Your 2020 Bene ts

E ective January 1, 2020 - December 31, 2020

OPEN ENROLLMENT

Health Bene ts
Open Enrollment Guide

COBRA Bene ciaries

Welcome to Your Benefits Guide

As a Qualified COBRA Beneficiary, you are entitled to the same Open Enrollment rights as an active employee. You can change benefit options or packages; add coverage for dependents, and switch to other group health plans offered by the District.

For information about the specific plans available to you go online to:

https://pcms.plansource.com

Usernaem: BUSDEmployee (case sensitive)

Password: benefits (case sensitive)

Click on "Obtain and Enrollment Form"

Contents

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 BASIC pacific immediately.

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 to enroll or change coverage will not be until next year's Open Enrollment, unless you experience a HIPAA special enrollment event during the year.

All forms are due to BASIC pacific no later than

5:00 pm on Friday, October 4, 2019.

- ☐ Dental Plan—adding coverage, changing plans or adding dependents, complete a Delta Dental Dual Choice enrollment/change form
- ☐ Vision Plan—adding coverage or adding dependents, complete a VSP enrollment/change form

Dependent Certification is REQUIRED!

If you are enrolling dependents, the following applicable certification must be provided. It is the COBRA Beneficiary's responsibility to obtain certification(s) and to submit such certification(s) to BASIC pacific in a timely manner. Failure to submit supporting documentation copies will result in dependents being denied coverage.

DO NOT SUBMIT ORIGINAL DOCUMENTS AS THEY WILL NOT BE RETURNED.

- ☐ **Spouse**—Marriage Certificate or Affidavit of Marriage/Domestic Partnership
- ☐ **Domestic Partner**—Declaration of Domestic Partnership form the California Secretary of States office, or Affidavit of Marriage/Domestic Partnership. If your domestic partnership is non-registered, you will need to complete a Domestic Partnership Application/Affidavit. Please contact BASIC pacific for the Affidavit.
- ☐ **Children**—Birth certificate, adoption paperwork, legal guardianship papers when applicable. Birth certificates must show the names of the parents.

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:

- **All enrollments and changes you make during this Open Enrollment period become effective January 1, 2020 even if you do not receive a new ID card by this date.**
- When you experience certain HIPAA special enrollment events such as marriage or the birth of 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 dental/vision coverage
- You want to enroll or make a change to dental/vision
- You want to submit completed enrollment/change form(s)
- You want to know what to expect after you enroll

You Wish to Maintain Current Dental/Vision Coverage

If you are currently enrolled in a dental and/or vision plan and do not want to make any changes, **NO FURTHER ACTION IS NECESSARY**. Unless you submit an open enrollment change form, your current dental and vision plan coverage will automatically continue at the same levels.

How to Submit Completed Open Enrollment/Change Form(s)

You may send your completed open enrollment/change form to:

Mail Forms to:
BASIC pacific
P.O. Box 2170
Rocklin, CA 95677

Submit the completed open enrollment change form through postal mail to BASIC pacific. BASIC must receive forms not later than 5:00 pm on October 4, 2019. Forms received after this date and time will not be accepted.

You Want to Know What Happens After Enrollment

ID Cards

You will not receive an ID card for the Delta Dental PPO (Fee-For-Service) or VSP vision coverage. If you newly enroll in the DeltaCare USA (DHMO) dental plan, you will receive an ID card.

Coverage is effective January 1, 2020 **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 BASIC pacific

Eligibility and Changes

Eligibility

As a COBRA Qualified Beneficiary you can participate in the benefits described in this Guide. Coverage begins January 1, 2020 if you are applying for coverage during Open Enrollment.

Your Dependents

Your eligible dependents include:

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

Your children include:

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

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

Making Changes

You can enroll in benefits during annual enrollment. When you elect coverage under the dental and/or vision plans, coverage stays in effect for the entire plan year (January 1, 2020— December 31, 2020) provided you do not reach the end of your continuation coverage during the plan year. 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), if you decline COBRA medical, dental or vision coverage for yourself or your dependents because you have other group 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 COBRA health care plan during the plan year.

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

For more information or to request special enrollment, contact BASIC pacific at (800) 574-5448.

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. You pay the entire cost of the dental plan plus a 2% administration charge. The following are the available plans offered to you:

- **Delta Dental –** DeltaCare USA (DHMO)
- **Delta Dental –** PPO (Fee-For-Service) (in-network and out-of-network)

DeltaCare USA (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 (Fee-For-Service) 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/Preventive	Various copays apply	100% (Not subject to deductible or calendar year max)	100% (Not subject to deductible or calendar year max)
Basic	Various copays apply	100%	100%
Major	Various copays apply	70%	70%
Orthodontia	Various copays apply	50%	50%
Lifetime Orthodontia Maximum	None	$1,000	
Implants	Not covered	70%	70%
TMJ Treatment	Not covered	Not covered	
Waiting Period	None	None	None

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

Vision

Your Vision Plan

BUSD offers vision coverage through Vision Service Plan (VSP). You, the COBRA Beneficiary, pay the full premium for this coverage plus a 2% administration charge. 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	Vision Service Plan	
Exam/Materials	$10 copay	
BENEFIT FREQUENCY		
Exam	Once every 12 months	
Lenses	Once every 12 months	
Frames	Once every 24 months	
Contact Lenses (in lieu of all other eyewear)	Once every 12 months	
COVERAGE	**In - Network**	**Out-of-Network**
Eye Exam	Covered in Full	up to $50.00
Single Lens	Covered in Full	up to $50.00
Bi-Focal Lenses	Covered in Full	up to $75.00
Tri-Focal Lenses	Covered in Full	up to $100.00
Lenticular Lenses	Covered in Full	up to $125.00
Frame Allowance	up to $140.00	up to $70.00
Contact Lenses		
Medically Necessary	Covered in Full	up to $210.00
Elective	up to $140.00	up to $105.00
Rate Guarantee	Guaranteed until 1/1/20	

Solid Tints and Dyes

Patient Option	Single Vision*	Multifocal*
Tinted/Photochromic	Covered in Full	Up to $5
Anti-reflective Coating	$37	$37
Polycarbonate for Children	Covered in Full	Covered in Full
Polycarbonate for Adult	$23	$28
Standard Progressives	N/A	Covered in Full
Premium & Custom Progessives	N/A	$80 - $160+
Tints/Photochromics	Covered in Full	Covered in Full
Scratch-Resistant Coating	$15	$15

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

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

Symptoms - including but not limited to:

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

Conditions - including but not limited to:

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

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

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

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

Monthly Dental/Vision/EAP Premium Rate Sheet

Delta Dental

Coverage	PPO	DeltaCare DHMO
One Rate—All Coverages	$103.79	$32.85

VSP

Coverage	
Single Beneficiary	$8.24
Beneficiary + One Dependent	$16.48
Beneficiary + Two or more Dependents	$26.56

Claremont (Employee Assistance Program)

Coverage	EAP
One Rate	$3.13

Rates include 2% COBRA Administration Fee

Contacts

If you have questions you can contact BASIC pacific at (800) 574-5448 or the plan carriers. Use this chart to help guide you to the right resource on the first try.

PLAN INFO	WEBSITE	CONTACT	GROUP #
Medical—CalPERS			
Medical Plans	www.calpers.ca.gov	(888) 225-7377	
Review your CalPERS *Health Benefit Summary* for specific carrier contact information			
Dental—Delta Dental			
PPO (Fee-For-Service)	www.deltadentalins.com	(866) 499-3001	7069
DeltaCare USA (DHMO		(800) 422-4234	5827
Vision—Vision Service Plan (VSP)			
Vision PPO	www.vsp.com	(800) 877-7195	12314888
COBRA Accounts—BASIC pacific			
Administration	www.basicpacific.com	(800) 574-5448	
Employee Assistance Program (EAP)—Claremont			
EAP	www.claremonteap.com	(800) 834-3773	