2021-2022 Benefits Booklet

BENEFITS FOR EVERY STEP OF THE WAY

10/01/2021 – 09/30/2022

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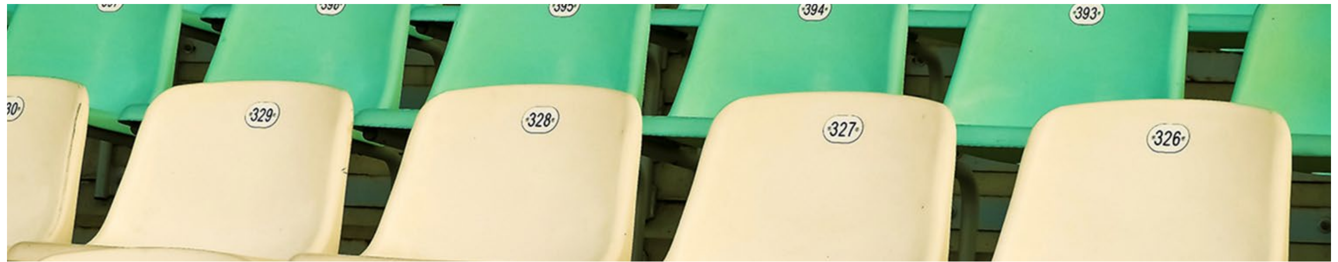
Medicare Part D Notice: If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a federal law gives you more choices about your prescription drug coverage. Please see the Annual Notice on pages 29-30 for more details.



District Message

At Fullerton School District we value your contributions to our success and want to provide you with a benefits package that protects your health and helps your financial security, now and in the future. We continually look for valuable benefits that support your needs, whether you are single, married, raising a family, or thinking ahead to retirement. We are committed to giving you the resources you need to understand your options and how your choices could affect you financially.

Please note the following 2021-2022 benefit changes:

- Effective October 1, 2021, the Blue Shield 10 HMO prescription drug plan will have a Brand and Specialty drug Deductible and copays will increase. For additional details, please see page 9 and review the Summary of Benefits and Coverage (SBC).
- Effective October 1, 2021, the Delta Dental PPO plan will include orthodontic services for adults. For additional details, please see page 16 and review the Benefit Summary.

We are providing you with this booklet to help you understand the benefits that are available to you and how to best use them. Please review it carefully and make sure to ask about any important issues that are not addressed here. A list of plan contacts and resources are provided on the back cover page of this booklet.

While we've made every effort to make sure that this booklet is comprehensive, it cannot provide a complete description of all benefit provisions. For more information, please visit **www.fullertonsd.org** or contact Insurance Benefits. The information in this booklet is a general outline of the benefits offered under the Fullerton School District benefits program. Specific details and limitations are provided in the plan documents, such as the Summary of Benefits and Coverage (SBC), Evidence of Coverage (EOC) and/or insurance policies. The plan documents contain the relevant plan provisions. If the information in this booklet differs from the plan documents, the plan documents will prevail.

The benefits in this summary are effective:

October 1, 2021 – September 30, 2022

IMPORTANT EMPLOYEE RESPONSIBILITIES

Review your benefits options.
Employees waiving coverage must complete and submit a Waiver of Coverage form.

If you have questions email Insurance Benefits:

Andrea Lopez | Employee Benefits Program Coordinator | andrea_lopez@myfsd.org

Jenny Morgan | Employee Benefits Technician | jenny_morgan@myfsd.org

Eligibility

WHO IS ELIGIBLE?

If you are employed working 50% or more (4 hours for Classified employees) you are eligible for the insurance benefits outlined in this overview.

You can enroll the following family members in our medical, dental and vision plans:

- Your spouse (the person who you are legally married to under state law, including a same-sex spouse).
- If you have registered your domestic partnership with your state or local government, your domestic partner is eligible for coverage. Please contact Insurance Benefits if you would like to add a registered domestic partner. Any premiums for your domestic partner paid for by Fullerton School District are taxable income and will be included on your W-2. Any premiums you pay for your domestic partner will be deducted on an after-tax basis.
- Your children (including your domestic partner's children):
    - Under age 26 are eligible to enroll in coverage. They do not have to live with you or be enrolled in school. They can be married and/or living and working on their own.
    - Coverage terminates at the end of the month of their 26th birthday.
    - Over age 26 ONLY if they are incapacitated due to a disability and primarily dependent on you for support.
    - Named in a Qualified Medical Child Support Order (QMCSO) as defined by federal law.

Please refer to the Summary Plan Description for complete details on how benefits eligibility is determined.

DEPENDENT VERIFICATION

Adding dependents is subject to eligibility verification in order to ensure only eligible individuals are participating in our plans. You will be required to provide proof of one or more of the following within 30 days of their eligibility:

- Prior year's tax return and marriage certificate
- State-issued certificate of domestic partnership
- Birth Certificate
- Final decree of divorce
- Court documents showing legal responsibility for adopted children, foster children or children under legal guardianship
- Physician's written certification of disabling condition (for dependent children over age 26 incapable of self-support)

If you do not supply the proper documentation to add dependents within 30 day period, you will not be able to add the dependent(s) until the next open enrollment period. **Verification of Dependent Eligibility form** found online **www.fullertonsd.org**.

WHEN CAN I ENROLL?

Open enrollment is the one time each year that employees can make changes to their benefit elections without a qualifying life event. Make sure to contact Insurance Benefits right away if you do have a qualifying life event and need to make a change (add or drop) to your coverage election. Life events include (but are not limited to):

- Birth or adoption of a baby or child
- Loss of other healthcare coverage
- Eligibility for new healthcare coverage
- Marriage
- Divorce

You have 30 days to make your change after the qualifying life event. **An employee may be held responsible for substantial charges if services are provided for a person who is found to be ineligible.**

Eligibility Continued

EMPLOYEES WITH DUAL COVERAGE

Fullerton School District coverage will be your primary health coverage. If your children are on both coverages of married parents, their primary coverage will be based on the parent with the earlier birthday in the year. In the case of divorce or separation, please see the Evidence of Coverage for your plan.

Please note Blue Shield HDHP/HSA plans do not allow dual coverage. You should make selections that will be beneficial in coordination with your secondary coverage. If you need assistance contact Member Services.

NEW HIRES

You must complete and return the enrollment forms and dependent verification documentation to Insurance Benefits within 30 days from date of hire. **Benefit forms are available online at www.fullertonsd.org, under Departments, Personnel Services, Benefits.**

Employees working 90% or more (7.20 or more hours per day) are required to enroll in a minimum of single medical coverage.

Employees who are regularly assigned to work 20 hours or more per week (.50 FTE – Certificated) in a permanent position, are eligible for pro-rata District paid Health and Welfare Benefits. Employee contributions vary according to benefit plans and hours worked per week.

Coverage begins on the 1st day of the month following Qualifying event.

QUALIFYING LIFE EVENTS[1]

If you qualify for a mid-year benefit change, you will be required to submit proof of the change. Changes must be submitted to Insurance Benefits within **30 days** of the life event.

The following are considered qualifying life events:

- Change in legal marital status, including marriage, divorce, legal separation, annulment, and death of a spouse
- Change in number of dependents, including birth, adoption, placement for adoption, or death of a dependent child
- Change in employment status that affects benefit eligibility, including the start or termination of employment by you, your spouse, or your dependent child
- Change in work schedule, including a switch between part-time and full-time employment that affects eligibility for benefits
- Change in a child's dependent status, either newly satisfying the requirements for dependent child status or ceasing to satisfy them
- Change in place of residence or worksite, including a change that affects the accessibility or network providers
- Change in your health coverage or your spouse's coverage attributable to your spouse's employment
- Change in an individual's eligibility for Medicare or Medicaid
- A court order resulting from a divorce, legal separation, annulment, or change in legal custody (including a Qualified Medical Child Support Order) requiring coverage for your child
- To purchase marketplace coverage, when an employee seeks to cease coverage under the employer's group health plan and purchases coverage through the Marketplace, without having to incur a period of either duplicate coverage or no coverage
- Reduction in hours, when an employee's hours of service are reduced so that he/she is expected to average less than 30 hours of service per week, but the reduction does not affect his/her eligibility for coverage under the employer's group health plan, as long as the employee and other dependents who lose coverage intend to enroll in other MEC
- An event that is a "special enrollment" under the Health Insurance Portability and Accountability Act (HIPAA) including acquisition of a new dependent by marriage, birth or adoption, or loss of coverage under another health insurance plan
- An event that is allowed under the Children's Health Insurance Program (CHIP) Reauthorization Act. Under provisions of the Act, employees have 60 days after the following events to request enrollment:
    - Employee or dependent loses eligibility for Medicaid
    - Employee or dependent becomes eligible to participate in a premium assistance program under Medicaid or CHIP

[1] Qualifying events only pertain to current active employees. For retirees please see appropriate union contract agreement for Retiree Benefits information.

Fullerton School District
Effective 10-1-2021

2021-2022 Employee Monthly Payroll Deductions Certificated, Classified, and Management

		Blue Shield PPO			Blue Shield HMO $10			Blue Shield HMO 30			Blue Sheild HMO TRIO			KAISER		
		SGL	2P	FAM	SGL	2P	FAM	SGL	2P	FAM	SGL	2P	FAM	SGL	2P	FAM
TENTHLY		1,035.60	2,012.40	2,817.60	842.40	1,638.00	2,294.40	777.60	1,507.20	2,109.60	714.00	1,382.40	1,929.60	726.00	1,406.40	1,972.80
ANNUAL		10,356.00	20,124.00	28,176.00	8,424.00	16,380.00	22,944.00	7,776.00	15,072.00	21,096.00	7,140.00	13,824.00	19,296.00	7,260.00	14,064.00	19,728.00
DISTRICT		10,356.00	16,600.00	19,296.00	8,424.00	16,380.00	19,296.00	7,776.00	15,072.00	19,296.00	7,140.00	13,824.00	19,296.00	7,260.00	14,064.00	19,296.00
DIST HSA Contr																
%	HRS	EMPLOYEE PAYROLL DEDUCTION:														
100%	8.00	0.00	352.40	888.00	0.00	0.00	364.80	0.00	0.00	180.00	0.00	0.00	0.00	0.00	0.00	43.20
	7.90	12.95	373.15	912.12	10.53	20.47	388.92	9.72	18.84	204.12	8.92	17.28	24.12	9.07	17.58	67.32
	7.80	25.89	393.90	936.24	21.06	40.95	413.04	19.44	37.68	228.24	17.85	34.56	48.24	18.15	35.16	91.44
	7.70	38.84	414.65	960.36	31.59	61.43	437.16	29.16	56.52	252.36	26.78	51.84	72.36	27.23	52.74	115.56
95%	7.60	51.78	435.40	984.48	42.12	81.90	461.28	38.88	75.36	276.48	35.70	69.12	96.48	36.30	70.32	139.68
	7.50	64.73	456.15	1,008.60	52.65	102.38	485.40	48.60	94.20	300.60	44.63	86.40	120.60	45.38	87.90	163.80
	7.40	77.67	476.90	1,032.72	63.18	122.85	509.52	58.32	113.04	324.72	53.55	103.68	144.72	54.45	105.48	187.92
	7.30	90.62	497.65	1,056.84	73.71	143.33	533.64	68.04	131.88	348.84	62.48	120.96	168.84	63.53	123.06	212.04
90%	7.20	103.56	518.40	1,080.96	84.24	163.80	557.76	77.76	150.72	372.96	71.40	138.24	192.96	72.60	140.64	236.16
	7.10	116.51	539.15	1,105.08	94.77	184.28	581.88	87.48	169.56	397.08	80.33	155.52	217.08	81.68	158.22	260.28
	7.00	129.45	559.90	1,129.20	105.30	204.75	606.00	97.20	188.40	421.20	89.25	172.80	241.20	90.75	175.80	284.40
	6.90	142.40	580.65	1,153.32	115.83	225.23	630.12	106.92	207.24	445.32	98.18	190.08	265.32	99.83	193.38	308.52
85%	6.80	155.34	601.40	1,177.44	126.36	245.70	654.24	116.64	226.08	469.44	107.10	207.36	289.44	108.90	210.96	332.64
	6.70	168.29	622.15	1,201.56	136.89	266.18	678.36	126.36	244.92	493.56	116.03	224.64	313.56	117.98	228.54	356.76
	6.60	181.23	642.90	1,225.68	147.42	286.65	702.48	136.08	263.76	517.68	124.95	241.92	337.68	127.05	246.12	380.88
	6.50	194.18	663.65	1,249.80	157.95	307.13	726.60	145.80	282.60	541.80	133.88	259.20	361.80	136.13	263.70	405.00
80%	6.40	207.12	684.40	1,273.92	168.48	327.60	750.72	155.52	301.44	565.92	142.80	276.48	385.92	145.20	281.28	429.12
	6.30	220.07	705.15	1,298.04	179.01	348.08	774.84	165.24	320.28	590.04	151.73	293.76	410.04	154.28	298.86	453.24
	6.20	233.01	725.90	1,322.16	189.54	368.55	798.96	174.96	339.12	614.16	160.65	311.04	434.16	163.35	316.44	477.36
	6.10	245.96	746.65	1,346.28	200.07	389.03	823.08	184.68	357.96	638.28	169.58	328.32	458.28	172.43	334.02	501.48
75%	6.00	258.90	767.40	1,370.40	210.60	409.50	847.20	194.40	376.80	662.40	178.50	345.60	482.40	181.50	351.60	525.60
	5.90	271.85	788.15	1,394.52	221.13	429.98	871.32	204.12	395.64	686.52	187.43	362.88	506.52	190.58	369.18	549.72
	5.80	284.79	808.90	1,418.64	231.66	450.45	895.44	213.84	414.48	710.64	196.35	380.16	530.64	199.65	386.76	573.84
	5.70	297.74	829.65	1,442.76	242.19	470.93	919.56	223.56	433.32	734.76	205.28	397.44	554.76	208.73	404.34	597.96
70%	5.60	310.68	850.40	1,466.88	252.72	491.40	943.68	233.28	452.16	758.88	214.20	414.72	578.88	217.80	421.92	622.08
	5.50	323.63	871.15	1,491.00	263.25	511.88	967.80	243.00	471.00	783.00	223.13	432.00	603.00	226.88	439.50	646.20
	5.40	336.57	891.90	1,515.12	273.78	532.35	991.92	252.72	489.84	807.12	232.05	449.28	627.12	235.95	457.08	670.32
	5.30	349.52	912.65	1,539.24	284.31	552.83	1,016.04	262.44	508.68	831.24	240.98	466.56	651.24	245.03	474.66	694.44
65%	5.20	362.46	933.40	1,563.36	294.84	573.30	1,040.16	272.16	527.52	855.36	249.90	483.84	675.36	254.10	492.24	718.56
	5.10	375.41	954.15	1,587.48	305.37	593.78	1,064.28	281.88	546.36	879.48	258.83	501.12	699.48	263.18	509.82	742.68
	5.00	388.35	974.90	1,611.60	315.90	614.25	1,088.40	291.60	565.20	903.60	267.75	518.40	723.60	272.25	527.40	766.80
	4.90	401.30	995.65	1,635.72	326.43	634.73	1,112.52	301.32	584.04	927.72	276.68	535.68	747.72	281.33	544.98	790.92
60%	4.80	414.24	1,016.40	1,659.84	336.96	655.20	1,136.64	311.04	602.88	951.84	285.60	552.96	771.84	290.40	562.56	815.04
	4.70	427.19	1,037.15	1,683.96	347.49	675.68	1,160.76	320.76	621.72	975.96	294.53	570.24	795.96	299.48	580.14	839.16
	4.60	440.13	1,057.90	1,708.08	358.02	696.15	1,184.88	330.48	640.56	1,000.08	303.45	587.52	820.08	308.55	597.72	863.28
	4.50	453.08	1,078.65	1,732.20	368.55	716.63	1,209.00	340.20	659.40	1,024.20	312.38	604.80	844.20	317.63	615.30	887.40
55%	4.40	466.02	1,099.40	1,756.32	379.08	737.10	1,233.12	349.92	678.24	1,048.32	321.30	622.08	868.32	326.70	632.88	911.52
	4.30	478.97	1,120.15	1,780.44	389.61	757.58	1,257.24	359.64	697.08	1,072.44	330.23	639.36	892.44	335.78	650.46	935.64
	4.20	491.91	1,140.90	1,804.56	400.14	778.05	1,281.36	369.36	715.92	1,096.56	339.15	656.64	916.56	344.85	668.04	959.76
	4.10	504.86	1,161.65	1,828.68	410.67	798.53	1,305.48	379.08	734.76	1,120.68	348.08	673.92	940.68	353.93	685.62	983.88
50%	4.00	517.80	1,182.40	1,852.80	421.20	819.00	1,329.60	388.80	753.60	1,144.80	357.00	691.20	964.80	363.00	703.20	1,008.00

Annual Cost Divided by ten
(vendor paid 12 months)
Part time prorated

Pro Rated % of Annual Deduction
No deductions in June and July

Fullerton School District
Effective 10-1-2021

2021-2022 Employee Monthly Payroll Deductions Certificated, Classified, and Management

VSP	VSP for Kaiser	Delta Dental PPO			Delta Care HMO					Blue Sheild PPO HSA			BLUE SHIELD HIGH DEDUCTIBLE		
FAM	FAM	SGL	2P	FAM	SGL	2P	FAM			SGL	2P	FAM	HEALTH SAVINGS ACCOUNT		
21.60	27.00	59.56	95.30	160.81	30.66	49.94	74.12	TENTHLY		668.59	1,331.35	1,892.14	SGL	2P	FAM
216.00	270.00	595.56	953.04	1,608.12	306.60	499.44	741.24	ANNUAL		6,685.92	13,313.52	18,921.36	DISTRICT CONTRIBUTION ANNUALLY		
216.00	0.00	595.56	953.04	1,608.12	306.60	499.44	741.24	DISTRICT		10,335.92	16,600.00	19,296.00	3,650.00	3,286.48	374.64
								DIST HSA Contr		3,650.00	3,286.48	374.64			
								%	HRS				Pro Rata District HSA Contibution		
0.00	27.00	0.00	0.00	0.00	0.00	0.00	0.00	100%	8.00	0.00	0.00	0.00	3,650.00	3,286.48	374.64
0.27	27.00	0.74	1.19	2.01	0.38	0.62	0.93		7.90	8.36	16.64	23.65	3,604.38	3,245.40	369.96
0.54	27.00	1.49	2.38	4.02	0.77	1.25	1.85		7.80	16.71	33.28	47.30	3,558.75	3,204.32	365.27
0.81	27.00	2.23	3.57	6.03	1.15	1.87	2.78		7.70	25.07	49.93	70.96	3,513.13	3,163.24	360.59
1.08	27.00	2.98	4.77	8.04	1.53	2.50	3.71	95%	7.60	33.43	66.57	94.61	3,467.50	3,122.16	355.91
1.35	27.00	3.72	5.96	10.05	1.92	3.12	4.63		7.50	41.79	83.21	118.26	3,421.88	3,081.08	351.23
1.62	27.00	4.47	7.15	12.06	2.30	3.75	5.56		7.40	50.14	99.85	141.91	3,376.25	3,039.99	346.54
1.89	27.00	5.21	8.34	14.07	2.68	4.37	6.49		7.30	58.50	116.49	165.56	3,330.63	2,998.91	341.86
2.16	27.00	5.96	9.53	16.08	3.07	4.99	7.41	90%	7.20	66.86	133.14	189.21	3,285.00	2,957.83	337.18
2.43	27.00	6.70	10.72	18.09	3.45	5.62	8.34		7.10	75.22	149.78	212.87	3,239.38	2,916.75	332.49
2.70	27.00	7.44	11.91	20.10	3.83	6.24	9.27		7.00	83.57	166.42	236.52	3,193.75	2,875.67	327.81
2.97	27.00	8.19	13.10	22.11	4.22	6.87	10.19		6.90	91.93	183.06	260.17	3,148.13	2,834.59	323.13
3.24	27.00	8.93	14.30	24.12	4.60	7.49	11.12	85%	6.80	100.29	199.70	283.82	3,102.50	2,793.51	318.44
3.51	27.00	9.68	15.49	26.13	4.98	8.12	12.05		6.70	108.65	216.34	307.47	3,056.88	2,752.43	313.76
3.78	27.00	10.42	16.68	28.14	5.37	8.74	12.97		6.60	117.00	232.99	331.12	3,011.25	2,711.35	309.08
4.05	27.00	11.17	17.87	30.15	5.75	9.36	13.90		6.50	125.36	249.63	354.78	2,965.63	2,670.27	304.40
4.32	27.00	11.91	19.06	32.16	6.13	9.99	14.82	80%	6.40	133.72	266.27	378.43	2,920.00	2,629.18	299.71
4.59	27.00	12.66	20.25	34.17	6.52	10.61	15.75		6.30	142.08	282.91	402.08	2,874.38	2,588.10	295.03
4.86	27.00	13.40	21.44	36.18	6.90	11.24	16.68		6.20	150.43	299.55	425.73	2,828.75	2,547.02	290.35
5.13	27.00	14.14	22.63	38.19	7.28	11.86	17.60		6.10	158.79	316.20	449.38	2,783.13	2,505.94	285.66
5.40	27.00	14.89	23.83	40.20	7.67	12.49	18.53	75%	6.00	167.15	332.84	473.03	2,737.50	2,464.86	280.98
5.67	27.00	15.63	25.02	42.21	8.05	13.11	19.46		5.90	175.51	349.48	496.69	2,691.88	2,423.78	276.30
5.94	27.00	16.38	26.21	44.22	8.43	13.73	20.38		5.80	183.86	366.12	520.34	2,646.25	2,382.70	271.61
6.21	27.00	17.12	27.40	46.23	8.81	14.36	21.31		5.70	192.22	382.76	543.99	2,600.63	2,341.62	266.93
6.48	27.00	17.87	28.59	48.24	9.20	14.98	22.24	70%	5.60	200.58	399.41	567.64	2,555.00	2,300.54	262.25
6.75	27.00	18.61	29.78	50.25	9.58	15.61	23.16		5.50	208.94	416.05	591.29	2,509.38	2,259.46	257.57
7.02	27.00	19.36	30.97	52.26	9.96	16.23	24.09		5.40	217.29	432.69	614.94	2,463.75	2,218.37	252.88
7.29	27.00	20.10	32.17	54.27	10.35	16.86	25.02		5.30	225.65	449.33	638.60	2,418.13	2,177.29	248.20
7.56	27.00	20.84	33.36	56.28	10.73	17.48	25.94	65%	5.20	234.01	465.97	662.25	2,372.50	2,136.21	243.52
7.83	27.00	21.59	34.55	58.29	11.11	18.10	26.87		5.10	242.36	482.62	685.90	2,326.88	2,095.13	238.83
8.10	27.00	22.33	35.74	60.30	11.50	18.73	27.80		5.00	250.72	499.26	709.55	2,281.25	2,054.05	234.15
8.37	27.00	23.08	36.93	62.31	11.88	19.35	28.72		4.90	259.08	515.90	733.20	2,235.63	2,012.97	229.47
8.64	27.00	23.82	38.12	64.32	12.26	19.98	29.65	60%	4.80	267.44	532.54	756.85	2,190.00	1,971.89	224.78
8.91	27.00	24.57	39.31	66.33	12.65	20.60	30.58		4.70	275.79	549.18	780.51	2,144.38	1,930.81	220.10
9.18	27.00	25.31	40.50	68.35	13.03	21.23	31.50		4.60	284.15	565.82	804.16	2,098.75	1,889.73	215.42
9.45	27.00	26.06	41.70	70.36	13.41	21.85	32.43		4.50	292.51	582.47	827.81	2,053.13	1,848.65	210.74
9.72	27.00	26.80	42.89	72.37	13.80	22.47	33.36	55%	4.40	300.87	599.11	851.46	2,007.50	1,807.56	206.05
9.99	27.00	27.54	44.08	74.38	14.18	23.10	34.28		4.30	309.22	615.75	875.11	1,961.88	1,766.48	201.37
10.26	27.00	28.29	45.27	76.39	14.56	23.72	35.21		4.20	317.58	632.39	898.76	1,916.25	1,725.40	196.69
10.53	27.00	29.03	46.46	78.40	14.95	24.35	36.14		4.10	325.94	649.03	922.42	1,870.63	1,684.32	192.00
10.80	27.00	29.78	47.65	80.41	15.33	24.97	37.06	50%	4.00	334.30	665.68	946.07	1,825.00	1,643.24	187.32

Annual Cost Divided by ten
(vendor paid 12 months)
Part time prorated

Pro Rated % of Annual Deduction
No deductions in June and July

Kaiser Medical Traditional HMO

This plan is available only in certain **California counties and cities ("Service Area")** as described in the Evidence of Coverage. You **must live and/or work in this select Service Area** in order to enroll in this plan. Find a Primary Care Physician by visiting **www.kp.org** or call member services **(800) 464-4000**.

Plan includes vision benefit. If you would like additional vision coverage you can enroll in the VSP vision plan on a voluntary basis.

	Member Copays
Calendar Year Deductible	None
Annual Out-of-Pocket Max	$1,500 individual $3,000 family
Physician Office Visit	$15 copay per visit
Specialist	$15 copay per visit
Preventive Services	No charge
Outpatient Diagnostic X-ray and Lab	No charge
Advanced Diagnostic Imaging (MRI/PET/CAT scans)	No charge
Inpatient Hospitalization	No charge
Physician Services	No charge
Outpatient Facility Services	
Surgery	$15 copay per procedure
Urgent Care	$15 copay per visit
Emergency Room (copay waived if admitted)	$100 copay per visit
Ambulance Services	$50 per trip
Durable Medical Equipment	No charge
Medically Necessary Acupuncture & Chiropractic Care[1] (up to 30 combined visits per year)	$10 copay per visit
Prescription Drugs (pharmacy or through mail order)	
Most Generic drugs	$15 copay
Most Brand drugs	$15 copay
Supply Limit	100 days

Vision Service	Benefit	Frequency
Eye examination	Covered by your Kaiser Permanente Health Plan benefit. Book an eye exam on kp2020.org. No charge for preventive screening.	No limit
Frames for prescription eyeglasses	$150 allowance toward the purchase price of a frame prescription glasses. To use the optical benefit, at least one of the two lenses requires a prescription.	24 months
Lenses	One pair of regular eyeglass lenses will be covered at no charge - standard, plastic single vision, bifocals or no-line progressives. Anti-reflective treatment for your lenses will be covered at no charge.	12 months
OR Contact lenses instead of eyeglasses	$150 allowance toward the purchase price of contact lenses, fitting, and dispensing.	12 months

[1] Services authorized and provided by American Specialty Health Plans of California (ASH Plans).

Blue Shield Medical TRIO HMO

Plan is available only in certain California counties and cities ("Service Area"). Members must access covered services through a network of physicians and facilities as directed by their Primary Care Physician. To find a Primary Care Physician visit **www.blueshieldca.com/sites/sisc** or call member services **(855) 256-9404**.

HMO Network: TRIO ACO HMO	Copays
Calendar Year Deductible	None
Medical Out-of-Pocket Max	$1,500 individual; $3,000 family
Physician/Specialist Office Visit	$30 copay per visit
Access+ Self-Referral[1]	$45 copay per visit
MDLive[2]	$5 copay per visit
Preventive Services	No charge
Diagnostic X-ray and Lab	No charge
Scans: CT, CAT, MRI, PET etc.	No charge
Inpatient Hospitalization (preauthorization required)	20% copay per admit
Physician Services	No charge
Outpatient Facility Services	
Surgery in an Ambulatory Surgery Center Surgery in a Hospital	No charge No charge
Urgent Care[3]	$30 copay per visit
Emergency Room (copay waived if admitted)	$150 copay per visit
Ambulance Services (ground or air)	$100 copay per visit
Durable Medical Equipment	20% coinsurance
Acupuncture & Chiropractic Care (up to 30 combined visits per year)	$10 copay per visit
Prescription Drugs[4]	**RX Copays**
Brand & Specialty Drug Deductible:	**$200 individual/$500 family**
Generic	
Network Pharmacy	$10 copay
Costco Pharmacy	$0 copay
Costco Mail Order	$0 copay
Brand	
Network Pharmacy	$35 copay after deductible
Costco Pharmacy	$35 copay after deductible
Costco Mail Order	$90 copay after deductible
Specialty – Navitus Mail Order	$35 copay after deductible
Supply Limit	Members may receive up to 30 days and/or up to 90 days supply of medication at participating pharmacies.

[1] If your PCP participates in our Access+ *Specialist*SM program, you may go directly to a specialist in your PCP's medical group or IPA without a referral for a higher copayment.
[2] Virtual access to providers and therapists.
[3] Urgent services Inside the Personal Physician's Service Area and rendered or referred by the Personal Physician or Personal Physician's Medical Group/IPA.
[4] Pharmacy Benefits are administered by **Navitus Health Solutions**. Navitus Specialty Rx supplies limited to no more than 30 days.

Blue Shield Medical Full Network HMOs

Plans are available only in certain California counties and cities ("Service Area"). Members must access covered services through a network of physicians and facilities as directed by their Primary Care Physician. To find a Primary Care Physician visit **www.blueshieldca.com/sites/sisc** or call member services **(855) 256-9404**.

HMO Network: Access+	HMO 10 Copays	HMO 30 Copays
Calendar Year Deductible	None	None
Medical Out-of-Pocket Max	$1,000 individual; $2,000 family	$1,500 individual; $3,000 family
Professional Services		
Physician/Specialist Office Visit	$10 copay per visit	$30 copay per visit
Access+ Self-Referral[1]	$30 copay per visit	$45 copay per visit
MDLive[2]	$5 copay per visit	$5 copay per visit
Preventive Services	No charge	No charge
Diagnostic X-ray and Lab	No charge	No charge
Scans: CT, CAT, MRI, PET etc.	No charge	No charge
Inpatient Hospitalization (preauthorization required)	No charge	20% copay per admit
Physician Services	No charge	No charge
Outpatient Facility Services		
Surgery in an Ambulatory Surgery Center Surgery in a Hospital	No charge No charge	No charge No charge
Urgent Care[3]	$10 copay per visit	$30 copay per visit
Emergency Room (copay waived if admitted)	$100 copay per visit	$150 copay per visit
Ambulance Services (ground or air)	$100 copay per visit	$100 copay per visit
Durable Medical Equipment	0% coinsurance	20% coinsurance
Acupuncture & Chiropractic Care (up to 30 combined visits per year)	$10 copay per visit	$10 copay per visit
Prescription Drugs[4]	**HMO 10 RX Copays**	**HMO 30 RX Copays**
Brand & Specialty Drug Deductible:	**$200 individual/$500 family**	**$200 individual/$500 family**
Generic		
Network Pharmacy	$10 copay	$10 copay
Costco Pharmacy	$0 copay	$0 copay
Costco Mail Order	$0 copay	$0 copay
Brand		
Network Pharmacy	$35 copay after deductible	$35 copay after deductible
Costco Pharmacy	$35 copay after deductible	$35 copay after deductible
Costco Mail Order	$90 copay after deductible	$90 copay after deductible
Specialty – Navitus Mail Order	$35 copay after deductible	$35 copay after deductible
Supply Limit	Members may receive up to 30 days and/or up to 90 days supply of medication at participating pharmacies.	

[1] If your PCP participates in our Access+ *Specialist*℠ program, you may go directly to a specialist in your PCP's medical group or IPA without a referral for a higher copayment.
[2] Virtual access to providers and therapists.
[3] Urgent services Inside the Personal Physician's Service Area and rendered or referred by the Personal Physician or Personal Physician's Medical Group/IPA.
[4] Pharmacy Benefits are administered by **Navitus Health Solutions**. Navitus Specialty Rx supplies limited to no more than 30 days.

Blue Shield Medical PPO

	In-Network	Out-of-Network[1]
Calendar Year Deductible	$100 individual; $300 family	
Medical Out-of-Pocket Max	$1,000 individual; $3,000 family	
Professional Services		
Physician/Specialist Office Visit	$0 copay for the first three visits then $20 copay (ded. waived)	50% coinsurance after deductible
MDLive[2]	$5 copay per visit	Not applicable
Preventive Services	No charge	Not covered
Diagnostic X-ray and Lab	10% coinsurance after deductible	Not covered
Scans: CT, CAT, MRI, PET etc.	10% coinsurance after deductible	50% coinsurance after deductible
Inpatient Hospitalization (preauthorization required)	10% coinsurance after deductible	0% coinsurance after deductible with $600/day max
Physician Services	10% coinsurance after deductible	50% coinsurance after deductible
Outpatient Facility Services		
Surgery in an Ambulatory Surgery Center Physician/surgeon fees	10% coinsurance after deductible 10% coinsurance after deductible	0% coinsurance after deductible with $350/day max 50% coinsurance after deductible
Urgent Care	$20 copay after deductible	50% coinsurance after deductible
Emergency Room (copay waived if admitted)	$100 copay per visit + 10% coinsurance	
Ambulance Services (ground or air)	$100 copay per visit + 10% coinsurance	
Durable Medical Equipment	10% coinsurance after deductible	Not covered
Acupuncture (up to 12 visits per year)	10% coinsurance after deductible	50% coinsurance after deductible
Chiropractic Care (up to 20 visits per year)	10% coinsurance after deductible	Not covered
Prescription Drugs[3]		
Generic		
Network Pharmacy	$7 copay	
Costco Pharmacy	$0 copay	
Costco Mail Order	$0 copay	
Brand		
Network Pharmacy	$25 copay	
Costco Pharmacy	$25 copay	
Costco Mail Order	$60 copay	
Specialty – Navitus Mail Order	$25 copay	
Supply Limit	Members may receive up to 30 days and/or up to 90 days supply of medication at participating pharmacies.	

[1] Non-participating providers can charge more than Blue Shield's allowable amounts. When members use non-participating providers, they must pay the applicable deductibles, copayments or coinsurance plus any amount that exceeds Blue Shield's allowable amount. Charges above the allowable amount do not count toward the calendar year medical deductible or out-of-pocket maximum.

[2] Virtual access to providers and therapists.

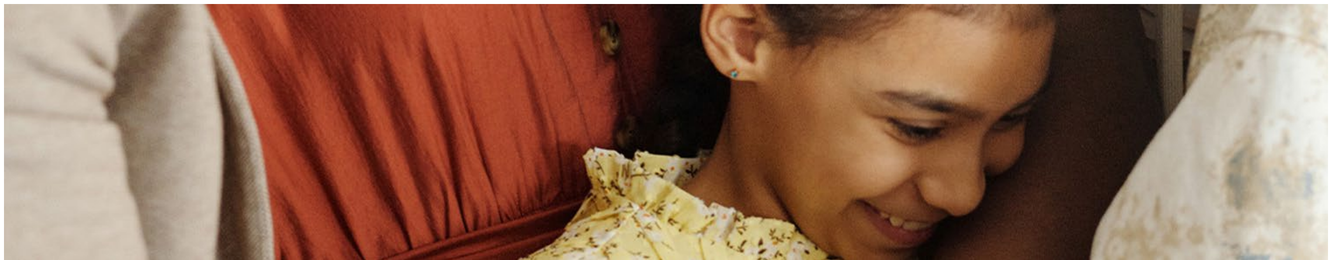
3 Pharmacy Benefits are administered by **Navitus Health Solutions**. Navitus Specialty Rx supplies limited to no more than 30 days.

Blue Shield Medical High Deductible PPO/HSA

	In-Network	Out-of-Network[1]
Calendar Year Deductible (all providers combined)	$3,000 individual; $5,200 family (For individual on family coverage plan, enrollee can receive benefits for covered services once individual deductible is met.)	
Medical Out-of-Pocket Max (includes plan deductible)	$5,000 individual; $10,000 family (For individual on family coverage plan, enrollee can receive 100% benefits for covered services once individual out-of-pocket maximum is met.)	
Professional Services		
Physician/Specialist Office Visit	10% coinsurance after deductible	50% coinsurance after deductible
MDLive[2]	$40 consult fee until deductible is met then $5 copay	Not applicable
Preventive Services	No charge (deductible waived)	Not covered
Diagnostic X-ray and Lab	10% coinsurance after deductible	Not covered
Scans: CT, CAT, MRI, PET etc.	10% coinsurance after deductible	50% coinsurance after deductible
Inpatient Hospitalization (preauthorization required)	10% coinsurance after deductible	0% coinsurance after deductible with $600/day max
Physician Services	10% coinsurance after deductible	50% coinsurance after deductible
Outpatient Facility Services		
Surgery in an Ambulatory Surgery Center Physician/surgeon fees	10% coinsurance after deductible 10% coinsurance after deductible	0% coinsurance after deductible with $350/day max 50% coinsurance after deductible
Urgent Care	10% coinsurance after deductible	50% coinsurance after deductible
Emergency Room (copay waived if admitted)	$100 copay per visit + 10% coinsurance	
Ambulance Services (ground or air)	$100 copay per visit + 10% coinsurance	
Durable Medical Equipment	10% coinsurance after deductible	Not covered
Acupuncture (up to 12 visits per year)	10% coinsurance after deductible	50% coinsurance after deductible
Chiropractic Care (up to 20 visits per year)	10% coinsurance after deductible	Not covered
Hearing Aid Benefit[3]	10% coinsurance after deductible	
Prescription Drugs[4]		
Generic Network Pharmacy Mail Order	 $9 copay after deductible $18 copay after deductible	
Brand Network Pharmacy Mail Order	 $35 copay after deductible $90 copay after deductible	
Specialty – Navitus Mail Order	$35 copay after deductible	
Supply Limit	Members may receive up to 30 days and/or up to 90 days supply of medication at participating pharmacies.	

[1] Non-participating providers can charge more than Blue Shield's allowable amounts. When members use non-participating providers, they must pay the applicable deductibles, copayments or coinsurance plus any amount that exceeds Blue Shield's allowable amount. Charges above the allowable amount do not count toward the calendar year medical deductible or out-of-pocket maximum.
[2] Virtual access to providers and therapists.
[3] Up to a max combined benefit of $700 per pair every 24 months for the hearing aid and ancillary equipment.
4 Pharmacy Benefits are administered by **Navitus Health Solutions**. Navitus Specialty Rx supplies limited to no more than 30 days.

Voya Off-the-Job Accident Plan – Blue Shield HDHP Members



If you enroll in the Blue Shield High Deductible Health Plan you are automatically enrolled in the Accident plan. The cost of coverage is included in the Blue Shield High Deductible Health Plan. Accident insurance is designed to help you pay for unexpected costs that result from an accidental injury. Accident insurance includes benefits for a wide range of common injuries such as fractures, dislocations, burns, emergency room or urgent care visit, and physical therapy.

If you or a covered family member suffers an accident, this plan will pay you a lump-sum, tax-free benefit. The amount of money you receive depends on the type and severity of your injury and can be used any way you choose.

HOW THE PLAN WORKS

Scenario: your gymnast daughter has a mishap on the uneven bars during a competition. Fortunately, she escapes serious injury but suffers a broken collarbone. After she receives medical care you can submit an Accident claim along with proof of treatment received to Voya. Voya will mail you a benefit payment check and you can use the money to help pay for the out-of-pocket costs.

Service	Billed Cost*	SISC Pays	You Pay	Accident Benefit
ER Visit	**$1,000**	**0% (deductible)**	**$1,000**	**$150**
X-Ray	**$500**	**0% (deductible)**	**$500**	**$30**
Fracture – setting in ER	**Included (ER)**	**N/A**		**$960**
Office visit – follow up	**$120**	**0% (deductible)**	**$120**	**$60**
Total	**$1,620**	**$0**	**$1,620**	**$1,200**

* Costs shown for illustrative purposes only and may not be representative of the actual cost of services.

HOW TO FILE A CLAIM

- Online: **www.voya.com**
- Over the Phone: (888) 238-4840
- Fax Claim Form: (877) 464-2280

Proof of treatment received is required for claims submission, such as emergency records, itemized bills, medical records, admit/discharge summary or office notes.

Voya's benefit payment(s) are made via check and are paid within 10 days.

Blue Shield Medical Anchor Bronze High Deductible PPO/HSA

	In-Network	Out-of-Network[1]
Calendar Year Deductible (all providers combined)	$5,000 individual; $10,000 family (For individual on family coverage plan, enrollee can receive benefits for covered services once individual deductible is met.)	
Medical Out-of-Pocket Max (includes plan deductible)	$6,350 individual; $12,700 family (For individual on family coverage plan, enrollee can receive 100% benefits for covered services once individual out-of-pocket maximum is met.)	
Professional Services		
Physician/Specialist Office Visit	30% coinsurance after deductible	50% coinsurance after deductible
MDLive[2]	$40 consult fee until deductible is met then $5 copay	Not applicable
Preventive Services	No charge (deductible waived)	Not covered
Diagnostic X-ray and Lab	30% coinsurance after deductible	Not covered
Scans: CT, CAT, MRI, PET etc.	30% coinsurance after deductible	50% coinsurance after deductible
Inpatient Hospitalization (preauthorization required)	30% coinsurance after deductible	0% coinsurance after deductible with $600/day max
Physician Services	30% coinsurance after deductible	50% coinsurance after deductible
Outpatient Facility Services		
Surgery in an Ambulatory Surgery Center Physician/surgeon fees	30% coinsurance after deductible 30% coinsurance after deductible	0% coinsurance after deductible with $350/day max 50% coinsurance after deductible
Urgent Care	30% coinsurance after deductible	50% coinsurance after deductible
Emergency Room (copay waived if admitted)	$100 copay per visit + 30% coinsurance	
Ambulance Services (ground or air)	$100 copay per visit + 30% coinsurance	
Durable Medical Equipment	30% coinsurance after deductible	Not covered
Acupuncture (up to 12 visits per year)	30% coinsurance after deductible	50% coinsurance after deductible
Chiropractic Care (up to 20 visits per year)	30% coinsurance after deductible	Not covered
Hearing Aid Benefit[3]	30% coinsurance after deductible	
Prescription Drugs[4]		
Generic Network Pharmacy Mail Order	 $9 copay after deductible $18 copay after deductible	
Brand Network Pharmacy Mail Order	 $35 copay after deductible $90 copay after deductible	
Specialty – Navitus Mail Order	$35 copay after deductible	
Supply Limit	Members may receive up to 30 days and/or up to 90 days supply of medication at participating pharmacies.	

[1] Non-participating providers can charge more than Blue Shield's allowable amounts. When members use non-participating providers, they must pay the applicable deductibles, copayments or coinsurance plus any amount that exceeds Blue Shield's allowable amount. Charges above the allowable amount do not count toward the calendar year medical deductible or out-of-pocket maximum.
[2] Virtual access to provider and therapists.
[3] Up to a max combined benefit of $700 per pair every 24 months for the hearing aid and ancillary equipment.
4 Pharmacy Benefits are administered by **Navitus Health Solutions**. Navitus Specialty Rx supplies limited to no more than 30 days.

Blue Shield PPO Plans – SISC Value Based Site of Care Benefit

SISC continually evaluates ways to limit unnecessary spending in an effort to keep benefits affordable without impacting access to high quality and safe care. Effective October 1, 2018, SISC Blue Shield PPO plans will limit the maximum benefit amount at an in-network outpatient hospital facility for the following five procedures:

	Arthroscopy	Cataract Surgery	Colonoscopy	Upper GI Endoscopy with Biopsy	Upper GI Endoscopy without Biopsy
Maximum benefit at an in-network outpatient hospital facility	$4,500	$2,000	$1,500	$1,250	$1,000
There is no limit at an in-network Ambulatory Service Center (ASC)	There is no benefit change at an ASC. The limits at an outpatient hospital facility do not apply at an ASC.				

Note: The value-based site of care benefit applies to facility fees only. The fees paid to physicians and any other practitioners who assist in the procedure, such as anesthesiologists or radiologists, are not affected by this change.

HOW THE VALUE-BASED SITE OF CARE BENEFIT WORKS

If you use an in-network outpatient hospital facility, you will be responsible for the regular deductible and coinsurance PLUS any amount by which the hospital charge exceeds the maximum benefit. This provision can be waived if your doctor receives advance certification from Blue Shield that you need to be in an outpatient hospital setting.*

* The benefit includes a simple process to exempt the member if the physician provides clinical justification for using a hospital. It also allows exceptions when: a member lives more than 30 miles from an Ambulatory Service Center (ASC) and a hospital that offers the service for less than the maximum benefit; or if a procedure cannot be scheduled in a medically appropriate timely manner due to available ASCs not having capacity.

If you use an in-network ASC, then there is no benefit change! You will only be responsible for the regular deductible and coinsurance.

EXAMPLE: Let's say you are scheduled to have cataract surgery at an in-network outpatient hospital facility and your doctor did not get advance certification from Blue Shield.

Using the average facility fees, the fee would be $4,000 at the outpatient hospital facility. That means you would have to pay $2,000 ($4,000 hospital fee minus the $2,000 limit) out of your own pocket in addition to your deductible and coinsurance.

It's important to know you can keep it simple and save a lot by using an ASC. The limits do not apply at an ASC!

IMPORTANT

Most physicians have privileges at both hospitals and ASCs. If you need one of the outpatient procedures on the list shown above, it will be up to you to either request treatment at the in-network ASC or have your doctor obtain an advance certification from Blue Shield.

Had you elected to have the procedure at an in-network ASC, you would have saved $2,000!

Limiting spending at higher cost facilities is one of the things we can all do to make a difference.

If you have questions contact Blue Shield member services at (855) 599-2657.

Health Savings Account (HSA)

The HSA enables tax-free savings for the qualified medical expenses of "eligible individuals" and their dependents.

An "eligible individual" or HSA owner is an individual:

- ✓ covered on a HSA-compatible High Deductible Health Plan (HDHP); **and**
- ✓ is not covered by a non-HSA compliant plan **or** Medicare; **and**
- ✓ not claimed as a dependent on another individual's tax return

Qualified medical expense are defined in Internal Revenue Code Section 213 [d]. In general they include specified deductibles, co-payments and other medical expenses not covered under the HDHP or in any other manner.

All HSA enrollees will be subject to the plan design and mid-year changes based on Federal/Legislative guidelines.

HSA ADVANTAGES

- HSA contributions are tax-deductible.
- Interest on an HSA is tax-deferred.
- HSAs are portable and owned by the individual; contributions cannot be taken away.
- Unspent balances roll over to the following year and can accumulate over a lifetime to help pay for uncovered Medicare expenses after retirement.
- In the event of the holder's death, HSA balances pass on free of tax to their designated beneficiaries.

FREQUENTLY ASKED QUESTIONS

Q: Does the District contribute to my HSA?
A: District contributes to some Blue Shield Medical High Deductible PPO/HSA plans. Please refer to Cost of Coverage (page 6) for District HSA contribution amounts.

Q: What is the calendar year maximum amount that can be contributed to an HSA?
A: For **2021**, if you have self-only HDHP coverage, you can contribute up to $3,600.
If you have family HDHP coverage, you can contribute up to $7,200.
If you are 55 or older you can make additional "catch-up" contributions up to $1,000 per year.

Q: How does the HSA plan work?
A: Money in the HSA can be used to pay for covered qualified medical expenses and prescriptions not paid by the HDHP. The HSA dollars used apply towards the plan's annual deductible. If all of the dollars are not spent, the money remaining in the account will roll over to the following year.
For additional resources on HSA plans, visit **www.irs.gov**.

Q: What if I have a Life Status Change (increase/decrease in coverage level due to adding or deleting a spouse, etc.)?
A: When increasing or decreasing coverage level during the plan year, the Health Savings Account contribution is adjusted based on the effective date of the change in coverage level. The contribution (difference between lower tier and higher tier) is available to pay for claims incurred after the effective date of the new coverage level. The deductible and out-of-pocket maximum will also change based on coverage selected. Any deductible/out-of-pocket maximum amounts will move with the individual to the new coverage level.

Website: www.sterlingadministration.com
Phone: (800) 617-4729
FAQ: www.sterlingadministration.com/faqs/hsa-faq/

Dental Options – PPO or DHMO

DeltaCare® USA DHMO Plan

You and your eligible dependents must select a primary dentist from the **DeltaCare® USA** DHMO directory. To find a dentist visit **deltadentalins.com/enrollees** or call **(800) 422-4234**. Member ID cards will be mailed to you.

Delta Dental PPO Plan

Under the Delta Dental PPO plan, Delta Dental pays a percentage of the allowed fees for covered diagnostic, preventive, basic and major services. Delta Dental PPO has many network dentists to choose from. **No member ID cards are distributed with this dental plan** - simply provide your dentist with your name, social security number, and that you are on the Delta Dental PPO plan. To find a dentist visit **deltadentalins.com/enrollees** or call **(866) 499-3001**.

	Delta PPO[1]		DeltaCare USA DHMO
	In-Network	**Out-Of-Network**	**In-Network**
Calendar Year Deductible **(waived for Diagnostic/Preventative and Orthodontics)**	$25 individual; $75 family		None
Annual Plan Maximum	**Delta Dental PPO dentists:** $2,500 per person each calendar year **Non-Delta Dental PPO dentists:** $2,000 per person each calendar year		Not applicable
Waiting Period(s)[2]: Basic, Major, Prosthodontics, or Orthodontics	None		Not applicable
Diagnostic & Preventive Services Exams Cleanings X-Rays	You pay 20%	You pay 20%	Copays vary by service; see contract for fee schedule
Basic Services Filings Posterior composite restorations and sealants Endodontics Periodontics Oral Surgery	You pay 20%	You pay 20%	Copays vary by service; see contract for fee schedule
Major Services Crowns Inlays/Onlays Restorations	You pay 50%	You pay 50%	Copays vary by service; see contract for fee schedule
Orthodontic Services Orthodontic Lifetime Maximum (adults and children)	You pay 50% $1,000	You pay 50% $1,000	Copays vary by service; see contract for fee schedule
Dental Accident Benefits	Plan pays 100%; separate $1,000 maximum per person each calendar year		Not applicable

[1] You can visit any licensed dentist, but your out-of-pocket costs may be higher if you choose a non-PPO dentist. Network dentists are paid contracted fees. You are responsible for any applicable deductibles, coinsurance, and amounts over plan maximums and charges for non-covered services. Reimbursement is based on PPO contracted fees for PPO dentists, Premier contracted fees for Premier dentists and program allowance for non-Delta Dental dentists.

[2] Limitations or waiting periods may apply for some benefits; some services may be excluded from your plan. Reimbursement is based on Delta Dental maximum contract allowances and not necessarily each dentist's submitted fees.

VSP Vision

VSP vision coverage for Blue Shield and Voluntary Supplemental Kaiser vision add-on coverage.

When you have an appointment, tell them you have VSP. There's **no ID card necessary.** If you'd like a card as a reference, you can print one on **www.vsp.com**. **To find a Provider** visit **www.vsp.com** or call **(800) 877-7195**.

Participating Retail Chains: Costco*, Cohen's, Visionworks and much more!

- A Costco membership is required to purchase eyewear (glasses and/or contacts) from Costco Optical
- A Costco membership is not required to receive an eye exam from a Costco optometrist

	VSP Provider Network: VSP Choice	
	In-Network Copayments	**Out-Of-Network[1] Reimbursements**
WellVision Exam	$25 copay for exam and glasses	Plan reimburses up to $45
Frequency	1 x every 12 months	In-network limitations apply
Lenses		
Single Vision Lens	Combined with exam	Plan reimburses up to $30
Bifocal Lens	Combined with exam	Plan reimburses up to $50
Trifocal Lens	Combined with exam	Plan reimburses up to $65
Progressive Lens	Combined with exam	Plan reimburses up to $81
Frequency	1 x every 12 months	In-network limitations apply
Frames[2]		
Benefit copay combined with exam	Plan pays up to $120 allowance Plan pays up to $140 allowance for Featured Frame Brands 20% savings on the amount over your allowance Plan pays up to $70 allowance for Costco frames	Plan reimburses up to $70
Frequency	1 x every 24 months	In-network limitations apply
Contacts[3] (Elective)		
Benefit (fitting & evaluation)	Plan pays up to $105 allowance, then 15% off any remaining balance	Plan reimburses up to $105
Frequency	1 x every 12 months	In-network limitations apply

[1] If you choose to, you may receive covered benefits outside of the VSP Choice network. Just pay in full at the time of service, obtain an itemized receipt, and file a claim for reimbursement of your out-of-network allowance. In-network benefits and discounts will not apply. **Out-of-Network Claim Forms** located online: **www.vsp.com**. Login to your account and access the ***Benefits & Claims*** section. You will be asked to upload your receipts or you may mail in receipts.

[2] You may select an eyeglass frame and receive an allowance toward the purchase price.

[3] In-lieu of frames.

Flexible Spending Account (FSA)

A Flexible Spending Account lets you set aside money—before it's taxed—through payroll deductions. The money can be used for eligible healthcare and dependent day care expenses you and your family expect to have over the next year. The main benefit of using an FSA is that you reduce your taxable income, which means you have more money to spend. And reimbursements from your FSA accounts are tax-free. The catch is that you have to use the money in your account by September 30, 2022. **You must re-enroll in this program each year**.

WEX Inc. (formerly Discovery Benefits) administers this program. Click here to watch FSA 101 video.

HEALTHCARE FSA

Eligible expenses include medical, dental, and vision costs including plan deductibles, copays, coinsurance amounts, and other non-covered healthcare costs for you and your tax dependents. **Your spouse or tax dependent children do not have to be covered on the Districts health plan.**

You may access your entire annual election from the first day of the plan year and you can set aside **up to $2,750 per year**.

Click here to search eligible expenses.

DEPENDENT CARE FSA

Eligible expenses may include daycare centers, in-home child care, and before or after school care for your dependent children under age 13. Other individuals may qualify if they are your tax dependent and are incapable of self-care. It is important to note that you can access money only after it is placed into your dependent care FSA account.

All caregivers must have a tax ID or Social Security number. This information must be included on your federal tax return. If you use the dependent care reimbursement account, the IRS will not allow you to claim a dependent care credit for reimbursed expenses. Consult your tax advisor to determine whether you should enroll in this plan. You can set aside **up to $5,000 per household** for eligible dependent care expenses for the year.

WEX Customer Support

P: (866) 451-3399
E: customerservice@discoverybenefits.com
W: www.wexinc.com

IMPORTANT CONSIDERATIONS

Expenses must be incurred between 10/01/21 and 9/30/2022.

Claims for the reimbursement of expenses incurred in any plan year shall be paid after claim has been filed. If a participant fails to submit a claim within 90 days after the end of the plan year, those expense claims will not be reimbursed. If a participant terminates employment during the plan year claims must be submitted within 30 days after termination of employment.

A participant in the Health FSA can keep (roll-over) up to $550 of unused money for use in the next plan year. Unused amounts are those remaining after expenses have been reimbursed during the runout period. Runout period is 90 days. Minimum annual rollover is $50 and a maximum of $550. Amounts in excess or below minimum rollover will be forfeited.

There's no "crossover" spending allowed between the healthcare and dependent care accounts.

Elections cannot be changed during the plan year, unless you have a qualified change in status (and the election change must be consistent with the event).

You cannot obtain reimbursement for eligible expenses for a domestic partner or their children, unless they qualify as your tax dependents (Important: questions about the tax status of your dependents should be addressed with your tax advisor).

Keep your receipts as proof that your expenses were eligible for IRS purposes.

Access your benefits anytime, anywhere.
Download the mobile app: Benefits By Discovery Benefits.

Life Insurance

If you have loved ones who depend on your income for support, having life and accidental death insurance can help protect your family's financial security and pay for large expenses such as housing and education, as well as day-to-day living expenses.

EMPLOYER PAID LIFE AND AD&D

Basic Life insurance pays your beneficiary a lump sum if you die. AD&D provides another layer of benefits to either you or your beneficiary if you suffer from loss of a limb, speech, sight, or hearing, or if you die in an accident. The cost of coverage is **paid in full by the District.** The District also provides dependent life insurance. Coverage is provided by Voya.

Life Amount	**$100,000**
AD&D Amount	**$100,000**

DEPENDENT LIFE

- Spouse or Domestic Partner $1,500 benefit amount
- Child (each)
    - From live birth but less than 6 months of age $500 benefit amount
    - 6 months but less than 26 years $1,500 benefit amount

IMPORTANT REMINDERS

Beneficiary: Make sure that you have named a beneficiary for your life insurance benefit. It's important to know that many states require that a spouse be named as the beneficiary, unless they sign a waiver.

Taxes: Due to IRS regulations, a life insurance benefit of $50,000 or more is considered a taxable benefit. You will see the value of the benefit included in your taxable income on your paycheck and W-2.

VOLUNTARY LIFE

Voluntary Life Insurance allows you to purchase additional life insurance to protect your family's financial security. Coverage is provided by Voya. Please contact Insurance Benefits for additional information.

Employee Voluntary Life Amount	
$10,000 up to $500,000 in increments of $10,000	
Spouse/Domestic Partner Voluntary Life Amount	
$10,000 up to $500,000 in increments of $10,000	
Child(ren) Voluntary Life Amount	
• From 14 days but less than 6 months of age	$1,000
• 6 months but less than 26 years	$2,500 up to $10,000 in increments of $2,500

IMPORTANT REMINDERS

Evidence of Insurability: Depending on the amount of voluntary life coverage you select, you may need to submit an Evidence of Insurability form, which involves providing the insurance company with additional information about your health.

Voluntary Life: if you purchase life insurance for a dependent and need to remove them from coverage due to a qualifying event, you must notify Insurance Benefits and complete a Change Request Form.

Getting Care When You Need It Now

The ER is not your only option! With many options for getting care, how do you choose? This chart can help you understand your options.

Where to go	What is it	What can be treated
Virtual Care	E-visits, telephone, and video visits are simple and secure ways to get care and save yourself an office visit.	• Cough, cold and flu • Sore throat • Eye conditions • Rash • Sinus problems • Urinary tract infection • Mental Health • And more…
Nurse Line	Speak directly to a registered nurse, 24/7 day or night who can help you with your health-related questions.	• Choosing appropriate medical care • Finding a doctor or hospital • Understanding treatment options • Achieving a healthier lifestyle • Answering medication questions
Your Doctor's Office	Go to a doctor's office when you need preventive or routine care. Your doctor can access your medical records, manage your medications and refer you to a specialist, if needed.	• Annual Physical • Checkups • Preventive services • Minor skin conditions • Vaccinations • General health management
Urgent Care (UC)	Urgent care is ideal for when you need care quickly, but it is not an emergency (and your doctor isn't available). Urgent care centers treat issues that aren't life threatening.	• Sprains • Strains • Minor burns • Minor infections • Minor broken bones • Cuts that may need a few stitches
Emergency Room (ER)	The ER is for serious life-threatening or very serious conditions that require immediate care. This is also when to call 911.	• Breathing difficulty • Chest pain • Heavy bleeding • Major broken bones • Major burns • Severe head injury • Spinal injuries • Sudden weakness or trouble talking

SISC Programs and Services

EMPLOYEE ASSISTANCE PROGRAM

There are times when everyone needs a little help or advice. The confidential Employee Assistance Program (EAP) through Anthem can help you with things like stress, anxiety, depression, chemical dependency, relationship issues, legal issues, parenting questions, financial counseling, and dependent care resources.

If you need counseling, you get up to 6 visits with a licensed professional and best of all, it's free.

Help is available 24/7, 365 days a year by telephone at (800) 999-7222.

Other resources are available online at www.anthemEAP.com; Company Code **SISC**.

The program is available to your family and household members.

MYSTRENGTH APP

My Strength is a smart phone application that provides free emotional health and wellness tools to all employees and household members. Members may download MyStrength to their smart phone and call EAP at 1-800-999-7222 for an assigned access code.

EXPERT MEDICAL OPINIONS

Previously Advance Medical, Teladoc Medical Experts provides medical second opinions from nationally recognized experts specializing in specific areas of need, with no required travel.

This service can also assist members with locating top, in-network doctors for in-person visits[1]. This program is sponsored by SISC and available at no cost to all eligible employees and covered dependents.

Getting started with Teladoc Medical Experts is completely confidential and only takes a few minutes.

To begin using this benefit, members must register online at www.teladoc.com/sisc/ or call Teladoc Medical Experts at (800) 835-2362.

[1] In-person visits/services will be subject to member's plan benefits.

SISC Blue Shield Programs

COSTCO GENERIC PRESCRIPTIONS

$0 co-pay for generic prescriptions. Costco membership is NOT required.

30 or 90-day supplies of most generics. Some narcotic pain and cough medications are not included in the Costco Free Generic or 90-day supply programs.

NAVITUS: SPECIALTY MEDICATIONS

Specialty medications are high-cost injectable, infused, oral, or inhaled medications that generally require special handling and may be subject to special rules such as quantity limits, prior authorization and/or step therapy. These medications have become a vital part of the treatment for chronic illnesses and complex diseases such as multiple sclerosis, rheumatoid arthritis and cancer. Some medications may involve special delivery and instructions that not all pharmacies can easily provide. These medications require personalized coordination between the member, the prescriber and pharmacy. Navitus Specialty helps patients stay on track with treatment while offering the highest standard of compassionate care through personalized support, free delivery and refill reminders. Most medications classified as Specialty can be found on the SISC Drug List located on Navitus' secure member website Navi-Gate for Members at www.navitus.com.

MDLIVE - TELEHEALTH

Consult with doctors and pediatricians over the phone or using online video for medical conditions such as cold, fever, sore throat, flu, infection, rash, and children's health issues. Physicians can prescribe medication when appropriate. Online behavioral health visits are also available.

To register or to learn more go to www.mdlive.com/sisc.

HINGE HEALTH

PPO members have access to Hinge Health at no cost to you. The program provides personalized, interactive physical therapy using the latest technology to help members conquer back, knee, or hip pain without drugs or surgery. Best of all, it can be done at home.

Eligible members receive wearable sensors and a monitoring device to guide you through virtual therapy sessions. You also receive unlimited access to a personal health coach, exercises, and educational articles on your condition and treatment options.

Click on the demo video to learn how it works: Back Demo Video

Visit hingehealth.com/sisc to learn more or call (855) 902-2777.

CARRUM HEALTH PROGRAM

PPO members can receive inpatient surgical procedures with no cost sharing (deductible applies for HSA members) at Scripps Hospital in San Diego.

Covered procedures:

- Total hip replacement
- Total knee replacement
- Cervical spinal fusion
- Lumbar spinal fusion
- Anterior/Posterior Spinal Fusion
- Discectomy/Spinal Decompression

For videos and resources, visit www.carrumhealth.com/sisc.

ENHANCED CANCER BENEFIT

Oncology Center of Excellence Program

PPO members can consult experts who can help you navigate the complex world of cancer treatment. Services include assistance in receiving an accurate initial diagnosis and developing a comprehensive care plan. Also covers care coordination services with a home provider, transportation benefits and more. To learn more go to sisc.hdplus.com or call (877) 220-3556.

SISC Blue Shield Programs

VIDA HEALTH

Digital Health Coaching App

Get one-on-one health coaching, therapy, digital programs and other tools and resources via online or mobile access. This program helps you prevent, manage or reverse conditions such as pre-diabetes, diabetes, hypertension, obesity, depression, anxiety, etc. To learn more go to vida.com/SISC or call (855) 442-5885.

CONDITION MANAGEMENT

Condition management is a confidential, voluntary program designed to help people with specific conditions stay as healthy as possible for as long as possible. Health management nurses work over the telephone with PPO plan participants who are living with one of the following conditions:

- Diabetes
- Coronary artery disease (CAD)

Please visit the Health Smarts web page at www.sischealth.com for additional information.

VALUE-BASED SITE OF CARE BENEFIT

PPO plans limit the maximum benefit amount at an in-network outpatient hospital facility for the following **five** procedures:

- Arthroscopy
- Cataract Surgery
- Colonoscopy
- Upper GI Endoscopy with Biopsy
- Upper GI Endoscopy without Biopsy

NOTE: The value-based site of care benefit applies to facility fees only. The fees paid to physicians and any other practitioners who assist in the procedure, such as anesthesiologists or radiologists, are not affected.

If you use an in-network outpatient hospital facility, you will be responsible for the regular deductible and coinsurance **PLUS** any amount by which the hospital charge exceeds the maximum benefit. This provision can be waived if your doctor receives advance certification from Blue Shield that you need to be in an outpatient hospital setting. The benefit includes a simple process to exempt the member if the physician provides clinical justification for using a hospital.

It also allows exceptions when:

- a member lives more than 30 miles from an ASC and a hospital that offers the service for less than the maximum benefit; or
- if a procedure cannot be scheduled in a medically appropriate timely manner due to available ASCs not having capacity.

If you use an in-network ASC, then there is no benefit change! You will only be responsible for the regular deductible and coinsurance. ASCs deliver the same quality of care as in an outpatient hospital setting at a lower price point due to a more efficient operating structure. Most physicians have privileges at both hospitals and ASCs. If you need one of the outpatient procedures on the list shown above, it will be up to you to either request treatment at the in-network ASC or have your doctor obtain an advance certification from Blue Shield.

If you have questions call member services.

Blue Shield Member Programs

DIABETES PREVENTION PROGRAM

Did you know that one in three people are at risk for developing type 2 diabetes? With the Diabetes Prevention Program, you can learn more about wellness, make changes to start losing weight and reduce your risk of developing type 2 diabetes.

Programs you can select may include:

- Weight Watchers
- Healthslate®
- Jenny Craig
- Noom®
- Retrofit℠
- Skinny Gene Project
- And more

Start the journey to a healthier you with a one-minute quiz. Visit www.solera4me.com/shield.

WELLVOLUTION – available to all Blue Shield members 18 and over.

Wellvolution is a health platform that gives you the tools you need to achieve your health goals.

Create a profile – Tell Wellvolution about your health goals. The information you give will help find the programs that are right for you.

Pick your program – Get recommended programs based on your health profile and decide which to try out.

Get a healthier you – Make healthier choices with your diet, exercise, sleep, and overall health.

Visit wellvolution.com to see all available programs and to get started!

Visit mywellvolution.com to get started!

PRENATAL PROGRAM

Blue Shield of California's Prenatal Program guides expectant parents from the first trimester to postnatal care and offers practical advice and useful information.

Enrolling in the program is simple. For more information, just call (877) 371-1511.

WELLNESS DISCOUNT PROGRAMS

Get help saving money and living healthier with a wide range of discount programs* including fitness club memberships; acupuncture, chiropractic services and massage therapy; eye exams, frames and contact lenses; and LASIK surgery. To learn more visit www.blueshieldca.com/wellnessdiscounts.

AWAY FROM HOME CARE PROGRAM

The Away From Home Care® program gives HMO members who are students, long-term travelers, workers on extended out-of-state assignments, and families living apart the convenience and flexibility of coverage for extended periods across the country. To learn more about Away From Home Care and whether your family is eligible, please call Blue Shield Member Services. Please note that Away From Home Care is not available in all areas and states, and benefits from the host plan may differ from the benefits in the Access+ HMO plan.

BLUE CARD OUT OF STATE

Provides you and your eligible family access to covered services, including urgent and emergency care, while you are traveling or working outside of California.

Phone: (800) 810-BLUE (2583)
Hours: 24/7

Key Terms

Health insurance seems to have its own language. You will get more out of your plans if understand the most common terms, explained below in plain English.

MEDICAL

OUT-OF-POCKET COST - A healthcare expense you are responsible for paying with your own money, whether from your bank account, credit card, or from a health account such as an HSA, FSA or HRA.

DEDUCTIBLE - The amount of healthcare expenses you have to pay for with your own money before your health plan will pay. The deductible does not apply to preventive care and certain other services.

COINSURANCE - After you meet the deductible amount, you and your health plan share the cost of covered expenses. Coinsurance is always a percentage totaling 100%. For example, if the plan pays 70% coinsurance, you are responsible for paying your coinsurance share, 30% of the cost.

COPAY - A set fee you pay whenever you use a particular healthcare service, for example, when you see your doctor or fill a prescription. After you pay the copay amount, your health plan pays the rest of the bill for that service.

IN-NETWORK / OUT-OF-NETWORK - Network providers (doctors, hospitals, labs, etc.) are contracted with your health plan and have agreed to charge lower fees to plan members, as negotiated in their contract with the health plan. Services from out-of-network providers can cost you more because the providers are under no obligation to limit their maximum fees. With some plans, such as HMOs and EPOs, services from out-of-network providers are not covered at all.

OUT-OF-POCKET MAXIMUM - The most you would pay from your own money for covered healthcare expenses in one year. Once you reach your plan's out-of-pocket maximum dollar amount (by paying your deductible, coinsurance and copays), the plan pays for all eligible expenses for the rest of the plan year.

PRESCRIPTION DRUG

BRAND NAME - A drug sold under its trademarked name. For example, Lipitor is the brand name of a common cholesterol medicine. You generally pay a higher copay for brand name drugs.

GENERIC DRUG - A drug that has the same active ingredients as a brand name drug, but is sold under a different name. For example, Atorvastatin is the generic name for medicines with the same formula as Lipitor. You generally pay a lower copay for generic drugs.

PREFERRED DRUG - Each health plan has a list of prescription medicines that are preferred based on an evaluation of effectiveness and cost. Another name for this list is a "formulary." The plan may charge more for non-preferred drugs or for brand name drugs that have generic versions. Drugs that are not on the preferred drug list may not be covered.

DENTAL

BASIC SERVICES - Dental services such as fillings, routine extractions and some oral surgery procedures.

DIAGNOSTIC AND PREVENTIVE SERVICES - Generally include routine cleanings, oral exams, x-rays, and fluoride treatments. Most plans limit preventive exams and cleanings to two times a year.

MAJOR SERVICES - Complex or restorative dental work such as crowns, bridges, dentures, inlays and onlays.

Important Plan Notices and Documents

HEALTH PLAN NOTICES

Notices must be provided to plan participants on an annual basis. Notices available in this booklet include:

- **HIPAA Notice of Special Enrollment Rights**
  Describes when you can enroll yourself and/or dependents in health coverage outside of open enrollment.
- **Women's Health and Cancer Rights Act**
  Describes benefits available to those that will or have undergone a mastectomy.
- **Newborns' and Mothers' Health Protection Act**
  Describes the rights of mother and newborn to stay in the hospital 48-96 hours after delivery.
- **Notice of Choice of Providers**
  Notifies you about the plan's requirement that you name a Primary Care Physician (PCP).
- **Medicare Part D Notice**
  Describes options to access prescription drug coverage for Medicare eligible individuals.

COBRA CONTINUATION COVERAGE

You and/or your dependents may have the right to continue coverage after you lose eligibility under the terms of our health plan. Upon enrollment, you and your dependents receive a COBRA Initial Notice that outlines the circumstances under which continued coverage is available and your obligations to notify the plan when you or your dependents experience a qualifying event. Please review this Notice carefully to make sure you understand your rights and obligations.

PLAN DOCUMENTS

Summary of Benefits and Coverage (SBC)

A Summary of Benefits and Coverage (SBC) is a document required by the Affordable Care Act (ACA) that presents benefit plan features in a standardized format. The following SBCs are available by contacting Insurance Benefits:

- Kaiser HMO
- Blue Shield of California Trio HMO
- Blue Shield of California 10 HMO
- Blue Shield of California 30 HMO
- Blue Shield of California PPO
- Blue Shield of California HDHP HSA
- Blue Shield of California Anchor Bronze

Summary Plan Description (SPD)

A Summary Plan Description, or SPD, is the legal document for describing benefits provided under the plan as well as plan rights and obligations to participants and beneficiaries.

Paper copies of these documents and notices are available if requested. If you would like a paper copy, please contact Insurance Benefits.

Statement of Material Modifications

This enrollment guide constitutes a Summary of Material Modifications (SMM) to the Fullerton School District Group Health Plan. It is meant to supplement and/or replace certain information in the SPD, so retain it for future reference along with your SPD. Please share these materials with your covered family members.

Required Federal Notices

Availability of Privacy Practices Notice

We maintain the HIPAA Notice of Privacy Practices for Fullerton School District describing how health information about you may be used and disclosed. You may obtain a copy of the Notice of Privacy Practices by contacting Insurance Benefits.

HIPAA Notice of Special Enrollment Rights

If you decline enrollment in Fullerton School District health plan for you or your dependents (including your spouse) because of other health insurance or group health plan coverage, you or your dependents may be able to enroll in Fullerton School District health plan without waiting for the next open enrollment period if you:

- Lose other health insurance or group health plan coverage. You must request enrollment within 30 days after the loss of other coverage.
- Gain a new dependent as a result of marriage, birth, adoption, or placement for adoption. You must request health plan enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.
- Lose Medicaid or Children's Health Insurance Program (CHIP) coverage because you are no longer eligible. You must request medical plan enrollment within 60 days after the loss of such coverage.

If you request a change due to a special enrollment event within the 30 day timeframe, coverage will be effective the date of birth, adoption or placement for adoption. For all other events, coverage will be effective the first of the month following your request for enrollment. In addition, you may enroll in Fullerton School District health plan if you become eligible for a state premium assistance program under Medicaid or CHIP. You must request enrollment within 60 days after you gain eligibility for medical plan coverage. If you request this change, coverage will be effective the first of the month following your request for enrollment. Specific restrictions may apply, depending on federal and state law.

Note: If your dependent becomes eligible for a special enrollment right, you may add the dependent to your current coverage or change to another health plan when options are available. Any other currently covered dependents may also switch to the new plan in which you enroll.

Women's Health and Cancer Rights Act

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

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Please see the plan benefit summary for copays, deductibles and coinsurance information. If you would like more information on WHCRA benefits, call your plan's Member Services.

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, call your plan's Member Services.

Availability of Summary Information

As an employee, the health benefits provided by Fullerton School District represent a significant component of your compensation package. They also provide important protection for you and your family in the case of illness or injury.

Fullerton School District offers a variety of benefit plans to eligible employees. The federal health care reform law requires that eligible members of an employer plan receive a Summary of Benefits and Coverage (SBC) for any medical and pharmacy plans available. The SBC is intended to provide important plan information to individuals, such as common benefit scenarios and definitions for frequently used terms. The SBC is intended to serve as an easy-to-read, informative summary of benefits available under a plan. SBCs and any revisions or amendments of the plans offered by Fullerton School District are available by contacting Insurance Benefits.

Notice of Choice of Providers

Blue Shield HMO plans 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, Blue Shield designates one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, call your plan's Member Services or visit www.blueshieldca.com/sisc.

For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from Blue Shield 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 Blue Shield's Member Services at (855) 256-9404 or visit www.blueshieldca.com/sisc.

Medicare Part D Notice

Important Notice from Fullerton School District About Your Prescription Drug Coverage and 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 Fullerton 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. Fullerton School District has determined that the prescription drug coverage offered by the Kaiser and Blue Shield medical plans are, 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 Fullerton School District coverage will be affected. See below for more information about what happens to your current coverage if you join a Medicare drug plan. **Important Note for Retiree Plans:** If you are eligible for the District's Retiree Medical Program, when a subscriber and spouse/domestic partner are both age 65 or older and retired, and are remaining on a SISC plan, they will automatically be enrolled in Medicare Part D. Do not enroll in a Medicare Part D plan outside of SISC. This will automatically disenroll you from your SISC Medicare Part D plan.

Since the existing prescription drug coverage under Fullerton School District is creditable (e.g., as good as Medicare coverage), you can retain your existing prescription drug coverage and choose not to enroll in a Part D plan; or you can enroll in a Part D plan as a supplement to, or in lieu of, your existing prescription drug coverage.

If you do decide to join a Medicare drug plan and drop your Fullerton School District prescription drug coverage, be aware that you and your dependents can only get this coverage back at open enrollment or if you experience an event that gives rise to a HIPAA Special Enrollment Right.

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 Fullerton 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 below 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 Fullerton 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 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 800-MEDICARE (800-633-4227). TTY users should call 877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at socialsecurity.gov, or call them at 800-772-1213 (TTY 800-325-0778).

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

Date:	October 1, 2021
Name of Entity/Sender:	Fullerton School District
Contact-Position/Office:	Insurance Benefits, (714) 447-2843
Address:	1401 W. Valencia Drive, Fullerton, CA 92833

CMS Form 10182-CC Updated April 1, 2011 According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0990. The time required to complete this information collection is estimated to average 8 hours per response initially, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

For Benefits Assistance

Provider	Plan	Phone Number	Website
Kaiser	HMO	(800) 464-4000	my.kp.org/sisc
Blue Shield	HMO	(855) 256-9404	www.blueshieldca.com/sisc
Blue Shield	PPO and HDHP	(855) 599-2657	www.blueshieldca.com/sisc
Blue Shield	MDLive	(800) 657-6169	www.mdlive.com/sisc
Teladoc Medical Experts	Expert Second Opinion Program	(808) 835-2362	http://www.teladoc.com/sisc/
Navitus	Blue Shield Pharmacy Benefits	(866) 333-2757	https://www.navitus.com
Costco	Blue Shield Pharmacy Benefits	(800) 607-6861	www.costco.com/Pharmacy
DeltaCare USA	Dental HMO	(800) 422-4234	www.deltadentalins.com
Delta Dental	Dental PPO	(866) 499-3001	www.deltadentalins.com
VSP	Vision	(800) 877-7195	www.vsp.com
Sterling Administration	Health Savings Account	(800) 617-4729	www.sterlingadministration.com
WEX Inc.	Flexible Spending Accounts	(866) 451-3399	www.wexinc.com
Voya/Reliastar	Life Insurance	(800) 955-7736	www.voya.com
Voya	Accident Insurance	(888) 238-4840	www.voya.com
Anthem	Employee Assistance Program	(800) 999-7222	www.anthemeap.com
Insurance Benefits			
Andrea Lopez	Benefits Coordinator	(714) 447-2834	Andrea_Lopez@myfsd.org
Jenny Morgan	Benefits Technician	(714) 447-7420	Jenny_Morgan@myfsd.org
Disability Insurance Please note benefit is not offered through the District nor is it affiliated with the District. Vendors listed below are Union preferred vendors.			
CSEA Preferred Vendor	American Fidelity	(800) 365-9180	americanfidelity.com
FETA Preferred Vendor	The Standard	(800) 522-0406	www.standard.com
FESMA Preferred Vendor	American Fidelity	(800) 365-9180	americanfidelity.com

Employee Benefits Booklet designed and developed by
Alliant EMPLOYEE BENEFITS
in conjunction with Fullerton School District.
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