



# Chandler Unified Benefits Guide

2012-2013



## About the Valley Schools Employee Benefits Trust

The Valley Schools Employee Benefits Trust (VSEBT) provides health, dental, life, vision, COBRA and other employee benefits to its members. VSEBT purchases these benefits as a group, but offers member Districts the flexibility to provide different benefits to their employees. Member entities (e.g., school districts) pay their premiums to VSEBT and then VSEBT pays our benefit vendors.

VSEBT is managed by the Valley Schools Management Group (VSMG), a non-profit, governmental entity formed in accordance with Arizona Revised Statutes Title 11, Sections 951, 952, 952.01, and 953 and in accordance with Arizona Department of Education Rule R7-2-1002A. VSMG exists to serve government entities wishing to purchase services on a cooperative basis. Underneath the VSMG umbrella are several pools and trusts, for a variety of needs such as workers' compensation, liability insurance, and employee benefits. VSMG acts as procurement, administration, accounting, and investor for our member governments.

By joining VSEBT, your District is able to get better rates and services offered than it may be able to negotiate on its own. The key advantage is size. The bigger an organization is, the more concessions our insurance vendors will make.

VSEBT employs full-time staff to follow up on management review and medical utilization information. We have a dedicated nursing team, and professional financial and program staff. In addition, we offer a wide array of wellness programs and other specialized services to member districts.

The bottom line: We work for you.

We are a non-profit government instrumentality and only exist to save our member districts money, provide them with excellent services, and help you – our member district's employees.

# ENROLLMENT ELIGIBILITY

This Benefits Guide describes your benefit options and their costs for 2012/13. It also outlines the steps you need to take to select and enroll in the appropriate coverage. Review the Guide carefully and feel free to contact your benefits representative if you have questions.

The benefits described in this booklet are effective from July 1, 2012 through June 30, 2013.

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## Who is Eligible?

Employees are eligible to participate in the District's benefit plans as of the first of the month after 60 days of active employment at 30 or more hours per week or on contract at 75% or more. As a special exception, Job Share partners receive half of the District contribution towards their elected medical plan. Employees who work 20 hours or more are eligible for voluntary benefits.

Benefit eligible employees can also extend medical, voluntary dental, voluntary vision, long term care insurance and voluntary life insurance coverage, to their eligible dependents. Eligible dependents are generally defined as:

- Your legal spouse
- Your or your spouse's dependent child(ren) under age 26.  
A dependent child includes your:
  - Natural child
  - Stepchild
  - Legally adopted child
  - Child placed for adoption
  - Child for whom you have legal guardianship
  - Child for whom health care coverage is required through a 'Qualified Medical Child Support Order'
  - Unmarried child of any age with a mental retardation or physical handicap who is incapable of self-sustaining employment as a result of that handicap. However, to be eligible for coverage, your child must have been covered by the District's or another medical insurance plan at the time he or she became disabled. Proof of the child's disability is required.
  - If you have questions, contact the Benefits Department to verify your dependents' eligibility. You may be asked to provide proof in support of your dependents' eligibility.

## When Are Changes Allowed?

Benefit plans are administered on a "policy year basis" – from July 1 through June 30 of each year. Thus, the elections you make during annual Open Enrollment are effective from July 1, 2012 through June 30, 2013.

Because some of the benefits you elect are offered on a pre-tax basis, the Internal Revenue Service (IRS) does not allow changes to these benefit elections outside of the annual Open Enrollment period unless you have a qualified mid-year "change in status event," such as:

- An employee's marriage or divorce
- The birth or adoption of an employee's child
- The death of an employee's spouse or child
- Change in the employee/spouse/dependent's employment status, work schedule or residence that affects their eligibility for benefit coverage
- Coverage of a child due to a Qualified Medical Child Support Order (QMSCO)
- Entitlement or loss of entitlement to Medicare or Medicaid
- Certain changes in the cost of coverage, composition of coverage or curtailment of coverage of the employee or spouse's plan
- Changes consistent with Special Enrollment rights and FMLA leaves

You need to notify your benefits representative within 31 days of a qualified life status change to request corresponding changes to your benefits.

## When Are Changes Allowed? (Continued)

### Changes Allowed under the Children's Health Insurance Program Reauthorization Act of 2009

Effective April 1, 2009, the Children's Health Insurance Program Reauthorization Act of 2009 creates a new special enrollment period that applies to group health plans, similar to those currently in effect for the loss of eligibility for other group coverage or qualifying life status changes.

Under this Act, group health plans must permit employees and dependents who are eligible for group health plan coverage to enroll in the plan if they:

- Lose eligibility for Medicaid or SCHIP coverage, OR
- Become eligible to participate in a premium assistance program under Medicaid or SCHIP

In both cases, you must request special enrollment within 60 days (of the loss of Medicaid/SCHIP or of the eligibility determination), or wait until the plan's next annual enrollment period to make a change.

Contact your benefits coordinator if you have questions.

## WHAT'S NEW FOR 2012/13

Open Enrollment is your opportunity to change your benefit elections, it is also the District's opportunity to introduce changes to our benefit programs. As of July 1, 2012, the following changes take effect:

### Dental Coverage

Dental will be offered as a voluntary benefit only.

- **Core Plan & Premier Premium Plan**
  - Check Up Plus - Deductible is waived for routine preventative services and annual preventative exams will be covered at 100%. The cost of your routine preventive services will *not* apply to your annual calendar year maximum limit.

### Choice Plus PPO Plan

- The plan year deductible remains at \$1,000 for individual and \$2,000 for family.
- Specialist co-pay has increased from \$35 to \$50.
- Emergency Room co-pay has increased from \$100 to \$500.

### High Deductible Health Plans (Formerly HSA Plans)

Employees who begin or continue coverage in 2012/13 will receive two deposits a year. The first deposit will be made in August and the second in January.

#### **The HSA 1400 plan is now HDHP 1500 plan.**

- The plan year deductible is \$1,500 for an individual and \$3,000 for family.

#### **The HSA 2600 plan is now HDHP 2700 plan.**

- The plan year deductible is \$2,700 for an individual and \$5,400 for family.
- The HDHP 2700 Plan includes an embedded deductible. "Embedded" means individual deductibles are active within the larger, overall family deductible and can determine when coverage begins. Some services, such as preventative care, could be covered by plan benefits prior to the individual or family deductible being reached. When a family member on the plan meets his or her individual deductible, plan benefits and coinsurance will apply to his or her claims. If the family deductible amount is met before a member reaches his or her individual deductible, benefits and coinsurance will also apply but will do so for the entire family. Embedded deductible applies to the 2700 plan only.

# AN OVERVIEW OF YOUR BENEFITS

## Annual Benefit Contribution

Your District provides an annual benefit contribution, which eligible employees use to offset their benefits costs each year. The 2012/13 contribution amount for eligible Chandler Unified School District employees is \$4,622.00.

## Medical — UnitedHealthcare Group Number 709724

You may choose from the following two different types of medical plans provided through UnitedHealthcare:

*Your medical plan options are described in more detail on the following pages. The medical plan premiums are listed on page 16.*

### Choice Plus UHC PPO Plan

### High Deductible Health Plans (HDHPs)

With the Choice Plus UHC PPO plan, you have the choice of receiving care from a UnitedHealthcare network provider or an out-of-network provider.

You receive a higher level of coverage (meaning, the plan pays a larger portion of the cost for the service) when you visit a UnitedHealthcare network provider than when you visit an out-of-network provider.

The District offers two HDHP plan options: the HDHP-1500 plan or the HDHP-2700 plan. The HDHP plans combine a high-deductible PPO plan with a tax-advantaged health savings account that helps you pay for eligible medical expenses.

You may visit any provider; however, you receive a higher level of coverage when you visit UnitedHealthcare network provider. In-network preventive care is covered at 100%.

## The Choice Plus UHC PPO Medical Plan

When you enroll in the Choice Plus UHC PPO plan you may visit any provider, including a specialist, without a referral. You can expect the highest level of benefits when you use a UnitedHealthcare network provider versus an out-of-network provider.

### Plan Year Deductible and Copayments

You pay a set copayment for some in-network services, such as doctor's office visits (\$25 per visit), and specialist's visits (\$50 per visit). No copay for preventative care visits. Your copayments do not count toward satisfaction of the plan year deductible.

You also pay for most services covered through "coinsurance" in full, until meeting the plan year deductible. The plan year deductible for in-network services is \$1,000 per individual and \$2,000 per family. For out-of-network services, the deductible is \$2,000 per individual and \$4,000 per family.

### Plan Benefits Coverage (Coinsurance)

Once you meet the deductible, the plan's coinsurance benefits kick in. Coinsurance is the percentage of eligible expenses that you and the plan share when you receive care.

The plan pays 80% and you pay 20% for in-network services subject to coinsurance. When you seek care out-of-network, UnitedHealthcare pays 50% of eligible expenses and you pay the balance.

You are responsible for your share of coinsurance until reaching the plan year "out-of-pocket maximum."

### Plan Year Out-of-Pocket Maximum

The plan year out-of-pocket maximum is the most you will pay for services covered through coinsurance during the plan year. When you reach the maximum, the plan pays 100% for eligible coinsurance expenses.

The out-of-pocket maximum for in-network services is \$2,000 per individual and \$4,000 per family. It's \$6,000 per individual and \$12,000 per family for out-of-network services.

The out-of-pocket maximum does not include the amounts you pay for copayments or your deductible. In addition, your share of coinsurance for out-of-network services in excess of UnitedHealthcare's allowable charges for a service does not count toward the out-of-pocket maximum. When you seek out-of-network care, be sure to discuss your possible share of the costs with your non-network provider and UnitedHealthcare before you receive care.

### Choice Plus UHC PPO Prescription Drug Coverage

Under the Choice Plus UHC PPO plan, you may fill your prescriptions through any pharmacy. However, you'll pay less out of your pocket when you use a participating retail pharmacy or the Medco Health home delivery network (available online through [www.myuhc.com](http://www.myuhc.com)).

Prescription drugs are covered under a "three-tier" schedule. A list of drugs found within each "tier" is available through the UnitedHealthcare Web site – [www.myuhc.com](http://www.myuhc.com). You must meet the plan's \$100 prescription drug deductible per person per plan year, not to exceed \$300 for all covered persons in family before coverage is provided.

### Free Advice - Care24

#### Available with Choice Plus and HDHP Plans

When you enroll in one of the District's medical plans, you will have access to UnitedHealthcare's 24-hour referral service, called "Care24." Care24 is staffed with registered nurses and master's level counselors who can help with almost any problem ranging from medical and family matters to personal, legal, financial, and emotional issues.

Care24 is confidential and provided at no additional cost to medical plan participants (employees and dependents). Call 1-888-887-4114 to access Care24.

To find a UnitedHealthcare network doctor, pharmacy, or facility (such as a hospital), refer to the online provider directory, available through [www.myuhc.com](http://www.myuhc.com), and follow the directions to locate a provider either by geography or name.

You do not need to be a registered member to access the provider directory.



# The High Deductible Health Plans with Health Savings Account

The HDHP options combine a high-deductible preferred provider plan with a tax-advantaged account that helps you pay for eligible medical expenses. The District pays for the cost of the employee's premiums and in addition, contributes funds to your HSA.

You can choose from two HDHP plan options provided through UnitedHealthcare:

- The HDHP-1500 plan
- The HDHP-2700 plan

Under either plan, you can see any doctor you want. However, you will pay less if you use a UnitedHealthcare network provider.

When you enroll in one of the HDHP plans, the District sets up and funds a Health Savings Account on your behalf.\* Each year, you can elect to contribute to your HSA until the total contributions – yours and the District's – equal the annual IRS maximum contribution. Employees who begin or continue coverage in 2012/13 will receive two equal deposits a year. The first deposit will be made in August, the second in January. If you choose to make voluntary contributions, they are deducted from your pay in equal increments throughout the year. The maximum HSA contribution for 2012 is \$3,100 for individual coverage and \$6,250 for family coverage. Employees age 55 and over are also eligible to make an additional "catch-up" contribution to their own HSA account. The amount allowed by the IRS in the 2012 tax year is \$1,000.

An HSA is similar to a regular checking account with a debit card – as long as a balance is available, you can use your HSA funds to pay for eligible healthcare expenses, including your deductible. Any remaining balance in your HSA at the plan year's end, rolls over for use in future years. Plus, you accumulate tax-free interest on your HSA funds, so you can use your account to save for care you may need in the future. **Standard fees may apply based upon your account choice and balance.**

Finally, your HSA is portable. If you leave the District or switch medical plans, you can use your funds for qualified healthcare expenses.

Your HSA account is provided through OptumHealth Bank.

## Plan Year Deductible

You must meet the plan year deductible before the plan pays most benefits. You can use your HSA funds to pay for qualified medical expense, including those incurred while meeting your deductible. Note: The HDHP plan covers most in-network preventive care services at 100%, no deductible. "Embedded" means individual deductibles are active within the larger, overall family deductible and can determine when coverage begins. Some services, such as preventative care, could be covered by plan benefits prior to the individual or family deductible being reached. When a family member on the plan meets his or her individual deductible, plan benefits and coinsurance will apply to his or her claims. If the family deductible amount is met before a member reaches his or her individual deductible, benefits and coinsurance will also apply but will do so for the entire family. Embedded deductible applies to the HDHP 2700 plan only.

## Plan Benefits Coverage (Coinsurance)

After meeting the plan year deductible, the plan pays coinsurance. The plans pay 80% and you pay 20% for most in-network charges. Out-of-network, UnitedHealthcare pays 50% of eligible expenses, then you pay the balance.

## Plan Year Out-of-Pocket Maximum

The out-of-pocket maximum is the most you will pay for eligible expenses, including prescription drugs, during the plan year. After reaching the maximum, the plan pays 100% for eligible expenses. In-network and out-of-network maximums accumulate separately. In addition, if you enroll in family coverage, the family out-of-pocket maximum applies. The IRS defines family coverage as individual plus one other person.

The amount you pay to satisfy your plan year deductible is included in the out-of-pocket maximum. However, your share of coinsurance for out-of-network services in excess of UnitedHealthcare's allowable charges does not count toward the out-of-pocket maximum.

## HDHP Plan Prescription Drug Coverage

Under an HDHP plan, you may fill your prescriptions through any pharmacy. However, you'll pay less when you use a participating retail pharmacy or the Medco Health home delivery network (available online through [www.myuhc.com](http://www.myuhc.com)).

You pay the cost for prescription drugs until meeting the plan year deductible. Then, you will pay copayments for your drugs under a "three-tier" schedule. A list of drugs found within each "tier" is available through the UnitedHealthcare Web site – [www.myuhc.com](http://www.myuhc.com).

## Preventive Drug Coverage

- "Preventive medications" are not subject to the plan year deductible under the HDHP plans – only the appropriate copayment will apply. The following categories of drugs are included:
- Anti-estrogens (breast cancer prevention)
- Anti-coagulants (heart attack and stroke prevention)
- Anti-platelets (stroke prevention)
- Lipid/cholesterol lowering agents (heart attack and heart disease prevention)
- Vitamins and hemantics
- Antihypertensives (blood pressure)

Specific drugs included in the categories above fall into a specific tier of coverage (i.e., tier 1, tier 2, or tier 3); you pay the applicable copayment. (Note: Copayments for prescription drugs do not count toward your annual deductible.)

A detailed and current list of the preventive drugs covered is available through the District's Web site.

## Contributing to the Medical Expense Reimbursement Accounts (Flexible Spending Account)

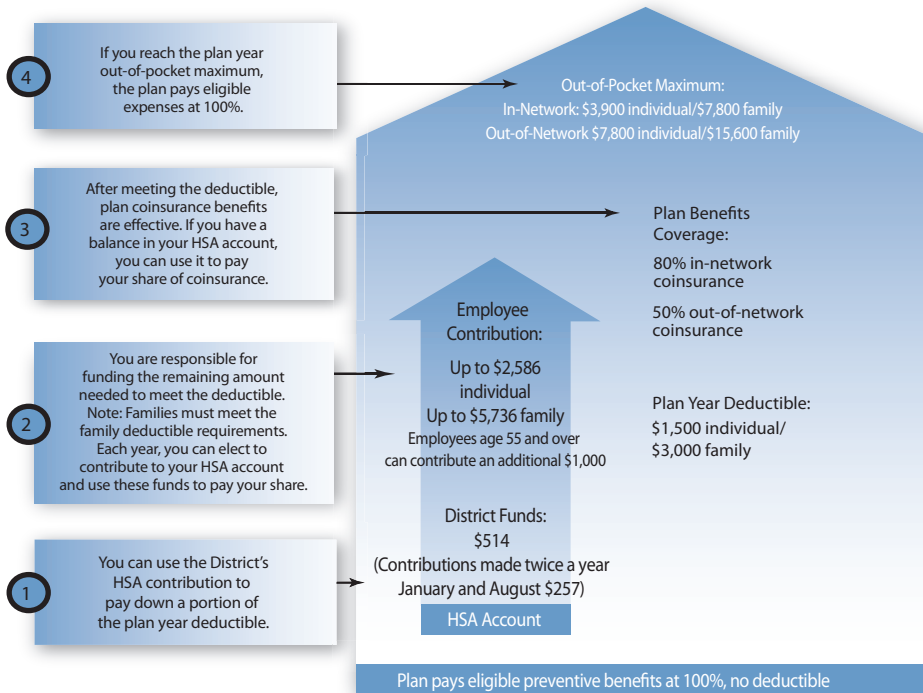
If you enroll in an HDHP plan and wish to contribute to the District's Medical Expense Reimbursement Account (FSA), special rules apply. You can only use your Medical Expense Reimbursement Account to reimburse yourself for your eligible dental and vision expenses. See page 12 for more information.

\* Medicare eligible employees can elect the High Deductible Health Plan but CANNOT contribute to a health savings account due to IRS regulations.

# High Deductible Health Plan Specifics

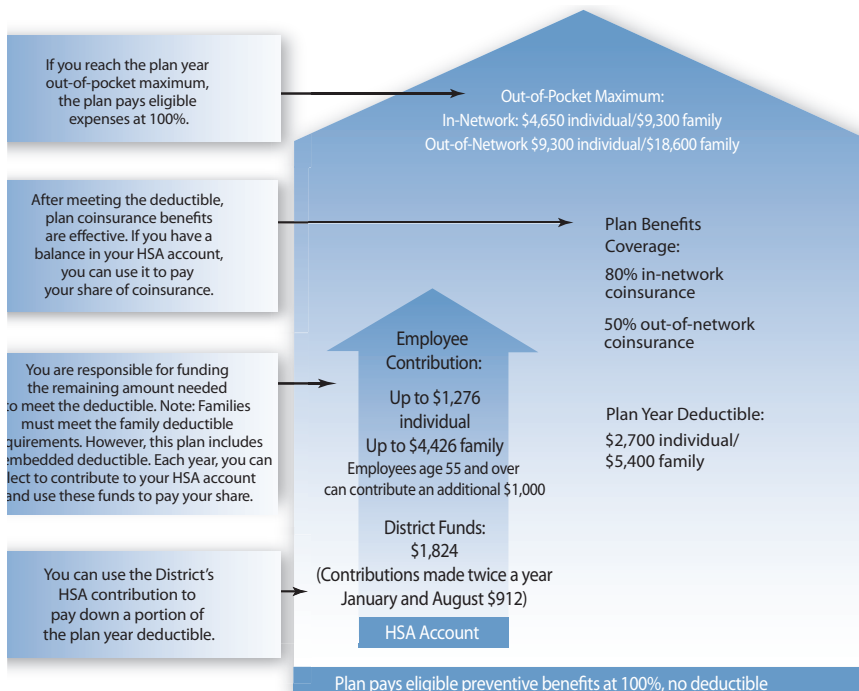
If an HDHP sounds right for your situation, you will need to decide which plan to enroll in – the HDHP–1500 plan or the HDHP–2700 plan. The plans share several similar features. However, there are a few significant differences between the plans, including the contribution the District makes to your HSA and the plan year deductibles and out-of-pocket maximums.

## HDHP – 1500 Plan



"Family" coverage includes an employee plus one or more dependent(s).  
If you elect Spousal Share Family Coverage, you may contribute up to \$5,222 to your HSA.

## HDHP – 2700 Plan



"Family" coverage includes an employee plus one or more dependent(s).  
If you elect Spousal Share Family Coverage, you may contribute up to \$2,602 to your HSA.

## Who Can Participate in a High Deductible Health Plan with an HSA?

You can participate in a high deductible health plan and contribute money to a health savings account, if you:

- Do not have coverage under any non-high deductible health plan (*less than a 1200 individual or 2400 family deductible*) that provides benefits covered by the high deductible health plan unless it is exclusively preventive care, or is "permitted coverage" or "permitted insurance" (as defined by federal regulations)
- Are not enrolled in Medicare
- Cannot be claimed as a dependent on someone else's tax return (except for your spouse)

### Special Note:

Individuals enrolled in Medicare and employees covered under another non-high deductible health plan may elect to enroll in a high deductible health plan (HDHP), however, they can not contribute or accept employer contributions in a Health Savings Account (HSA). If you elect to participate in the high deductible plan through the district, this plan will become your primary health insurance coverage.

## Comparison of Medical Benefits

Following is a comparison of each plan's features. You can also find more information through the District's Web site at <http://www.chandler.k12.az.us/site/default.aspx?PageID=1> Click on Human Resources > Benefits > General Information.

Plan Features	Choice Plus UHC PPO Plan		HDHP-1500 Plan		HDHP-2700 Plan	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Plan Year Deductible	Individual \$1,000; Family \$2,000	Individual \$2,000; Family \$4,000	Individual \$1,500; Family \$3,000	Individual \$3,000; Family \$6,000	Individual \$2,700; Family \$5,400	Individual \$5,400; Family \$10,800
Coinsurance	Plan pays 80% after deductible	Plan pays 50% after deductible	Plan pays 80% after deductible	Plan pays 50% after deductible	Plan pays 80% after deductible	Plan pays 50% after deductible
Out-of-Pocket Maximum <sup>1</sup>	Individual \$2,000; Family \$4,000	Individual \$6,000; Family \$12,000	Individual \$3,900; Family \$7,800	Individual \$7,800; Family \$15,600	Individual \$4,650; Family \$9,300	Individual \$9,300; Family \$18,600
Office Visit	\$25 copay Primary Care <sup>2</sup> \$50 copay Specialist	Plan pays 50% of eligible expenses after deductible	Plan pays 80% of eligible expenses after deductible	Plan pays 50% of eligible expenses after deductible	Plan pays 80% of eligible expenses after deductible	Plan pays 50% of eligible expenses after deductible
Preventive Care	Plan pays 100%	No Benefits	Plan pays 100% Deductible waived	No Benefits	Plan pays 100% Deductible waived	No Benefits
Emergency Room Visit	\$500 copay, waived if admitted	\$500 copay, waived if admitted	Plan pays 80% of eligible expenses after deductible	Plan pays 80% of eligible expenses after deductible	Plan pays 80% of eligible expenses after deductible	Plan pays 80% of eligible expenses after deductible
Urgent Care Visit	\$50 copay	Plan pays 50% of eligible expenses after deductible	Plan pays 80% of eligible expenses after deductible	Plan pays 50% of eligible expenses after deductible	Plan pays 80% of eligible expenses after deductible	Plan pays 50% of eligible expenses after deductible
Inpatient Hospital	Plan pays 80% of eligible expenses after deductible	Plan pays 50% of eligible expenses after deductible	Plan pays 80% of eligible expenses after deductible	Plan pays 50% of eligible expenses after deductible	Plan pays 80% of eligible expenses after deductible	Plan pays 50% of eligible expenses after deductible
Eye Examination <sup>3</sup>	\$25 copay	Plan pays 50% of eligible expenses after deductible	Plan pays 80% of eligible expenses after deductible	Plan pays 50% of eligible expenses after deductible	Plan pays 80% of eligible expenses after deductible	Plan pays 50% of eligible expenses after deductible
Prescription Medicine <sup>4</sup>	Tier 1 \$10 copay/retail \$25 copay/home delivery	\$10 copay, plus amount over wholesale price	You pay 100% UHC negotiated cost before deductible, then \$10 copay/retail \$25 copay/home delivery	You pay full retail cost before deductible then \$10 copay/retail plus amount over wholesale price	You pay 100% UHC negotiated cost before deductible, then \$10 copay/retail \$25 copay/home delivery	You pay full retail cost before deductible then \$10 copay plus amount over wholesale price
	Tier 2 \$35 copay/retail \$87.50 copay/home delivery	\$35 copay, plus amount over wholesale price	You pay 100% UHC negotiated cost before deductible, then \$30 copay/retail \$75 copay/home delivery	You pay full retail cost before deductible then \$30 copay plus amount over wholesale price	You pay 100% UHC negotiated cost before deductible, then \$30 copay/retail \$75 copay/home delivery	You pay full retail cost before deductible then \$30 copay plus amount over wholesale price
	Tier 3 \$50 copay/retail \$125 copay/home delivery	\$50 copay, plus amount over wholesale price	You pay 100% UHC negotiated cost before deductible, then \$50 copay/retail \$125 copay/home delivery	You pay full retail cost before deductible then \$50 copay plus amount over wholesale price	You pay 100% UHC negotiated cost before deductible, then \$50 copay/retail \$125 copay/home delivery	You pay full retail cost before deductible then \$50 copay plus amount over wholesale price
	Prescription drugs subject to plan year deductible of \$100 individual/\$300 family		Preventive medications not subject to plan year deductible. <i>Refer to page 4 for more information.</i>		Preventive medications not subject to plan year deductible. <i>Refer to page 4 for more information.</i>	

<sup>1</sup>Excluding deductible and copays for Choice Plus UHC PPO Plan.

<sup>2</sup>Primary Care is limited to General or Family Practice, Internal Medicine and Pediatrics.

<sup>3</sup>Limited to once every other plan year.

<sup>4</sup>30-day supply provided through retail; 90-day supply provided through home delivery.



# Dental Coverage - Delta Dental of Arizona (Group Number 4267)

## Voluntary Dental Plan - Core Plan

The Delta Dental plan allows you to visit any dentist or specialist without a referral. The coverage levels provided will typically be higher when you visit a Delta Dental network provider. If you choose to visit a non-participating provider, Delta Dental will still provide benefits (at reduced levels). Note: The plan covers eligible dependents up to age 26.

When making an appointment with your dentist, verify that they are participating with Delta Dental. You can also verify your dentist's affiliation with Delta and/or find a Delta Dental provider through the Delta Dental Web site at [www.deltadentalaz.com](http://www.deltadentalaz.com), or by calling Delta Dental at 800-352-6132, extension 5.

As you seek dental care, you must first meet the plan year deductible (\$50 per person; \$150 per family) before benefit coverage kicks in. Deductible is waived for routine services, and does NOT apply toward your calendar year maximum. The plan pays benefits up to an annual maximum limit of \$1,500 per person.

To find a Delta Dental provider visit the Delta Dental Web site at [www.deltadentalaz.com](http://www.deltadentalaz.com), or call Delta Dental at 800-352-6132, extension 5.

### Voluntary Delta Dental Plan Highlights — Core Plan

Dental Services	Coverage
Diagnostic Care, (exams and x-rays) and Preventive Care (routine cleanings)	
<ul style="list-style-type: none"><li>Two exams and routine cleanings (twice in a plan year).</li></ul>	In-network: 100%
<ul style="list-style-type: none"><li>Full mouth/Panorex x-rays (once in a five-year period; Bitewing x-rays (once in a plan year); and periapical ( six per plan year).</li></ul>	Out-of-network: 100% of charges allowed by Delta Dental; you are responsible for the balance.
<ul style="list-style-type: none"><li>Topical application of fluoride for children to age 17 (twice in a plan year).</li></ul>	
<ul style="list-style-type: none"><li>Emergency treatment for the relief of pain.</li></ul>	
<ul style="list-style-type: none"><li>Space maintainers (for missing posterior primary (baby) teeth up to age 14).</li></ul>	
Basic Services and Restorative Services	After meeting the plan year deductible...
<ul style="list-style-type: none"><li>Stainless steel crowns (for primary (baby) teeth only).</li></ul>	In-network: 70%; you are responsible for the balance
<ul style="list-style-type: none"><li>Fillings consisting of silver amalgam or synthetic tooth color fillings; also includes non-surgical extractions.</li></ul>	Out-of-network: 70% of charges allowed by Delta Dental; you are responsible for the balance.
<ul style="list-style-type: none"><li>Emergency treatment for the relief of pain.</li></ul>	
<ul style="list-style-type: none"><li>Oral surgery: simple extractions.</li></ul>	
Major Services - Becomes a benefit following 6 months of continuous group coverage under this plan.	After meeting the plan year deductible...
<ul style="list-style-type: none"><li>Endodontics</li></ul>	In-network: 40%; you are responsible for the balance
<ul style="list-style-type: none"><li>Periodontics (non surgical once every two years; surgical once every three years).</li></ul>	Out-of-network: 40% of charges allowed by
<ul style="list-style-type: none"><li>Prosthodontics (seven-year waiting period from replacement last performed).</li></ul>	Delta Dental; you are responsible for the balance.
<ul style="list-style-type: none"><li>Bridge and Denture Repair (seven-year waiting period from replacement last performed).</li></ul>	
<ul style="list-style-type: none"><li>Crowns (seven-year waiting period from replacement last performed).</li></ul>	
NO Orthodontic Services	
Plan Year Deductible (applies to basic and major services only)	\$50 per individual/\$150 per family
Plan Year Benefit Maximum	\$1,500 per individual

In the event you need dental work over \$250, ask your dentist to submit a pre-estimate of benefits to Delta Dental. This permits Delta to review the treatment plan and let you know what your financial responsibility for the treatment will be prior to the service being performed.

## Dental Coverage - Delta Dental of Arizona (Group Number 4267)

### Voluntary Dental Plan - Premier Premium Plan

The Delta Dental plan allows you to visit any dentist or specialist without a referral. The coverage levels provided will typically be higher when you visit a Delta Dental network provider. If you choose to visit a non-participating provider, Delta Dental will still provide benefits (at reduced levels). Note: The plan covers eligible dependents up to age 26.

When making an appointment with your dentist, verify that they are participating with Delta Dental. You can also verify your dentist's affiliation with Delta and/or find a Delta Dental provider through the Delta Dental Web site at [www.deltadentalaz.com](http://www.deltadentalaz.com), or by calling Delta Dental at 800-352-6132, extension 5.

As you seek dental care, you must first meet the plan year deductible (\$50 per person; \$150 per family) before benefit coverage kicks in. Deductible is waived for routine services, and does NOT apply toward your calendar year maximum. The plan pays benefits up to an annual maximum limit of \$1,500 per person. Some services, such as orthodontia and care of TMJ, are subject to lifetime maximum limits, as well.

### Voluntary Delta Dental Plan Highlights — Premier Premium Plan

Dental Services	Coverage
Diagnostic Care, (exams and x-rays) and Preventive Care (routine cleanings)	
<ul style="list-style-type: none"><li>Two exams and routine cleanings (twice in a plan year).</li></ul>	In-network: 100%
<ul style="list-style-type: none"><li>Full mouth/Panorex x-rays (once in a five-year period; Bitewing x-rays (once in a plan year); and periapical ( six per plan year).</li></ul>	Out-of-network: 100% of charges allowed by Delta Dental; you are responsible for the balance.
<ul style="list-style-type: none"><li>Topical application of fluoride for children to age 17 (twice in a plan year).</li></ul>	
<ul style="list-style-type: none"><li>Space maintainers (for missing posterior primary (baby) teeth up to age 14).</li></ul>	
Basic Services and Restorative Services	After meeting the plan year deductible...
<ul style="list-style-type: none"><li>Fillings consisting of sliver amalgam or synthetic tooth color fillings; also includes non-surgical extractions.</li></ul>	In-network: 80%; you are responsible for the balance
<ul style="list-style-type: none"><li>Stainless steel crowns (for primary (baby) teeth up to age 14).</li></ul>	Out-of-network: 80% of charges allowed by
<ul style="list-style-type: none"><li>Sealants for children (once per three year period for permanent molars and bicuspid up to age 19).</li></ul>	Delta Dental; you are responsible for the balance
<ul style="list-style-type: none"><li>Emergency treatments for the relief of pain.</li></ul>	
<ul style="list-style-type: none"><li>Oral surgery: simple extractions.</li></ul>	
Major Services	After meeting the plan year deductible...
<ul style="list-style-type: none"><li>Endodontics</li></ul>	In-network: 50%; you are responsible for the balance
<ul style="list-style-type: none"><li>Periodontics (non surgical once every two years; surgical once every three years).</li></ul>	Out-of-network: 50% of charges allowed by
<ul style="list-style-type: none"><li>Prosthodontics (five-year waiting period from replacement last performed).</li></ul>	Delta Dental; you are responsible for the balance.
<ul style="list-style-type: none"><li>Bridge and Denture Repair (seven-year waiting period from replacement last performed).</li></ul>	
<ul style="list-style-type: none"><li>Crowns (seven-year waiting period from replacement last performed).</li></ul>	
Orthodontic Services	
<ul style="list-style-type: none"><li>Benefits provided for adults and children age 8 and older.</li></ul>	After meeting the plan year deductible...
<ul style="list-style-type: none"><li>Lifetime maximum benefit of \$750 per patient; this maximum is separate from your plan year maximum benefit.</li></ul>	In-network: 50%; you are responsible for the balance
<ul style="list-style-type: none"><li>Payable in two payments - upon initial banding and twelve months after.</li></ul>	Out-of-network: 50% of charges allowed by Delta Dental; you are responsible for the balance.
Plan Year Deductible (applies to basic and major services)	\$50 per individual/\$150 per family
Plan Year Benefit Maximum	\$1,500 per individual

In the event you need dental work over \$250, ask your dentist to submit a pre-estimate of benefits to Delta Dental. This permits Delta to review the treatment plan and let you know what your financial responsibility for the treatment will be prior to the service being performed.

## Voluntary Vision -- Vision Service Plan (Not Covered through UHC Medical Plans)

Eligible employees can choose to enroll in voluntary vision coverage through VSP. (Note: The District's medical plans cover eye exams, once every two years and offer a small discount for some lenses, frames and contacts. If you require vision care in addition to regular exams, you should consider whether the VSP voluntary vision plan makes sense for you.)

You pay the cost for your voluntary vision plan premiums. Premiums are based on the number of dependents (if any) you choose to enroll. Under the VSP plan, you may visit any vision care provider. However, benefits are provided at significantly higher levels when you visit a VSP network doctor.

### Highlights of 2012/13 Vision Plan Benefits

Eye exams*	In Network: The Plan pays 100% after your \$10 copay. Out-of-network: The plan pays up to \$50
Lenses*	In Network: The Plan pays 100% after your \$20 copay for single vision, lined bifocal, lined trifocal, and photochromic lenses and tints Out-of-network: The plan pays up to: \$50 for single vision lenses, \$75 for lined bifocal lenses, \$100 for lined trifocal lenses
Frames*	In Network: The plan provides an allowance of \$130 plus a 20% discount Out-of-network: The plan pays up to \$75
Contacts*	In Network: In lieu of lenses and frames, the plan provides an allowance of \$130, which applies to the cost of contacts and the contact lens fitting exam. You receive a 15% discount on this exam, which is in addition to your initial vision exam. Out-of-network: The plan pays up to \$105 for the exam, contact lens fitting, and lenses.

\*The benefits outlined above are provided once every 12 months, when you enroll in this plan.

To find a VSP provider, visit [www.vsp.com](http://www.vsp.com) or call 800-877-7195.

You can also find a VSP provider through the District's Web site.

You will not receive a plan ID card from VSP when you enroll. So, when making your appointment, tell your provider you are a VSP member. Your provider and VSP take care of the rest.

## Basic Life Insurance – Sun Life

The District provides eligible employees with basic life insurance coverage in the amount of \$50,000.

After you reach age 65, the policy amount is reduced. An accelerated death benefit is also available in the event of your eligible terminal illness.

You must designate a beneficiary for the basic life insurance benefit who is 18 years or older. You may add or change your beneficiary by completing the 2012/13 Benefit Election/Enrollment Form and returning it to the benefits department.

\* Please note: As a special exception, Job Share employees are eligible for the basic life insurance benefit.

## Voluntary Life Insurance – Sun Life

If eligible, you have the opportunity to purchase voluntary life insurance coverage for yourself and your eligible spouse and dependent children. The voluntary life insurance premiums are listed on page 17.

### Highlights of 2012/13 Voluntary Life Insurance Coverage

Voluntary Life Insurance Options	How much coverage can you buy?
Coverage for yourself if you are an active, full-time employee working at least 20 hours per week	You can purchase coverage in \$10,000 "units" up to five times your annual earnings. The maximum benefit is \$500,000.
Coverage for your eligible spouse under age 70.	You can purchase coverage in \$10,000 "units" up to \$150,000. The coverage level you elect for your spouse cannot exceed 100% of your basic and voluntary life insurance coverage combined. You are not required to elect coverage for yourself to purchase coverage for your spouse.
Coverage for your eligible unmarried, dependent children at least 14 days old and under age 25.	You can purchase coverage in \$2,000 "units" up to \$10,000. The maximum benefit for children under six months is \$500. You can elect this coverage only if you purchase voluntary coverage for yourself and/or your spouse, unless you are eligible for basic coverage (working 30 more hours a week).

No one may be covered more than once under this plan.

After you reach age 70, the policy amount is reduced. When your spouse reaches age 70, his/her coverage ceases. Also note, an accelerated death benefit is available in the event of your eligible terminal illness. Refer to your plan certificate for a complete schedule of benefits.

### IMPORTANT — WHEN EVIDENCE OF GOOD HEALTH IS REQUIRED

If you are not currently enrolled in voluntary life insurance coverage but wish to enroll now, OR if you wish to increase your current coverage level during this year's Open Enrollment, you must provide Sun Life with evidence of your good health, by completing the Sun Life Evidence of Insurability form. Coverage will not be issued until Sun Life approves your evidence of good health.

## Voluntary Short-Term Disability – Assurant

To enroll or change your current coverage, complete and return the Assurant Employee Enrollment Form for Group Disability.

Increases to your current coverage are subject to the plan's pre-existing limitation.

The voluntary short-term disability insurance plan is underwritten by Assurant Employee Benefits. If you receive a salary increase, your short term disability does not increase automatically.

Voluntary Short-Term Disability coverage helps provide income protection for employees with unexpected health events, associated expenses and possible time away from work due to a non-occupational injury or sickness.

Eligible employees can elect to purchase voluntary short-term disability coverage. The plan provides monthly benefits from \$360 to \$5,000, based on your annual salary, not to exceed 66 2/3% of your salary. Benefits are paid in the event you cannot work due to a covered non-occupational sickness or injury, for up to six months of continuous disability. This plan covers maternity the same as a sickness. Benefits begin following the plan's seven day elimination period. Benefits are paid in addition to accumulated sick leave and are paid year-round, even when school is not in session.

Premium costs for short-term disability coverage are listed on page 18.

Your benefit payment will be offset by other sources as defined by the Assurant group policies. These sources include, but are not limited to Social Security and State Retirement Systems. However, the minimum monthly benefit amount payable under the voluntary short-term disability policy can not be lower than 10% of your gross monthly benefit, regardless of the amount of income you receive from other sources. Income received from salary continuation or accumulated sick leave plans will not be deducted from your gross disability benefit.

### IMPORTANT – PRE-EXISTING CONDITION LIMITATIONS

The policy does not pay benefits for disabilities that begin within 12 months of your initial enrollment in the plan, if you received medical treatment, consultation, care, or services (including diagnostic measures), or took prescribed drugs or medicines for the disabling condition during the 12 months prior to your initial enrollment date. To be eligible for coverage during pregnancy, you cannot be pregnant before the benefit effective date (e.g., July 1, 2012, if you are enrolling during Open Enrollment).

During the 2012/13 Open Enrollment, employees can purchase coverage from \$360 to \$5000, not to exceed 66 2/3% of your salary. If you are currently enrolled in the plan, you can increase your coverage amount by one benefit level of coverage (not to exceed 66 2/3% of your salary) without evidence of good health. All new applicants and increases over the one level, must provide evidence of good health to our insurance carrier, Assurant. Pre-existing conditions limitations apply to both new applications and increases in coverage.

## Long Term Care Insurance

### Long Term Care Insurance - UNUM

Long Term Care insurance provides a monthly benefit to help offset the cost of personal and medical care for an individual who is unable to carry out the normal activities of daily living, such as dressing, bathing, going to the bathroom, eating, moving, etc, or when someone suffers a severe cognitive impairment. Care could be provided in the home, in an assisted living, a residential care facility, or in a skilled nursing facility.

### Base Plan Long Term Care Insurance

The district provides eligible employees coverage under the base plan. Employees working full-time (30 hours or more per week) or job-share employees working 20 hours or more per week are eligible for coverage. The base plan provides a monthly benefit of \$2,000 for a total lifetime maximum of \$48,000.

### Voluntary Long Term Care Insurance

Employees eligible for the base plan, have the opportunity to purchase additional coverage for themselves and their spouse. Employees who are not eligible for the base plan but work between 20-29 hours per week may purchase long term care at their own expense. Family members of eligible employees between the ages of 18-80 may purchase coverage at the district group rates. Spouses and family members will need to provide evidence of insurability and are subject to underwriting approval.

# Flexible Spending Accounts (FSAs)

The Flexible Spending Accounts — the Medical Expense Reimbursement Account and the Dependent Care Account — are separate flexible spending accounts that can help you save money on taxes by allowing you to pay for certain expenses with before-tax dollars.

If you would like to participate in an FSA for 2012/13, you must complete the flexible spending account enrollment form, even if you are currently a participant.

## How Flexible Spending Accounts Work

- You decide how much you want to contribute on an annual basis into one or both of the FSAs when you enroll.
- Your FSA contributions are deducted from your paycheck, in equal amounts on a before-tax basis.
- Your election stays in effect for the entire plan year (July 1 through June 30). You cannot increase, decrease, or cancel your contributions outside of the plan's enrollment period, unless you have a qualified life status change (see page 2 for information about status changes).
- You use your FSA contributions to pay your eligible expenses under the Medical Expense Reimbursement Account or Dependent Care Account. The IRS clearly defines eligible expenses, and only those that comply with the Internal Revenue Code are eligible for reimbursement.
- You cannot use the contributions you make to the Medical Expense Reimbursement Account to reimburse yourself for eligible expenses under the Dependent Care Account, or vice versa.
- The plans are administered by BASIC Western USA.

## The Medical Expense Reimbursement Account

The Medical Expense Reimbursement Account lets you set aside before-tax dollars to help you pay for eligible medical, dental, and vision care expenses. You can contribute between \$500 and \$2,500 for 2012/13. You do not need to be enrolled in a District healthcare plan to contribute to this FSA, however, you must work a minimum of 20 hours per week to enroll.

You can sign up and participate in the Medical Expense Reimbursement Account if you take a HDHP and set up the HSA Fund Account. However, you can ONLY be reimbursed for you dental and vision expenses through the Medical Expense Reimbursement Account until you submit an Explanation of Benefits (EOB)

from the carrier that shows you have met the annual IRS specified deductible. In 2012/13, the amounts are \$1,200 of your medical deductible for your high deductible plan if you are covered as a single OR \$2,400 of your medical deductible if you have family coverage. (The IRS defines family as individual plus one other person on the HDHP.) Medical expenses incurred after this requirement is met are eligible for payment through the Medical Expense Reimbursement Account.

## Eligible Expenses

Healthcare expenses that are eligible for reimbursement under an FSA are clearly defined by the IRS. In general, you can use the money in the Medical Expense Reimbursement Account to pay for eligible healthcare expenses that are not covered by your or your spouse's healthcare plans or used as healthcare deductions on your income tax return.

A quick one page reference to flex eligible expenses is provided on the BASIC website at: [https://www.basiconline.com/wp-content/uploads/2011/08/flex\\_eligible\\_expenses.pdf](https://www.basiconline.com/wp-content/uploads/2011/08/flex_eligible_expenses.pdf)

Upon using your FSA debit card you will be required to substantiate your purchase. Documentation must include the following information: provider name, service provided, date of service and amount charged. Failure to substantiate your purchase may result in deactivation of your FSA debit card.

## Getting Reimbursed

You can use the plan's Flex Convenience debit card to pay most eligible expenses through your Medical Expense Reimbursement Account. Alternatively, you may submit your expenses for reimbursement.

To request reimbursement, you must submit a Flex Card Claim Form with receipt. The form is found at: <https://www.basiconline.com/wp-content/uploads/2011/08/cardclaimform.pdf>. You may mail or fax the form (address or fax number indicated on the form). You may also use the secure website to upload your reimbursement request: <http://claims.basiconline.com/>. The same process may be used to substantiate purchases made using FSA debit card.

Refer to the BASIC Western USA Web site at [www.basiconline.com](http://www.basiconline.com), or contact a BASIC representative at 800-473-0455 for more detailed information regarding FSAs.

## Using the Medical Expense Reimbursement Account with Health Savings Account:

If you choose to enroll in one of the HDHP medical plans and you also wish to contribute to the Medical Expense Reimbursement Account, you can use your Medical Expense Reimbursement Account funds on a "limited purpose" basis – to pay your eligible dental and vision care expenses only.

## FSA: USE IT OR LOSE IT RULE

The IRS governs the administration of Flexible Spending Account plans, and once you elect to set aside money in an FSA, you must use it for eligible expenses during the plan year. You should make every effort to file your FSA claims as you incur expenses. However, you have 90 days after the plan year end (June 30) to file claims for reimbursement. After that point, you forfeit, or "lose," any unused funds. Because of this IRS "use it or lose it" rule, be sure to carefully estimate the amount you want to contribute to the FSAs before making your elections.

**NOTE: Keep all receipts in the event of an IRS Audit**



# Flexible Spending Accounts (FSAs)

## FSA: USE IT OR LOSE IT RULE

The IRS governs the administration of Flexible Spending Account plans, and once you elect to set aside money in an FSA, you must use it for eligible expenses during the plan year. You should make every effort to file your FSA claims as you incur expenses. However, you have 90 days after the plan year end (June 30) to file claims for reimbursement. After that point, you forfeit, or “lose,” any unused funds. Because of this IRS “use it or lose it” rule, be sure to carefully estimate the amount you want to contribute to the FSAs before making your elections.

## The Dependent Care Account

The Dependent Care Account lets you set aside before-tax dollars to help you pay the cost of care for your eligible dependents so that you (and your spouse) can work outside your home. You can contribute between \$500 and \$5,000 annually. However, your contributions can be limited by your tax-filing status, by your spouse's participation in a similar plan, if your spouse is disabled or a full-time student, or if you use the federal dependent care tax credit. Consult your tax or financial advisor to determine how much to contribute to the Dependent Care Account.

## Eligible Expenses

The Dependent Care Account is strictly monitored by the IRS, and only those expenses that comply with the Internal Revenue Code are covered. Eligible expenses may include your costs for child day care, or care for an elder dependent while you are working during the day.

A detailed summary of eligible expenses is available through the IRS website at: [www.irs.gov/pub/irs-pdf/p503.pdf](http://www.irs.gov/pub/irs-pdf/p503.pdf).

## Getting Reimbursed

If accepted by your dependent care provider, you can use the plan's Flex Convenience debit card to pay most eligible expenses through your Dependent Care Account. Alternatively, you may submit your expenses for reimbursement through paper claim forms. To request reimbursement, you must submit a flex card claim form with receipt. The form is found at: <https://www.basiconline.com/wp-content/uploads/2011/08/cardclaimform.pdf>. You may mail or fax the form (address and fax number is listed on the form). You may also use the secure website to upload your reimbursement request: <http://claims.basiconline.com/>. The same process may be used to substantiate transactions made using the FSA debit card.

To avoid the need to continuously submit receipts for the same exact service, provider and amount you must submit a Reoccurring Expense form. The form can be found on the BASIC website at: <https://www.basiconline.com/wp-content/uploads/2011/08/FlexRecurringExpenseForm2.pdf>. Submit this form to BASIC to include your documentation/receipts for the transaction you would like to establish as your recurring expense(s).

## Making Your Annual FSA Election

The IRS requires you to elect your FSA contributions every year. If you wish to participate, you need to make your 2012/13 election during Open Enrollment or your initial benefit enrollment period. Your current contribution, if any, will not carry forward. If you choose to enroll for 2012/13, your contribution will be deducted from your pay in equal increments throughout the plan year on a pre-tax basis.

**NOTE: Keep all receipts in the event of an IRS Audit**

# COMPLETING YOUR ENROLLMENT

We encourage all employees to take an active role in their initial benefits enrollment process and on an ongoing basis as you use your benefits throughout the coming year.

**If you wish to enroll or continue with your current benefits during Open Enrollment, you must elect your benefits through Employee Online.**

After the Open Enrollment period ends, employees must complete and return the 2012/13 benefit elections form to your benefits department. Required forms can be found on the District website under benefit forms. The benefit elections you wish to make for 2012/13 will determine which forms you need to complete and return to the benefits department. Also, depending on the elections you wish to make, you may need to complete and return additional forms, as well. See the list below.

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## Vision Coverage - VSP

Employees who wish to purchase coverage for themselves or their dependents must complete and submit the following forms to the benefits department:

- Benefit Election Enrollment Form

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## Dental Coverage - Delta Dental

Employees who wish to purchase coverage for themselves or their dependents must complete and submit the following forms to the benefits department:

- Benefit Election Enrollment Form

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## Voluntary Life Insurance Coverage – SunLife

Employees who wish to change their current voluntary life insurance election(s), as well as employees who are not currently enrolled must complete:

- Voluntary Life Insurance Application
- Evidence of Insurability Form

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## Short-Term Disability Insurance – Assurant

Employees who are not currently enrolled in the plan, or those who wish to increase or decrease their current coverage level must complete:

- Employee Enrollment Form for Group Disability. Be sure to complete the back side of the form if you are increasing your current coverage by more than one level, or if you are electing coverage over \$3,000.

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## Flexible Spending Account Enrollment Form – BASIC

Employees who wish to contribute to the Medical Expense Reimbursement Account and/or Dependent Care Account during Open Enrollment, must make your election through Employee Online. Employees who wish to contribute outside of the Open Enrollment Period must complete and submit the following form(s) to the benefits department:

- Flex Spending Account Enrollment Form
- Additional Debit Card Request Form (only if you wish to request additional debit cards for your dependents)

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## Long Term Care Insurance - UNUM

Eligible employees who wish to purchase coverage for themselves or their spouse must complete and submit the following forms to the benefits department:

- Employee Enrollment Form
- Long Term Care Insurance Application with HIPAA Authorization & Acknowledgement of Disclosure or Rating Practices

During the 2012/13 Open Enrollment period, if you do not complete your enrollment by May 16, 2012, your current elections end. You will NOT have an opportunity to elect coverage until next year's Open Enrollment period unless you have a qualified life status change. You must choose a medical plan or waive. Your current elections will NOT carry over automatically.

When enrolling as a new hire, the 2012/13 Benefit/Election Form will be collected at your benefits orientation. If you elect optional plans, those required forms may be returned via District mail. Forms must be returned within 31 days of your eligibility for benefits.

For other enrollment periods, in most cases, you must return all of your paperwork within 31 days of your benefit eligibility date. If you do not complete the enrollment process, you will not have an opportunity to elect coverage until next year's Open Enrollment period unless you have a qualified life status change.

**During Open Enrollment, return all required forms to the benefits department by May 16, 2012.**

If you would like to contribute to a Flexible Spending Account for 2012/13, you must make your Benefit Election using Employee Online.

Employees eligible for a Flexible Spending Account after the Open Enrollment period, will be required to complete an enrollment form.

## Waiving Medical Coverage

You are NOT required to enroll in medical coverage through the District. For example, if you have medical coverage through another source (e.g., your spouse's employer-sponsored plan), you might find it more practical or cost-effective for you to cover your family under that plan. If you choose to waive coverage, there will be no monetary compensation.

**Note:** If you choose to enroll in one of the District's medical plans, your employer plan will become your primary coverage.

## CONTACT INFORMATION

Contact our plan providers directly if you have questions or would like more detailed information about our plans.

If you need further assistance regarding your benefits plans, contact the benefits department.

Plan Providers	For Questions About...	Phone	Web site
UnitedHealthcare	Choice Plus PPO Plan HDHP-1500 Plan HDHP-2700 Plan	866-844-4864	<a href="http://www.myuhc.com">www.myuhc.com</a>
UnitedHealthcare Vision		877-532-9300	
Delta Dental of Arizona	Delta Dental Plans	602-938-3131 800-352-6132	<a href="http://www.deltadentalaz.com">www.deltadentalaz.com</a>
Vision Service Plan (VSP)	Voluntary Vision Plan	800-877-7195	<a href="http://www.vsp.com">www.vsp.com</a>
Sun Life	Basic Life Insurance Plan Voluntary Life Insurance Plans	800-247-6875	<a href="http://www.sunlife-usa.com">www.sunlife-usa.com</a>
Assurant (Brockhurst and Associates, local agent)	Voluntary Short-Term Disability Plan	602-263-9265	N/A
BASIC Western USA	Flexible Spending Accounts	800-444-1922 Ext. 1	<a href="http://www.basiconline.com">www.basiconline.com</a>
OptumHealth Bank	HSA Account Information	800-791-9361	<a href="http://www.myuhc.com">www.myuhc.com</a> <a href="http://www.optumhealthbank.com">www.optumhealthbank.com</a>
Care24	Nurse Advice Financial Advice Legal Advice	888-887-4114	N/A
UNUM	Long Term Care Insurance Plan	800-227-4165	<a href="http://w3.unum.com/enroll/cusd/">http://w3.unum.com/enroll/cusd/</a>

### Chandler Unified School District Human Resources Technicians

*Questions related to Health Plans should be directed to THE BENEFITS DEPARTMENT. Questions regarding enrollment and eligibility should be directed to your HR Technician.*

Contact	Phone	Sites Assigned
Dianne Steiman	X7639	PJHS; Frye; Independence; Bologna; Liberty; Patterson; Riggs; Ryan; CHS; San Marcos; Weinberg; Warehouse; Hall
Maricela Garcia	X7605	WJHS; Galveston; Perry High; Humphrey; Sanborn; AZ College Prep; Support Services
Kathy Beickman	X7638	BHS; SJHS; Freedom; Fulton; Santan Elem; Tarwater; IRC; Transportation; Early College; Hill Academy; District Office
Pam Lundbohm	X7665	HHS; Hamilton Prep; Basha Elem; Hancock; Jacobson; Food Service; Navarette
Cindy Plimmer	X7648	AJHS; Chandler Care Center; Erie; Community Education; Conley; Haley; CTA-Goodman; Hartford; Kids Express; Shumway; Lil' Express; Knox; BJHS; Anderson Elementary

### Chandler Unified School District Benefits Department

Dee Ostrowicki Benefits Coordinator	X7036	Contact for complex benefits questions and issues.
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# 2012-2013 BENEFITS COSTS

## Medical Plan

### Medical Plan Coverage Options and Premiums

Eligible Employee Only Coverage when you work 30+ hours per week	Choice Plus UHC PPO	HDHP 1500	HDHP 2700
*Annual District Contribution to Eligible Employee	\$4,622.00	\$4,622.00	\$4,622.00
Annual Premium (Cost) for "Employee Only" Coverage	\$9,060.00	\$4,108.00	\$2,798.00
Remaining Balance = Annual District Contribution to Employee HSA	N/A	\$514.00	\$1,824.00
Difference = Employee Cost	\$4,438.00	N/A	N/A
Bi-weekly payments are deducted from employee's checks over 22 pays.	\$201.73	N/A	N/A
Employees who begin(or continue) coverage 2012/13 will receive 2 deposits a year. The first deposit will be in August, the second in January. Each deposit will be:	N/A	\$257.00	\$912.00
VOLUNTARY annual maximum employee contribution to HSA account.	N/A	\$2,586.00	\$1,276.00

#### Dependent Coverage (Employee-paid)

Important: The costs below for the Choice Plus plan include the cost of the employee only coverage. District contribution for employee coverage is reflected in the rates below. The district contribution remains the same regardless of the level of coverage.

1. Spousal Coverage	Choice Plus UHC PPO	HDHP 1500	HDHP 2700
Employee-Paid Annual Cost for Employee & Spousal Coverage	\$15,468.00	\$4,584.00	\$3,432.00
Monthly Cost for comparison purposes.	\$1,289.00	\$382.00	\$286.00
Bi-weekly payments are deducted from employee's checks over 22 pays.	\$703.09	\$208.36	\$156.00
VOLUNTARY annual maximum employee contribution to HSA account.	N/A	\$5,736.00	\$4,426.00
2. Child(ren) Coverage	Choice Plus UHC PPO	HDHP 1500	HDHP 2700
Employee-Paid Annual Cost for Employee & Child(ren) Coverage	\$14,748.00	\$4,260.00	\$3,204.00
Monthly Cost for comparison purposes.	\$1,229.00	\$355.00	\$267.00
Bi-weekly payments are deducted from employee's checks over 22 pays.	\$670.36	\$193.64	\$145.64
VOLUNTARY annual maximum employee contribution to HSA account.	N/A	\$5,736.00	\$4,426.00
3. Family Coverage	Choice Plus UHC PPO	HDHP 1500	HDHP 2700
Employee-Paid Annual Cost for Family Coverage	\$21,432.00	\$7,104.00	\$5,232.00
Monthly Cost for comparison purposes.	\$1,786.00	\$592.00	\$436.00
Bi-weekly payments are deducted from employee's checks over 22 pays.	\$974.18	\$322.91	\$237.82
VOLUNTARY annual maximum employee contribution to HSA account.	N/A	\$5,736.00	\$4,426.00
4. Spousal Share family Coverage (Spouses both employed by District who elect family coverage.)	Choice Plus UHC PPO	HDHP 1500	HDHP 2700
Employee-Paid Annual Cost for Family Coverage	\$16,810.00	\$2,996.00	\$2,434.00
Monthly Cost for comparison purposes.	\$1,400.83	\$249.67	\$202.83
Bi-weekly payments are deducted from employee's checks over 22 pays.	\$764.09	\$136.18	\$110.64
Annual District Contribution to Employees HSA	N/A	\$514.00 per spouse	\$1,824.00 per spouse
Annual district contribution to HSA is made twice a year. The first deposit will be made in August, the second in January. Bi-annual contribution is:	N/A	\$257.00 per spouse	\$912.00 per spouse
VOLUNTARY annual maximum combined employee contribution to HSA account.	N/A	\$5,222.00	\$2,602.00

Employees between 55 and 65 may also make an additional catch up contribution of \$1,000.00 per year. Employees who begin(or continue) coverage in 2012/13 will receive two deposits a year. The first deposit will be in August, the second in January. Voluntary HSA contributions are spread equally over 22 pays.

\* Employee can earn an additional \$200.00 by completing wellness exams and completing Health Risk Assessment online at: [www.myuhc.com](http://www.myuhc.com). For more information check your employee benefits website.

## 2012-2013 BENEFITS COSTS (Continued)

### Voluntary Vision Plan

Voluntary Vision Plan Premiums – 22 deductions per year

	Employee Only	Employee + Spouse or Child	Employee + 2 or More
Payroll Deduction	\$4.28	\$6.21	\$11.14

### Dental Plan - Core Plan

Voluntary Dental Plan Premiums – Core Plan

	Employee Only	Employee + Spouse	Employee + Dependents	Employee + Family
22 deductions per year	\$14.12	\$27.23	\$30.99	\$50.47

### Dental Plan - Premier Premium Plan

Voluntary Dental Plan Premiums – Premier Premium Plan

	Employee Only	Employee + Spouse	Employee + Dependents	Employee + Family
22 deductions per year	\$20.03	\$39.35	\$44.87	\$73.61

### Voluntary Life Insurance

Monthly Voluntary Life Insurance Premiums Per \$10,000 of Coverage – Employee Coverage

Age	Cost per \$10,000 of Coverage	Age	Cost per \$10,000 of Coverage	Age	Cost per \$10,000 of Coverage
Under age 20	\$0.40	40-44	\$1.03	65-69	\$8.87
20-24	\$0.47	45-49	\$1.66	70-74	\$13.65
25-29	\$0.50	50-54	\$2.40	75-79	\$19.52
30-34	\$0.58	55-59	\$4.12	80 & Over	\$29.58
35-39	\$0.70	60-64	\$6.20		

Monthly Voluntary Life Insurance Premiums Per \$10,000 of Coverage – Spouse Coverage

Age	Cost per \$10,000 of Coverage	Age	Cost per \$10,000 of Coverage	Age	Cost per \$10,000 of Coverage
Under age 20	\$0.40	40-44	\$1.03	65-69	\$8.87*
20-24	\$0.47	45-49	\$1.66		
25-29	\$0.50	50-54	\$2.40		
30-34	\$0.58	55-59	\$4.12		
35-39	\$0.70	60-64	\$6.20		

\* Coverage ceases for your spouse at age 70; at that time he/she may convert this coverage to a permanent life insurance policy.

- Coverage for your dependent children is \$0.53 per \$2,000 of coverage, regardless of the number of children you enroll.



# 2012-2013 BENEFITS COSTS (Continued)

## Long Term Care Insurance

To access long term care rates, visit the UNUM website: <http://w3.unum.com/enroll/cusd> click on calculator to calculate your rate.

## Voluntary Short-Term Disability

### Voluntary Short-Term Disability Coverage Levels and Premiums – 22 deductions per year

Minimum Gross Annual Salary	Maximum Monthly Benefit	Your cost per pay period – 22 deductions	Minimum Gross Annual Salary	Maximum Monthly Benefit	Your cost per pay period – 22 deductions
\$6,480	\$360	\$3.83	\$49,500	\$2,750	\$29.25
\$9,180	\$510	\$5.43	\$54,000	\$3,000	\$31.91
\$13,500	\$750	\$7.98	\$58,500	\$3,250	\$34.57
\$18,000	\$1,000	\$10.64	\$63,000	\$3,500	\$37.23
\$21,600	\$1,200	\$12.76	\$67,500	\$3,750	\$39.89
\$27,000	\$1,500	\$15.95	\$72,000	\$4,000	\$42.55
\$30,600	\$1,700	\$18.08	\$76,500	\$4,250	\$45.21
\$36,000	\$2,000	\$21.27	\$81,000	\$4,500	\$47.86
\$40,500	\$2,250	\$23.93	\$85,500	\$4,750	\$50.53
\$45,000	\$2,500	\$26.59	\$90,000	\$5,000	\$53.18

This Benefits Guide provides only the highlights of certain provisions of the benefit programs available to eligible District members effective July 1, 2012. Complete details are contained in the respective plan documents and insurance contracts. In case of conflict between the information in this Benefits Guide and the wording in the official plan documents, the plan documents will govern. 2012/13 benefits contracts supersede all previous plan documents and contracts.

# IMPORTANT NOTICES

## Private Health Information

A portion of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) addresses the protection of confidential health information. It applies to all health benefit plans. In short, the idea is to make sure that confidential health information that identifies (or could be used to identify) you is kept completely confidential. This individually identifiable health information is known as “protected health information” (PHI), and it will not be used or disclosed without your written authorization, except as described in the HIPAA Privacy Notice or as otherwise permitted by federal and state health information privacy laws.

The HIPAA Privacy Notice is available through your District’s web site or by request from your employer’s benefits department. It spells out what the plans are required by law to do and how the plans will comply, as well as provides an explanation of your rights regarding your own health information. If you have any immediate questions or concerns, please contact your employer’s benefits department.

## Women’s Health and Cancer Rights Act

The District health plans, as required by the Women’s Health and Cancer Rights Act of 1998, provide benefits for mastectomy-related services. These services include:

- 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 resulting from mastectomy (including lymphedema)

Plan limits, deductibles, copayments, and coinsurance apply to these benefits. For more information, call UnitedHealthcare at 866-844-4864.

## Changes Allowed under the Children’s Health Insurance Program Reauthorization Act of 2009

Effective April 1, 2009, the Children’s Health Insurance Program Reauthorization Act of 2009 creates a new special enrollment period that applies to group health plans, similar to those currently in effect for the loss of eligibility for other group coverage or qualifying life status changes.

Under this Act, group health plans must permit employees and dependents who are eligible for group health plan coverage to enroll in the plan if they:

- Lose eligibility for Medicaid or SCHIP coverage, OR
- Become eligible to participate in a premium assistance program under Medicaid or SCHIP

In both cases, you must request special enrollment within 60 days (of the loss of Medicaid/SCHIP or of the eligibility determination), or wait until the plan’s next annual enrollment period to make a change.

Contact your benefits representative if you have questions.

## Declining Coverage and Special Enrollment Periods

You may elect to decline coverage in the group health plans. If you decline coverage due to your participation (and/or your eligible spouse’s or dependents’ participation) in other coverage, you will be entitled to enroll in the group health plan at other specified times.

For additional information regarding the situations under which you may be eligible to enroll through a “special enrollment period,” contact your benefits representative.

## Continuation Coverage Under COBRA

COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family, who are covered under the plan, when they would otherwise lose their group health coverage. For additional information about your rights and obligations under the plan and under federal law, refer to the “General Notice of COBRA Continuation Coverage Rights” available upon request from your employer’s benefits department.

## Medicare Notice of Creditable Coverage

If you or your eligible dependents are currently Medicare eligible, or will become Medicare eligible during the next 12 months, you need to be sure that you understand whether the prescription drug coverage that you elect under the three plan options sponsored by Valley Schools Employee Benefit Trust is or is not creditable (as valuable as) Medicare’s prescription drug coverage. Contact the benefits department for more information.

