TUSD

2010 – 2011
Benefits Handbook

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.

TUSD

Financial Services

1010 E, 10th Street
Tucson, AZ 85719

August 2010

Dear TUSD Employee:

Welcome to a new and exciting school year for TUSD! Several TUSD staff members have been hard at work implementing new District-wide software that will enhance and streamline several processes, including the open enrollment process for **2011**. Refer to the TUSD internet site for updates as we progress towards the completion of this project: TUSD1.org > Site Map > Finances > TUSD S.M.A.R.T.

In the pages that follow, we are pleased to present the menu of employee benefits for the plan year October 1, 2010 through September 30, 2011 for your review. 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. Some notable changes include offering an EPO Plan (formerly the HMO), a PPO Plan and a High Deductible Health Plan.

For all returning/continuing employees, as TUSD transitions to a new medical vendor and provider network, you will have to submit open enrollment forms **for all benefit plan elections**. If you do not submit an Open Enrollment form, you risk not being enrolled in benefits at this time. You **must** submit your forms to the Benefits Office no later than **12:00 noon on August 31st.**

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 insurance 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 enrolled in any insurance 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** and choose My Online Tools and then My Personal Health Suite.

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.

We look forward to the exciting changes this year brings as we continue to strengthen our focus on your health and wellness.

Sincerely,

Bonnie Betz
Chief Financial Officer

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

WELCOME

AmeriBen is pleased to announce that we will be administering benefits for Tucson Unified School District Employee Benefit Trust effective October 1, 2010.

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 now 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, most larger companies find that self-funding gives them more control over benefits offered and costs less than traditional medical insurance products.

How does this change affect me?

You will be receiving new identification cards by October 1, 2010. Please be sure to look for your new ID cards, destroy the current Aetna ID card, and present your new ID card to your doctors and pharmacists for services rendered after September 30, 2010.

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.

AmeriBen is dedicated to providing excellent customer service to all participants and providers. We are looking forward to building successful relationships and appreciate opportunities to assist you.

Sincerely,

AmeriBen

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Open Enrollment Meetings: 2010 – 2011 School Year

TUSD will hold Open Enrollment meetings offering employees an opportunity to speak directly with various plan representatives

Remember: copiers will not be available at the sites
Employees are responsible for making their own copies
All sessions at the schools will be held in the Cafeteria

T.U.S.D. Annual Benefits Open Enrollment Meetings

DAY/DATE	TIME	LOCATION	ADDRESS
Tuesday, August 17	3:00 p.m. - 5:30 p.m.	Cholla High	2001 W. Starr Pass Blvd.
Thursday, August 19	7:00 a.m. – 12:30 p.m.	Engineering, Facilities & Planning Warehouse	2050 E. Winsett
Monday, August 23	1:30 p.m. – 4:00 p.m.	Maroon Room	1010 E. Tenth St.
Wednesday, August 25	3:00 p.m. – 5:30 p.m.	Rincon High	421 N. Arcadia
Monday, August 30	3:00 p.m. – 5:30 p.m.	Governing Board Room & Maroon Room	1010 E. Tenth St.
Tuesday, August 31	7:30 a.m. – 12:00 noon	Governing Board Room & Maroon Room	1010 E. Tenth St.

Vendors will be on-site for all OE dates

2010-2011 Open Enrollment Period: July 30th through 12:00 Noon on August 31st

***Open Enrollment*:** **You MUST submit an Open Enrollment form for all elections, including changes.** All forms must be submitted to the Benefits Office no later than 12:00 Noon on August 31, 2010. All new rates and changes will go into effect on October 1, 2010.

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. **Failure to provide a social security number or HICN will result in a dependent's non-enrollment or possible drop from the plan.**

***New Hires*:** **You MUST submit your Insurance Enrollment Form within 30 days from your date of hire.** If you do not submit your form in time, you will not be eligible to elect insurance until the next Open Enrollment period, or qualifying event.

FAQs for Returning or Existing Employees

Do I have to submit an enrollment form?
Yes, since TUSD is implementing a new medical vendor and provider network, **all employees will need to re-enroll in all benefits**. Failure to submit an Open Enrollment form may result in loss of coverage for the 2010-2011 plan year.

After the Open Enrollment period ends at 12:00 noon on August 31, 2010, you will not be able to make changes until the next Open Enrollment period unless you experience a qualifying event (change in family or employment status). See the list of the qualifying events at the back of this handbook. You will have 30 days from the date of the event to turn in an Insurance Enrollment Change form.

What will happen if I do not turn in an Open Enrollment form?
If you do not submit an Open Enrollment form, all of your current benefits elections will remain the same (employee only, family coverage, etc.) and you will be placed in a comparable plan (HMO participants will be enrolled in the EPO Plan and POS participants will be enrolled in the PPO Plan).

Changes will only occur if the appropriate sections are completed accurately and are received in the TUSD Benefits Office prior to the deadline.

Do I have to submit all three pages of the Open Enrollment form?
Yes. Also, please be sure to sign all pages on which you make changes.

Are there any changes to the Medical Plan?
Yes, TUSD will offer an EPO (formerly the HMO Plan), a PPO Plan and a High Deductible Plan with a slight increase in rates. Be sure to check AmeriBen.com or the TUSD benefits website to ensure your physicians are contracted with Blue Cross Blue Shield of Arizona provider network.

What is new this year?
TUSD has to AmeriBen, a Third Party Administrator of the TUSD medical plans, using the Blue Cross Blue Shield of Arizona provider network. TUSD has also changed to Jorgensen Brooks Group for the employer-paid EAP insurance. All other vendors remain the same.

We encourage you to update your Beneficiary Designation form and submit it to the Benefits Office during this open enrollment period. This form is available on the Benefits Intranet site and in the TUSD Human Resources Customer Service Area.

Where do I submit my enrollment form?
- At each of the Open Enrollment meetings, there will be benefit staff members to assist in reviewing your forms and benefit selections. You may submit your open enrollment paperwork to any staff member.

- During normal business hours, employees may bring enrollment forms to the Human Resources Customer Service area where a benefit associate will be available to assist with reviewing the documents prior to submittal.

- Enrollment forms may also be sent via interoffice mail – **forms must arrive in the Benefits Office by the deadline of 12:00 Noon on August 31, 2010.** Please allow enough transit time.

When does the Open Enrollment period end?
Open Enrollment ends at **12:00 Noon on August 31, 2010.** All enrollment forms must be received in the Benefits Office by Noon, Monday, August 31, 2010. **No changes will be allowed after this date.**

What does the dollar amount on my 2010 Open Enrollment form mean?
The premiums on the individualized 2010 Open Enrollment form reflect the employee's **actual per paycheck costs** for insurance, per pay period, over 20 pay periods.

Open Enrollment FAQs (Cont'd)

When will elections made during Open Enrollment go into effect?
Elections made during Open Enrollment will be effective with the beginning of the new plan year**, October 1, 2010.** The new deductions will begin on the October 15, 2010 paycheck.

Since the Benefit Plan Year is October 1 through September 30, you will see last year's rates for the first three paychecks of the new school year. The new rates begin on October 1, and continue until the end of September 2011.

Please note: new premiums for Additional Employee/Spouse Life Insurance and Short Term Disability may occur in later paychecks**. If you are electing an increase and/or new enrollment in Additional Employee or Spouse Life Insurance, or new enrollment in Short Term Disability, you will need to submit an Evidence of Insurability (EOI) or Personal Health Application to the appropriate insurance carrier before your election and/or increase can occur.**

The Evidence of Insurability form for the Short Term Disability plan and the Personal Health Application for the Additional Life Insurance plan are available at the Open Enrollment Meetings, Human Resources Customer Service and on the Benefits Intranet. The EOI should be mailed directly to Aetna STD and/or The Harford Life Insurance Company.

If approved, your new insurance will become effective on the first day of the calendar month following approval of your EOI/application. Employees are responsible for communicating directly with the short-term disability or life insurance company regarding their application status.

NOTE: Making changes to your open enrollment form for Short Term Disability and/or Additional Employee or Spouse Life insurance when an EOI/Personal Health Application is required, does **NOT** mean you are automatically enrolled in the new/increased amount of coverage.

Can I add my spouse, Domestic Partner and/or child(ren) to my insurance now?
Yes. You may enroll your spouse, domestic partner and children/domestic partner children in your insurance during the open enrollment period. The Affidavit of Domestic Partnership must be completed in order to enroll a domestic partner. Children of your Domestic Partner may be enrolled only if you have your Domestic Partner enrolled. The Affidavit of Domestic Partnership is available at the back of this handbook, as well as on the Benefits intranet website and Human Resources Customer Service.

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. **Failure to provide a social security number or HICN will result in a dependent's non-enrollment or possible drop from the plan.**

The coverage for the Domestic Partner will be the same as if covering a spouse; however, such coverage will result in imputed income for the employee. Premiums deducted for a domestic partner will be considered taxable and taken out on an after-tax basis on your paycheck.

Please note: in accordance with Internal Revenue Code Section 125, 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 qualifying event occurs or until next year's open enrollment period.

Remember: You must submit an Insurance Enrollment Change form within 30 days of a qualified status change. If the Benefits Office does not receive your paperwork in a timely fashion, your request for enrollment changes will be denied in accordance with IRC Section 125.

WELCOME

New TUSD Employee!

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 insurance enrollment forms within 30 days of your date of hire if you are enrolling in ANY insurance plan. **IF YOU *DO NOT* SUBMIT THE INSURANCE 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 QUALIFYING EVENT.**

☐ Review this handbook for an overview of the TUSD Benefits Package.

FAQs for New Hires

Am I eligible for insurance?
An employee of TUSD is eligible for benefits if 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 1/5th contract.

Your coverage will become effective on the first day of the month after 30 days of employment and have submitted a completed and signed Insurance Enrollment forms.

If you are a retiree of the Arizona State Retirement System, you are not considered a benefits eligible employee.

If you are eligible for benefits, you are also eligible for medical, dental, and vision coverage for your eligible dependents. If you acquire an eligible dependent, by either 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 qualified status change, also known as a qualifying event. The list of qualifying events and eligible dependents are available at the end of this handbook.

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. **Failure to provide a social security number or HICN will result in a dependent's non-enrollment or possible drop from the plan.**

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 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 Additional Life Insurance coverage after the first 30 days of employment due to a qualifying event 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 insurance enrollment form mean?
The premiums on the insurance enrollment form are the costs for insurance per pay period, for each of the 20 pay periods.

The cost for the medical is the total per pay period cost, including the District contribution. If you are a full time employee, deduct $250.39 (the District contribution) from the premium listed on the Insurance Enrollment form to determine your actual per pay period out-of-pocket premium deduction.

The medical cost for part-time employees is pro-rated. Please contact the Benefits Office at 225-6144 for more information.

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

Since the Benefit Plan Year is October 1 through September 30, 2011, you will see last year's rates for the first three paychecks of the new school year. The new rates beginning on this October 1st will continue until the end of September next school year. Employees may see adjustments to their paychecks if they make a mid-year change to their benefit elections, begin employment after school starts or end employment before school ends

FAQs for New Hires (Cont'd)

Where do I submit my insurance enrollment form?
You may bring the insurance enrollment forms Human Resources at 1010 E. 10th St. at the Morrow Ed Center, Building A, during regular business hours and a benefit associate will assist you.

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.** You have 30 days from your date of hire or the qualifying event. **No exceptions will be made**.

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

What will happen if I do not turn in an insurance enrollment form?
If you do not turn in an insurance enrollment form, you will not be enrolled in medical insurance. You will have to wait until the next Open Enrollment period or until you experience a qualifying event to enroll in insurance.

Can I add my Domestic Partner to my insurance?
Yes. 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 appropriate Insurance Enrollment forms. Children of your Domestic Partner may be enrolled only if you have your Domestic Partner enrolled. For more information, see Domestic Partner Insurance Options under the General Information section of this handbook.

Will I have insurance coverage during the summer?
Only if you continue your employment in the next school year, will you have insurance coverage during the summer. For more information on when your insurance may end, review the General Information sections.

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), **you will have coordination of benefits issues.** Please contact the Benefits Office with any questions you have on this subject.

How much will TUSD contribute toward my insurance?
TUSD contributes up to the equivalent of the employee only Exclusive Provider Organization (EPO) cost, $5,007.80 per year (equal to $ per pay period for the 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 may contribute $24.75 on a per paycheck basis to a Health Savings Account for employees enrolled in the High Deductible Health Plan. 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 (see the Medical Insurance Information section for more information). In addition, contact AmeriBen for forms needed to enroll.

Some grandfathered employees will receive full coverage for employee only PPO benefits. Employees must refer to their bargaining unit agreement for more information.

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General Benefits FAQs

The out-of-pocket costs on the 2010 Open Enrollment form reflect the employee's actual cost. The District contribution has already been deducted from the cost of coverage on the Open Enrollment form.

The costs on the 2010 Insurance Enrollment Form (for new hires and qualifying event changes) reflect the total cost of the insurance.

The cost to insure my dependent(s) is very 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.

Why are insurance premiums taken over 20 pay periods?

Payroll deductions for the entire year are taken on 20 paychecks, September through May to coincide with the school year. This means that the employee is paying for the full 12 months of insurance in 20 paychecks. For 12-month employees, this means that there are no benefits deductions taken during the summer months of June, July and August. This also means that employees may see adjustments to their paychecks if they make a mid-year change to their benefits elections, begin employment after school starts, end employment before school ends or go on an unpaid leave of absence.

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

Yes. Employee premiums for medical, dental, vision and the Aflac products are deducted on a pre-tax basis. Premium deductions for Additional Life Insurance, Allstate Workplace Division products and Aetna Short-Term Disability are taken on an after 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 medical, dental and vision plan selections, including level of coverage (number of dependents), during the year unless a qualifying event is experienced.

Please note: premiums deducted for a domestic partner will be taken on an after-tax basis.

Premium deductions for Additional Life Insurance, Aetna Short-Term Disability and the Allstate Workplace Division products are taken on an after tax basis and therefore, any benefits received are not reduced by taxes.

General Benefits FAQs (Cont'd)

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.

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 Insurance Enrollment forms. Termination of coverage for your Domestic Partner requires completion of the Statement of Termination of the Domestic Partnership and completion of the Insurance Enrollment forms.

Both Domestic Partnership forms are available in Human Resources Customer Service.

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 qualifying event, 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.

Who is an eligible dependent?
Please see a detailed list of eligible dependents at the back of this handbook.

Reminder: The Domestic Partner Affidavit must be signed, notarized and submitted to Human Resource Customer Resources 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 qualifying event occurs or until next year's Open Enrollment period.

What is a qualifying event (change in status)?
A qualifying event is a change to an employee's family or employment status. A complete list appears at the back of this handbook.

Under the District's Internal Revenue Code Section 125 Plan, changes in benefit options during the plan year are permissible ONLY upon a qualifying event and must be made within 30 days of the event.

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.
- **Mid-Year Qualifying Events**
  - Insurance elections due to a birth, adoption, or placement for adoption, are effective on the date of the event. Example: coverage for a newborn is the date of birth.
  - Insurance elections for all other qualified events are effective the first of the month following the event. Example: coverage begins on December 1st for your spouse whom you married on November 15th

When does my insurance end?
- If you terminate your benefit elections due to a qualifying event (resignation, divorce, etc.), your benefits will terminate at the end of the month in which the qualifying event occurs.
- If you are a twelve-month employee, your benefits will end at the end of the month in which you terminate.
- If you resign at the end of the school year, are not a 12-month employee and work the last day of your contract, your benefits will end on June 30th.

General Benefits FAQs (Cont'd)

If you fail to return to work at the beginning of the following school year, your benefits will be *retroactively terminated back to June 30th*

If I take an unpaid leave of absence from work, how are my premiums paid while I am on leave?

- **For a short-term leave of absence:** TUSD will continue to pay for your base medical insurance. The TUSD Benefits Office will either bill you on a per-pay-period basis or collect the missed premiums for dependents and/or other insurance coverage upon your return.

- **For a Family Medical Leave of Absence:** TUSD will continue to pay for your base medical insurance. Premiums for dependents and/or other insurance coverage will be billed to you while you are on leave.

- **For a long-term leave of absence:** (Board Approved), your benefits will be terminated at the end of the month in which your leave is approved. You will receive a COBRA notice to continue your medical, dental and/or vision coverage for which you were enrolled. You must pay the COBRA Administrator monthly in order to continue your coverage while you are out on leave. If you want to continue your life insurance coverage, contact the Benefits Office at 225-6144. Upon return to work, **you <u>MUST</u> complete a new insurance enrollment form to enroll in benefits,** which will begin on the first of the month following 30 days of employment.

General Benefits Information (Cont'd)

What are the vendors' phone numbers and websites?

AmeriBen	(877) 955-1570	www.ameriben.com
Aetna Short Term Disability	(877) 832-8241 – Claims (800) 660-9913 – EOI Status	
Aflac	(520) 647-2730 (800) 462-3522	www.aflac.com
Allstate Workplace Division	(520) 327-1972	www.allstateatwork.com
Arizona State Retirement System (Long Term Disability, Retirement)	(520) 239-3100	www.azasrs.gov
Avēsis, Inc. (Vision)	(800) 828-9341	www.avesis.com
Jorgensen-Brooks Group (EAP)	(520) 575-8623 – Tucson (888) 520-5400 – Out of Area	www.jorgensenbrooks.com
Delta Dental (Dental)	(800) 352-6132 ext. 1	www.deltadentalaz.com
Employers Dental Service – EDS (Dental)	(520) 696-4343	www.mydentalplan.net
Hartford Insurance (Life)	(800) 523-2233	www.thehartfordatwork.com.

What if I still have questions?

- The **Benefits website** contains valuable benefits information including links to provider websites. From the TUSD homepage on the **TUSD intranet**, click on Department Web Sites > Benefits.

- Benefits information can be accessed from home through the TUSD Internet site. From the **TUSD Internet** homepage, 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 225-6144. The email address is Benefits@tusd1.org.**

Medical Insurance FAQs – AmeriBen

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

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.

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 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 PPO plan that may allow contributions to a Health Savings Account (HSA). This plan contains a high deductible. A deductible is the amount you pay out-of-pocket before the medical coverage begins payment for qualified expenses. Most services obtained by the employee and/or dependent need to be paid **out-of-pocket** until the deductible is met. (Note: the cost of an in-network provider is going to be at the contracted rate with the BCBSAZ PPO network providers.)

This year the District may contribute $24.75 on a per paycheck basis to a Health Savings Account for an employee enrolled in the High Deductible Health Plan. A Health Savings Account (HSA) 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.

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?

TUSD can only send a contribution to your HSA after you have completed the appropriate forms. Contact AmeriBen for further details: (877) 955-1570. In addition, employees need to complete the **TUSD HSA Authorization form** if you want to contribute to your account pre-taxed earnings. Both forms are available on the Benefits website and need to be submitted to the Benefits Office upon your HDHP enrollment.

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

What types of prescription drug plans are offered?

The AmeriBen EPO and PPO (In-Network) have a three-level prescription drug plan. This means that medications are divided into three categories.
Tier One drugs cost $10 co-pay.
Tier Two drugs cost $30 co-pay.
Tier Three - Non-Preferred drugs cost $60 co-pay.

Mail Order can also be more affordable than your regular co-pay. Please review the plan summaries for co-pays.

The High Deductible plan is required by law for all prescription drugs to be paid at **full cost** until the plan deductible is met. Please see the plan summaries for more details.

Is my doctor covered?

For the most up-to-date list of physicians and facilities, go to **www.ameriben.com,** click on "benefit participants" and then "my online tools" and then "important links". You can also visit the Blue Cross Blue Shield of AZ site directly at http://www.azblue.com/Provider-Directory/Health-Dental.aspx" and select PPO providers.

Medical Insurance FAQs – AmeriBen (Cont'd)

The AmeriBen website, 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.

Once you are a member of AmeriBen, you may access your personalized information at **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 AmeriBen is currently treating me. What options do I have?
Although AmeriBen processes your claims, they do not contract with providers. 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. The Provider Nomination form is available on the TUSD intranet at Department Websites > Benefits > Medical (AmeriBen).

What will be my costs if I obtain services outside of the network?
A member **cannot** choose to go outside of the network in the Open Access HMO plan.
When members choose to go outside of the network in the Participating Provider Option (PPO) and the High Deductible Health plan (HDHP), they will be subject to a higher deductible and co-insurance.

Please note:

- **The member is responsible for any amount above the allowed amount by BCBSAZ provider network and the provider's billed charges.** This difference will not be applied toward the deductible and/or out-of-pocket maximum.

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

Selecting a PCP
The 2010 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 check the website 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.
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**.

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 the 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 Insurance FAQs – AmeriBen (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. Currently, the co-pay for the Walk-In Clinics is $40 for EPO (specialist co-pay) and $15 for PPO (PCP co-pay). A list of clinics in the AmeriBen network can be found on the Benefits intranet site and on **www.azblue.com/Provider-Directory/Health-Dental.aspx**.

Are there any pre-existing condition exclusions?
There are no pre-existing condition exclusions when an eligible employee enrolls, upon becoming a benefits eligible employee, at Open Enrollment and upon a qualifying event. **TUSD plans do have a list of items that need to be pre-certified prior to utilization.** You can find this list on the Benefits intranet site. This list applies to all three of the medical plans offered by TUSD.

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 either of the following is true:

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

I have Medicare or another health insurance plan. How will my medical benefits be affected if I enroll with AmeriBen?
You should contact Medicare or the other health insurance company directly to determine how enrolling in the TUSD plan will affect you. Depending on your situation, it may not be beneficial to enroll in medical insurance with AmeriBen as a TUSD employee if you have Medicare or another health insurance plan.

What wellness information can I access with AmeriBen?
HealthCare Suite: My Personal Health Suite is our new personalized online health and wellness program accessed through the AmeriBen website. Our 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
- Make healthy food choices with confidence
- Stay healthy as you age
- 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:

- 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, we offer 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** 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. 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.**

THIS IS A BENEFITS SNAPSHOT AND DOES NOT REPLACE THE BENEFIT SUMMARY OR CERTIFICATE OF COVERAGE

TUSD	**EPO**	**PPO**		**HDHP PPO**	
	In-Network	In-Network	Out of Network	Preferred Care	Non-Preferred Care
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	$15/$30 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	$200 co-pay	$200 co-pay	Same as preferred care	20%	Same as preferred care
Prescriptions Tier 1 Generic	$10	$10	30%	20%	40%
Prescriptions Tier 2 Formulary Brand	$30	$30	30%	20%	40%
Prescriptions Tier 3 Non-Formulary Brand	$60	$60	30%	20%	40%
Mail Order	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

Comparison Chart of Medical Plans (Cont'd)

TUSD	EPO	PPO		HDHP PPO	
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% limited to $2,500 per plan year	10% Limited to $2,500 per plan year	30% Limited to $2,500 per plan year	20% Limited to $2,500 per plan year	40% Limited to $2,500 per plan year
Lab/Radiology/X-Ray	Covered 100%	100%	30%	20%	40%
Mammograms	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 unlimited visits per plan year	30% unlimited visits per plan year	20% co-pay unlimited visits per plan year	40% unlimited visits per plan year
Mental Health - Outpatient	$40 co-pay limited to 20 visits per plan year	$30 co-pay limited to 20 visits per plan year	30%copay limited to 20 visits per plan year	20%copay limited to 20 visits per plan year	40%copay limited to 20 visits per plan year
Mental Health - Inpatient	$150 per admission limited to 30 days per plan year	10% per admission limited to 30 days per plan year	30% per admission limited to 30 days per plan year	20% per admission limited to 30 days per plan year	40% per admission limited to 30 days per plan year
* Preventive care received by a preferred provider is covered at 100% and the deductible is waived.					

Medical Benefit Exclusions (*by way of example but not limited to*):

This plan does not cover all health care expenses and includes exclusions and limitations. Members should refer to their plan documents to determine which health care services are covered and to what extent. The following is a partial list of services and supplies that are generally not covered. However, your plan documents may contain exceptions to this list based on state mandates or the plan design or rider(s) purchased by your employer.

All medical or hospital services not specifically covered in, or which are limited or excluded in the plan documents; Charges related to any eye surgery mainly to correct refractive errors; Cosmetic surgery, including breast reductions; Custodial care; Dental care and X-rays; Donor egg retrieval; Experimental and investigational procedures; Hearing aids; Immunizations for travel or work; Infertility services, including, but not limited to, artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI and other related services, unless specifically listed as covered in your plan documents; Nonmedically necessary services or supplies; Orthotics; Over-the-counter medications and supplies; Reversal of sterilization; Services for the treatment of sexual dysfunction or inadequacies, including therapy, supplies, or counseling; and special duty nursing. Weight control services including surgical procedures, medical treatments, weight control/loss programs, dietary regimens and supplements, appetite suppressants and other medications; food or food supplements, exercise programs, exercise or other equipment; and other services and supplies that are primarily intended to control weight or treat obesity, including Morbid Obesity, or for the purpose of weight reduction, regardless of the existence of co morbid conditions. This material is for information purposes only and is neither an offer of coverage nor medical advice. It contains only a partial general description of plan benefits or programs and does not constitute a contract. TUSD does not provide health care services and, therefore, cannot guarantee results or outcomes. Consult the plan documents (i.e.: Group Insurance Certificate and/or Group Policy) to determine governing contractual provisions, including procedures, exclusions and limitation relating to the plan. The availability of any particular provider cannot be guaranteed, and provider network composition is subject to change without notice.

Some benefits are subject to limitations or visit maximums. Certain services require precertification or prior approval of coverage. Failure to precertify for these services may lead to substantially reduced benefits or denial of coverage. Some of the benefits requiring precertification may include, but are not limited to, inpatient hospital, inpatient mental health, inpatient skilled nursing, outpatient surgery, substance abuse (detoxification, inpatient and outpatient rehabilitation). When the Member's preferred provider is coordinating care, the preferred provider will obtain the precertification. When the member utilizes a nonpreferred provider, Member must obtain the precertification. Precertification requirements may vary. Depending on the plan selected, new prescription drugs not yet reviewed by the medication review committee are either available under plans with an open formulary or excluded from coverage unless a medical exception is obtained under plans that use a closed formulary.

They may also be subject to precertification or step-therapy. Non-prescription drugs and drugs in the Limitations and Exclusions section of the plan documents (received after Open Enrollment) are not covered, and medical exceptions are not available for them. While this information is believed to be accurate as of the print date, it is subject to change.

Plans are provided by TUSD and administered by AmeriBen

Medical Insurance Rates

The total **per pay period** premiums (**based on 20 pays**) are identified in the chart below. **Please note:** These premiums reflect the **total cost** of insurance and have **not** been reduced by the TUSD contribution.

These rates are in effect October 1, 2010 – September 30, 2011. Coverage is NOT guaranteed during the summer months of 2011 if you do not return to work in the 2011-2012 school year.

If you are a full-time benefits eligible employee, the District will contribute the full amount of the Employee Only HMO coverage. To determine your out-of-pocket premiums for dependent and/or non-HMO coverage on a per-pay period basis (for each of the 20 pays), subtract the $250.39 from the amount listed.

AmeriBen	**Open Access (EPO)**	**Open Choice (PPO)**	**High Deductible Health Plan (HDHP)**
Employee Only	250.39	300.47	225.65
Employee + Spouse	533.39	640.07	480.63
Employee + Child(ren)	509.81	611.76	460.32
Employee + Family	757.42	908.91	681.45

* Employees enrolled in the High Deductible Health Plan (HDHP) may receive $24.75 per pay period contribution to a Health Savings Account (provided they submit the appropriate forms) Contact AmeriBen for details: (877) 955-1570. In addition, employees must submit a TUSD HSA Authorization forms to the Benefits Office.

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.**

Delta Dental of Arizona is the carrier for the dental indemnity 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**

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. 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 employee is responsible for paying the balance.

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 insurance enrollment form. If a dental provider is not listed, EDS will assign one.

Employees electing the PPO dental plan provided by **Delta Dental** are not required to select a dentist in the network.

Where can I get a list of the dental providers?
The provider directory for **EDS** is included in the new-hire benefits packet. You can also obtain one by visiting **www.mydentalplan.net**, or by contacting EDS Customer Service at 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** 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.

No, there are no pre-existing conditions for either plan option.

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.

Dental Insurance FAQs (Cont'd)

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, <u>there is no benefit</u>.**

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

	Employers Dental Services (EDS) (pre-paid plan)	**Delta Dental (High Option)**	**Delta Dental (Low Option)**
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
	You Pay:	**You Pay:**	**You Pay:**
Routine Services			
Diagnostic Services	$5.00 office visit No charge for x-rays	0%	20%
Preventive Services	$7.00 adult cleaning*	0%	20%
Basic Services			
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%
Major Services			
Periodontics	See above	High Option – Basic Coverage	60%
Crowns	$280+LAB*	20%	60%
Prosthetic Repairs/Adj	$25 adjust partial denture*	50%	60%
Prosthetics	$325+Lab, complete denture, upper*	50%	60%
Orthodontic Services			
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.*

Dental Insurance Rates

The total per pay period premiums (based on 20 pays) are identified in the chart below
The District does not contribute to dental premiums

	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 FAQs

Who is the vision services provider?
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.** 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.

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 is included in the new-hire benefits packet; however, directories are also located online at **www.avesis.com** or contact Avēsis Customer Service Department at (800) 828-9341.

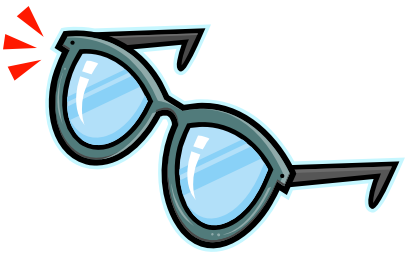
What is the difference between the two Avēsis plans?
The Advantage Plus plan
this plan allows for co-payments when services are obtained from network participating providers. Reimbursement up to certain dollar amounts is allowed for out-of-network benefits.

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



Comparison Chart of Vision Plans

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

Vision Insurance Rates

The total per pay period costs (based on 20 pays) are identified in the chart below. **The District does not contribute to vision premiums.**

Avēsis	**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

Critical Illness and Cancer Care Coverage FAQs

Who are the providers for Critical Illness and Cancer Care coverage?
Allstate Workplace Division provides Critical Illness Insurance with an optional cancer rider.

Aflac offers a Personal Cancer Indemnity and Specified Health Event Plan. All Aflac plans are portable and do not coordinate with any other TUSD benefits.

What is the difference in these plans?
The Personal Cancer Indemnity plan with Aflac has three levels of coverage from which the employee can select. Aflac will pay a specific amount for the occurrence or treatment that is related to cancer. Benefits include a First-Occurrence Benefit, Hospital Confinement, Radiation and Chemotherapy, Immunotherapy, Cancer Screening, Experimental Treatments, Surgery, Reconstruction and Transplants, Home health and Hospice Care, Transportation and Lodging, and much more. Premiums range $13.62 to $38.64 per pay period.

The Specified Health Event plan with Aflac will pay a specific amount for the occurrence of specific health events such as Heart Attack & Coronary Artery Bypass Surgery, Stroke, Coma, End-stage Renal Failure, Major Organ Transplants, major Third Degree Burns, Coma, and much more. Premiums start at $5.46 per pay period.

For additional information, contact AFLAC customer service at (800) 462-3522 or visit their website: **www.aflac.com**

Allstate Workplace Division Critical Illness Insurance * pays a lump sum benefit upon the diagnosis of a covered serious illness. Some examples of covered serious illnesses are Heart Attack, Stroke, Multiple Sclerosis, and Alzheimer's disease with a cancer benefit option. Available benefit amounts from $5,000 to $50,000. An annual Wellness Benefit is also included for each insured. Benefits are portable and no age reduction of benefits.

*Allstate Workplace Division (AWD) is the marketing name for American Heritage Life Insurance Company (Home Office: Jacksonville, FL), a wholly owned subsidiary of The Allstate Corporation. Critical Illness coverage is provided by policy CILP1 and riders CICR1 and WBR3, or state variation thereof, underwritten by American Heritage Life Insurance Company. The coverage has exclusions and limitations. For costs and complete details, review the AWD brochure in the Open Enrollment packet or contact **AWD Customer Service at (800) 521-3535.**

How much does this coverage cost?
Premiums are based on the employee's age and plan selection. Refer to the materials in your new-hire packet for the cost of coverage or contact a representative during Open Enrollment.

Will Critical Illness and Cancer Care premiums be deducted from my paycheck on a pre-tax basis?
Premiums for the AFLAC plans will be deducted on a pre-tax basis and therefore fall under the IRC Section 125 plan for enrollment and cancellation purposes. However, the benefits paid will not be taxed because the plans are not considered to be income replacement.

Premiums for the Allstate Workplace Division policies are deducted on an after-tax basis. However, the IRC Section 125 guidelines are followed for enrollment and cancellation purposes.

There are differences between the Aflac plans and Allstate Workplace Division policies. Please review the materials carefully to determine which product is better for you.

Do these plans/policies replace medical insurance?
No. These plans/policies supplement any medical insurance plan by offering cash payments to offset the out-of-pocket costs associated with specific health events.

How do I sign up?
Information and application forms are available in your new-hire packet. During Open Enrollment, you MUST contact the representatives from the appropriate company to ENROLL.

Critical Illness and Cancer Care Coverage FAQs (cont'd)

For **Allstate Workplace Division (AWD)**, you may contact your AWD representative Debbie Bachel at 327-1972 or **(AWD)** Customer Service at (800) 521-3535.

Written correspondence for **Allstate** can be sent to:
Debbie Bachel and Associates
4751 N. 1st Ave, #101
Tucson, AZ 85718

For **Aflac** information or enrollment, contact any member of the Enrollment Team:
Phil Brenfleck, (520) 780-8914,
phillip_brenfleck@us.aflac
Beth Lake, (520) 302-3584, beth_lake@us.aflac.com
Gilbert Velasco, (520) 256-8439,
gilbert_velasco@us.aflac.com (bilingual)
Rachel Day, (520) 820-8797,
rachel_day@us.aflac.com

Or you may contact the **Aflac Regional Office**:
Attn: Seth Knowlton
3795 N. Oracle Rd, Suite 103
Tucson, AZ 85705
Phone: (520) 647-2730

Life Insurance FAQs

Who is the life insurance carrier?
Hartford Life and Accident Insurance Company is the provider for Basic Life Insurance (District paid) and the Additional Life Insurance (employee paid). Both are term life insurance policies. A Hartford Life Insurance brochure will be available at the Open Enrollment Benefit meetings or the TUSD Benefits intranet site. For further information, contact **Hartford Life at (800) 523-2233**, or online at **www.thehartfordatwork.com.**

What is the purpose of life insurance?
The purpose of life insurance is to provide cash to the member's beneficiary after his/her death and ensure that the beneficiaries are not burdened with debt. Determine the amount of insurance needed by evaluating the beneficiary's financial obligations and loss of income created by the death.

Term Life Insurance provides protection for a specific period of time, i.e., employment with TUSD. Benefit is paid only if member dies during the term.

Does TUSD provide life insurance?
Yes. TUSD will provide Basic Life Insurance and Accidental Death and Dismemberment (AD&D) coverage from Hartford Life. All full-time benefits eligible employees shall be provided with a term life insurance policy equal to the employee's annual base salary for the 2010-2011 school year, but not less than $10,000. All part-time employees shall be provided with a term life insurance policy equal to half of the employee's annual base salary for the 2010-2011 school 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.

Employees electing Employee Additional Life Insurance for the first time, or are requesting an increase in coverage, must complete a **Personal Health Application** for the coverage because it is subject to medical underwriting approval. The form is available at the Open Enrollment meetings and is available on the TUSD Benefits intranet site. ***It is the employee's responsibility to follow up with the insurance company regarding the status of their application for coverage.***

Employees may elect Additional 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 Additional 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. **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, or requesting an increase in coverage for their spouse must complete a Personal Health Application. The form is available at the Open Enrollment meetings and the Benefit Office Intranet Site.

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 Dependents Life Insurance for eligible children. The amount will apply to all eligible children.

The employee must have Additional Life Insurance for her/himself in order to elect additional life insurance for a dependent child. While Dependents Life Insurance is in effect, each new child becomes insured immediately. **More than one employee may not insure a child.**

Life Insurance FAQs (Cont'd)

Cost of Life Insurance
There has been no change in the life insurance premium this year. To determine the per pay period cost of insurance, please refer to the Premium Rate chart at the back of this handbook. It also can be accessed from the Benefits Intranet Site.

When will my life insurance go into effect?
Please refer to the Additional Life Employee Brochure available during the Open Enrollment meetings for more information regarding the following requirements that must be satisfied for the life insurance to become effective.

A Personal Health Application is required when electing coverage for the first time or requesting an increase to his/her current amount of coverage. New-hire employees must complete an application if their requested Additional Employee Life insurance exceeds the guaranteed issue of the lesser of $250,000 or three times their annual salary.

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.

If you are enrolling in Additional Life Insurance for the first time or increasing your coverage, and you are actively at work, your life insurance will go into effect on the first day of the calendar month coinciding with or next following the date your Personal Health Application is approved.

If you are decreasing Additional Life Insurance coverage, any changes made during Open Enrollment will go into effect on October 1, 2010.

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

What happens to my Life Insurance coverage when 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 225-6144 or **Benefits@tusd1.org** for detailed 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** 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 **E**mployee **A**ssistance **P**rogram 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.**

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?
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

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**

What STD plan do I have now?
Continuing employees must refer to the Short-Term Disability (STD) section on page three of your individualized 2010 Open Enrollment Insurance form. Your current STD election will be **underlined.**

What are the differences between the three plans?
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.

The 0/3 plan has no waiting period for injury and 3 days for illness. That means that the employee has no waiting period before the income replacement plan begins due to an injury and a 3-day waiting period for an illness. **This plan is closed to new enrollment**.

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.

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.

I am a continuing employee and I am currently enrolled in STD. What are my options?
Employees enrolled in the 0/3 or 7/14 plan have the option of continuing with this plan ***or*** switching to the 7/14 or 14/21 plan. **These employees will <u>not</u> be required to submit Evidence of Insurability.**

Employees enrolled in the 14/21 plan and electing the 7/14 plan **WILL** be required to submit an **EOI**.

Please note: employees enrolled in the 0/3 plan who opt out of that plan and/or change to the 7/14 or 14/21 plan, cannot return to the 0/3 plan in the future

Where is the Evidence of Insurability form?
The Evidence of Insurability (EOI) form is available in the Open Enrollment packet, at the Open Enrollment meetings and TUSD Human Resources Customer Service. The form is also on the TUSD Benefits intranet site under Short Term Disability.

How do I complete the form?
To complete the EOI, you will need to include the following Plan Sponsor Information:
Control Number: **620368**
Suffix: 7/14 Plan is **21**; 14/21 Plan is **22**
Account: **001 for both plans**
Send your form to Aetna who will contact TUSD for employment verification.

I am a new employee or just not currently enrolled in STD. What are my options?
Currently employed who are not enrolled in short-term disability and want to elect the 7/14 or 14/21 plan, must circle "Elect" on the 2010 Open Enrollment Insurance form AND submit an EOI to Aetna Life Insurance Company. If you are approved, coverage will begin the first of the month following approval.

Short Term Disability FAQs (Cont'd)

Please note: it is the **employee's responsibility** to follow up with the insurance company regarding the status of their application for coverage.

New Employees must circle "elect" for the appropriate plan. Insurance will be effective the first of the month after 30 days. Evidence of Insurability is not required.

*** this is a general enrollment guide/summary of the STD benefits. Refer to the Benefit Documents for complete information**

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 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 ASRS, 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.* Effective July 1, 2010, all benefits eligible employees have an after-tax deduction of .25% from their bi-weekly paycheck to pay for this benefit. TUSD matches this contribution.

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. 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**
- Visit the ASRS website for LTD information and brochure at **www.azasrs.gov**. (800)495-9301

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 the ASRS, please contact them at 239-3100 or www.azasrs.gov.

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 2010 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, 2010.**

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

What is the difference between a 403(b) and 457?*
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. You may not take a distribution of plan accumulations without penalty unless you have attained age 591/2 or separated from service in the year in which you turn 55 or older*. The 457 allows distributions "without the 10% penalty" prior to age 55.
*For detailed information on all of these rules, please go to **www.tsacg.com** and click on the online video presentation.

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. TSACG will be 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** 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?
The 457 Plan Provider for TUSD is **Great-West Retirement Services,** offering their EducatorsMoney program.

To enroll in the 457 plan, call EducatorsMoney toll-free at **1 (877) 816-0548/option 3**, or visit their website at **www.educatorsmoney.com** and follow these steps:

1. In the "Enter here" section, click "Guest"
2. Click Enroll
3. Enter your Social Security Number
4. In the Plan Number field, enter: 350219-01
5. In the Password field, enter: 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, Human Resources Customer Service or the TSACG website:
https://www.tsacg.com/employee_site/districts/arizona/tucson.htm
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 Benefits website, as well as the TSACG website under the TUSD webpage

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Tucson Unified School District
TUSD
Celebrate the US!

Financial Services

1010 E, 10th 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.**

Law requires this announcement, 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 plan, PPO plan and High Deductible Health Plan (HDHP) 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 TUSD 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 November 15th through December 31st); or
- for beneficiaries leaving employer/union coverage, you may be eligible for a 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 November 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:
Option 1	You can select or keep your current medical and prescription drug coverage with the EPO, PPO or HDHP plans offered by TUSD and **you do not have to enroll in a Medicare prescription drug plan.**	You will continue to be able to use your prescription drug benefits through the EPO, PPO or HDHP plans offered by TUSD. • You may, in the future, enroll in a Medicare prescription drug plan during Medicare's annual enrollment period (during November 15-December 31 of each year). • 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.
Option 2	You can select or keep your current medical and prescription drug coverage with the EPO, PPO or HDHP plans offered by TUSD **and also enroll in a Medicare prescription drug plan**. If you enroll in a Medicare prescription drug plan, you will need to pay the Medicare Part D premium out of your own pocket.	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. 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: • for Medicare eligible Retirees and their Medicare eligible Dependents, Medicare Part D coverage pays primary and this group health plan pays secondary. • for Medicare eligible Active Employees and their Medicare eligible Dependents, this group health plan pays primary and Medicare Part D coverage pays secondary. Note that you may not drop just the prescription drug coverage under the EPO, PPO or HDHP plans 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. Note that each Medicare prescription drug plan (PDP) may differ. Compare coverage, such as: • PDPs may have different premium amounts; • PDPs cover different brand name drugs at different costs to you; • PDPs may have different prescription drug deductibles and different drug copayments; • PDPs may have different networks for retail pharmacies and mail order services.

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**
- 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 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 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, 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. 10th 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 23, 2010) is intended to serve as your Medicare Notice of Creditable Coverage, as required by law.

5091748v1/03245.003

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 lymph edema). For more information, call *the TUSD Benefits Office at (520) 225-6144*.

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 the TUSD Benefits Office at (520) 225-6144.

Where to Find a HIPAA Privacy Notice for Our Group Health Plan

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

COBRA Administration

To obtain a copy of this HIPAA Notice of Privacy Practice for the above noted group health plan benefits, write or call the Benefits Department at 1010 E. 10th St, (520) 225-6144 or by email at 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 benefits offered by Tucson Unified School District can be obtained by contacting those insurance companies directly.

Delta Dental	(800) 352-6132
Employers Dental Service	(520) 696-4343

Special Enrollment Notice

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. **Failure to provide a social security number or HICN will result in a dependent's non-enrollment or possible drop from the plan.**

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.

Qualifying Events

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 (mid-year) if you have a qualifying change in your status (as permitted by the IRS) affecting your benefit needs. Any mid-year 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.***

1. Change in legal marital status, including marriage, divorce, legal separation, annulment, death of spouse or begin/end of domestic partnership.

2. Change in the number of dependents, including birth, adoption, placement for adoption, or death of a dependent.

3. Change in employment status, including termination or commencement of employment of the employee, spouse/domestic partner or dependent that affects eligibility for benefits.

4. Significant changes in work schedule of employment by the employee, spouse/domestic partner, or dependent that affects the eligibility for benefits, including a switch between full-time and part-time status, a strike or lockout, or commencement or return from an unpaid leave of absence.

5. Change in primary residence that impairs eligibility for benefits.

6. The dependent satisfies or ceases to satisfy the eligibility requirements.

7. If the employee, spouse/domestic partner, or dependent becomes entitled to or loses entitlement to Medicare or Medicaid, the employee may elect to cancel the coverage of the employee, spouse/domestic partner, or dependent. If an employee, spouse or dependent has been entitled to such coverage, the cafeteria plan may permit the employee to make a prospective election to commence or increase coverage of that employee, spouse, or dependent under the health plan.

8. If the plan receives a Qualified Medical Child Support Order (QMCSO) pertaining to an employee's dependent, the child will be added to the employee's plan (if the QMCSO requires coverage) or drop the child from the employee's plan (if the QMCSO requires the other parent to provide coverage).

9. Spouse /domestic partner's annual open enrollment.

Eligible dependents include: Spouse, Domestic Partner*, Children, Stepchildren, Adopted Children, Domestic Partner Children* and Guardianship of Children (Court documentation required).

***Affidavit of Domestic Partnership is required.**

Eligible Dependents

Eligible dependents are:

- Dependent child
- Spouse
- Domestic Partner
- Domestic Partner child

For the purposes of health care benefits provided through TUSD, a **Dependent Child** is any of the employee's children including a:

- natural child, stepchild, legally adopted child, or child placed for adoption with the employee; (proof of adoption or placement for adoption may be requested) or
- child for whom the employee has legal guardianship under a court order (proof of guardianship may be requested);] or
- foster child, lawfully placed with the employee, for whom health coverage is not provided by the State (proof of foster child placement may be requested); or
- grandchild; provided the Dependent Child depends on the employee for **more than one-half of their support** and **is not a "qualifying child" of any other person**. The term "qualifying child" is defined in the Internal Revenue Code (IRC) in Section 152 (c).

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. **Failure to provide a social security number or HICN will result in a dependent's non-enrollment or possible drop from the plan.**

If the employee is the legal guardian of a child who is not a "relative," as listed in IRC Section 152(d)(2)(A) through (G), the child must, for the entire year, have the same principal place of abode as the employee and be a member of the employee's household (Proof of the same principal place of abode may be requested).

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 Handicapped (as that term is defined in this Plan); the child is incapable of self-sustaining employment as a result of that handicap; and that handicap existed before the attainment of this Plan's age limit. This Plan may require initial and periodic proof of handicap. A Dependent Child who is not covered under the Plan but becomes handicapped 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. The Affidavit of Domestic Partnership follows.

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 qualifying event occurs or until next year's Open Enrollment period.*

Affidavit of Domestic Partnership

I, _____ and
(Print employee's name)

I, _____
(Print partner's name)

declare under penalty of perjury that we are domestic partners within the meaning of the following declaration:

1. We have an intimate, committed relationship of mutual caring and intend to remain sole domestic partners indefinitely; and,
2. We share the same principal residence; and
3. We agree to be responsible for each other's basic living expenses during our domestic partnership such as food, shelter, or medical expenses; we also agree that we share financial obligations and any third party who is owed these expenses can collect from either of us; and
4. We are both 18 years of age or older; and
5. Neither of us is married; and
6. Neither of us is related by blood to the other such as a parent, brother, sister, half brother or sister, niece, nephew, aunt, uncle, grandparent or grandchild; and
7. Neither of us has a different domestic partner now;
8. Neither of us has had a different domestic partner in the last six (6) months unless a previous domestic partnership terminated by death.
9. Domestic partnership commenced on _____

Each of us agrees to notify the TUSD Benefits Office within 30 days in writing if there is any change of circumstances attested to in this Affidavit.

Each of us understands TUSD will report the health insurance deductions for the domestic partner as imputed income to the eligible employee who has enrolled a Domestic Partner for coverage under the plan if the partner does not qualify as a dependent of the employee as that term is defined by Section 152(a) of the Internal Revenue Code.

Each of us understands that the non-employee domestic partner does <u>not</u> have rights to continuing coverage under federal law through COBRA.

Each of us understands the rules of the plan and declares under penalty of perjury under the law of the state of residence that the statements we have made here are true and correct.

_____ _____

(Signature of Employee) (Date)

_____ _____

(Signature of Partner) (Date)

_____

Common Residence Address City State Zip Code

State of Arizona)
) ss.
County of _____)

SUBSCRIBED AND SWORN TO before me this ____ day of _____ , 20 ____

By _____ and _____ .

_____

Notary Public

My Commission Expires:

_____

Additional 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.

Additional 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

Family Medical Leave (FML) of Absence

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

REASON for FML	WHO QUALIFIES	EXCEPTIONS / NOTES
1. Birth or Childcare during child's first year. 2. Adoption or foster placement of child. "State Action" foster care placement – up to 12 months after placement. 3. Care for employee's seriously ill spouse, child or parent. 4. Employee's serious health condition. 5. Spouse, child, or parent has a qualifying military exigency/orders. 6. Care for covered service member with serious injury/illness	All Employee Groups who: 1. Work full-time, or is considered a full-time employee – see Note 4 below, 2. Have worked a minimum of 12 months, and 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.	An employee may elect to use *none, some or all* of his/her accrued **paid** leave balances, before starting the unpaid FML. Doctor's verification/DOL Certification of serious health condition is required. This unpaid FML may not exceed 12/ (26 weeks for Military Exigency) workweeks, or 60 workdays. Intermittent FMLA may be an option with administrator approval. Certain limitations and impact on students may prohibit this option.

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 HMO coverage. If the employee has any benefits beyond employee-only HMO 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: an employee, who works 6 hours per day, is considered a full-time employee in TUSD; however, most of these employees also work on a less than 12-month contract. That means a 6-hour per day, 9.5-month contracted employee only works 1,212 hours per year, which means that if he/she has any absences, then he/she would not be eligible for an FML. Eligibility may be met by counting hours worked at TUSD and another qualified FML eligible employer. Employee must work 1250 hours within 12 months.

Note 5: A FML may not be used consecutively with any type short-term leave, except for Consensus and Blue-Collar employees.

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

Unpaid Leaves of Absence

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 for employee-only HMO coverage. If the employee has any benefits beyond employee-only HMO coverage, he/she will be billed for any additional costs.

Note 2: To be paid for a holiday, the employee must be on some type of paid status on the day before, or the day after the holiday. (Paid status includes paid Sick, Personal or Vacation leave.)

Note 3: 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. This form is available to order from the Warehouse Catalog or on the District's Web Site.

TYPE OF LEAVE	EXCEPTIONS / NOTES
Health of employee	Doctor's verification of illness, with projected date of return, must accompany request.
Health of immediate family	Immediate family is defined in agreements.
New infant care or child care	
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 in	
Sabbatical	Follow procedures in appropriate agreement

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; however, employee will receive a COBRA Notice advising him/her of rights to continue coverage, if he/she makes arrangement to pay the insurance 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

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 in the same bargaining unit, except that an Administrator may donate to any employee group. An employee may not donate to his/her immediate supervisor.

    a. Administrators, Psychologists and Research Project Managers may donate any number of sick leave days to each other, provided that, after the donation, he/she still has 30 or more days of sick leave.
    b. Consensus, White Collar and Food Services employees may donate a maximum of five sick leave days for every 30 days of accumulated sick leave.
    c. Supervisory and Blue Collar employees may donate a maximum of five sick leave days annually if he/she has at least 30 days of accumulated sick leave.
    d. Supervisory, White Collar and Food Service may donate to each other.

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. Days of leave, not the actual salary/wage of the donor, will be donated. 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.

Paid Leaves of Absence

Absence Sheets must be submitted for the following types of paid leaves.

(Exceptions: Sabbatical, Assault by Student, Special Bereavement, Acts of Nature/God and Assignment to Home.)

TYPE OF LEAVE	WHO QUALIFIES	EXCEPTIONS / NOTES
Sick	All Employee Groups	May accumulate without limit
Personal	All Employee Groups	
Vacation	12-Month Employees - in all groups	
Family Illness	All Employee Groups	Taken as Sick Leave
Bereavement	All Employee Groups	Taken as Sick or Personal Leave
Holidays	All Employee Groups	Must be on paid status on workday before or after holiday
Jury or Judicial	All Employee Groups	Proof of attendance is required
On-The-Job Injury or Illness	All Employee Groups And Volunteers	If assigned Light Duty, will get full pay from home site. If on Light Duty, no Absence Sheet required.
Sabbatical	Consensus / Administrators	For Professional Study/Research at ½ pay/benefits. Refer to Agreement.
Released Time	All Employee Groups	Governing Board approves if it costs money or is out-of-state.
Assault by Student	Consensus White Collar / Food Service	Up to two days only. Some type of incident report must be filed. No Absence Sheet required.
Special Bereavement for Faculty or Student's Death	Consensus / White Collar / Food Service	No documentation or Absence Sheet required.
Emergency for Acts of God (Floods, fires, etc.)	All except White Collar / Food Service / Blue Collar	No Absence Sheet required.
45 Minute Early Release	All Employee Groups	If possible, may leave early on day before any Holiday Break.
Assignment to Home	All Employee Groups	Determined by Administrator (Must contact Legal Dept.) No PAF or Absence Sheet required, but letter to employee is required.
Military	All Employee Groups	30 days in any 2 consecutive Fed. Govt. FYs. Code Absence Sheet as "RT-MIL"
Exchange Teaching	Consensus	

Note: An employee who is a victim of a crime may use all of his/her paid Sick Leave, Personal Leave, Vacation and Compensatory Time. The employee must present written notice from the hearing source, law enforcement official or the prosecutor. These absences must be reported on the Absence Sheets as SK. Once all paid leave is gone, the victim must also be allowed to request and be given an unpaid leave.

Glossary of Health Insurance Terms

On March 23, 2010, President Obama signed the Patient Protection and Affordable Care Act (PPACA) into law. When making decisions about health coverage, consumers should know the specific meanings of terms used to discuss health insurance. Below are definitions for some of the more commonly used terms and how PPACA impacts their use.

-A-

Actuarial justification — The demonstration by an insurer that the premiums collected are reasonable, given the benefits provided under the plan or that the distribution of *premiums* among policyholders are proportional to the distribution of their expected costs, subject to limitations of state and federal law. PPACA requires insurers to publicly disclose the actuarial justifications behind unreasonable premium increases.

Adjusted community rating — A way of pricing insurance where *premiums* are not based upon a policyholder's health status, but may be based upon other factors, such as age and geographic location. PPACA requires the use of adjusted community rating, with maximum variation for age of 3:1 and for tobacco use of 1.5:1.

Annual limit — Many health insurance plans place dollar limits upon the claims the insurer will pay over the course of a plan year. PPACA prohibits annual limits for *essential benefits* for plan years beginning after Sept. 23, 2010.

-B-

Balance billing — When you receive services from a health care provider that does not participate in your insurer's network, the health care provider is not obligated to accept the insurer's payment as payment in full and may bill you for unpaid amount. This is known as "balance billing."

-C-

CHIP — The Children's Health Insurance Program (CHIP) provides coverage to low- and moderate-income children. Like *Medicaid*, it is jointly funded and administered by the states and the federal government. It was originally called the State Children's Health Insurance Program (SCHIP).

COBRA coverage — Congress passed the Consolidated Omnibus Budget Reconciliation Act (COBRA) health benefit provisions in 1986. COBRA provides certain former employees, retirees, spouses, former spouses and dependent children the right to temporary continuation of health coverage at group rates. The law generally covers health plans maintained by private-sector employers with 20 or more employees, employee organizations, or state or local governments. Many states have "mini-COBRA" laws that apply to the employees of employers with less than 20 employees.

Coinsurance — A percentage of a health care provider's charge for which the patient is financially responsible under the terms of the policy.

Community rating — A way of pricing insurance, where every policyholder pays the same premium, regardless of health status, age or other factors.

Co-Op Plan — A health insurance plan that will be sold by member-owned and operated non-profit organizations through *Exchanges* when they open in 2014. PPACA provides grants and loans to help Co-Op plans enter the marketplace.

Co-payment — A flat-dollar amount which a patient must pay when visiting a health care provider.

Cost-sharing — Health care provider charges for which a patient is responsible under the terms of a health plan. Common forms of cost-sharing include *deductibles*, *coinsurance* and *co-payments*. *Balance-billed* charges from *out-of-network physicians* are not considered cost-sharing. PPACA prohibits total cost-sharing exceed $5,950 for an individual and $11,900 for a family. These amounts will be adjusted annually to reflect the growth of premiums.

-D-

Deductible — A dollar amount that a patient must pay for health care services each year before the insurer will begin paying claims under a policy. PPACA limits annual deductibles for small group policies to $2,000 for policies that cover an individual, and $4,000 for other policies. These amounts will be adjusted annually to reflect the growth of premiums.

Disease management — A broad approach to appropriate coordination of the entire disease treatment process that often involves shifting away from more expensive inpatient and acute care to areas such as preventive medicine, patient counseling and education, and outpatient care. The process is intended to reduce health care costs and improve the quality of life for individuals by preventing or minimizing the effects of a disease, usually a chronic condition.

-E-

ERISA — The Employee Retirement Income Security Act of 1974 (ERISA) is a comprehensive and complex statute that federalizes the law of employee benefits. ERISA applies to most kinds of employee benefit plans, including plans covering health care benefits, which are called employee welfare benefit plans.

Essential Benefits — PPACA requires all health insurance plans sold after 2014 to include a basic package of benefits including hospitalization, outpatient services, maternity care, prescription drugs, emergency care and preventive services among other benefits. It also places restrictions on the amount of *cost-sharing* that patients must pay for these services.

Exchange — PPACA creates new "American Health Benefit Exchanges" in each state to assist individuals and small businesses in comparing and purchasing *qualified health insurance plans*. Exchanges will also determine who qualifies for subsidies and make subsidy payments to insurers on behalf of individuals receiving them. They will also accept applications for other health coverage programs such as *Medicaid* and *CHIP*.

External review — The review of a health plan's determination that a requested or provided health care service or treatment is not or was not medically necessary by a person or entity with no affiliation or connection to the health plan. PPACA requires all health plans to provide an external review process that meets minimum standards.

-F-

Formulary — The list of drugs covered fully or in part by a health plan.

-G-

Grandfathered plan — A health plan that an individual was enrolled in prior to March 23, 2010. Grandfathered plans are exempted from most changes required by PPACA. New employees may be added to group plans that are grandfathered, and new family members may be added to all grandfathered plans.

Group health plan — An employee welfare benefit plan that is established or maintained by an employer or by an employee organization (such as a union), or both, that provides medical care for participants or their dependents directly or through insurance, reimbursement or otherwise.

Guaranteed issue — A requirement that health insurers sell a health insurance policy to any person who requests coverage. PPACA requires that all health insurance be sold on a guaranteed-issue basis beginning in 2014.

Guaranteed renewability — A requirement that health insurers renew coverage under a health plan except for failure to pay premium or fraud. *HIPAA* requires that all health insurance be guaranteed renewable.

-H-

Health Maintenance Organization (HMO) — A type of managed care organization (health plan) that provides health care coverage through a network of hospitals, doctors and other health care providers. Typically, the HMO only pays for care that is provided from an *in-network provider*. Depending on the type of coverage you have, state and federal rules govern disputes between enrolled individuals and the plan.

Health Savings Account (HSA) — The Medicare bill signed by President Bush on Dec. 8, 2003 created HSAs. Individuals covered by a *qualified high deductible health plan (HDHP)* (and have no other first dollar coverage) are able to open an HSA on a tax preferred basis to save for future qualified medical and retiree health expenses. Additional information about HSAs can be found on the U.S. Treasury Web site: http://www.treas.gov/offices/public-affairs/hsa/.

High Deductible Health Plan (HDHP) — A type of health insurance plan that, compared to traditional health insurance plans, requires greater *out-of-pocket spending*, although *premiums* may be lower. In 2010, an HSA-qualifying HDHP must have a deductible of at least $1,200 for single coverage and $2,400 for family coverage. The plan must also limit the total amount of out-of-pocket *cost-sharing* for covered benefits each year to $5,950 for single coverage and $11,900 for families.

High risk pool — A state-subsidized health plan that provides coverage for individuals *with pre-existing health care conditions* who cannot purchase it in the private market. PPACA creates a temporary federal high risk pool program, which may be administered by the states, to provide coverage to individuals with pre-existing conditions who have been uninsured for at least 6 months.
HIPAA (Health Insurance Portability and Accountability Act of 1996) — The federal law enacted in 1996 which eased the "job lock" problem by making it easier for individuals to move from job to job without the risk of being unable to obtain health insurance or having to wait for coverage due to *pre-existing medical conditions*.

-I-
In-Network provider — A health care provider (such as a hospital or doctor) that is contracted to be part of the network for a managed care organization (such as an *HMO* or *PPO*). The provider agrees to the managed care organization's rules and fee schedules in order to be part of the network and agrees not to *balance bill* patients for amounts beyond the agreed upon fee.
Individual mandate — A requirement that everyone maintain health insurance coverage. PPACA requires that everyone who can purchase health insurance for less than 8% of their household income do so or pay a tax penalty.
Individual market — The market for health insurance coverage offered to individuals other than in connection with a *group health plan*. PPACA makes numerous changes to the rules governing insurers in the individual market.
Internal review — The review of the health plan's determination that a requested or provided health care service or treatment health care service is not or was not medically necessary by an individual(s) associated with the health plan. PPACA requires all plans to conduct an internal review upon request of the patient or the patient's representative.
Interstate compact — An agreement between two or more states. PPACA provides guidelines for states to enter into interstate compacts to allow health insurance policies to be sold in multiple states.

-J-
Job Lock — The situation where individuals remain in their current job because they have an illness or condition that may make them unable to obtain health insurance coverage if they leave that job. PPACA would eliminate job lock by prohibiting insurers from refusing to cover individuals due to health status.

-L-
Lifetime limit — Many health insurance plans place dollar limits upon the claims that the insurer will pay over the course of an individual's life. PPACA prohibits lifetime limits on benefits beginning with on Sept. 23, 2010.
Limited Benefits Plan — A type of health plan that provides coverage for only certain specified health care services or treatments or provides coverage for health care services or treatments for a certain amount during a specified period.

-M-
Mandated benefit — A requirement in state or federal law that all health insurance policies provide coverage for a specific health care service.
Medicaid — A joint state and federal program that provides health care coverage to eligible categories of low-income individuals. Rules for eligible categories (such as children, pregnant women, people with disabilities, etc), and for income and asset requirements, vary by state. Coverage is generally available to all individuals who meet these state eligibility requirements. Medicaid often pays for long-term care (such as nursing home care). PPACA extends eligibility for Medicaid to all individuals earning up to $29,326 for a family of four.
Medical loss ratio — The percentage of health insurance *premiums* that are spent by the insurance company on health care services. PPACA requires that large group plans spend 85% of premiums on clinical services and other activities for the quality of care for enrollees. *Small group* and *individual market* plans must devote 80% of premiums to these purposes.
Medicare — A federal government program that provides health care coverage for all eligible individuals age 65 or older or under age 65 with a disability, regardless of income or assets. Eligible individuals can receive coverage for hospital services (Medicare Part A), medical services (Medicare Part B), and prescription drugs (Medicare Part D). Together, Medicare Part A and B are known as Original Medicare. Benefits can also be provided through a *Medicare Advantage* plan (Medicare Part C).
Medicare Advantage — An option *Medicare* beneficiaries can choose to receive most or all of their Medicare benefits through a private insurance company. Also known as Medicare Part C. Plans contract with the federal government and are required to offer at least the same benefits as original Medicare, but may follow different rules and may offer additional benefits. Unlike original Medicare, enrollees may not be covered at any health care provider that accepts Medicare, and may be required to pay higher costs if they choose an *out-of-network provider* or one outside of the plan's service area.

Medicare Supplement (Medigap) Insurance — Private insurance policies that can be purchased to "fill-in the gaps" and pay for certain out-of-pocket expenses (like deductibles and coinsurance) not covered by original *Medicare* (Part A and Part B).
Multi-state plan — A plan, created by PPACA and overseen by the U.S. Office of Personnel Management (OPM), that will be available in every state through *Exchanges* beginning in 2014.

-O-
Open enrollment period — A specified period during which individuals may enroll in a health insurance plan each year. In certain situations, such as if one has had a birth, death or divorce in their family, individuals may be allowed to enroll in a plan outside of the open enrollment period.
Out-of-network provider — A health care provider (such as a hospital or doctor) that is not contracted to be part of a managed care organization's network (such as an *HMO* or *PPO*). Depending on the managed care organization's rules, an individual may not be covered at all or may be required to pay a higher portion of the total costs when he/she seeks care from an out-of-network provider.
Out-of-pocket limit — An annual limitation on all *cost-sharing* for which patients are responsible under a health insurance plan. This limit does not apply to *premiums*, *balance-billed* charges from out of network health care providers or services that are not covered by the plan. PPACA requires out-of-pocket limits of $5,950 per individual and $11,900 per family, beginning in 2014. These amounts will be adjusted annually to account for the growth of health insurance *premiums*.

-P-
Patient Protection and Affordable Care Act (PPACA) — Legislation (Public Law 111-148) signed by President Obama on March 23, 2010. Commonly referred to as the health reform law.
Pre-existing condition exclusion — The period of time that an individual receives no benefits under a health benefit plan for an illness or medical condition for which an individual received medical advice, diagnosis, care or treatment within a specified period of time prior to the date of enrollment in the health benefit plan. PPACA prohibits pre-existing condition exclusions for all plans beginning January 2014.
Preferred Provider Organization (PPO) — A type of managed care organization (health plan) that provides health care coverage through a network of providers. Typically the PPO requires the policyholder to pay higher costs when they seek care from an *out-of-network provider*. Depending on the type of coverage you have, state and federal rules govern disputes between enrolled individuals and the plan.
Premium — The periodic payment required to keep a policy in force.
Preventive benefits — Covered services that are intended to prevent disease or to identify disease while it is more easily treatable. PPACA requires insurers to provide coverage for preventive benefits without *deductibles*, *co-payments* or *coinsurance*.

-Q-
Qualified health plan — A health insurance policy that is sold through an *Exchange*. PPACA requires Exchanges to certify that qualified health plans meet minimum standards contained in the law.

-R-
Rate review — Review by insurance regulators of proposed *premiums* and premium increases. During the rate review process, regulators will examine proposed premiums to ensure that they are sufficient to pay all claims, that they are not unreasonably high in relation to the benefits being provided, and that they are not unfairly discriminatory to any individual or group of individuals.
Reinsurance — Insurance purchased by insurers from other insurers to limit the total loss an insurer would experience in case of a disaster or unexpectedly high claims. PPACA directs states to create temporary reinsurance programs to stabilize their *individual markets* during the implementation of health reform.
Rescission — The process of voiding a health plan from its inception usually based on the grounds of material misrepresentation or omission on the application for insurance coverage that would have resulted in a different decision by the health insurer with respect to issuing coverage. PPACA prohibits rescissions except in cases of fraud or intentional misrepresentation of a relevant fact.
Risk adjustment — A process through which insurance plans that enroll a disproportionate number of sick individuals are reimbursed for that risk by other plans who enroll a disproportionate number of healthy individuals. PPACA requires states to conduct risk adjustment for all non-*grandfathered* health insurance plans.
Risk corridor — A temporary provision in PPACA that requires plans whose costs are lower than anticipated to make payments into a fund that reimburses plans whose costs are higher than expected.

-S-

Self-insured — *Group health plans* may be self-insured or fully insured. A plan is self-insured (or self-funded), when the employer assumes the financial risk for providing health care benefits to its employees. A plan is fully insured when all benefits are guaranteed under a contract of insurance that transfers that risk to an insurer.

Small group market — The market for health insurance coverage offered to small businesses – those with between 2 and 50 employees in most states. PPACA will broaden the market to those with between 1 and 100 employees.

Solvency — The ability of a health insurance plan to meet all of its financial obligations. State insurance regulators carefully monitor the solvency of all health insurance plans and require corrective action if a plan's financial situation becomes hazardous. In extreme circumstances, a state may seize control of a plan that is in danger of insolvency.

-U-

Usual, Customary and Reasonable charge (UCR) — The cost associated with a health care service that is consistent with the going rate for identical or similar services within a particular geographic area. Reimbursement for *out-of-network providers* is often set at a percentage of the usual, customary and reasonable charge, which may differ from what the provider actually charges for a service.

-W-

Waiting period — A period of time that an individual must wait either after becoming employed or submitting an application for a health insurance plan before coverage becomes effective and claims may be paid. *Premiums* are not collected during this period.

NOTES