstated.**

Contents

Where to Obtain Information/Enrollment Forms

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

- The District's MyBenefits website

  https://pcms.plansource.com
  Username: BUSDRetiree
  Password: benefits
  Click on "Obtain an Enrollment Form"

- The Office of Risk Management/Benefits Department
- The Open Enrollment Fair

Important Changes in the 2014 Benefit Offerings & Increases

2014 Plan Increases

Health care continues to be a concern for employers and employees/retirees 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.

Health Net		**Kaiser**	
HMO High Option:	14.51%	HMO Plan:	0%
HMO Low Option:	14.51%	Senior Advantage High Option:	5.29%
PPO Plan:	19.05%	Senior Advantage Low Option:	5.29%
POS Plan:	7.15%		
FlexNet:	14.51%		
HMO COB High Option:	10.95%		
Seniority Plus:	3.00%		

Delta Dental		**VSP**	
DeltaCare DHMO:	0%	Vision	2.03%
Dental PPO Plan:	0%		

2014 Plan Updates

General

- Definition of spouse has changed - With the decision to overturn Defense of Marriage Act (DOMA) earlier this year, we want to remind retirees that in California, both same and opposite sex spouses are eligible dependents. 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. Please see page 5 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 flouride 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 BCRAs, the breast cancer susceptibility genes, with no cost sharing.

Health Net

- **PPO, POS, FlexNet** - many of the 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
    - **FlexNe**t - Air ambulance maximum of $750 each incident is being removed.

2014 Plan Updates

Delta Dental PPO - Effective 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

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, retirees 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.

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.

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. Retirees 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 retiree's same-sex spouse if within statue 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 - changing plans, complete an enrollment/change form
- ❑ Dental Plan - changing plans, complete an enrollment/change form

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, you do not have to complete any paperwork.

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:

- 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 or your spouse (if enrolled) turn 65
- When you experience certain HIPAA special enrollment events such as getting married or adding a child; 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 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 change your current coverage
- How to submit completed enrollment/change form
- You want to know what to expect after you enroll

You Wish to Maintain Current Coverage

If you are currently enrolled in a medical, dental, and/or vision plan (through COBRA) 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.

You Want to Change your Current Coverage

1. Review your options, ask questions and talk with your family. If you're thinking of changing medical plans:
    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 19 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 HIPAA special enrollment event (for example, you get married or have a child). HIPAA special enrollment events are explained in more detail on page 10 of this Guide.
    b. You or your spouse (if enrolled) turns 65
    c. 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 (under 65 only)
    b. **Estimate and Compare Medical Expenses by Option** — Estimate what your total annual medical expenses (out-of-pocket costs) would be under each plan (under 65 only)
    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
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 (must already be enrolled).

How to Submit Completed Enrollment/Change Form

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

1. Walk-in: Retirees may submit the completed enrollment/change form by coming to the Office of Risk Management/Benefits Department window (See window hours below).
2. Mail: Retirees may submit the completed enrollment/change form 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 enrollment/change forms at the Wellness Fair on October 17, 2013 from 12:00 pm to 5:30 pm.
4. Retiree Session: Office of Risk Management/Benefits Department staff will be accepting enrollment/change forms at the Retiree Open Enrollment session on October 10, 2013 from 12:00 pm to 3:00 pm.

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

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 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 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 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 carrier after you receive your ID card and request that your PCP be changed. PCP changes are not effective immediately. Generally, the change will be the first of the following month.

Eligibility and Changes

Eligibility

Under present District policy, you, your spouse, domestic partner and eligible dependents may remain participant(s) in the BUSD health plan system. However, if at the time of your retirement or at any future date, you choose to leave the District's plans, you and your dependents do not have future eligibility. As a Retiree you can participate in the benefits described in this Guide provided you are already enrolled. Coverage begins January 1, 2014 if you are changing coverage during Open Enrollment.

Your Dependents

Your eligible dependents include:

- Your spouse (as defined by applicable state law)
- 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 enrolled on your plan prior to turning 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 for whom 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 the termination of your benefits.

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 Districts 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 5)

Making Changes

You can change your medical or dental benefit plans during open enrollment. Coverage stays in effect for the entire plan year (January 1, 2014 - December 31, 2014) . You cannot change your coverage, start coverage or add any family members to your coverage during the plan year unless you have a HIPAA special enrollment event.

HIPAA Special Enrollment Rights

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), a retiree has the right to enroll family members. if:

- You get married
- Your spouse loses other group coverage
- You have a child born to or placed for adoption

For any HIPAA special enrollment event, you must request enrollment within 30 days after you get married, your spouse's other group coverage ends or you acquire the new dependent.

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

PREMIUM COSTS

The collective bargaining contract in effect at the time of your retirement lists the terms and conditions of your eligibility and defines if you qualify for a District contribution toward the cost of your retiree health insurance benefits (medical and/or dental). After the period during which the District has agreed to pay some or all of your premium, you may remain on the BUSD health plan by paying the entire amount of your own health plan premium.

Medical - Early Retirees

Your Medical Plans

You have the choice of several medical plans. For your specific plan options and costs, please refer to page 12 & 17.

- 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 membership)

You Must Enroll

If you do not elect to change your medical plan during open enrollment, you will have to wait until the next open enrollment period unless you turn 65.

Enrolling in an HMO?

Be sure to elect a primary care physician!

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

NOTE: If your enrolled spouse is 65 years of age or older, they will need to be enrolled in Medicare and enrolled in the Medicare plan that is associated with your Early Retiree medical plan. Please review the carrier benefit summaries for a description of these plans.

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 Website.

Note: Formularies are updated regularly. Please refer to your plan's website to see any updates. Contact information is on page 19 of this Guide. It is a good idea to keep checking back to determine if your prescriptions are a part of the formulary.

Comparing Your Medical Plan Options - Early Retirees

Closed to new membership

	Kaiser HMO High Option	Kaiser HMO Low Option	Health Net HMO High Option 2TX	Health Net HMO Low Option 2LZ	Health Net POS			Health Net PPO	
					HMO	In-Network PPO	Out-of-Network	In-Network	Out-of-Network
Annual Deductible (individual/family)	N/A	N/A	N/A	N/A	N/A	N/A	$200 / $600	$1,000 / $3,000	
Annual Out-of-Pocket Limit (individual / family)	$1,500 / $3,000	$1,500 / $3,000	$1,500 / $3,000 / $4,500	$1,500 / $3,000 / $4,500	$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	Unlimited	Unlimited
Office Visits	$15 copay	$25 copay	$10 copay	$25 copay	$10 copay	$20 copay	30%	$20 copay	40%
Preventive Care	No charge	No charge	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	No charge	No charge	30%	No charge	Not covered
Specialist Consultations	$15 copay	$25 copay	$10 copay	$25 copay	$10 copay	$20 copay	30%	$20 copay	40%
Room & Board Hospital Inpatient (semi-private)	$250 copay	$250 copay	No charge	$250 copay	No charge	10%	30%	20%	$500 + 40%
Outpatient Surgery	$50 copay per procedure	$50 copay per procedure	No charge	$250 copay	No charge	10%	30%	20%	$500 + 40%
Emergency Room Services (copay waived if admitted)	$50 copay	$50 copay	$35 copay	$100 copay	$35 copay	$50 copay	30%	$100 + 20%	$100 + 40%
Urgent Care Services	$15 copay	$25 copay	$35 copay	$50 copay	$35 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	$10 G / $20 B / $35 NF up to a 30 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	$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	$20 G / $40 B / $70 NF up to a 90 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	$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 up to 30 visits per calendar year	$10 copay	30%	30%	$20 copay	40% (up to $25 per visit)
						up to 15 visits per calendar year combined		up to 12 visits per calendar year combined	

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

Medical - Retirees Over 65

Your Medical Plans

You have the choice of several medical plans. For your specific plan costs, please see page 18.

- Kaiser High Option Senior Advantage—$15 office visit copay
- Kaiser Low Option Senior Advantage—$25 office visit copay
- Health Net High Option HMO COB—$10 office visit copay
- Health Net Seniority Plus—$10 office visit copay
- Health Net FlexNet—20% coinsurance (out-of-area)

You Must Enroll

If you do not change your medical plan during open enrollment, you will have to wait until the next open enrollment period.

Enrolling in an HMO?

Be sure to elect a primary care physician!

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

NOTE: If your enrolled spouse is under the age of 65, they will need to be enrolled in the Early Retiree plan associated with your Medicare plan. Please see page 12 for a description of these plans.

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 attached benefit summaries provides for each plan 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 website to see any updates. Contact information is on page 19 of this Guide. It is a good idea to keep checking back to determine if your prescriptions are a part of the formulary.

Cost of Coverage: How You Pay for Health Care Costs

Depending on your retirement agreement, you may share the costs of health care premiums with the District, pay the full cost or the District may pay 100% of your premium until a certain age. You will, however, share the costs of health care services with your medical plan. As you choose your medical plan, consider the following types of costs:

- **Premium.** A premium is the total cost for your medical insurance.
- **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 Plan provides coverage for both in-network and out-of-network services (but you pay less when you use in-network providers). Generally, your premium and ongoing costs will be lower with a more restrictive plan and higher with a plan that has broader coverage and more flexibility. When trying to decide which plan to choose, consider these questions:

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

Dental

Your Dental Plans

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

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

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

The 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% (Not subject to deductible or calendar year max)	100% (Not subject to deductible or calendar year max)
Basic	Various copays apply	100%	100%
Major	Various copays apply	70%	70%
Orthodontia	Various copays apply	50%	50%
Lifetime Orthodontia Maximum	None	$1,000	
Implants	Not covered	70%	70%
TMJ Treatment	Not covered	Not covered	
Waiting Period	None	None	None

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

Vision

Your Vision Plan

Unless you elected vision through COBRA, this benefit is not available to be added during open enrollment. BUSD offers vision coverage through Vision Service Plan (VSP). If enrolled, you pay the full premium for this coverage and a 2% administration fee. VSP has one of the most extensive network of optometrists and ophthalmologists and 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 Elective	Covered in full $140 allowance	Up to $210 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.*

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

Symptoms - including but not limited to:

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

Conditions - including but not limited to:

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

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

- Average 35-40% savings on non-covered lens options and 30% off additional glasses and sunglasses
- Average of 15 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.

Early Retiree - Monthly Premiums

Health Net Plan Rates - Early Retirees (No Medicare)					
Coverage	**HMO "High Option"**	**HMO "Low Option"**	**POS ***	**PPO**	**FlexNet**
Retiree Only	$1,144.95	$989.89	$1,443.00	$812.37	$1,358.34
Retiree + One Dependent	$2,293.14	$1,979.81	$2,885.99	$1,624.73	$2,716.68
Retiree + 2 or more Dependents	$3,244.79	$2,801.43	$4,083.67	$2,299.02	$3,844.09

*POS plan is closed to new participants

Kaiser Permanente HMO Plan Rates Early Retirees (No Medicare)		
Coverage	**HMO "High Option"**	**HMO "Low Option"**
Retiree Only	$556.28	$539.53
Retiree + One Dependent	$1,112.55	$1,079.07
Retiree + 2 or more Dependents	$1,574.26	$1,526.88

Delta Dental		
	PPO	**DeltaCare DHMO**
One Rate - All Coverages	$107.51	$32.21

Retirees Over 65 - Monthly Premiums

Coverage	Health Net HMO "High Option"	Health Net Flex Net	Health Net HMO "Low Option"	Health Net PPO	Health Net Seniority Plus / HMO "High Option"	Health Net Seniority Plus / HMO "Low Option" for <65	Kaiser Senior Advantage "High Option"	Kaiser Senior Advantage "Low Option"
Retiree (M)	$575.52	$575.52	$575.52	$575.52	$451.15	$451.15	$295.62	$254.67
Retiree (M) + Spouse (NM)	$1,723.71	$1,933.86	$1,565.44	$1,387.88	$1,599.34	$1,441.07	$851.89	$794.21
Retiree (NM) + Spouse (M)	$1,720.47	$1,933.86	$1,565.41	$1,387.88	$1,596.10	$1,441.04	$851.90	$794.20
Retiree (M) + Spouse (M)	$1,151.04	$1,151.04	$1,151.04	$1,151.04	$902.30	$902.30	$591.24	$509.34
Retiree (M) + Child (NM)	$1,723.71	$1,933.86	$1,565.44	$1,387.88	$1,599.34	$1,441.07	$851.89	$794.21
Retiree (M) + Children (NM)	$2,675.36	$3,061.27	$2,387.05	$2,062.17	$2,550.99	$2,262.68	$1,313.60	$1,242.02
Retiree (M) + Spouse (M) + Child (NM)	$2,299.23	$2,509.38	$2,140.96	$1,963.40	$2,050.49	$1,892.22	$1,052.95	$957.15
Retiree (M) + Spouse (NM) + Child (NM)	$2,675.36	$3,061.27	$2,387.05	$2,062.17	$2,550.99	$2,262.68	$1,313.60	$1,242.02
Retiree (NM) + Spouse (M) + Child (NM)	$2,868.66	$3,292.20	$2,555.33	$2,200.25	$2,744.29	$2,430.96	$1,313.61	$1,242.01
Retiree (M) + Spouse (M) + Children (NM)	$3,250.88	$3,636.79	$2,962.57	$2,637.69	$3,002.14	$2,713.83	$1,052.95	$957.15
Retiree (M) + Spouse (NM) + Children (NM)	$2,675.36	$3,061.27	$2,387.05	$2,062.17	$2,550.99	$2,262.68	$1,313.60	$1,242.02
Retiree (NM) + Spouse (M) + Children (NM)	$3,820.31	$4,419.61	$3,376.95	$2,874.54	$3,695.94	$3,252.58	$1,313.61	$1,242.01

M = Enrolled in Medicare
NM = No Medicare Enrollment

If you or your spouse are over 65 and don't have Medicare or if you have not assigned your Medicare, please contact the District for your premium rate.

Contacts

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

PLAN INFO	WEBSITE	CONTACT	GROUP #
BUSD Office of Risk Management/Benefits Department			
(510) 644-6666	External: www.berkeleyschools.net (click on "Teachers and Staff")		
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
Retiree Billing/COBRA—Custom Benefit Administrators (CBA)			
Administration	www.cbadministrators.com	(800) 574-5448	
Medicare			
General Information	www.medicare.gov	(800) MEDICARE	
Personal Information	www.MyMedicare.gov	(800) 633-4227	

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.

<u>When Can You Join A Medicare Drug Plan?</u>

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.

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

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 any 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 this 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 13, 2013
Name of Entity/Sender:	Berkeley Unified School District
Contact - Position/Office:	Belinda Stuckey
Address:	2020 Bonar Street Berkeley, CA 94702
Phone Number:	(510) 644-6666

Annual Notices

Special Enrollment Notice

If an eligible retiree acquires a new dependent as a result of marriage, birth, adoption or placement for adoption, the eligible retiree may be able to enroll any eligible dependents, provided that the eligible retiree requests enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Furthermore, eligible retirees 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.

Mothers' and Newborns' 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 our 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 our 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.