



# 2011 – 2012 Benefits Handbook

EFFECTIVE 10/01/2011 – 09/30/2012

***Issued: 08/01/2011***

**NOTE: This handbook is strictly a summary of the plans offered by Tucson Unified School District and is not a substitute for the official plan documents, policies or certificates of coverage. If there are discrepancies between the official plan documents and this handbook, the official plan documents, policies, certificates or benefits and conditions required by the Patient Protection and Affordable Care Act (healthcare reform law) will govern.**



Dear Employee,

Welcome to TUSD! In the pages that follow, we are pleased to present the employee benefits offering. We encourage you to take some time to review this Benefits Handbook in its entirety as it contains important information about your benefits as a TUSD benefits eligible employee.

**If you are a newly hired benefits eligible employee or an employee returning from a Governing Board approved Leave of Absence**, please review all information and submit your benefit enrollment forms to the Benefits Office **no later than 30 days after your date of hire (or return to work)**. If you do not submit these forms by your deadline, you will not be able to enroll in any non-mandatory benefits until the next Open Enrollment period or upon a qualifying event.

While we strive to provide a solid benefits package for TUSD employees and their family members, we all must recognize that establishing and maintaining good overall health is the best medical plan of all. For more information on the tools available to TUSD employees, please visit [www.myameriben.com](http://www.myameriben.com) and choose My Online Tools and then My Personal Health Suite. You can also take advantage of free health coaching and wellness activities from the Wellness Council of Arizona team for TUSD.

TUSD provides an Employee Assistance Program (EAP) at **no cost** to employees and their family members for short-term counseling needs. EAP services are available any time of the day or night and same day appointments are often available. EAP services can be used for just about anything that affects an employee's mental health including stress, depression, or financial and legal concerns.

Sincerely,

The Benefits Office

**How are we doing? Let us know!**

**In order to improve our communications and information to you, please send your feedback about this booklet or other benefits processes to us at [Benefits@TUSD1.org](mailto:Benefits@TUSD1.org)**



P.O. Box 7186  
Boise, ID 83707  
Toll Free (877) 955-1570  
[www.myameriben.com](http://www.myameriben.com)



## WELCOME

AmeriBen is the third party administrator and is responsible for administering your benefit claims, answering benefit inquiries, and handling other routine administrative functions.

### **What is A Third Party Administrator (TPA)?**

A Third Party Administrator (TPA) applies benefits on claims according to the Plan Document. A simpler way to describe what AmeriBen does is AmeriBen process claims for your medical plan.

### **What is the difference between an insurance carrier and a Third Party Administrator?**

An insurance carrier provides a standard benefit program, charges a premium, and pays claims. Since your medical plan is self-funded, a TPA is needed for claims processing. AmeriBen contracts with companies like yours, to process claims and administer or apply the benefits according to the Plan Document.

Having a self-funded plan allows your company to tailor benefits to better meet the needs of employees and their dependants, keep plan designs more competitive and manage costs more effectively. In today's environment of rising health care costs, larger companies find that self-funding gives them more control over benefits offered and costs less than traditional medical insurance products.

### **How does this affect me?**

If you enroll in the Medical plan, please be sure to watch for your ID cards to be delivered to your home address, and present your new ID card to your doctors and pharmacists for services rendered after your benefits effective date.

AmeriBen's Customer Care Center is available to answer your questions about the plan benefits or to provide information concerning the status of your claims Monday through Friday, 7:00am to 6:00pm Mountain or 8:00 AM to 5:00 PM Pacific. You can contact the Customer Care Center at 1-877-955-1570 or log onto our website at [www.myameriben.com](http://www.myameriben.com).

AmeriBen is dedicated to providing excellent customer service to all participants and providers. We look forward to continuing to build a successful relationship with you and TUSD and appreciate opportunities to assist you.

Sincerely,

AmeriBen

Boise, ID

Portland, OR

Salt Lake City, UT

Phoenix, AZ

# TUSD

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# WELCOME

## *Welcome to TUSD!*

This section contains information about being a Tucson Unified School District benefits eligible employee. *(If you are a retiree of the Arizona State Retirement System, you are not considered a benefits eligible employee. Please contact Human Resources for further information and required documents to complete.)*

Please use the following checklist to ensure you have reviewed and / or completed all required documents:

- Complete and submit the “Insurance Packet Document” at new hire orientation.
  
- Complete the life insurance beneficiary form to designate a beneficiary for your District paid life insurance benefit. **ALL BENEFITS ELIGIBLE EMPLOYEES MUST COMPLETE THIS FORM EVEN IF YOU ARE WAIVING ALL OTHER INSURANCE.**
  
- Complete and return all THREE of the benefit enrollment forms within 30 days of your date of hire if you are enrolling in ANY insurance plan. **IF YOU DO NOT SUBMIT THE BENEFIT PLAN ENROLLMENT FORM WITHIN 30 DAYS OF YOUR DATE OF HIRE, YOU WILL NOT BE ALLOWED TO ENROLL IN INSURANCE UNTIL THE NEXT OPEN ENROLLMENT OR UNTIL YOU EXPERIENCE A PERMISSABLE MID-YEAR STATUS CHANGE.**
  
- Review this handbook in its entirety for an overview of the TUSD Benefits Package.
  
- Review this handbook for Leave of Absence; please contact Human Resources at (520) 225-6035 with any questions.
  
- Review this handbook for basic Payroll information; please contact Payroll at (520) 225-6150 with any questions.

# TUSD

## **Benefits Providers Listing**

All Plans may be accessed on the TUSD Benefits Intranet: <a href="http://intranet/hr/benefits.asp">http://intranet/hr/benefits.asp</a>				
<b>Medical</b>	TUSD Self-Insured Medical Plans	EPO – similar to an HMO (no coverage for out-of-network; out of state coverage for emergency only) PPO – Preferred Provider Organization HDHP – High Deductible Health Plan with a Health Savings Account through Wells Fargo (monthly fee applies)	(877) 955-1570	<a href="http://www.ameriben.com">www.ameriben.com</a>  For medical network providers, see the BCBSAZ website: <a href="http://www.azblue.com">www.azblue.com</a>
<b>Prescription</b>	TUSD Self-Insured Pharmacy Plan	US Script manages TUSD's pharmacy benefit. Mail order is available also from US Script's partner, Rx Direct. Specialty injectables are available from BioScrip.	(800) 460-8988	<a href="http://www.usscript.com">www.usscript.com</a>  RX DIRECT: (800) 785-4197 BIOSCRIP: (877) 811-5978
<b>Dental</b>	EDS Discount Plan	EDS is a pre-paid discount plan	(520) 696-4343	<a href="http://www.mydentalplan.net">www.mydentalplan.net</a> <b>EDS</b>
	Delta Dental High Option Delta Dental Low Option	Delta Dental offers 2 levels of traditional dental insurance.	(800) 352-6132 Ext. 1	<a href="http://www.deltadental.com">www.deltadental.com</a> 
<b>Vision</b>	Avesis PPO Avesis Discount Plan	Traditional PPO Vision plan – be sure to use a contracted provider. If you do not choose Vision PPO, you will be enrolled in the discount plan at no cost to you.	(800) 828-9341	<a href="http://www.Avesis.com">www.Avesis.com</a> 
<b>Life &amp; AD&amp;D Insurance</b>	The Hartford	Basic Life and AD&D – provided to all benefits eligible employees at no cost (District paid). Supplemental Life and AD&D for you, your spouse, or children (employee paid).	(800) 523-2233	<a href="http://www.thehartfordatwork.com">www.thehartfordatwork.com</a> 
<b>Short Term Disability</b>	Aetna	This is an income protection plan; any claims submitted must be approved by Aetna and meet Aetna's definition of disability.	(877) 832-8241 – Claims (800) 660-9913 – EOI Status	
<b>Long Term Disability</b>	Arizona State Retirement System (ASRS)	This is a mandatory benefit provided by ASRS. To learn more, visit <a href="http://www.azasrs.gov">www.azasrs.gov</a> .	(520) 239-3100	<a href="http://www.azasrs.gov">www.azasrs.gov</a>
<b>Employee Assistance Program</b>	Jorgensen Brooks Group	No cost short-term counseling needs (mental health, financial, and legal concerns) for employees & family members.	(520) 575-8623 Tucson (888) 520-5400 Out of Area	<a href="http://www.jorgensenbrooks.com">www.jorgensenbrooks.com</a> 

### *What if I still have questions?*

- Benefits information can be accessed from the TUSD Benefits Intranet site, or from home through the TUSD Internet site. From the **TUSD Internet** homepage (<http://intranet/hr/benefits.asp>), or from home - click on the Employees Tab, then on the Employee Benefits link (on the right hand side). You may also contact the TUSD Benefits Office with questions. **The phone number is (520) 225-6144. The email address is [Benefits@tusd1.org](mailto:Benefits@tusd1.org).**

## General Benefits FAQs

### ***Am I eligible for insurance?***

An employee of TUSD is eligible for benefits if they are not a retiree of the Arizona State Retirement system, and they are in classified positions and work a minimum of 20 hours per week or they are in certified positions and have a minimum of a 1/5<sup>th</sup> contract.

If you are eligible for benefits, you are also eligible for medical, dental, and vision for your eligible dependents. If you acquire an eligible dependent by marriage, domestic partnership, birth, adoption or placement for adoption after you have submitted your form, you may enroll them in your insurance based on a permissible mid-year status change. The list of permissible status changes and eligible dependents are available in this handbook (see Table of Contents).

Section 111 of the Medicare, Medicaid and SCHIP Extension Act of 2007 (MMSEA), a federal law that became effective January 1, 2009, requires that group health insurers, claims processing third-party administrators, and certain employer self-funded/self-administered plans report specific information about Medicare beneficiaries who have other group coverage.

**If you are unable or unwilling to provide a social security number for your dependents who want to enroll in the health plan, then you must complete a CMS form available on the TUSD Benefits website.**

### ***When will my insurance go into effect?***

Benefits go into effect the first of the month following 30 days of employment.

New hires have a "Guarantee Issue" (GI) limit for Additional Employee Life Insurance. If electing coverage within 30 days of becoming eligible, you may apply for an amount up to the lesser of (a) three times your annual earnings or (b) \$250,000, without providing Evidence of Insurability.

For Short-Term Disability, the full amount is available to new hires without providing Evidence of Insurability. If the employee elects Short-Term Disability or Supplemental Life Insurance coverage after the first 30 days of employment due to a permissible mid-year status change or at Open Enrollment, **an Evidence of Insurability or Personal Health Application will be required and will only become effective upon approval by the respective insurance carrier.** It is the employee's responsibility to communicate directly with the short-term disability or life insurance company regarding their approval status.

### ***What does the dollar amount on the benefit enrollment form mean?***

#### Medical Costs shown on the form:

**FULL-TIME:** The premiums on the benefit enrollment form are per pay employee costs for each of the 20 pay periods. **The District is paying an additional \$250.39 per pay above what you see on the form.**

**PART-TIME:** If you are part-time, your cost will be higher than what is shown on the form since the District will be paying LESS than \$250.39 per pay toward your employee coverage.

Please contact the Benefits Office at (520) 225-6144 if you need more information.

The cost for all other insurance is identified on the benefit enrollment form. These are the costs per pay period to be deducted from your paycheck. **There is no District contribution for this additional coverage.**

**ADJUSTMENTS:** Employees may be charged an additional catch-up amount for adding dependents after deductions begin (for a mid-year status change), or beginning employment after school starts.

## *General Benefits FAQs (Cont'd)*

### *Where do I submit my benefit enrollment form?*

You may bring the benefit enrollment forms to the Benefits Office at 1010 E. 10<sup>th</sup> St. at the Morrow Ed Center, Building A, during regular business hours and a Benefit Associate will assist you if needed.

The forms may also be sent back via interoffice mail to the Benefits Office. **Be sure to allow enough time to ensure that it arrives at the TUSD Benefits Office by the deadline.** We are not responsible for lost or mis-directed forms not received or received after the deadline. You have 30 days from your date of hire or date of the permissible mid-year status change.

**No exceptions will be made.**

**Be sure to sign ALL pages of the Enrollment Form before submitting it to the TUSD Benefits Office.**

### *What will happen if I do not turn in a benefit enrollment form?*

If you do not turn in a benefit enrollment form, you will be enrolled in Basic Life and EAP only since the District provides those. You will have to wait until the next Open Enrollment period or until you experience a permissible mid-year status change to enroll in other coverage.

### *Will I have insurance coverage during the summer?*

Benefits remain in effect for the summer unless your employment terminates with TUSD. Please call the Benefits Office for additional information.

### *If I already have medical insurance through another company, can I still elect TUSD medical?*

If you elect medical insurance through TUSD, this insurance election becomes your **primary** insurance. **Please be aware:** If you elect insurance with TUSD **and** have insurance through another company (e.g., with your spouse's employer), **Coordination of Benefits will apply.** Please contact the Benefits Office with any questions you have on this subject.

### *I have Medicare or another health insurance plan. How will my medical benefits be affected if I enroll with AmeriBen?*

If you enroll in TUSD medical coverage, it will be considered "primary." You should contact Medicare or the other health insurance company directly to determine how enrolling in the TUSD plan may affect your other coverage. You will have to determine if its beneficial to enroll in medical coverage with TUSD if you have Medicare or another health insurance plan.

### *How much will TUSD contribute toward my insurance?*

TUSD contributes \$5,007.80 per year (equal to \$250.39 per pay period for 20 pay periods) for each full-time, benefit-eligible employee.

Part-time, benefit-eligible employees will be funded at a prorated amount. Part-time employees electing medical insurance must pay the difference of the premium not funded by the District.

This year the District will contribute \$13.46 on a per paycheck basis (for the same standard 20 deductions TUSD uses) to a Health Savings Account for employees enrolled in the High Deductible Health Plan but only after you submit a signed Wells Fargo Account Authorization form **and** Wells Fargo confirms they can open your account. A Health Savings Account is a special tax-advantaged account – meaning money goes in tax-free, earns interest tax-free and is not taxed when it is withdrawn to pay for qualified expenses. This is only available to employees who elect the High Deductible Health Plan. TUSD does not process retroactive HSA contributions.

### *When does my insurance begin?*

- **New-hires** – insurance elections are effective the first of the month following 30 days of employment.
- **Open Enrollment** – insurance elections and changes are effective on October 1.
- **Permissible Mid-Year Status Change**
  - See Page 42

## *General Benefits FAQs*

### *What is a permissible mid-year status change?*

A status change is a change to an employee's family or employment status. A list of permissible mid-year status changes appears on Page 42 of this handbook, along with the effective date of coverage that will apply.

**The Internal Revenue Code Section 125 rules that guide our benefit plan only allow certain changes during the year and then only for certain reasons. Changes must be requested within 30 days of the permissible mid-year status change. For example, if you get married, you have 30 days from the date of marriage to request enrollment of your new spouse on this plan. Contact the TUSD Benefits Office.**

### *The cost to insure my dependent(s) is high. Do I have any other options?*

**Yes.** TUSD offers a High Deductible Health Plan (HDHP), which offers lower premiums for employees. This is a PPO plan with a high deductible (see the Medical Insurance Information section for more information). A deductible is the amount you pay out-of-pocket before the medical coverage begins payment for qualified expenses. Please make sure that you are able to afford the costs associated with a high deductible before signing up for a plan with lower dependent premiums. You can contact the TUSD Benefits Office for more information on the HDHP.

If you are unable to afford insurance through TUSD for your family, you may want to consider contacting a private insurance agent or insurance company directly and inquire about an **individual insurance policy**.

Depending on your income level, you and/or your dependents may qualify for medical insurance through **AHCCCS**. Call (800) 528-0142 for more information.

**Pima Community Access Program (PCAP)** is a not-for-profit organization that provides access to professional health care at discounted prices the uninsured adult can afford. For eligibility requirements and more information, call (520) 694-0418 or visit their website at [www.pcap.cc](http://www.pcap.cc).

### *Why are insurance premiums taken over 20 pay periods?*

Payroll deductions for the entire year are taken on 20 paychecks. Seventeen (17) deductions occur from October through May to coincide with the school year. Deductions resume in the second part of August, and in September (3 deductions) for a total of 20 deductions. This means that the employee is paying for the full 12 months of coverage in 20 paychecks.

Benefit deductions are not taken during the summer months of June, July and the first part of August. This also means that employees may see adjustments to their paychecks if they make a change to their benefits elections, begin employment after school starts, end employment before school ends or for certain leaves of absence.

### *Are my insurance premiums taken on a pre-tax basis?*

Only premiums for medical, dental, vision are deducted on a pre-tax basis.

Section 125 of the Internal Revenue Code allows employers to deduct premiums before taxes are calculated. Deducting premiums with pre-tax dollars means that the money is taken from the paycheck before federal, state and Social Security taxes are calculated. The employee's taxes are reduced because the money used to purchase qualified benefits is not reported on the W-2 as part of the employee's taxable income.

**Payment of premiums on a pre-tax basis means that the employee has signed on for a salary reduction agreement in accordance with the Internal Revenue Service.**

Employees may not make any changes to their coverage elections, including level of coverage (number of dependents), during the year, unless a permissible mid-year status change is experienced.

### *Do I need to enroll in the medical plan in order to be able to select another insurance plan, such as dental or vision?*

**No.** The cafeteria plan allows you to select only the benefit options that you need.

## *General Benefits FAQs (Cont'd)*

### *What options do I have for my Domestic Partner?*

Individuals who qualify as a Domestic Partner, as that term is defined in the Affidavit of Domestic Partnership, may be eligible to enroll for coverage upon completion of the Affidavit of Domestic Partnership **and** completion of the Benefit enrollment forms. Termination of coverage for your Domestic Partner requires completion of the Statement of Termination of the Domestic Partnership and completion of the Benefit enrollment forms. Both Domestic Partnership forms are available from the Benefits Office on the TUSD Benefits intranet site.

The coverage for the Domestic Partner will be the same as if covering a Spouse; however, the premium for the Domestic Partners (and Domestic Partner's children, if applicable) will be paid on an after-tax basis.

A Domestic Partner may enroll during Initial Enrollment, when experiencing a permissible mid-year status change, or during the Open Enrollment period. Coverage of the Domestic Partner will become effective the first of the month after receipt and approval of the Affidavit of Domestic Partnership. Children of your Domestic Partner may be enrolled only if you have your Domestic Partner enrolled.

**Reminder:** The Domestic Partner Affidavit must be signed, notarized and submitted to the Benefits Office to add a Domestic Partner on your insurance.

**Please note:** in accordance with Internal Revenue Code, once an employee has added or dropped his/her dependents from the insurance coverage (medical, dental and/or vision) no further changes are allowed until a permissible mid-year status change occurs or until next year's Open Enrollment period.

### *When does my insurance end?*

- If you terminate due to a qualifying event (i.e. resignation), your benefits will terminate at the

end of the month in which the qualifying event occurs.

**If you fail to return to work at the beginning of the following school year or plan not to return, please notify both Human Resources at (520) 225-6035 and the Benefits Office immediately at (520) 225-6144.**

### *If I take a leave of absence from work, how are my premiums paid while I am on leave?*

**For a Short-Term leave of absence and/or a Family Medical Leave of Absence:** If you are enrolled in the medical plan, TUSD will continue to pay its portion while you are FMLA eligible. If you remain on Payroll using your accrued time, your premiums will continue to be deducted. ***For any premiums not deducted via payroll, the TUSD Benefits Office will either bill you on a per-pay-period basis or collect the missed premiums for dependents and/or other coverage upon your return.***

**For a Board Approved long-term leave of absence:** Your benefits will be terminated at the end of the month in which your leave is approved. You will receive a COBRA notice (mailed to your home) and may elect to continue your medical, dental and/or vision coverage for which you were enrolled. If you elect, you must pay the COBRA Administrator monthly in order to continue your coverage while you are out on leave. You will receive a Conversion & Portability notice from the Hartford to continue your life insurance coverage.

Upon returning to work from a Board Approved leave, you **MUST** complete a new benefit enrollment form to enroll in Active benefits, which will begin on the 1<sup>st</sup> of the month following 30 days of employment.

## Medical Coverage FAQs

*What are the differences between the Exclusive Provider Organization (EPO), Open Choice (PPO) and the High Deductible Health Plan (HDHP)?*

**All plans utilize the Blue Cross Blue Shield of Arizona provider network.**

**Exclusive Provider Organization (EPO)** - Members access health care through the **network** of contracted providers. These health care service providers comprise the health plan's network. The advantages of the EPO plan are minimal paperwork and lower/predictable out-of-pocket co-payments. You can also visit network specialists without referrals if the specialist does not require it.

**Participating Provider Option (PPO)** - Members can access health care through providers that are on the plan's network, as well as those not considered in-network. However, the out-of-pocket expenses will be higher if out-of-network providers are seen. Members pay a deductible before most benefits become payable under the plan, as well as a fixed percentage of covered health care costs (called co-insurance). The premium is higher because the member is paying for the greater flexibility to obtain health care in or out-of-network.

**High Deductible Health Plan (HDHP)** – This is a high deductible PPO plan that allows contributions to a Health Savings Account (HSA). A **Health Savings Account (HSA)** is a tax-advantaged, personal savings account that works in conjunction with an HSA-compatible health plan being offered by your employer. The Wells Fargo HSA offers an interest-bearing, FDIC-insured deposit account and the option to invest in mutual funds once the deposit account reaches a minimum balance of \$2,000. You can use your HSA to pay for qualified medical expenses now or later in life—all tax-free.

One great advantage of the HSA is that the money stays with you even if you changes jobs, retire or change insurance plans. There is no 'use-it-or-lose-it' provision, as with a Flexible Spending Account. Any unused deposits, rollover year after year and can accumulate interest and investment earnings.

To learn more about how an HSA can help you save for current and future healthcare costs, go to

[wellsfargo.com/hsa](http://wellsfargo.com/hsa) or call Wells Fargo HSA Customer Service at 1-866-884-7374.

An employee can contribute additional pre-tax money to this HSA up to the limit allowed by the Internal Revenue Service. The HSA is only available to employees who elect the HDHP.

The HSA is a Federal program and covered by the Family Protection Act. This Act does not recognize domestic partnerships even if the state of residency does. You may enroll your qualified domestic partner in the HDHP, however, you are not allowed, per IRS code, to make deposits to an HSA for your domestic partner or use your HSA funds for expenses incurred by a domestic partner.

*If I enroll in the HDHP, how do I set up my HSA account?*

Simply complete the **Wells Fargo Account Authorization form** (<http://intranet/hr/Documents/hsaWellsFargoAccountAuthorizationForm.pdf>) and submit it with your enrollment forms. TUSD submits to Wells Fargo via a secure online method, and once your account is approved by Wells Fargo, TUSD will begin contributions. You may also complete and submit the **TUSD Authorization Deduction form** if you also want to contribute to your account. Both forms are available on the Benefits website. Wells Fargo will charge \$3.75 per month out of your account until your account reaches a balance of \$5000.

*What types of prescription drug plans are offered?*

The plans have a three-level prescription drug plan and may be subject to deductible, generic and/or step-therapy restrictions.

Medications are divided into three categories.

<b>Generic</b> drugs	\$10 co-pay
<b>Brand name</b> drugs	\$30 co-pay
<b>Non-Formulary</b> drugs	\$60 co-pay

**Mail Order** can also be more affordable than your regular co-pay. Please review the Medical Plan Comparison Chart for co-pays.

The High Deductible plan requires most prescription drugs to be paid at **full cost** until the plan deductible is met. Certain preventive medications are not subject to the deductible; please see the Plan Document or contact AmeriBen for more information.

## *Medical Coverage FAQs (Cont'd)*

The Blue Cross Blue Shield of Arizona provider directory and detailed instructions on how to find a provider can be accessed from the TUSD Benefits Intranet. <http://intranet/hr/benefits.asp> - click on the BCBS PPO directory link.

Once your enrollment has been uploaded by TUSD to AmeriBen, you may access your personalized information at [www.myameriben.com](http://www.myameriben.com). Using this website, you can review your benefits plan information, find participating physicians, view the status of a claim, order ID cards, choose paperless EOB's, etc.

### *A provider that does not accept Blue Cross Blue Shield is currently treating me. What options do I have?*

It is in your best interest to use a network provider. To determine if your provider is part of the network, ask them if they contract with Blue Cross Blue Shield of Arizona (BCBSAZ). If your provider does not currently have a contract with BCBSAZ, talk with your doctor and request that he/she contact BCBSAZ for a Provider Nomination form or find a provider in the BCBS network at: <http://www.azblue.com/CHSPProviderSearch/Specmenu7.htm?search=chs4>

### *What will be my costs if I obtain services outside of the network?*

An EPO member does not have coverage outside of the BCBS network for non-emergent services so will pay the full cost. For PPO and HDHP, when members choose to go outside of the BCBS network they will be subject to a higher deductible and co-insurance.

#### **Please note:**

The member's total responsibility for out-of-network services can include the deductible (if applicable), co-insurance and the difference between the billed charges and the allowed amount.

### *Selecting a Primary Care Physician (PCP)*

The 2011 TUSD plans are Open Access, meaning you do not need to select a primary care physician (PCP) to manage your care and refer you to other providers in the network. While it is not required, we highly recommend you select a PCP who can coordinate your health care. Your PCP serves as

your main contact in the health care world and provides you with basic care.

### *How can I speak to an AmeriBen Customer Service Representative?*

You may call (877) 955-1570 to speak directly to an AmeriBen representative familiar with the TUSD plan design Monday through Friday from 7:00 am to 7:00 pm, Pacific Time. For after hours you can register and check the website [www.myameriben.com](http://www.myameriben.com) to review benefit information, network providers or claim status 24/7.

### *Can my child access the plan if he/she is a student and lives outside of Arizona?*

Dependent children who live in another state can access care through the PHCS network if the employee is enrolled in any of the TUSD plans. Call AmeriBen to designate this network for your out-of-state child. To obtain a provider listing for another area, contact AmeriBen Customer Service toll free at: (877) 955-1570. For after hours assistance, check the PHCS website through [www.myameriben.com](http://www.myameriben.com).

### *What is the difference between a co-payment and a co-insurance amount?*

A **co-payment** is a cost sharing arrangement in which a member pays a specified charge for a specific service. **Co-insurance** is the portion paid by the member that is a percentage of the service provider's cost (i.e., 70% paid by the plan and 30% paid by the member)

### *What is an Out-of-Pocket Maximum?*

These are co-insurance costs paid by the member and do not include the deductible or co-payments. For example, in the Participating Provider Option (PPO) plan, an employee enrolled in employee only coverage will pay all charges for in-network services for hospital-inpatient stay until the \$500 deductible has been met, plus 10% of costs after that. Once the out-of-pocket maximum has been met, e.g., \$1,000 for individual, the member does not pay any more, except for co-payments.

## *Medical Coverage FAQs (Cont'd)*

The out of pocket maximum amounts are different based on whether you are enrolled as an individual or with dependents. The following member costs are not used to satisfy the out-of-pocket maximum: deductible, co-payments, prescription drugs, failure to obtain or follow pre-certification, mental illness and substance abuse, infertility, use of emergency room for non-emergency care and charges in excess of eligible expenses.

### *What is the difference between Emergency Services, Urgent Care and Walk-In Clinics?*

**Emergency services** are those services required because of unforeseen injuries or acute illness for which a delay in treatment would result in permanent physical impairment or loss of life.

**Urgent care** is defined as those services required because of unforeseen injuries or acute illness that require immediate attention. A list of Urgent Care facilities in the BCBSAZ network can be located on the Benefits intranet site.

**Walk-In Clinics** are available at many local pharmacies to provide convenient health care. These clinics offer professional health care providers who can treat common conditions such as strep throat, pink eye, rashes or respiratory illnesses. Most clinics are open seven days a week with extended evening and weekend hours. A list of clinics in the Blue Cross Blue Shield network can be found at <http://www.azblue.com/CHSPProviderSearch/Specmenu7.htm?search=chs4>

### *Are there any pre-existing condition exclusions?*

No, there are no pre-existing condition exclusions in the Medical Plan. However, **TUSD plans do have a list of services that need to be pre-certified prior to utilization.** Examples of services that need to be pre-certified are MRI's, CT Scans - you can find this list on the Benefits intranet site or in the Medical Plan Documents.

### *What is not covered under the health plan?*

TUSD will **not** pay benefits for any of the services, treatments, items or supplies described in the

section titled "Medical Benefit Exclusions," even if of the following is true:

- It is recommended or prescribed by a physician.
- It is the only available treatment for your condition

### *What wellness information can I access?*

#### **Wellness Council of Arizona (WELCO):**

AmeriBen has contracted with WELCO and offers a variety of FREE one-on-one or group activities to assist you in your wellness and fitness goals:

- Health Coaching
- Weight Reduction & Maintenance
- Exercise Classes
- Relieving stress, and more

#### **AmeriBen - HealthCare Suite:**

My Personal Health Suite is a personalized online health and wellness program accessed through the AmeriBen website. The secure online health and wellness program helps you find convenient ways to make health changes. You can learn how to:

- Stay fit at your own pace
- Stay healthy as you age
- Make healthy food choices with confidence
- Relieve stress, and more

#### **Start with an online Health Assessment**

This questionnaire asks about your health habits history to help identify some of your health needs. Your answers are confidential. They help us offer programs that fit your personal health needs.

#### **Review your personalized Health Reports and Action Plan**

You will receive easy-to-understand Health Reports and a printable one-page Health Summary, which you can choose to share with your doctor. You will also get an Action Plan that is just for you, suggesting a combination of the following Healthy Living Programs, such as:

- Weight Loss
- Get in Shape
- Stress Relief
- Healthier Diet
- Healthy Aging
- Healthy Heart
- Cancer Fighting
- Diabetes Fighting
- Smoke-Free
- Alcohol Awareness
- Maintenance Program

Choose the programs, tools, and information that are right for you. Each program includes interactive tools to help you reach your health goals in a fun and interesting way. You can use an online Fitness Planner, a Healthy Shopping List and more. You can also find more information and articles to help you stay at your healthiest.

*Is there a tool to help me manage my medical information?*

TUSD seeks to give people information to make better decisions. To further this goal, AmeriBen offers a secure online tool that can help our members, in concert with their health care providers, to achieve their optimal health: the Personal Health Record. The Personal Health Record can help people become better informed, organized, and active with regard to their health, health information, and health care. You may enter physician offices, labs, diagnostic treatment, and prescription drugs as well as history or allergies. The result is a comprehensive profile that members can access anytime online, and print to share with providers. This is available at the [www.myameriben.com](http://www.myameriben.com) site by choosing **My Online Tools** and then **My Personal Health Suite**.



## Comparison Chart of Medical Plans

The medical plan comparison charts that follow contain a partial listing of the benefits offered to employees and eligible dependents. Please remember that benefits are subject to plan limitations and exclusions. Network providers are those hospitals and physicians contracted with Blue Cross Blue Shield of Arizona. **For the EPO plan, coverage outside of Arizona is limited to life-threatening medical emergencies.**

**While every effort has been made to ensure the accuracy of this chart, in the event of any discrepancy, the legal documents, policies, or certificates of coverage pertaining to the various benefits will prevail.**

This summary is not intended to be a complete benefit description.

Benefit Description	EPO	PPO		HDHP PPO	
	In-Network ONLY	In-Network	Out of Network	In-Network Preferred Care	Out-of-Network Non-Preferred Care
	Co-Pay	Co-Pay (\$) or Co-Insurance (%)	Co-Pay (\$) or Co-Insurance (%)	Co-Insurance (%)	Co-Insurance (%)
Deductible - Individual	None	\$500	\$500	\$1,500	\$1,500
Deductible - Family	None	\$1,000	\$1,000	\$3,000	\$3,000
Out of Pocket Max - Individual	\$2,000	\$1,000	\$3,000	\$5,500	\$9,500
Out of Pocket Max - Family	\$6,000	\$2,000	\$6,000	\$11,000	\$19,000
Physician Office Services (PCP/Specialist)	\$25/\$40 co-pay	\$25/\$40 co-pay	*30%	*20%	*40%
Preventive Care (see Plan Document for Eligible Preventive Care Services)	100%	100%	*30%	100%	N/A
Walgreen's Take Care Clinic	\$25 co-pay	\$25 co-pay	*30%	*20%	%40
Routine Eye Examinations	\$40 co-pay, 1 visit per 24 months	\$30 co-pay, 1 visit per 24 months	*30%	N/A	N/A
Urgent Care	\$35 co-pay	\$85 co-pay	*30%	*20%	*40%
Emergency Room (Life-Threatening)	\$200 co-pay	\$200 co-pay	Same as in-network care	*20%	Same as in-network care
Prescription Drugs (subject to generic and step-therapy restrictions):					
Retail (up to a 30-day supply) Tier 1 Generic	\$10	\$10	*30%	*20%	*40%
Tier 2 Formulary Brand	\$30	\$30	*30%	*20%	*40%
Tier 3 Non-Formulary Brand & Specialty Drugs	\$60	\$60	*30%	*20%	*40%
Mail Order (via Rx Direct)	2x the co-pay price for a 31-90 day supply	2x the co-pay price for a 31-90 day supply	N/A	*20%	N/A
* After Deductible NOTE: Certain preventive care and medications received by a <b>preferred provider</b> are covered at 100% and the deductible (if applicable) is waived; please see the Plan Document or contact AmeriBen for more information. Once the applicable out-of-pocket maximum has been met, the member does not pay any more, except for co-payments					

**Comparison Chart of Medical Plans (Cont'd)**

TUSD	EPO	PPO		HDHP PPO	
	Co-Pay	Co-Pay (\$) or Co-Insurance (%)	Co-Pay (\$) or Co-Insurance (%)	Co-Insurance (%)	Co-Insurance (%)
Maternity Services	\$150 per admission	*10%	*30%	*20%	*40%
Hospital - Inpatient Stay	\$150 per admission	*10%	*30%	*20%	*40%
Outpatient Procedure	\$75 co-pay	*10%	*30%	*20%	*40%
Ambulance Services	Covered 100%	*10%	*30%	*20%	*40%
Durable Medical Equipment	100%	*10%	*30%	*20%	*40%
Lab/Radiology/X-Ray	Covered 100%	*100%	*30%	*20%	*40%
Mammograms (may be covered 100% if preventive)	Covered 100%	*100%	*30%	*100%	*40%
CT Scans, Pet Scans, MRI, Nuclear Medicine	Covered 100%	*100%	*30%	*20%	*40%
Outpatient Short Term Rehab (i.e.: Physical Therapy)	\$40 co-pay Limited to 60 visits per plan year	\$30 Limited to 60 visits per plan year	*30% Limited to 60 visits per plan year	*20% Limited to 60 visits per plan year	*40% Limited to 60 visits per plan year
Chiropractic Care	\$40 co-pay Limited to 60 visits per plan year	\$30 co-pay Un-Limited visits per plan year	30%* Un-Limited visits per plan year	*20% co-pay Un-Limited visits per plan year	*40% Un-Limited visits per plan year
Mental Health - Outpatient	\$40 co-pay	\$30 co-pay	*30%	*20%	*40%
Mental Health - Inpatient	\$150 per admission	*10% per admission	*30% per admission	*20% per admission	*40% per admission
* After Deductible NOTE: Certain preventive care and medications received by a <b>preferred in-network provider</b> are covered at 100% and the deductible (if applicable) is waived; please see the Plan Document or contact AmeriBen for more information. Once the applicable out-of-pocket maximum has been met, the member does not pay any more coinsurance for the remainder of the year, except for co-payments.					

The TUSD Medical Plan Documents and forms can be located at: <http://intranet/hr/ameriben.asp>. If you cannot access the intranet just contact the Benefits Office at 520-225-6144 and we will provide you with a hard copy free of charge.

**^NOTE: If you are currently enrolled in the HDHP Plan, and wish to continue that plan, you do not need to submit another Wells Fargo Authorization form. However, if you also want to contribute to your HSA through payroll deduction, a TUSD contribution form is required.**

**^If you wish to enroll in the High Deductible Health Plan for the first time, you MUST submit a signed Wells Fargo Authorization form with your enrollment forms. Once your HSA has been approved by Wells Fargo, TUSD can begin contributions to your HSA. Retroactive contributions will not be offered by TUSD.**

## Costs for Medical / Dental / Vision Plans

### Based on 20 Paycheck Deductions

\* Employees who enroll in the High Deductible Health Plan (HDHP) will receive \$13.46 contribution to a \*Wells Fargo Health Savings Account as part of the \*District Contribution (you must submit the Wells Fargo Authorization form with your TUSD benefits enrollment forms, and Wells Fargo approves your account can be established). Contact the Benefits Office with questions at 520-225-6144.

	Administered by AmeriBen using BCBS AZ PPO Network					
	EPO		PPO		^HDHP	
	District Pays	You Pay	District Pays	You Pay	*District Pays	You Pay
Employee Only	\$ 250.39	\$ 12.52	\$ 250.39	\$ 65.11	\$ 236.93	\$0.00
Employee + Spouse	\$ 250.39	\$ 309.67	\$ 250.39	\$ 421.68	\$ 236.93	\$267.73
Employee + Child(ren)	\$ 250.39	\$ 284.91	\$ 250.39	\$ 391.96	\$ 236.93	\$246.41
Employee + Family	\$ 250.39	\$ 544.90	\$ 250.39	\$ 703.97	\$ 236.93	\$478.60

\*Wells Fargo charges a monthly fee of \$3.75 per month; if your account balance reaches \$5000, Wells Fargo will waive this monthly fee.

Dental Insurance Rates (no district contribution toward dental)			
	EMPLOYERS DENTAL SERVICES (EDS)	DELTA DENTAL	
		HIGH OPTION	LOW OPTION
Employee Only	\$ 4.95	\$27.46	\$17.07
Employee + Spouse	\$10.40	\$65.97	\$41.00
Employee + Child(ren)	\$14.42	\$59.85	\$37.19
Employee + Family	\$15.59	\$94.91	\$58.98

Vision Insurance Rates (no district contribution toward vision)		
Avësis	PREFERRED PLUS (PPO PLAN)	DISCOUNT PLAN
Employee Only	\$4.14	No Charge
Employee + Spouse	\$7.26	No Charge
Employee + Children	\$8.39	No Charge
Employee + Family	\$10.81	No Charge

## *Dental Insurance FAQs*

### *Who are the TUSD dental providers?*

**Employers Dental Services (EDS)** is the carrier for the pre-paid dental plan. Contact information:

- **Customer Service – (520) 696-4343** (Spanish speaking representatives are available).
- You also can find or change a dentist, order ID cards, look up plan benefits **online at [www.mydentalplan.net](http://www.mydentalplan.net)**.

**Delta Dental of Arizona** is the carrier for the dental indemnity (high and low option) plans. Contact information:

- **Customer Service: (800) 352-6132, ext. 1.**

To locate a Delta Dental provider or specialist, view claims history or access your dental benefit information as a member any time at [www.deltadentalaz.com](http://www.deltadentalaz.com)

### *What is the difference between the pre-paid dental and the dental indemnity plans?*

A **pre-paid dental plan (EDS)** is similar to a medical HMO. There are no deductibles, claim forms to file and no calendar year maximum dollar limit; all necessary treatment can be rendered in a plan year. These types of plans provide treatment and services based on contracted co-payments that apply when an EDS general dentist performs the services. Specialty care is provided at a discounted rate. **You must select a dentist within the EDS network to obtain services.**

Delta Dental of Arizona (PPO). One of the many advantages of being a subscriber is the freedom to choose your own dentist. Payment will be based on the pricing method for the state in which services are rendered, not to exceed the Maximum Reimbursable Amount for that state - no balance billing if you see a Delta Dental contracted provider. A participating dentist is a dentist who has signed an agreement with a Delta Dental Member Company. Once the deductibles have been met for the plan year, the plan pays a percentage of the dentist's charges up to the annual maximum and the member is responsible to pay their portion of the co-insurance for the service rendered according to the employer summary of benefits.

Delta offers two plan options, a **High Option and a Low Option**. The differences between the High and

Low options include the percentage of coverage (also known as co-insurance), plan year benefit maximum, plan year deductible for the family, coverage of orthodontic services. On the High plan there are no benefit waiting periods. On the Low option there is a **six-month waiting period for Basic, Major and Orthodontic services. The waiting period does not apply to Routine services on the low option.** Please refer to the plan summaries that are available at Open Enrollment or in your new-hire packet for additional information.

### *Do I have to select a dentist in a network?*

Employees who are electing the pre-paid dental plan, offered by **Employers Dental Services**, **MUST** identify a dentist's provider number from the EDS provider network directory on the benefit enrollment form. If a dental provider is not listed, EDS will assign one.

Employees have "Freedom of Choice" when electing Delta Dental. Delta Dental provider network is Nationwide. Members who elect to use an Out of Network provider may be balance billed and are subject to the providers non-contracted fees.

### *Where can I get a list of the dental providers?*

The provider directory for **EDS** can be accessed by visiting [www.mydentalplan.net](http://www.mydentalplan.net), or by contacting EDS Customer Service at (520) 696-4343.

**Delta Dental** strongly encourages members to utilize the services of Participating Dentists. By receiving care from one of their Participating Dentists, members will receive lower out-of-pocket costs and get the most out of the dental benefits. To locate a dentist or find out if a dentist is part of the Delta Dental network, visit [www.deltadentalaz.com](http://www.deltadentalaz.com) select Subscriber and then Dentist search, or call Customer Service at (800) 352-6132, ext. 1.

### *Are there any waiting periods or pre-existing condition exclusions on the dental plans?*

- No waiting period on the High option.
- 6 month waiting period for Basic, Major, Orthodontic services on the Low option.
- There are no pre-existing conditions for either plan option.

## *Dental Insurance FAQs (Cont'd)*

**Employers Dental Services** does not have any waiting periods or pre-existing condition exclusions except for treatment in progress prior to the date any person becomes a member under the EDS plan

### *Are orthodontic services included?*

**Employers Dental Services** covers orthodontic services for adults and children. EDS orthodontists offer 25% off their normal and customary fees. The treatment plan and payment terms are defined by the contract signed with the chosen EDS orthodontist. There is no referral required and no lifetime benefit maximum. Individuals receiving orthodontic treatment under another program at time of enrollment are not eligible to participate. This is considered treatment in progress and is therefore, excluded.

**Delta Dental** covers orthodontic services for adults and children age eight (8) or older. The Low Option plan covers 40% of the costs with a lifetime orthodontia benefit limited to a maximum of \$1,000 per patient. The High Option plan covers 50% of the costs with a lifetime orthodontia benefit limited to a maximum of \$1,500 per patient. These maximums are separate from the plan year benefit

maximums for other dental benefits. Orthodontia claims paid before enrollment with Delta Dental will apply to the lifetime orthodontia maximum.

**In order to receive Orthodontics benefits you must be banded with Delta Dental of Arizona.** This benefit is payable in two (2) payments - upon initial banding and twelve months after. **If you are currently banded with another dental plan, prior to enrolling onto the TUSD Delta Dental plan, there is no benefit.**

## Comparison Chart of Dental Plans

The dental plan comparison charts contain a partial listing of the benefits offered to employees and eligible dependents. **Consult the EDS schedule of benefits for a complete list of member costs – listed below are just a few of the common services and multiple charges may occur per visit.** Benefits are subject to plan limitations and exclusions. While every effort has been made to ensure the accuracy of this chart, in the event of any discrepancies, the legal documents, policies, or certificates of coverage pertaining to the various benefits will prevail. **This summary is not intended to be a complete benefit description**

	<b>Employers Dental Services (EDS) (pre-paid plan)</b>	<b>Delta Dental (High Option)</b>	<b>Delta Dental (Low Option)</b>
Deductible- Individual	No Deductible	\$50	\$50
Deductible- Family	No Deductible	\$100	\$150
Maximum Benefit	Unlimited	\$2,000	\$1,000
Pre-Existing Conditions and/or Waiting Period	No exclusion for pre-existing condition, except for procedures in progress	None	6-month waiting period for Basic, Major and Orthodontic Services / No Pre-existing Conditions for services
<b>You Pay:</b>			<b>You Pay:</b>
<u>Routine Services</u>	\$5.00 office visit		
Diagnostic Services	No charge for x-rays	0%	20%
Preventive Services	\$7.00 adult cleaning*	0%	20%
<u>Basic Services</u>			
Endodontics	\$305 Molar root canal*	20%	40%
Periodontics	\$90 Periodontal Scaling and Root Planing*	20%	Low Option-Major Coverage
Oral Surgery	\$55 Extraction*	20%	40%
<u>Major Services</u>		High Option – Basic Coverage	
Periodontics	See above		60%
Crowns	\$280+LAB*	20%	60%
Prosthetic Repairs/Adj	\$25 adjust partial denture*	50%	60%
Prosthetics	\$325+Lab, complete denture, upper*	50%	60%
<u>Orthodontic Services</u>			
Orthodontics	25% Discount	50%	60%
Coverage Maximum	No lifetime limit	\$1,500 per covered person. Lifetime maximum	\$1,000 per covered person Lifetime max

\* NOTE: EDS co payments apply when a general dentist provides treatment. Specialty care by an EDS specialist is a discounted rate.

## *Vision Insurance FAQs*

### *Who is the vision services provider for TUSD?*

**Avēsis Incorporated** is the provider for vision examinations, including the prescription of corrective eyewear where indicated.

Avēsis Customer Service Department can be reached at (800) 828-9341 or online at [www.avesis.com](http://www.avesis.com). The website offers many services including verification of your eligibility, search for a vision provider, printing a copy of your membership card, Frequently Asked Questions and more.

<b>Avēsis</b>	<b>PPO</b>	<b>Discount</b>
Examination	12 months	12 months
Lenses	12 months	12 months
Frame	12 months	12 months
<b>Examination Co-pay</b>	\$10 co-pay	Up to \$45
<b>Optical Materials Co-pay (Lenses &amp; Frame Combined)</b>	\$15 co-pay	Refer to Schedule Below
<b>Standard Spectacle Lenses</b>		
Single Vision Lenses	Covered-In-Full after co-pay	\$35 co-pay
Bifocal Lenses	Covered-In-Full after co-pay	\$50 co-pay
Trifocal Lenses	Covered-In-Full after co-pay	\$65 co-pay
Lenticular Lenses	Covered-In-Full after co-pay	\$80 co-pay
<b>Frame</b>		
<b>Frame</b>	\$50 wholesale cost Covered-In-Full after co-pay (up to approximately \$100-\$150 retail value)	20-50% off
<b>Contact Lenses</b>		
<b>Elective Lenses</b>	10-20% discount & \$130 allowance	10-20% savings
<b>Necessary Lenses</b>	Covered-in-Full	10-20% savings
<b>LASIK/PRK</b>		
	Up to 25% savings + \$150 allowance	Up to 20% savings

*Who are the service providers under the Avēsis plans?* Avēsis providers include many independent providers as well as large retail chains. The provider directory for Avēsis can be located online at [www.avesis.com](http://www.avesis.com) or contact Avēsis Customer Service Department at (800) 828-9341.

*What is the difference between the two Avēsis plans?*

#### **The Advantage Plus plan**

This plan allows for co-payments when services are obtained from network participating providers. Reimbursement up to certain dollar amounts is allowed for out-of-network benefits.

#### **The Advantage Discount plan**

Allows you to access services only through a network provider and you pay the discounted fees.

Please refer to the plan summaries that are available at Open Enrollment or in your new-hire packet for additional information.

When determining which plan would be best, review your anticipated vision expenses and annual premiums. An employee planning to obtain services out-of-network must remember that the Preferred Plus plan allows reimbursements according to the Out-Of-Network Reimbursement schedule.

**To get the most from your vision insurance benefit,** keep in mind that prices for frames and lenses often vary from provider to provider. Be a good consumer and compare prices before purchasing lenses and frames.

## Life Insurance FAQs

### *Who is the life insurance carrier?*

**Hartford Life and Accident Insurance Company** is the provider for Basic Life Insurance/Accidental Death & Dismemberment [AD&D] (District paid) and Supplemental Life Insurance (Employee paid). Both are term life insurance policies. A Hartford Life Insurance brochure is available at Open Enrollment meetings or the TUSD Benefits intranet site <http://intranet/hr/benefits.asp>. For further information, contact **Hartford Life at (800) 523-2233**, or online at [www.thehartfordatwork.com](http://www.thehartfordatwork.com).

### *What is the purpose of life insurance?*

The purpose of life insurance is to provide a cash benefit to the member's beneficiary after his/her death. Determine the amount of insurance needed by evaluating the beneficiary's financial obligations and loss of income created by the death.

### *What is the Basic Life Insurance benefit?*

TUSD will provide Basic Life Insurance and Accidental Death and Dismemberment (AD&D) coverage underwritten from The Hartford. Employees shall be provided with a term life insurance policy:

- Full-Time - equal to the employee's annual base salary as of the beginning of the benefit year, but not less than \$10,000.
- Part-time employees shall be provided with a term life insurance policy equal to half of the employee's annual base salary at the beginning of the benefit year, but not less than \$5,000.

Basic AD&D insurance pays an additional death benefit in the event of a covered accidental death or a dismemberment benefit for a covered accidental loss of a hand, foot, hearing, speech or sight. Quadriplegia, hemiplegia and paraplegia are also covered.

### *Is Supplemental Life Insurance available?*

**Yes.** You may elect supplemental life insurance for yourself and your covered dependents (see next sections). The employee must have Supplemental Life Insurance for her/himself in order to elect supplemental life insurance for a dependent child.

While Dependents Life Insurance is in effect, each newly enrolled child becomes insured immediately. **More than one employee may not insure the same child under the TUSD plan.**

### *Do I have to submit a health application?*

**A Personal Health Application (PHA)** is not required when electing coverage within the "Guaranteed Issue" range. New-hire employees must complete a PHA only if their requested Additional Employee Life insurance exceeds the Guaranteed Issue of the lesser of \$250,000 or three times their annual salary.

Should you wish to elect coverage above the Guaranteed Issue, the form is available in your new hire packet or on the Benefits Intranet site. You may elect Supplemental Life coverage in units of \$10,000, with a minimum of \$20,000 and a maximum of \$1,000,000; but not to exceed 6 times their earnings, rounded to the next higher multiple of \$10,000, if not already a multiple of \$10,000.

### **Accidental Death and Dismemberment**

Additional AD&D coverage is included in the cost of the Additional Employee, Spouse and Child Life Insurance. The amount of Additional AD&D Insurance will equal the amount of Employee, Spouse and Child Life coverage.

### **Spouse Life Insurance**

Spouse Additional Life Insurance is available in units of \$5,000 to a maximum of \$250,000, but not to exceed 100% of the employee's Additional Life Insurance coverage. Upon hire, employees may elect \$25,000 of "Guaranteed Issue" for the spouse. **Employees must have elected Additional Life Insurance for themselves in an amount equal to or greater than the amount elected for their spouses.**

A Personal Health Application **MUST** be completed by the spouse of any employee electing coverage for the first time for their spouse that exceeds the Guaranteed Issue amount, or requesting an increase in coverage for their spouse in a subsequent year. This form is the same Personal Health Application in your new hire packet.

## *Life Insurance FAQs (Cont'd)*

**NOTE:** An employee cannot have dual life insurance coverage: i.e., covered as a dependent (spouse or child) of another TUSD employee while also employed at TUSD.

### **Child Life Insurance**

Employees may elect \$1,000, \$5,000 or \$10,000 of Dependent Life Insurance for eligible children. The amount will apply to all eligible children

### **Cost of Life Insurance**

To determine the per pay period cost of insurance, please refer to the Premium Rate chart in this booklet.

**An active work requirement.** This means that for employees who are incapable of active work because of sickness, injury or pregnancy on the day before the scheduled effective date of insurance (including Dependents Life Insurance) or an increase in insurance, their insurance or increase, will not become effective until the day after one full day of active work as an eligible employee is completed.

### **Effective Dates**

Basic Life and Supplemental Life within the Guaranteed Issue range will go into effect on the first day of the month following 30 days of employment.

Supplemental Life over the Guaranteed Issue amount will go into effect the 1<sup>st</sup> day of the month following notice from The Hartford to TUSD of their approval.

Child Life Insurance goes into effect immediately once Employee Supplemental Life Insurance is approved.

### ***What happens to my Life Insurance coverage if I leave TUSD or go on a Board Approved Leave of Absence?***

You may have the ability to port or convert your coverage, depending on your situation. If you are applying for Long Term Disability, you may qualify for a Waiver of Premium. Contact the Benefits Office at (520) 225-6144 for additional information.

### **Estate Guidance Program**

A will is an important legal document that allows employees to stipulate their directions upon death concerning property inheritance, child guardianship and estate management. As part of your life insurance with The Hartford, you have access to Hartford Estate Guidance program. Estate-Guidance is a service for employees that makes it fast and easy to prepare a will on-line. To access The Hartford's Estate Guidance service on-line, visit [www.EstateGuidance.com/wills](http://www.EstateGuidance.com/wills) and use the promotional code **WILLHLF**. You will have 30 days from the date you start your will to complete it. For further information, please see the Estate Guidance flyer on the Benefits Office Intranet site.



## *Employee Assistance Program (EAP) FAQs*

### *What is EAP?*

EAP is an **Employee Assistance Program** that assists employees, dependents and any household members to live healthier, happier lives.

**Jorgensen Brooks Group EAP Services** provides counseling and referrals to help employees, dependents and household members reduce their stress and resolve problems. Contact Jorgensen Brooks Group in the Tucson area at (520) 575-8623 or outside the Tucson area at (888) 520-5400. You can also view the website at [www.jorgensenbrooks.com](http://www.jorgensenbrooks.com).

### *What is the cost?*

EAP is a confidential benefit provided by TUSD for benefit eligible employees and their eligible dependents and household members at **no cost**.

### *What kinds of issues can I get help with through my EAP?*

Employees and eligible family members can discuss anything that affects their well-being with a Jorgensen Brooks Group Counselor, Legal and/or Financial Advisor. This includes issues such as:

- Depression or Anxiety
- Relationship Conflict
- Workplace Conflicts
- Grief; Death and Dying
- Alcohol Abuse/Drug Abuse
- Stress Management
- Caring for an Elderly Parent
- Domestic Violence
- Financial Difficulties
- Legal Difficulties

### *Will anyone find out that I used EAP services?*

**No, EAP visits are completely confidential.** Meetings with a Jorgensen Brooks Group EAP counselor remain private unless you sign a consent form for a release of information.

### *How do I make an appointment?*

Call Jorgensen Brooks Group at (520) 575-8623 Tucson Metro area or (888) 520-5400 outside the Tucson area Monday – Friday 8:00 a.m. to 5:00 p.m. If you are in crisis situation, Jorgensen Brooks Group counselors are available 24 hours a day, 7 days a week.

*To make an appointment for legal or financial services, please call the Tucson Metro office at (520) 575-8623.*

EAP participants may see a Jorgensen Brooks Group provider by appointment regardless of where the employee or dependent lives.



## Short Term Disability FAQs

This section is a general enrollment guide/summary of the STD benefits. Refer to the Aetna Summary of Coverage in your new hire packet.

### *What is Short-Term Disability insurance?*

Short-Term Disability (STD) insurance provides a weekly benefit if the eligible employee meets the definition of disability. The weekly benefit is equal to 66 2/3% of the employee's weekly earnings, to a maximum of \$2,500 per week. Benefits may be payable for up to 26 weeks.

### *Who is the provider of the Short-Term Disability insurance?*

**Aetna Life Insurance Company** underwrites the Short Term Disability income protection insurance. Contact information: **Customer Service is (866) 282-8495**

**New Employees – as a new employee, you have this initial opportunity to enroll without having to submit an Aetna health application (Evidence of Insurability).** Should you choose not to enroll at this time, and wish to enroll at a future Open Enrollment period, you will have to submit a health application in order to be considered.

### *What is the cost?*

Please refer to your TUSD Enrollment Form. The cost is a calculation against your salary.

### *What is the benefit if I have an approved claim?*

All plans have a weekly benefit equal to 66 2/3% of the employee's weekly earnings, to a maximum of \$2,500 per week for up to 26 weeks. The difference between the plans is the length of the waiting period before benefits begin. You must be unable to work and meet Aetna's "Definition of Disability" for your short-term disability claim to be approved by Aetna.

### *What plans are available?*

1. **While there is a 0/3 plan with no waiting period for injury and 3 days for illness, this plan is closed to new enrollment.**
2. **The 7/14 plan has waiting periods of 7 days for injury and 14 days for illness.** Because of the longer waiting period, the premium is lower than the 0/3 plan premium.
3. **The 14/21 plan has waiting periods of 14 days for injury and 21 days for illness.** This plan is also offset by leave accruals. This means that you must use your leave accruals before receiving benefits from this plan. Because of the longer waiting period and use of sick leave, the premium is lower than both the 0/3 and 7/14 plan premiums.

Remember to consider the amount of sick, personal and/or vacation time you currently have when selecting a Short Term Disability Plan. If you have enough paid time off to get you through a couple of weeks or longer, you may wish to elect a less expensive disability plan.



## *ASRS Long Term Disability Information*

### *What is Long Term Disability Income Program?*

Long Term Disability (LTD) provides you with a monthly benefit designed to partially replace lost income lost during periods of **total disability** resulting from a covered injury, sickness or pregnancy.

It is provided to you as a benefit through the Arizona State Retirement System (ASRS). The ASRS has contracted with **Sedgwick Claim Management Services** for administration of the LTD plan. Sedgwick makes all initial decisions regarding claims submitted under the LTD plan.

### *Who is eligible for Long Term Disability?*

All **benefits eligible employees** are automatically enrolled in Long Term Disability provided through the Arizona State Retirement System.

### *What are the Long Term Disability benefits?*

After being off work for six months due to disability, eligible employees whose claim is approved will receive benefits under ASRS' Long Term disability Income Plan equal to 66 2/3% of their monthly earnings. Because the LTD plan is partially funded

by TUSD, 50% of any benefits that are received are subject to taxes.

### *Who Pays for Long Term Disability?*

All benefits eligible employees are automatically enrolled in Long Term Disability provided by the Arizona State Retirement System. *This is not a voluntary or optional plan – active members contributing to ASRS are also part of the ASRS Long Term Disability Income Program.* Employees contribute a set percentage of their earnings for the ASRS LTD and TUSD matches these contributions.

### *How do I file a Long Term Disability claim?*

To obtain the application packet necessary to file an LTD claim, you need to contact Human Resources at (520) 225-6035. You should submit an application if you have been out for three months and you believe you will be out of work for at least six months due to a disability.

If you have questions:

- Contact Sedgwick CMS by phone at (818) 591-9444
- Visit their website at [www.sedgwickcms.com/calabasas](http://www.sedgwickcms.com/calabasas)
- Visit the ASRS website for LTD information and brochure at [www.azasrs.gov](http://www.azasrs.gov).

## *Retirement Savings Plans FAQs*

The **Arizona State Retirement System (ASRS)** is the mandatory retirement plan for all benefit eligible employees. Employees contribute a set percentage of their earnings to the ASRS and TUSD matches these contributions. For more information on this benefit, please contact ASRS at (520) 239-3100 or visit [www.azasrs.gov](http://www.azasrs.gov).

### *What other deferred income plans are available?*

TUSD also offers employees the ability to set aside money through payroll deductions on a tax-deferred basis under two Internal Revenue Code options, the **403(b)** and **457**. The Internal Revenue Code limits the amount employees can contribute annually to the 403(b) and 457 plans. The maximum annual limit for 2011 for both the 403(b) and 457 plans is **\$16,500**

- **You can contribute an additional \$5,500 for a total of \$22,000 if you are age 50 or older as of December 31, 2011.**

These limits are not coordinated so you can contribute up to the maximum in both plans in the same year.

Both plans allow employees to set aside money from their paycheck on a pre-tax basis to save for retirement. Taxes are paid on the savings when a distribution is taken from the plan. IRS rules restrict 403b plan distributions to participants who are currently employed. For detailed information on taxation rules, please go to [www.tsacg.com](http://www.tsacg.com) and click on the online video presentation.

**To enroll in a 403(b) plan you must first set up an account with your vendor of choice and then submit a completed Salary Reduction Agreement form to TSACG.** This form is available on the TSACG website: [https://www.tsacg.com/employee\\_site/forms/arizona/tucson\\_forms.htm](https://www.tsacg.com/employee_site/forms/arizona/tucson_forms.htm).

### *Who is TSA Consulting Group?*

In response to the Internal Revenue Service requirements that became effective January 1, 2009, TSA Consulting Group, Inc. (TSACG) administers the 403(b) and 457 plans.

**IMPORTANT: TSACG is responsible for the approval process of all transactions such as Distributions, Exchanges, Transfers, 403(b)**

**Loans, and Rollovers.** Upon reviewing submitted transaction paperwork to ensure that the transaction complies with IRS regulations, TSACG will forward approved paperwork to your authorized provider who will complete the transaction by disbursing funds directly to you or directly to an account specified by you. To submit a transaction, please visit [www.tsacg.com](http://www.tsacg.com) and click on "Plan Transactions" for full instructions and required TPA forms.

The cost for the district to outsource administration of this program is \$2.50 per month per participant. Half of the fee may be paid by the 403(b) provider you choose and the other half by the employee who participates or contributes to an account. Some providers have chosen to pass on their portion of the fee to participants. Contact your provider directly if you have questions.

### *How do I sign up for a 457?*

The 457 Plan Provider for TUSD is **Great-West Retirement Services**.

To enroll in the 457 plan, call Great West Retirement Services toll-free at **(877) 816-0548**, or visit their website at [www.GWRS.com](http://www.GWRS.com) and follow these steps:

1. Start on the Right hand side of the website,
2. Below Username and PIN
3. Go to First Time Visiting? (Just below that)  
Click on Let's Get Started!
4. Enter your Plan Id 350219-01
5. Enter your Social Security Number
6. Enter PIN or Group Account Password  
TUSD457

You must enroll in the 457 plan **at least one month prior** to your intended contribution.

The **403(b)** retirement plan vendors offer valuable investment information on their websites. Employees interested in participating can get a list of approved vendors from the Benefits website (<http://www.tusd1.org/contents/depart/benefits/Documents/403bvendor.pdf>), or the TSACG website:

[https://www.tsacg.com/employee\\_site/districts/arizona/tucson.htm](https://www.tsacg.com/employee_site/districts/arizona/tucson.htm)

## *Payroll Information*

**This section contains information about Tucson Unified School District Payroll.**

Please visit the TUSD Payroll Intranet site at [http://intranet/financedept/index\\_payroll.asp](http://intranet/financedept/index_payroll.asp) for:

- Employee Self Service
- Direct Deposit (view your paycheck)
- Work Schedules
- Payroll Deadline Schedules.
- Printable Tax Forms and Information
- Employee Payroll Forms
- Work Logs, Time Sheets and Instructions

### **Address and Phone – Keep us up to date!**

Please be sure to keep your address and phone number up to date with TUSD at all times. You can update this information via Self Service.

### **Employee Self Service**

The Payroll Department is pleased to offer you PeopleSoft Employee Self Service tools:

- View your most recent and past paychecks
- Change your Arizona or Federal tax withholdings

Once you've logged in, HR self-service functions are available at the same page. Through HR self-service, you can change your address or contact information

### **How to log in**

Go to <http://hrweb.admin.tusd.local/psp/HRPROD/?cmd=login>

Your user ID is your employee ID number, which can be found in the top middle of your pay statement.

Your password is the last four digits of your social security number and the four digits of your birth year (for example, 55551964).

You can view Self Service Instructions on the site also.

**Family Medical Leave (FML) of Absence (Human Resources)**

Human Resources ONLY determines eligibility and qualifications – governed by federal law.

REASON for FML	WHO QUALIFIES	EXCEPTIONS / NOTES
<ol style="list-style-type: none"> <li>1. Birth or Childcare during child’s first year.</li> <li>2. Adoption or foster placement of child. “State Action” foster care placement – up to 12 months after placement.</li> <li>3. Care for employee’s seriously ill spouse, child or parent.</li> <li>4. Employee’s serious health condition.</li> <li>5. Spouse, child, or parent has a qualifying military exigency/orders.</li> <li>6. Care for covered service member with serious injury/illness</li> </ol>	<p>All Employee Groups who:</p> <ol style="list-style-type: none"> <li>1. Work full-time, or is considered a full-time employee – see Note 4 below,</li> <li>2. Have worked a minimum of 12 months, and</li> <li>3. Have worked a minimum of 1,250 hours during the past 12 months from the request date, or since a previous FMLA leave. Only those hours actually worked count towards the 1,250 hours. Other paid and unpaid leave is not counted – see Note 2 below.</li> </ol>	<p>An employee may elect to use accrued <b>paid</b> leave balances during FML.</p> <p>Doctor’s verification/DOL Certification of serious health condition is required.</p> <p>This unpaid FML may not exceed 12/ (26 weeks for Military Exigency) workweeks, or 60 workdays.</p> <p>Intermittent FMLA may be an option with administrator approval. Certain limitations and impact on students may prohibit this option.</p>

**Note 1:** If the employee is receiving insurance benefits from TUSD, the District will continue to pay its portion of the premium for employee-only (equivalent to the EPO plan) coverage during FMLA. If the employee has any benefits beyond employee-only coverage, he/she will be billed for any additional costs.

**Note 2:** Paid time off, such as sick and personal leave, does not count towards the 1,250 hours worked requirement.

**Note 3:** The start date for a Family Medical Leave may be applied retroactively.

**Note 4:** The definition of full time employee is determined by Family Medical Leave Act, not by TUSD. Employees must work 1250 hours within the last 12 months to be eligible for FMLA. Eligibility may be met by counting hours worked at TUSD and another qualified FML eligible employer.

**Note 5:** A FML may not be used consecutively with any type short-term leave; check Bargaining Unit Agreements.

**Note 6:** For Blue-Collar employees only, seniority continues to accrue during FML only.

**Please call Human Resources at (520) 225-6035  
with any FMLA or other Leave of Absence questions.**

**Unpaid Leaves of Absence (Human Resources)**

**Short Term Leave of Absence:** Approved by the Site Administrator.

TYPE OF LEAVE	WHO QUALIFIES	EXCEPTIONS / NOTES
Short Term Leave	All Employee Agreements	For up to 30 workdays only. Refer to Employee Agreement.

Note 1: If the employee is receiving insurance benefits from TUSD, the District will continue to pay its portion of the premium equivalent to employee-only EPO coverage. If the employee has any benefits beyond employee-only coverage, he/she will be billed for any additional costs.

Note 2: All paid leave must be used prior to starting an unpaid Short-Term Medical Leave. Check each Bargaining unit to see what rules apply.

**Governing Board-Approved Leave of Absence:**

*“The Governing Board may authorize leaves of absence for school district personnel when it deems such leaves of absence to be reasonable and for good cause and not detrimental to education within the school district. Leaves of absence shall be limited to a period of not to exceed one year.” - AZ Education Code 15-510*

Requests for Governing Board-Approved Leaves of Absence must be submitted on the District’s *“Request for Leave of Absence (LOA) Form”* and be signed by the appropriate Administrator(s) before the Governing Board will consider the request.

TYPE OF LEAVE	EXCEPTIONS / NOTES
Health of employee	Doctor’s verification of illness must accompany request.
Health of immediate family	Immediate family is defined in agreements.
New infant care or child care	Includes adoption
Course of study, education or training	May require registration documentation
Military Service	Military orders are required
Campaign or serve in public office	
Association or union activities	
Travel	Only for Consensus employees
Exchange Teaching	
Sabbatical	Follow procedures in Consensus.

Note 1: Requests for a partial leave are not forwarded to the Governing Board **IF** the request is from a full time employee AND the Administrator does not recommend approval.

Note 2: If employee has medical, dental and/or vision insurance, this coverage will be terminated. Employees are eligible to continue coverage through COBRA. Employee is responsible to “elect” and pay premiums.

Note 3: Administrators, Psychologists, and Research Project Managers must work three consecutive years to be eligible. Confidential, Professional, White Collar and Food Services must work one year, and Blue Collar employees must work three-months. Consensus may apply at any time.

Note 4: An employee could be on a leave for up to 5-years of cumulative military service and must be returned to not just the position held when the military leave started, but the job in which the person would have been employed if the continuous employment of such person had not been interrupted.

Note 5: An employee who has Alternate Pay (ENP), also known as “Summer Pay”, will be paid that money in a lump-sum payment after the unpaid leave starts.

## *Sick Bank Donations (Human Resources)*

### Medical Leave Assistance Program

1. If the employee has a serious, non-work related illness or injury that is anticipated to last continuously for four or more weeks, and the employee will run out of **paid** sick and personal leave balances, then that employee may request access to the Medical Leave Assistance Program, more commonly known as sick bank donations. (Note: Pregnancy is not considered a serious illness for the purposes of receiving sick bank donations.)
2. Requests for access to the program, along with a doctor's verifying statement, should be submitted to Human Resources. The request will be posted for ten working days only. **Additional requests will not be considered.** Donations may be accepted ONLY during the posting period. Only one sick bank poster will be posted for each illness or injury.
3. There are certain restrictions on what the donor employee may donate. Days of leave, not the actual salary of the donor, will be donated. An employee may donate only to employees as stipulated in the employee agreements. An employee may not donate to his/her immediate supervisor.
4. The recipient employee will be credited with the number of days donated, up to one week after the projected date of return to work. Excess donated days will be held in reserve and credited to the employee only if needed. If not needed, all days of more than one week will be restored to the donor.

**Please call Human Resources at (520) 225-6035  
for Sick Bank Donation questions.**



1010 E, 10<sup>th</sup> Street  
Tucson, AZ 85719

## **Medicare Part D Notice:**

### **Important Notice from Tucson Unified School District (TUSD) about Prescription Drug Coverage for People with Medicare**

**This notice is for people with 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 Tucson Unified School District (TUSD) and the prescription drug coverage available for people with Medicare. It also explains the options you have under Medicare's prescription drug coverage and can help you decide whether or not you want to enroll in that Medicare prescription drug coverage. At the end of this notice is information on where you can get help to make a decision about Medicare's prescription drug coverage.

- **If you and/or your family members are not now eligible for Medicare, and will not be eligible during the next 12 months, you may disregard this Notice.**
- **If, however, you and/or your family members are now eligible for Medicare or may become eligible for Medicare in the next 12 months, you should read this Notice very carefully.**

This announcement is required by law whether the group health plan's coverage is primary or secondary to Medicare. Because it is not possible for our Plan to always know when a Plan participant or their eligible spouse or children have Medicare coverage or will soon become eligible for Medicare we have decided to provide this Notice to all plan participants.

Prescription drug coverage for Medicare-eligible people is available through Medicare prescription drug plans (PDPs) and Medicare Advantage Plans (like an HMO or PPO) that offer prescription drug coverage. All Medicare prescription drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more drug coverage for a higher monthly premium.

**TUSD has determined that the prescription drug coverage under the following prescription drug plan options (the EPO, PPO and HDHP plans) are "creditable."**

"Creditable" means that the value of this Plan's prescription drug benefit is, on average for all plan participants, expected to pay out as much as or more than the standard Medicare prescription drug coverage will pay.

Because the plan option noted above are, on average, at least as good as the standard Medicare prescription drug coverage, **you can elect or keep prescription drug coverage under the EPO, PPO or HDHP medical plans noted above and you will not pay extra if you later decide to enroll in Medicare prescription drug coverage.** You may enroll in Medicare prescription drug coverage at a later time, and because you maintain creditable coverage, you will not have to pay a higher premium (a late enrollment fee penalty).

#### **REMEMBER TO KEEP THIS 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).**

## WHEN CAN YOU JOIN A MEDICARE DRUG PLAN?

Medicare-eligible people can enroll in a Medicare prescription drug plan at one of the following 3 times:

- when they first become eligible for Medicare; or
- during Medicare's annual election period (from **October 15<sup>th</sup>** through **December 7<sup>th</sup>**); or
- for beneficiaries leaving employer/union coverage, you may be eligible for a two month Special Enrollment Period (SEP) in which to sign up for a Medicare prescription drug plan.

When you make your decision whether to enroll in a Medicare prescription drug plan, you should also compare your current prescription drug coverage, (including which drugs are covered and at what cost) with the coverage and cost of the plans offering Medicare prescription drug coverage in your area.

## YOUR RIGHT TO RECEIVE A NOTICE

You will receive this notice at least every 12 months and at other times in the future such as if the creditable/non-creditable status of the prescription drug coverage through this plan changes. You may also request a copy of a Notice at any time.

## WHY CREDITABLE COVERAGE IS IMPORTANT (When you will pay a higher premium (penalty) to join a Medicare drug plan)

If you do not have creditable prescription drug coverage when you are first eligible to enroll in a Medicare prescription drug plan and you elect or continue prescription drug coverage under a **non-creditable** prescription drug plan, then at a later date when you decide to elect Medicare prescription drug coverage you may pay a higher premium (a penalty) for that Medicare prescription drug coverage for as long as you have that Medicare coverage.

Maintaining creditable prescription drug coverage will help you avoid Medicare's late enrollment penalty. This **late enrollment penalty** is described below:

If you go 63 continuous days or longer without creditable prescription drug coverage (meaning drug coverage that is at least as good as Medicare's 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 either Medicare prescription drug coverage or coverage under a creditable prescription drug plan. You may have to pay this higher premium (the penalty) as long as you have Medicare prescription drug coverage.

For example, if 19 months pass where you do not have creditable prescription drug coverage, when you decide to join Medicare's drug coverage your monthly premium will always be at least 19% higher than the Medicare base beneficiary premium. Additionally, if you go 63 days or longer without prescription drug coverage you may also have to wait until the next Medicare open enrollment period in order to enroll for Medicare prescription drug coverage.

## WHAT ARE MY CHOICES?

You can choose any **one** of the following options:

Your Choices:	What you can do:	What this option means to you:
<p><b>Option 1</b></p>	<p>You can select or keep your current medical and prescription drug coverage with the EPO, PPO or HDHP medical plan(s) offered by TUSD and <b>you do not have to enroll in a Medicare prescription drug plan.</b></p>	<p>You will continue to be able to use your prescription drug benefits through the EPO, PPO or HDHP medical plan(s) offered by TUSD.</p> <ul style="list-style-type: none"> <li>You may, in the future, enroll in a Medicare prescription drug plan during Medicare's annual enrollment period (during October 15<sup>th</sup> through December 7<sup>th</sup> of each year).</li> <li>As long as you are enrolled in creditable drug coverage you will not have to pay a higher premium (a late enrollment fee) to Medicare when you do choose, at a later date, to sign up for a Medicare prescription drug plan.</li> </ul>
<p><b>Option 2</b></p>	<p>You can select or keep your current medical and prescription drug coverage with the EPO, PPO or HDHP medical plan(s) offered by TUSD <b>and also enroll in a Medicare prescription drug plan.</b></p> <p>If you enroll in a Medicare prescription drug plan you will need to pay the Medicare Part D premium out of your own pocket.</p>	<p>Your current coverage pays for other health expenses in addition to prescription drugs. If you enroll in a Medicare prescription drug plan, you and your eligible dependents will still be eligible to receive all of your current health and prescription drug benefits.</p> <p>Having dual prescription drug coverage under this Plan and Medicare means that you will still be able to receive all your current health coverage and this Plan will coordinate its drug payments with Medicare, as follows:</p> <ul style="list-style-type: none"> <li>for Medicare eligible Retirees and their Medicare eligible Dependents, Medicare Part D coverage pays primary and this group health plan pays secondary.</li> <li>for Medicare eligible Active Employees and their Medicare eligible Dependents, this group health plan pays primary and Medicare Part D coverage pays secondary.</li> </ul> <p>Note that you may not drop just the prescription drug coverage under the EPO, PPO or HDHP medical plan(s) offered by TUSD. That is because prescription drug coverage is part of the entire medical plan. Generally, you may only drop medical plan coverage at this Plan's next Open Enrollment period.</p> <p>Note that each Medicare prescription drug plan (PDP) may differ. Compare coverage, such as:</p> <ul style="list-style-type: none"> <li>PDPs may have different premium amounts;</li> <li>PDPs cover different brand name drugs at different costs to you;</li> <li>PDPs may have different prescription drug deductibles and different drug copayments;</li> <li>PDPs may have different networks for retail pharmacies and mail order services.</li> </ul> <p><b>IMPORTANT NOTE:</b> If you are enrolled in the High Deductible Health Plan (HDHP) with the Health Savings Account (HSA) you may not continue to make contributions to your HSA once you are enrolled in Medicare including being enrolled in a Medicare Part D drug plan.</p>

## **FOR MORE INFORMATION ABOUT YOUR OPTIONS UNDER MEDICARE'S PRESCRIPTION DRUG COVERAGE**

More detailed information about Medicare plans that offer prescription drug coverage is available in the "Medicare & You" handbook. A person enrolled in Medicare (a "beneficiary") will get a copy of this handbook in the mail each year from Medicare. A Medicare beneficiary may also be contacted directly by Medicare-approved prescription drug plans.

For more information about Medicare prescription drug coverage:

- Visit [www.medicare.gov](http://www.medicare.gov)
- Call your State Health Insurance Assistance Program (see your copy of the Medicare & You handbook for their telephone number), for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

### **Para más información sobre sus opciones bajo la cobertura de Medicare para recetas médicas.**

Revise el manual "Medicare Y Usted" para información más detallada sobre los planes de Medicare que ofrecen cobertura para recetas médicas. Visite [www.medicare.gov](http://www.medicare.gov) por el Internet o llame GRATIS al 1 800 MEDICARE (1-800-633-4227). Los usuarios con teléfono de texto (TTY) deben llamar al 1-877-486-2048. Para más información sobre la ayuda adicional, visite la SSA en línea en [www.socialsecurity.gov](http://www.socialsecurity.gov) por Internet, o llámeles al 1-800-772-1213 (Los usuarios con teléfono de texto (TTY) deberán llamar al 1-800-325-0778).

**For people with limited income and resources**, extra help paying for a Medicare prescription drug plan is available. Information about this extra help is available from the Social Security Administration (SSA). For more information about this extra help, visit SSA online at [www.socialsecurity.gov](http://www.socialsecurity.gov), or call them at 1-800-772-1213 (TTY 1-800-325-0778).

### **For more information about this notice or your current prescription drug coverage contact:**

TUSD Benefits Office  
1010 E. 10<sup>th</sup> St. Tucson, AZ 85719  
Phone number: (520) 225-6144

As in all cases, Tucson Unified School District (TUSD) reserves the right to modify benefits at any time, in accordance with applicable law. This document (dated July 31, 2011) is intended to serve as your Medicare Notice of Creditable Coverage, as required by law.

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## *Important Plan Information*

### **Mid-Year Changes To Your Medical Plan Elections**

**IMPORTANT:** After this open enrollment period is completed, generally you **will not** be allowed to change your benefit elections or add/delete dependents until next years' open enrollment, unless you have a Special Enrollment event or a Mid-year Change in Status as outlined below:

- ***Special Enrollment:***

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, **you must request enrollment within 30 days** after your or your dependent's other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, **you must request enrollment within 30 days** after the marriage, birth, adoption, or placement for adoption.

Section 111 of the Medicare, Medicaid and SCHIP Extension Act of 2007 (MMSEA), a new federal law that became effective January 1, 2009, requires that group health insurers, claims processing third-party administrators, and certain employer self-funded/self-administered plans report specific information about Medicare beneficiaries who have other group coverage. This reporting is to assist CMS and other health insurance plans to properly coordinate payment of benefits among plans so that your claims are paid promptly and correctly.

**If you are unable or unwilling to provide a social security number for your dependents who want to enroll in the health plan, then you must complete a CMS form available from the TUSD Benefits Office or on the benefits website.**

Effective April 1, 2009, you and your dependents may also enroll in this plan if you (or your dependents):

- Have coverage through **Medicaid or a State Children's Health Insurance Program (CHIP)** and you (or your dependents) lose eligibility for that coverage. However, you must request enrollment within **60 days** after the Medicaid or CHIP coverage ends.
- Become eligible for a premium assistance program through **Medicaid or CHIP**. However, you must request enrollment within **60 days** after you (or your dependents) is determined to be eligible for such assistance.

To request special enrollment or to obtain more information,  
contact the TUSD Benefits Office at (520) 225-6144.

- ***Mid-Year Change in Status Event (see page 42 for a list):***

The following events **may** allow certain changes in benefits mid-year, **if** permitted by the Internal Revenue Service (IRS):

- Change in legal marital status (e.g. marriage, divorce/legal separation, death).
- Change in number or status of dependents (e.g. birth, adoption, death).
- Change in employee/spouse/dependent's employment status, work schedule, or residence that affects their eligibility for benefits.
- Coverage of a child due to a QMCSO.

- 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 must notify the plan in writing within 30 days of the mid-year change in status event by contacting the Benefits Office at 225-6144. The Plan will determine if your change request is permitted and if so, changes become effective prospectively, on the first day of the month, following the approved change in status event (except for newborn and adopted children, who are covered back to the date of birth, adoption, or placement for adoption).

## **COBRA Coverage**

In compliance with a federal law referred to as COBRA Continuation Coverage, this plan offers its eligible employees and their covered dependents (known as qualified beneficiaries) the opportunity to elect temporary continuation of their group health coverage when that coverage would otherwise end because of certain events (called qualifying events).

Qualified beneficiaries are entitled to elect COBRA when qualifying events occur, and, as a result of the qualifying event, coverage of that qualified beneficiary ends. Qualified beneficiaries who elect COBRA Continuation Coverage must pay for it at their own expense.

Qualifying events include termination of employment, reduction in hours of work making the employee ineligible for coverage, death of the employee, divorce/legal separation, or a child ceasing to be an eligible dependent child. The maximum period of COBRA coverage is generally either 18 months or 36 months, depending on which qualifying event occurred.

In order to have the chance to elect COBRA coverage after a divorce/legal separation or a child ceasing to be a dependent child under the plan, **you and/or a family member must inform the plan in writing of that event no later than 60 days after that event occurs.** That notice should be sent to the Benefits Office via first class mail and is to include the employee's name, the qualifying event, the date of the event, and the appropriate documentation in support of the qualifying event (such as divorce documents). If you have questions about COBRA contact the Benefits Office.

## **Medicaid and the Children's Health Insurance Program (CHIP) Offer Free Or Low-Cost Health Coverage To Children And Families**

If you are eligible for health coverage from your employer, but are unable to afford the premiums, some States have premium assistance programs that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for employer-sponsored health coverage, but need assistance in paying their health premiums.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, you can contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, you can contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **[www.insurekidsnow.gov](http://www.insurekidsnow.gov)** to find out how to apply. If you qualify, you can ask the State if it has a program that might help you pay the premiums for an employer-sponsored plan.

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, your employer's health plan is required to permit you and your dependents to enroll in the plan – as long as you and your dependents are eligible, but not already enrolled in the employer's plan. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance.**

If you live in one of the following States, you may be eligible for assistance paying your employer health plan premiums. The following list of States is current as of January 31, 2011. You should contact your State for further information on eligibility –

<b>ALABAMA – Medicaid</b>	<b>CALIFORNIA – Medicaid</b>
Website: <a href="http://www.medicaid.alabama.gov">http://www.medicaid.alabama.gov</a> Phone: 1-800-362-1504	Website: <a href="http://www.dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx">http://www.dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx</a> Phone: 1-866-298-8443
<b>ALASKA – Medicaid</b>	<b>COLORADO – Medicaid and CHIP</b>
Website: <a href="http://health.hss.state.ak.us/dpa/programs/medicaid/">http://health.hss.state.ak.us/dpa/programs/medicaid/</a> Phone (Outside of Anchorage): 1-888-318-8890 Phone (Anchorage): 907-269-6529	Medicaid Website: <a href="http://www.colorado.gov/">http://www.colorado.gov/</a> Medicaid Phone (In state): 1-800-866-3513 Medicaid Phone (Out of state): 1-800-221-3943 CHIP Website: <a href="http://www.CHPplus.org">http:// www.CHPplus.org</a> CHIP Phone: 303-866-3243
<b>ARIZONA – CHIP</b>	
Website: <a href="http://www.azahcccs.gov/applicants/default.aspx">http://www.azahcccs.gov/applicants/default.aspx</a> Phone (Outside of Maricopa County): 1-877-764-5437 Phone (Maricopa County): 602-417-5437	
<b>ARKANSAS – CHIP</b>	<b>FLORIDA – Medicaid</b>
Website: <a href="http://www.arkidsfirst.com/">http://www.arkidsfirst.com/</a> Phone: 1-888-474-8275	Website: <a href="http://www.fdhc.state.fl.us/Medicaid/index.shtml">http://www.fdhc.state.fl.us/Medicaid/index.shtml</a> Phone: 1-877-357-3268
<b>GEORGIA – Medicaid</b>	<b>MISSOURI – Medicaid</b>
Website: <a href="http://dch.georgia.gov/">http://dch.georgia.gov/</a> Click on Programs, then Medicaid Phone: 1-800-869-1150	Website: <a href="http://www.dss.mo.gov/mhd/participants/pages/hipp.htm">http://www.dss.mo.gov/mhd/participants/pages/hipp.htm</a> Phone: 573-751-2005
<b>IDAHO – Medicaid and CHIP</b>	<b>MONTANA – Medicaid</b>
Medicaid Website: <a href="http://www.accesstohealthinsurance.idaho.gov">www.accesstohealthinsurance.idaho.gov</a> Medicaid Phone: 1-800-926-2588 CHIP Website: <a href="http://www.medicaid.idaho.gov">www.medicaid.idaho.gov</a> CHIP Phone: 1-800-926-2588	Website: <a href="http://medicaidprovider.hhs.mt.gov/clientpages/clientindex.shtml">http://medicaidprovider.hhs.mt.gov/clientpages/clientindex.shtml</a> Phone: 1-800-694-3084
<b>INDIANA – Medicaid</b>	<b>NEBRASKA – Medicaid</b>
Website: <a href="http://www.in.gov/fssa">http://www.in.gov/fssa</a> Phone: 1-800-889-9948	Website: <a href="http://www.dhhs.ne.gov/med/medindex.htm">http://www.dhhs.ne.gov/med/medindex.htm</a> Phone: 1-877-255-3092

<b>IOWA – Medicaid</b>	<b>NEVADA – Medicaid and CHIP</b>
Website: <a href="http://www.dhs.state.ia.us/hipp/">www.dhs.state.ia.us/hipp/</a> Phone: 1-888-346-9562	Medicaid Website: <a href="http://dwss.nv.gov/">http://dwss.nv.gov/</a> Medicaid Phone: 1-800-992-0900 CHIP Website: <a href="http://www.nevadacheckup.nv.org/">http://www.nevadacheckup.nv.org/</a> CHIP Phone: 1-877-543-7669
<b>KANSAS – Medicaid</b>	
Website: <a href="https://www.khpa.ks.gov">https://www.khpa.ks.gov</a> Phone: 1-800-792-4884	
<b>KENTUCKY – Medicaid</b>	<b>NEW HAMPSHIRE – Medicaid</b>
Website: <a href="http://chfs.ky.gov/dms/default.htm">http://chfs.ky.gov/dms/default.htm</a> Phone: 1-800-635-2570	Website: <a href="http://www.dhhs.nh.gov/ombp/index.htm">www.dhhs.nh.gov/ombp/index.htm</a> Phone: 603-271-4238
<b>LOUISIANA – Medicaid</b>	<b>NEW JERSEY – Medicaid and CHIP</b>
Website: <a href="http://www.lahipp.dhh.louisiana.gov">http://www.lahipp.dhh.louisiana.gov</a> Phone: 1-888-342-6207	Medicaid Website: <a href="http://www.state.nj.us/humanservices/dmahs/clients/medicaid/">http://www.state.nj.us/humanservices/dmahs/clients/medicaid/</a> Medicaid Phone: 1-800-356-1561 CHIP Website: <a href="http://www.njfamilycare.org/index.html">http://www.njfamilycare.org/index.html</a> CHIP Phone: 1-800-701-0710
<b>MAINE – Medicaid</b>	
Website: <a href="http://www.maine.gov/dhhs/OIAS/public-assistance/index.html">http://www.maine.gov/dhhs/OIAS/public-assistance/index.html</a> Phone: 1-800-321-5557	
<b>MASSACHUSETTS – Medicaid and CHIP</b>	<b>NEW MEXICO – Medicaid and CHIP</b>
Medicaid & CHIP Website: <a href="http://www.mass.gov/MassHealth">http://www.mass.gov/MassHealth</a> Medicaid & CHIP Phone: 1-800-462-1120	Medicaid Website: <a href="http://www.hsd.state.nm.us/mad/index.html">http://www.hsd.state.nm.us/mad/index.html</a> Medicaid Phone: 1-888-997-2583 CHIP Website: <a href="http://www.hsd.state.nm.us/mad/index.html">http://www.hsd.state.nm.us/mad/index.html</a> Click on Insure New Mexico CHIP Phone: 1-888-997-2583
<b>MINNESOTA – Medicaid</b>	
Website: <a href="http://www.dhs.state.mn.us/">http://www.dhs.state.mn.us/</a> Click on Health Care, then Medical Assistance Phone (Outside of Twin City area): 800-657-3739 Phone (Twin City area): 651-431-2670	
<b>NEW YORK – Medicaid</b>	<b>TEXAS – Medicaid</b>
Website: <a href="http://www.nyhealth.gov/health_care/medicaid/">http://www.nyhealth.gov/health_care/medicaid/</a> Phone: 1-800-541-2831	Website: <a href="https://www.gethiptexas.com/">https://www.gethiptexas.com/</a> Phone: 1-800-440-0493
<b>NORTH CAROLINA – Medicaid</b>	<b>UTAH – Medicaid</b>
Website: <a href="http://www.nc.gov">http://www.nc.gov</a> Phone: 919-855-4100	Website: <a href="http://health.utah.gov/upp">http://health.utah.gov/upp</a> Phone: 1-866-435-7414
<b>NORTH DAKOTA – Medicaid</b>	<b>VERMONT – Medicaid</b>
Website: <a href="http://www.nd.gov/dhs/services/medicalserv/medicaid/">http://www.nd.gov/dhs/services/medicalserv/medicaid/</a> Phone: 1-800-755-2604	Website: <a href="http://www.greenmountaincare.org/">http://www.greenmountaincare.org/</a> Phone: 1-800-250-8427
<b>OKLAHOMA – Medicaid</b>	<b>VIRGINIA – Medicaid and CHIP</b>
Website: <a href="http://www.insureoklahoma.org">http://www.insureoklahoma.org</a> Phone: 1-888-365-3742	Medicaid Website: <a href="http://www.dmas.virginia.gov/rcp-IPP.html">http://www.dmas.virginia.gov/rcp-IPP.html</a> Medicaid Phone: 1-800-432-5924 CHIP Website: <a href="http://www.famis.org/">http://www.famis.org/</a> CHIP Phone: 1-866-873-2647
<b>OREGON – Medicaid and CHIP</b>	<b>WASHINGTON – Medicaid</b>
Medicaid & CHIP Website: <a href="http://www.oregonhealthykids.gov">http://www.oregonhealthykids.gov</a> Medicaid & CHIP Phone: 1-877-314-5678	Website: <a href="http://hrsa.dshs.wa.gov/premiumpymt/Apply.shtm">http://hrsa.dshs.wa.gov/premiumpymt/Apply.shtm</a> Phone: 1-800-562-3022 ext. 15473

<b>PENNSYLVANIA – Medicaid</b>	<b>WEST VIRGINIA – Medicaid</b>
Website: http://www.dpw.state.pa.us/partnersproviders/medicallassistance/doingbusiness/003670053.htm Phone: 1-800-644-7730	Website: http://www.wvrecovery.com/hipp.htm Phone: 304-342-1604
<b>RHODE ISLAND – Medicaid</b>	<b>WISCONSIN – Medicaid</b>
Website: www.dhs.ri.gov Phone: 401-462-5300	Website: http://www.badgercareplus.org/pubs/p-10095.htm Phone: 1-800-362-3002
<b>SOUTH CAROLINA – Medicaid</b>	<b>WYOMING – Medicaid</b>
Website: http://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://www.health.wyo.gov/healthcarefin/index.html Phone: 307-777-7531

To see if any more States have added a premium assistance program since January 31, 2011, or for more information on special enrollment rights, you can contact either:

U.S. Department of Labor  
Employee Benefits Security Administration  
[www.dol.gov/ebsa](http://www.dol.gov/ebsa)  
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services  
Centers for Medicare & Medicaid Services  
[www.cms.hhs.gov](http://www.cms.hhs.gov)  
1-877-267-2323, Ext. 61565

OMB Control Number 1210-0137 (expires 09/30/2013)

**Annual Notice: Women’s Health and Cancer Rights Act (WHCRA)**

Your group health plan, as required by the Women’s Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema). For more information, call AmeriBen at (877) 955-1570.

This coverage is subject to any plan co-payments, referral requirements, annual deductibles and coinsurance provisions that may be applicable, consistent with those established for other benefits under the plan.

If you have any questions about whether your plan covers mastectomies or reconstructive surgery, please contact AmeriBen at (877) 955-1570.

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**HIPAA Privacy Notice for Dental and Vision Plans**

HIPAA Privacy pertains to the following group health plan benefits sponsored by Tucson Unified School District:

The Medical plans including outpatient retail prescription drugs and COBRA Administration

To obtain a copy of this Plan’s HIPAA Notice of Privacy Practice for the above noted group health plan benefits, write or call the Benefits Department at 1010 E. 10<sup>th</sup> St, (520) 225-6144 or by email at [Benefits@tusd1.org](mailto:Benefits@tusd1.org). The Notice can also be found on the TUSD intranet. From the intranet homepage, click on Benefits, “HIPAA Privacy Notice” in the table of contents.

HIPAA Privacy Notices that pertain to the insured dental and vision benefits offered by Tucson Unified School District can be obtained by contacting those insurance companies directly.

Delta Dental	(800) 352-6132
Employers Dental Service (EDS)	(520) 696-4343
Avesis	(800) 828-9341

## Permissible Mid-Year Status Changes

Government regulations generally require that your Plan coverage remain in effect throughout the Plan Year (from October 1 through September 30), but you may be able to make some changes during the year if you have a permissible mid-year status change affecting your benefit needs. Any permissible mid-year status change in elections must be on account of and corresponding with the IRC approved status change. Election changes ***must be submitted with appropriate documentation on a TUSD enrollment form to the TUSD Benefits Office within 30 days of the change event.***

***Under IRS rules, changes associated with these permissible mid-year change in status change on a prospective basis except for birth/adoption.***

<b>A Brief Summary of Common Change of Status Events and the Mid-Year Enrollment Changes Allowed Under the Medical Plan</b> Mid-year changes <u>are only those permitted in accordance with Section 125 of the Internal Revenue Code.</u>		
This chart is only a summary of some of the permitted medical plan changes and is not all-inclusive.		
This chart should NOT be referenced for a Health FSA or Dependent Care Assistance Plan (DCAP).		
If you experience the following Event...	You may make the following change(s)* within 31 days (where applicable 60 days) of the Event...	YOU MAY <u>NOT</u> make these types of changes...
<b>Family Events</b>		
Marriage	<ul style="list-style-type: none"> <li>• Enroll yourself, if applicable</li> <li>• Enroll your new Spouse and other eligible dependents</li> <li>• Drop health coverage (to enroll in your Spouse's plan)</li> <li>• Change health plans, when options are available</li> </ul>	<ul style="list-style-type: none"> <li>• Drop health coverage and not enroll in Spouse's plan; if you do, you won't receive coverage.</li> </ul>
Divorce or Legal Separation	<ul style="list-style-type: none"> <li>• Remove your Spouse from your health coverage</li> <li>• Enroll yourself (and your children) if you or they were previously enrolled in your Spouse's plan</li> </ul>	<ul style="list-style-type: none"> <li>• Change health plans</li> <li>• Drop health coverage for yourself or any other covered individual</li> </ul>
Gain a child due to birth or adoption	<ul style="list-style-type: none"> <li>• Enroll yourself, if applicable</li> <li>• Enroll the eligible child and any other eligible dependents</li> <li>• Change health plans, when options are available</li> </ul>	<ul style="list-style-type: none"> <li>• Drop health coverage for yourself or any other covered individuals</li> </ul>
Child requires coverage due to a QMCSO	<ul style="list-style-type: none"> <li>• Add child named on QMCSO to your health coverage (enroll yourself, if applicable and not already enrolled)</li> <li>• Change health plans, when options are available, to accommodate the child named on the QMCSO</li> </ul>	<ul style="list-style-type: none"> <li>• Make any other changes, except as required by the QMCSO</li> </ul>

**A Brief Summary of Common Change of Status Events and  
the Mid-Year Enrollment Changes Allowed Under the Medical Plan**  
Mid-year changes are only those permitted in accordance with Section 125 of the Internal Revenue Code.

This chart is only a summary of some of the permitted medical plan changes and is not all-inclusive.

This chart should NOT be referenced for a Health FSA or Dependent Care Assistance Plan (DCAP).

<b>If you experience the following Event...</b>	<b>You may make the following change(s)* within 31 days (where applicable 60 days) of the Event...</b>	<b>YOU MAY <u>NOT</u> make these types of changes...</b>
Loss of a child's eligibility (e.g., child reaches the maximum age for coverage)	<ul style="list-style-type: none"> <li>Remove the child from your health coverage</li> <li>Child will be offered COBRA.</li> </ul>	<ul style="list-style-type: none"> <li>Change health plans</li> <li>Drop health coverage for yourself or any other covered individuals</li> </ul>
Death of a dependent (spouse, domestic partner or child)	<ul style="list-style-type: none"> <li>Remove the dependent from your health coverage</li> <li>Change health plans, when options are available</li> </ul>	<ul style="list-style-type: none"> <li>Drop health coverage for yourself or any other covered individuals</li> </ul>
Covered person has become entitled to (or lost entitlement to) <ul style="list-style-type: none"> <li>* Medicaid or</li> <li>* Medicare</li> </ul>	<ul style="list-style-type: none"> <li>Drop coverage for the person who became entitled to Medicare or Medicaid.</li> <li>Add the person who lost Medicare/Medicaid entitlement.</li> </ul>	<ul style="list-style-type: none"> <li>Drop health coverage for yourself or any other covered individuals</li> </ul>
<b>Employment Status Events</b>		
Spouse becomes eligible for health benefits in another group health plan	<ul style="list-style-type: none"> <li>Remove your Spouse from your health coverage, with proof of other plan coverage</li> <li>Remove your children from your health coverage, with proof of other plan coverage</li> <li>Drop coverage for yourself only with proof that Spouse added you to the Spouse's new group health plan</li> </ul>	<ul style="list-style-type: none"> <li>Change health plans</li> <li>Add any eligible dependents to your health coverage</li> </ul>
Spouse loses employment or otherwise becomes ineligible for health benefits in another plan	<ul style="list-style-type: none"> <li>Enroll your Spouse and, if applicable, eligible children in your health plan</li> <li>Enroll yourself in a health plan if previously not enrolled because you were covered under your Spouse's plan</li> <li>Change health plans, when options are available</li> </ul>	<ul style="list-style-type: none"> <li>Drop health coverage for yourself or any other covered dependents</li> </ul>
You lose employment or otherwise become ineligible for health benefits	<ul style="list-style-type: none"> <li>Enroll in your Spouse's plan, if available</li> <li>Elect temporary COBRA coverage for the Qualified Beneficiaries (you and your covered dependents)</li> </ul>	

**A Brief Summary of Common Change of Status Events and  
the Mid-Year Enrollment Changes Allowed Under the Medical Plan**  
Mid-year changes are only those permitted in accordance with Section 125 of the Internal Revenue Code.

This chart is only a summary of some of the permitted medical plan changes and is not all-inclusive.

This chart should NOT be referenced for a Health FSA or Dependent Care Assistance Plan (DCAP).

If you experience the following Event...	You may make the following change(s)* within 31 days (*where applicable 60 days) of the Event...	YOU MAY <u>NOT</u> make these types of changes...
Change in primary residence of the employee that impairs eligibility for health benefits.	<ul style="list-style-type: none"> <li>• Change plans</li> <li>• Remove coverage for yourself and any eligible covered dependents.</li> </ul>	
Spouse or domestic partner's Open Enrollment.	<ul style="list-style-type: none"> <li>• Make <b>corresponding</b> changes to TUSD health benefits (for example, spouse enrolls in medical at own employer allowing TUSD employee to remove spouse from TUSD medical coverage).</li> </ul>	<ul style="list-style-type: none"> <li>• Drop or add any non-corresponding coverage for yourself or any other covered dependents</li> </ul>
<b><i>Proof of a status change is required to make a corresponding change in coverage/enrollment.</i></b>		
<b>Note: Loss of coverage due to non-payment of COBRA or an Individual Health Policy is not a Qualifying Event.</b>		

# Tucson Unified School District (TUSD) HIPAA Notice of Privacy Practices

Esta noticia es disponible en español si usted lo pide. Por favor contacte el Funcionario de Privacidad: (520) 225-6002.

## Purpose of This Privacy Notice

This Notice describes how medical information about you may be used and disclosed and how you may get access to this information.

**Please review this information carefully.**

## This Notice is required by law.

The Tucson Unified School District's self-funded group health plan that includes the medical plan options (the medical provider network, medical plan claim administrator, medical plan utilization management administrator), the outpatient retail prescription drug program and COBRA administration, (hereafter referred to as the "Plan"), is required by law to take reasonable steps to maintain the privacy of your personally identifiable health information (called **Protected Health Information or PHI**) and to inform you about:

1. The Plan's uses and disclosures of PHI,
2. Your rights to privacy with respect to your PHI,
3. The Plan's duties with respect to your PHI,
4. Your right to file a complaint with the Plan and with the Secretary of the U.S. Department of Health and Human Services (HHS), and
5. The person or office you should contact for further information about the Plan's privacy practices.

PHI use and disclosure by the Plan is regulated by the federal law, Health Insurance Portability and Accountability Act, commonly called HIPAA. You may find these rules in 45 *Code of Federal Regulations* Parts 160 and 164. This Notice attempts to summarize key points in the regulation. The regulations will supersede this Notice if there is any discrepancy between the information in this Notice and the regulations. The Plan will abide by the terms of the Notice currently in effect. The Plan reserves the right to change the terms of this Notice and to make the new Notice provisions effective for all PHI it maintains.

You may also receive a Privacy Notice from insurance companies who offer Plan participants insured health care services, such as the dental and vision plan benefits. Each of these notices will describe your rights as it pertains to that plan and in compliance with the federal regulation, HIPAA. This Privacy Notice however, pertains to your protected health information held by the TUSD benefit plan (the "Plan") and outside companies contracted with TUSD to help administer Plan benefits, also called "business associates".

## Effective Date

The effective date of this Notice is October 1, 2010 and this notice replaces the notice(s) previously distributed to you.

**Privacy Officer**

The Plan has designated a Privacy Officer to oversee the administration of privacy by the Plan and to receive complaints. The Privacy Officer may be contacted at:

**TUSD Privacy Officer**  
ATTN: Benefits Office  
1010 E. Tenth St. Tucson, AZ 85719  
(520) 225-6002

**Your Protected Health Information**

The term “Protected Health Information” (PHI) includes all information related to your past, present or future health condition(s) that individually identifies you or could reasonably be used to identify you and is transferred to another entity or maintained by the Plan in oral, written, electronic or any other form.

**PHI does not include** health information contained in employment records held by your employer in its role as an employer, including but not limited to health information on disability, work-related illness/injury, sick leave, Family or Medical leave (FMLA), life insurance, drug testing, etc.

This Notice does not apply to information that has been de-identified. **De-identified information** is information that does not identify you, and with respect to which there is no reasonable basis to believe that the information can be used to identify you, is not individually identifiable health information.

**When the Plan May Disclose Your PHI**

Under the law, the Plan may disclose your PHI without your written authorization in the following cases:

- **At your request.** If you request it, the Plan is required to give you access to your PHI in order to inspect it and copy it.
- **As required by an agency of the government.** The Secretary of the Department of Health and Human Services may require the disclosure of your PHI to investigate or determine the Plan’s compliance with the privacy regulations.
- **For treatment, payment or health care operations.** The Plan and its business associates will use your PHI (except psychotherapy notes in certain instances as described below) without your consent, authorization or opportunity to agree or object in order to carry out treatment, payment, or health care operations.

The Plan does not need your consent or authorization to release your PHI when you request it, a government agency requires it, or the Plan uses it for treatment, payment, or health care operations.

The Plan Sponsor has **amended its Plan documents** to protect your PHI as required by federal law. The Plan may disclose PHI to the Plan Sponsor for purposes of treatment, payment, and health care operations in accordance with the Plan amendment. The Plan may disclose PHI to the Plan Sponsor for review of your appeal of a benefit or for other reasons related to the administration of the Plan.

<b>Definitions and Examples of Treatment, Payment and Health Care Operations</b>	
<b>Treatment is health care.</b>	<p>Treatment is the provision, coordination, or management of health care and related services. It also includes but is not limited to coordination of benefits with a third party and consultations and referrals between one or more of your health care providers.</p> <ul style="list-style-type: none"> <li>• <b>For example:</b> The Plan discloses to a treating specialist the name of your treating primary care physician so the two can confer regarding your treatment plan.</li> </ul>

<p><b>Payment</b> is paying claims for health care and related activities.</p>	<p>Payment includes but is not limited to making payment for the provision of health care, determination of eligibility, claims management, and utilization review activities such as the assessment of medical necessity and appropriateness of care.</p> <ul style="list-style-type: none"> <li>• <b>For example:</b> The Plan tells your doctor whether you are eligible for coverage or what percentage of the bill will be paid by the Plan. If we contract with third parties to help us with payment, such as a claims payer, we will disclose pertinent information to them. These third parties are known as “<b>business associates.</b>”</li> </ul>
<p><b>Health Care Operations</b> keep the Plan operating soundly.</p>	<p>Health care operations includes but is not limited to quality assessment and improvement, business planning and development, reviewing competence or qualifications of health care professionals, underwriting, premium rating and other insurance activities relating to creating or renewing insurance contracts. It also includes disease management, case management, conducting or arranging for medical review, legal services and auditing functions including fraud and abuse compliance programs and general administrative activities.</p> <ul style="list-style-type: none"> <li>• <b>For example:</b> The Plan uses information from your medical claims to refer you to a health care management program, to project future benefit costs or to audit the accuracy of its claims processing functions.</li> </ul>

**When the Disclosure of Your PHI Requires Your Written Authorization**

Generally, the Plan will require that you sign a valid authorization form in order to use or disclose your PHI **other than:**

- When you request your own PHI
- A government agency requires it, or
- The Plan uses it for treatment, payment, or health care operation.

Although the Plan does not routinely obtain psychotherapy notes, generally, an authorization will be required by the Plan before the Plan will use or disclose psychotherapy notes about you. **Psychotherapy notes** are separately filed notes about your conversations with your mental health professional during a counseling session. They do not include summary information about your mental health treatment. However, the Plan may use and disclose such notes when needed by the Plan to defend itself against litigation filed by you. The Plan generally will require an authorization form for uses and disclosure of your PHI for **marketing** purposes.

**Use or Disclosure of Your PHI Where You Will Be Given an Opportunity to Agree or Disagree Before the Use or Release**

Disclosure of your PHI to family members, other relatives and your close personal friends is allowed if:

- The information is directly relevant to the family or friend’s involvement with your care or payment for that care, and
- You have either agreed to the disclosure or have been given an opportunity to object and have not objected.

[Under this Plan your PHI will automatically be disclosed to internal employer departments as outlined below, in order to facilitate processing of appropriate paperwork. If you disagree with this automatic disclosure by the Plan you may contact the Privacy Officer to request that such automatic disclosure not occur without your written authorization:

- In the event of your death while you are covered by this Plan, when the Plan is notified it will automatically communicate this information to the following internal departments: Human Resources, Payroll and Benefits.
- In the event the Plan is notified of a work-related illness or injury, the Plan may communicate this information to the Worker’s Compensation/Risk Management department.
- In the event the Plan is notified of a condition that may initiate a short-term disability benefit, the Plan will automatically communicate this information to the Plan’s Disability Coordinator and STD insurance company.
- In the event the Plan is notified of a situation where it may be possible to initiate a medical leave under the Family and Medical Leave Act (FMLA) benefit, the Plan will automatically communicate this information to the TUSD FMLA Coordinator.

Note that PHI obtained by the Plan Sponsor’s employees through Plan administration activities will NOT be used for employment related decisions.

### Use or Disclosure of Your PHI Where Consent, Authorization or Opportunity to Object Is Not Required

In general, the Plan does not need your written authorization to release your PHI if required by law or for public health and safety purposes. The Plan and its business associates are allowed to use and disclose your PHI without your written authorization (in compliance with section 164.512) under the following circumstances:

1. When **required by law**.
2. When permitted for **purposes of public health activities**. This includes reporting product defects, permitting product recalls and conducting post-marketing surveillance. PHI may also be used or disclosed if you have been exposed to a communicable disease or are at risk of spreading a disease or condition, if authorized by law.
3. When authorized by law to report information about **abuse, neglect or domestic violence** to public authorities if a reasonable belief exists that you may be a victim of abuse, neglect or domestic violence. In such case, the Plan will promptly inform you that such a disclosure has been or will be made unless that notice would cause a risk of serious harm. For the purpose of reporting child abuse or neglect, it is not necessary to inform the minor that such a disclosure has been or will be made. Disclosure may generally be made to the minor's parents or other representatives, although there may be circumstances under federal or state law when the parents or other representatives may not be given access to the minor's PHI.
4. To a **public health oversight agency for oversight activities authorized by law**. These activities include civil, administrative or criminal investigations, inspections, licensure or disciplinary actions (for example, to investigate complaints against providers) and other activities necessary for appropriate oversight of government benefit programs (for example, to investigate Medicare or Medicaid fraud).
5. When required **for judicial or administrative proceedings**. For example, your PHI may be disclosed in response to a subpoena or discovery request, provided certain conditions are met, including that:
  - the requesting party must give the Plan satisfactory assurances that a good faith attempt has been made to provide you with a written Notice, and
  - the Notice provided sufficient information about the proceeding to permit you to raise an objection, and
  - no objections were raised or were resolved in favor of disclosure by the court or tribunal.
6. When required for **law enforcement health purposes** (for example, to report certain types of wounds).
7. For **law enforcement purposes** if the law enforcement official represents that the information is not intended to be used against the individual, the immediate law enforcement activity would be materially and adversely affected by waiting to obtain the individual's agreement and the Plan, in its best judgment, determines that disclosure is in the best interest of the individual. Law enforcement purposes include:
  - identifying or locating a suspect, fugitive, material witness or missing person, and
  - disclosing information about an individual who is or is suspected to be a victim of a crime.
8. When required to be given **to a coroner or medical examiner** to identify a deceased person, determine a cause of death or other authorized duties. When required to be given **to funeral directors** to carry out their duties with respect to the decedent; for use and disclosures for cadaveric **organ, eye or tissue donation** purposes.
9. For **research**, subject to certain conditions.
10. When, consistent with applicable law and standards of ethical conduct, the Plan in good faith believes the use or disclosure is necessary to prevent or lessen a serious and **imminent threat to the health or safety** of a person or the public and the disclosure is to a person reasonably able to prevent or lessen the threat, including the target of the threat.
11. When authorized by and to the extent necessary to comply with **workers' compensation** or other similar programs established by law.
12. When required, for **specialized government functions**, to military authorities under certain circumstances, or to authorized federal officials for lawful intelligence, counter intelligence and other national security activities.

Except as otherwise indicated in this Notice, uses and disclosures will be made only with your written authorization subject to your right to revoke your authorization and information used and disclosed will be made in compliance with the minimum necessary standards of the regulation.

## **Your Individual Privacy Rights**

### **A. You May Request Restrictions on PHI Uses and Disclosures**

You may request the Plan to restrict the uses and disclosures of your PHI:

- To carry out treatment, payment or health care operations, or
- To family members, relatives, friends or other persons identified by you who are involved in your care.

The Plan, however, is not required to agree to your request if the Plan Administrator or Privacy Officer determines it to be unreasonable, for example, if it would interfere with the Plan's ability to pay a claim.

The Plan will accommodate an individual's reasonable request to receive communications of PHI by alternative means or at alternative locations where the request includes a statement that disclosure could endanger the individual. You or your personal representative will be required to complete a form to request restrictions on the uses and disclosures of your PHI. To make such a request contact the Privacy Officer at their address listed on the first page of this Notice.

### **B. You May Inspect and Copy Your PHI**

You have the right to inspect and obtain a copy of your PHI (except psychotherapy notes and information compiled in reasonable contemplation of an administrative action or proceeding) contained in a "designated record set," for as long as the Plan maintains the PHI.

A **Designated Record Set** includes your medical records and billing records that are maintained by or for a covered health care provider. Records include enrollment, payment, billing, claims adjudication and case or medical management record systems maintained by or for a health plan or other information used in whole or in part by or for the covered entity to make decisions about you. Information used for quality control or peer review analyses and not used to make decisions about you is not included in the designated record set.

The Plan must provide the requested information within 30 days of its receipt of the request, if the information is maintained onsite or within 60 days if the information is maintained offsite. A single 30-day extension is allowed if the Plan is unable to comply with the deadline and notifies you in writing in advance of the reasons for the delay and the date by which the Plan will provide the requested information.

You or your personal representative will be required to complete a form to request access to the PHI in your Designated Record Set. Requests for access to your PHI should be made to the Plan's Privacy Officer at their address listed on the first page of this Notice.

If access is denied, you or your personal representative will be provided with a written denial describing the basis for the denial, a description of how you may exercise those review rights and a description of how you may complain to the Plan's Privacy Officer or the Secretary of the U.S. Department of Health and Human Services.

### **C. You Have the Right to Amend Your PHI**

You or your Personal Representative have the right to request that the Plan amend your PHI or a record about you in a designated record set for as long as the PHI is maintained in the designated record set. The Plan has 60 days after receiving your request to act on it. The Plan is allowed a single 30-day extension if the Plan is unable to comply with the 60-day deadline (provided that the Plan notifies you in writing in advance of the reasons for the delay and the date by which the Plan will provide the requested information).

If the Plan denied your request in whole or part, the Plan must provide you with a written denial that explains the basis for the decision. You or your personal representative may then submit a written statement disagreeing with the denial and have that statement included with any future disclosures of your PHI. You should make your request to amend PHI to the Privacy Officer at their address listed on the first page of this Notice.

You or your personal representative may be required to complete a form to request amendment of your PHI. Forms are available from the Privacy Officer at their address listed on the first page of this Notice.

- D. **You Have the Right to Receive an Accounting of the Plan's PHI Disclosures**  
At your request, the Plan will also provide you with an accounting of disclosures by the Plan of your PHI during the six years (or shorter period if requested) before the date of your request. The Plan will not provide you with an accounting of disclosures related to treatment, payment, or health care operations, or disclosures made to you or authorized by you in writing.
- The Plan has 60 days after its receipt of your request to provide the accounting. The Plan is allowed an additional 30 days if the Plan gives you a written statement of the reasons for the delay and the date by which the accounting will be provided. If you request more than one accounting within a 12-month period, the Plan may charge a reasonable, cost-based fee for each subsequent accounting.
- E. **You have the Right to Request that PHI be Transmitted to You Confidentially**  
The Plan will permit and accommodate your reasonable request to have PHI sent to you by alternative means or to an alternative location (such as mailing PHI to a different address or allowing you to personally pick up the PHI that would otherwise be mailed), if you provide a written request to the Plan that the disclosure of PHI to your usual location could endanger you. If you believe you have this situation, you should contact the Plan's Privacy Officer to discuss your request for confidential PHI transmission.
- F. **You Have the Right to Receive a Paper or Electronic Copy of This Notice Upon Request**  
To obtain a paper or electronic copy of this Notice, contact the Plan's Privacy Officer at their address listed on the first page of this Notice or go to the website:  
<http://www.tusd.k12.az.us/contents/depart/benefits/index.asp>

### **Your Personal Representative**

You may exercise your rights to your PHI by designating a personal representative. Your personal representative will be required to produce evidence of the authority to act on your behalf **before** the personal representative will be given access to your PHI or be allowed to take any action for you. Under this Plan, proof of such authority will include (1) a completed, signed and approved form to Appoint a Personal Representative; (2) a notarized power of attorney for health care purposes; (3) or a court-appointed conservator or guardian. You may obtain this form by contacting the Privacy Officer at their address listed on the first page of this Notice.

The Plan retains discretion to deny access to your PHI to a personal representative to provide protection to those vulnerable people who depend on others to exercise their rights under these rules and who may be subject to abuse or neglect.

Because this law gives adults certain rights (and generally children age 18 and older are adults), if you have **dependent children age 18 and older** (e.g. students) covered under the Plan, and the child wants you, as the parent(s), to be able to access their protected health information, that child will need to complete a Personal Representative form to designate you and/or your spouse as their personal representative.

The Plan will consider a parent, guardian, or other person acting *in loco parentis* as the personal representative of an unemancipated minor (a child generally under age 18) unless the applicable law requires otherwise. **In loco parentis** may be further defined by state law, but in general it refers to a person who has been treated as a parent by the child and who has formed a meaningful parental relationship with the child for a substantial period of time.

Spouses and unemancipated minors may, however, request that the Plan restrict PHI that goes to family members as described above under the section titled "Your Individual Privacy Rights."

## **The Plan's Duties**

The Plan is required by law to maintain the privacy of your PHI and to provide you and your eligible dependents with Notice of its legal duties and privacy practices. The Plan is required to comply with the terms of this Notice. However, the Plan reserves the right to change its privacy practices and the terms of this Notice and to apply the changes to any PHI maintained by the Plan.

**Notice Distribution:** The Notice will be provided to each person when they initially enroll for benefits in the Plan (the Notice is provided in the Plan's New Employee packets). The Notice is also available on the Plan's website at: <http://www.tusd.k12.az.us/contents/depart/benefits/index.asp>. The Notice will also be provided upon request. Once every three years the Plan will notify the individuals then covered by the Plan where to obtain a copy of the Notice. This Plan will satisfy the requirements of the HIPAA regulation by providing the Notice to the named insured (covered employee) of the Plan; however, employees are encouraged to share this Notice with other family members covered under the Plan.

**Notice Revisions:** If a privacy practice of this Plan is changed affecting this Notice, a revised version of this Notice will be provided to you and all participants covered by the Plan at the time of the change. Any revised version of the Notice will be distributed within 60 days of the effective date of a material change to the uses and disclosures of PHI, your individual rights, the duties of the Plan or other privacy practices stated in this Notice.

### Disclosing Only the Minimum Necessary Protected Health Information

When using or disclosing PHI or when requesting PHI from another covered entity, the Plan will make reasonable efforts not to use, disclose or request more than the minimum amount of PHI necessary to accomplish the intended purpose of the use, disclosure or request, taking into consideration practical and technological limitations. However, the minimum necessary standard will not apply in the following situations:

- Disclosures to or requests by a health care provider for treatment,
- Uses or disclosures made to you,
- Disclosures made to the Secretary of the U.S. Department of Health and Human Services in accordance with their enforcement activities under HIPAA,
- Uses of disclosures required by law, and
- Uses of disclosures required for the Plan's compliance with the HIPAA privacy regulations.

This Notice does not apply to information that has been de-identified. **De-identified information** is information that does not identify you and there is no reasonable basis to believe that the information can be used to identify you.

In addition, the Plan may use or disclose "summary health information" to the Plan Sponsor for obtaining premium bids or modifying, amending or terminating the group health Plan. **Summary health information** means information that summarizes claims history, claims expenses or type of claims experienced by individuals for whom the Plan Sponsor has provided health benefits under a group health plan. Identifying information will be deleted from summary health information, in accordance with HIPAA.

### Your Right to File a Complaint

**If you believe that your privacy rights have been violated, you may file a complaint with the Plan in care of the Plan's Privacy Officer, at the address listed on the first page of this Notice.** Neither your employer nor the Plan will retaliate against you for filing a complaint.

You may also file a complaint (within 180 days of the date you know or should have known about an act or omission) with the Secretary of the U.S. Department of Health and Human Services by contacting the Office for Civil Rights, U.S. Department of Health & Human Services 90 Seventh St., Suite 4-100 San Francisco, CA 94103 phone: (415) 437-8310 or (415) 437-8311 (TDD) or fax: (415) 437-8329 or, contact the Plan's Privacy Officer for more information about how to file a complaint.

### If You Need More Information

If you have any questions regarding this Notice or the subjects addressed in it, you may contact the Plan's Privacy Officer at the address listed on the first page of this Notice.

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## *Eligible Dependents*

**Eligible dependents can include:** Spouse, Domestic Partner (Affidavit of Domestic Partnership is required), Natural Children, Stepchildren, Adopted Children, Children of a Domestic Partner (if you enroll your Domestic Partner), and Guardianship of Children i.e. grandchildren (court documentation required).

**\*Affidavit of Domestic Partnership is required and benefits may be imputed as income to employee. The form is available on the benefits website: [http://intranet/hr/ben\\_forms.asp](http://intranet/hr/ben_forms.asp).**

**The following individuals are not eligible dependents: son-in-law, daughter, niece/nephew or grandchild unless the employee has legal guardianship of the child.**

Section 111 of the Medicare, Medicaid and SCHIP Extension Act of 2007 (MMSEA), a new federal law that became effective January 1, 2009, requires that group health insurers, claims processing third-party administrators, and certain employer self-funded/self-administered plans report specific information about Medicare beneficiaries who have other group coverage. This reporting is to assist CMS and other health insurance plans to properly coordinate payment of benefits among plans so that your claims are paid promptly and correctly.

**If you are unable or unwilling to provide a social security number for your dependents who want to enroll in the health plan, then you must complete a CMS form available from the TUSD Benefits Office or on the benefits website.**

**Dependent Children are eligible to remain on the TUSD benefit plan until the age of 26, regardless of student status.**

A dependent child also includes an unmarried child who is 26 years of age or older and is mentally or physically disabled (as that term is defined in this Plan); the child is incapable of self-sustaining employment as a result of that disability; and that disability existed before the attainment of this Plan's age limit. This Plan may require initial and periodic proof of disability. A Dependent Child who is not covered under the Plan but becomes disabled after reaching the Plan's Dependent age limit is not eligible to enroll as a Dependent under this Plan.

A dependent child also includes a child for whom health care coverage is required through a "Qualified Medical Child Support Order" or other court or administrative order, even if the child does not reside within the service area.

**Spouse** means a person to whom the employee is legally married.

**Domestic Partner** means an individual with whom the employee meets the criteria defined in the **Affidavit of Domestic Partnership**. The Affidavit must be signed, notarized and submitted to TUSD Benefits Office.

***Please note:*** that in accordance with Internal Revenue Code, once an employee has added or dropped his/her dependents from the insurance coverage (medical, dental and/or vision) no further changes are allowed until a Special Enrollment or Permissible Mid-Year Status Change occurs or until next year's Open Enrollment period.

## Supplemental Life Insurance Premiums

### Employee Life and AD&D Benefit Election Options - Costs per 20 Pay Periods

Age	\$10,000	\$20,000	\$30,000	\$40,000	\$50,000	\$60,000	\$70,000	\$80,000	\$90,000	\$100,000
<30	\$0.48	\$0.96	\$1.44	\$1.92	\$2.40	\$2.88	\$3.36	\$3.84	\$4.32	\$4.80
30-34	\$0.60	\$1.20	\$1.80	\$2.40	\$3.00	\$3.60	\$4.20	\$4.80	\$5.40	\$6.00
35-39	\$0.66	\$1.32	\$1.98	\$2.64	\$3.30	\$3.96	\$4.62	\$5.28	\$5.94	\$6.60
40-44	\$0.90	\$1.80	\$2.70	\$3.60	\$4.50	\$5.40	\$6.30	\$7.20	\$8.10	\$9.00
45-49	\$1.38	\$2.76	\$4.14	\$5.52	\$6.90	\$8.28	\$9.66	\$11.04	\$12.42	\$13.80
50-54	\$2.22	\$4.44	\$6.66	\$8.88	\$11.10	\$13.32	\$15.54	\$17.76	\$19.98	\$22.20
55-59	\$3.90	\$7.80	\$11.70	\$15.60	\$19.50	\$23.40	\$27.30	\$31.20	\$35.10	\$39.00
60-64	\$4.38	\$8.76	\$13.14	\$17.52	\$21.90	\$26.28	\$30.66	\$35.04	\$39.42	\$43.80
65-69	\$10.80	\$21.60	\$32.40	\$43.20	\$54.00	\$64.80	\$75.60	\$86.40	\$97.20	\$108.00
70-74*	\$8.39	\$16.77	\$25.16	\$33.54	\$41.93	\$50.31	\$58.70	\$67.08	\$75.47	\$83.85
75-79*	\$10.56	\$21.12	\$31.68	\$42.24	\$52.80	\$63.36	\$73.92	\$84.48	\$95.04	\$105.60
80+*	\$5.28	\$10.56	\$15.84	\$21.12	\$26.40	\$31.68	\$36.96	\$42.24	\$47.52	\$52.80

  

Age	\$110,000	\$120,000	\$130,000	\$140,000	\$150,000	\$160,000	\$170,000	\$180,000	\$190,000	\$200,000
<30	\$5.28	\$5.76	\$6.24	\$6.72	\$7.20	\$7.68	\$8.16	\$8.64	\$9.12	\$9.60
30-34	\$6.60	\$7.20	\$7.80	\$8.40	\$9.00	\$9.60	\$10.20	\$10.80	\$11.40	\$12.00
35-39	\$7.26	\$7.92	\$8.58	\$9.24	\$9.90	\$10.56	\$11.22	\$11.88	\$12.54	\$13.20
40-44	\$9.90	\$10.80	\$11.70	\$12.60	\$13.50	\$14.40	\$15.30	\$16.20	\$17.10	\$18.00
45-49	\$15.18	\$16.56	\$17.94	\$19.32	\$20.70	\$22.08	\$23.46	\$24.84	\$26.22	\$27.60
50-54	\$24.42	\$26.64	\$28.86	\$31.08	\$33.30	\$35.52	\$37.74	\$39.96	\$42.18	\$44.40
55-59	\$42.90	\$46.80	\$50.70	\$54.60	\$58.50	\$62.40	\$66.30	\$70.20	\$74.10	\$78.00
60-64	\$48.18	\$52.56	\$56.94	\$61.32	\$65.70	\$70.08	\$74.46	\$78.84	\$83.22	\$87.60
65-69	\$118.80	\$129.60	\$140.40	\$151.20	\$162.00	\$172.80	\$183.60	\$194.40	\$205.20	\$216.00
70-74*	\$92.24	\$100.62	\$109.01	\$117.39	\$125.78	\$134.16	\$142.55	\$150.93	\$159.32	\$167.70
75-79*	\$116.16	\$126.72	\$137.28	\$147.84	\$158.40	\$168.96	\$179.52	\$190.08	\$200.64	\$211.20
80+*	\$58.08	\$63.36	\$68.64	\$73.92	\$79.20	\$84.48	\$89.76	\$95.04	\$100.32	\$105.60

\* Premiums are based on age reductions. Benefits reduce by 35% at age 70, 50% at age 75, 75% at age 80.

If you would like to see the cost for more than \$200,000, just follow this example:

36 year old would like \$300,000 of coverage. Take the premium for \$100,000 (\$6.60) plus the premium for \$200,000 (\$13.20) and your premium would be \$19.80 per pay check for \$300,000 of Life and AD&D.



## Supplemental Life Insurance Premiums (cont'd)

### Spouse Life and AD&D Benefit Election Options - Costs per 20 Pay Periods

Age	\$5,000	\$10,000	\$15,000	\$20,000	\$25,000	\$30,000	\$35,000	\$40,000	\$45,000	\$50,000
<30	\$0.24	\$0.48	\$0.72	\$0.96	\$1.20	\$1.44	\$1.68	\$1.92	\$2.16	\$2.40
30-34	\$0.30	\$0.60	\$0.90	\$1.20	\$1.50	\$1.80	\$2.10	\$2.40	\$2.70	\$3.00
35-39	\$0.33	\$0.66	\$0.99	\$1.32	\$1.65	\$1.98	\$2.31	\$2.64	\$2.97	\$3.30
40-44	\$0.45	\$0.90	\$1.35	\$1.80	\$2.25	\$2.70	\$3.15	\$3.60	\$4.05	\$4.50
45-49	\$0.69	\$1.38	\$2.07	\$2.76	\$3.45	\$4.14	\$4.83	\$5.52	\$6.21	\$6.90
50-54	\$1.11	\$2.22	\$3.33	\$4.44	\$5.55	\$6.66	\$7.77	\$8.88	\$9.99	\$11.10
55-59	\$1.95	\$3.90	\$5.85	\$7.80	\$9.75	\$11.70	\$13.65	\$15.60	\$17.55	\$19.50
60-64	\$2.19	\$4.38	\$6.57	\$8.76	\$10.95	\$13.14	\$15.33	\$17.52	\$19.71	\$21.90
65-69	\$5.40	\$10.80	\$16.20	\$21.60	\$27.00	\$32.40	\$37.80	\$43.20	\$48.60	\$54.00
70-74*	\$4.52	\$8.39	\$12.90	\$16.77	\$21.29	\$25.16	\$29.67	\$33.54	\$38.06	\$41.93
75-79*	\$5.28	\$10.56	\$15.84	\$21.12	\$26.40	\$31.68	\$36.96	\$42.24	\$47.52	\$52.80
80+*	\$3.17	\$5.28	\$8.45	\$10.56	\$13.73	\$15.84	\$19.01	\$21.12	\$24.29	\$26.40

\* Premiums are based on age reductions. Benefits reduce by 35% at age 70, 50% at age 75, 75% at age 80.

If you would like to see the cost for more than \$50,000, just follow this example:

36 year old would like \$75,000 of coverage. Take the premium for \$50,000 (\$3.30) plus the premium for \$25,000 (\$1.65) and your premium would be \$4.95 per pay check for \$75,000 of Life and AD&D.

### Child)ren Life and AD&D Options - Cost per 20 Pay Periods

Option	Cost
\$1,000	\$0.19
\$5,000	\$0.96
\$10,000	\$1.92

