



2014 – 2015 Benefits Handbook

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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.

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Checklist

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, a Substitute, or a Temp Hourly employee, 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.
- ☐ Review this handbook in its entirety for an overview of the TUSD Benefits Package.
- ☐ 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 FOUR of the benefit enrollment forms within 30 days of your date of hire if you are enrolling in ANY insurance plan. **IF YOU DO NOT SUBMIT THE BENEFIT PLAN ENROLLMENT FORMS WITHIN 30 DAYS OF YOUR DATE OF HIRE, YOU WILL NOT BE ALLOWED TO ENROLL IN ANY OPTIONAL COVERAGE UNTIL THE NEXT OPEN ENROLLMENT PERIOD OR UNLESS YOU EXPERIENCE A PERMISSABLE MID-YEAR STATUS CHANGE.**
- ☐ Be sure to complete any necessary additional forms that may be required (such as High Deductible Health Plan HSA Enrollment (online with Wells Fargo, or the TUSD HSA Authorization form) If additional forms are required, it will be noted in this booklet for that particular coverage.
- ☐ For Leave of Absence information, please contact Benefits at (520) 225-6144.
- ☐ Review this handbook for basic Payroll information; please contact Payroll at (520) 225-6150 with any questions.
- ☐ Review this handbook for basic Technology Services information; please contact TS at (520) 225-6333 with any questions.
- ☐ Your Coverage Begins: The 1st of the month following 30 days of employment
- ☐ Coverage ends:
 - ☐ For separations that occur in the months of September through April, your benefits will terminate at the end of the month in which the qualifying event (your separation) occurs.
 - ☐ If you go on a Governing Board Leave of Absence, coverage ends the last day of that month and you will be offered COBRA for any medical, dental, vision or EAP coverage that you had.
 - ☐ For separations that occur in the months of May, June, July and August, coverage will end on the last day of the Plan Year (August 31st). For any medical, dental, vision or EAP coverage that you had when you separate, you will be offered COBRA (continuation coverage).

TUSD

TUSD		2014-2015 Employee Benefits	
Medical	 <p>For medical network providers, see the BCBSAZ website: www.azblue.com</p>	<p>TUSD offers two Self-Insured Medical Plans:</p> <ol style="list-style-type: none"> 1. PPO 2. HDHP with Health Savings Account 	(877) 955-1570
Health Savings Account		The Health Savings Account is available if you enroll in the High Deductible Health Plan.	1-866-884-7374
Prescription		Pharmacy benefits are provided through CVS Caremark for Retail, Mail Order, and Specialty medications.	(855) 848-9161
Dental	EDS	EDS is a pre-paid discount dental plan	(520) 696-4343
		Delta Dental offers 2 levels of traditional dental insurance.	(800) 352-6132 Ext. 1
Vision		Traditional PPO Vision plan – be sure to use a contracted provider. If you do not choose Vision PPO, you will be enrolled in the discount plan at no cost to you.	(800) 828-9341
Life & AD&D Insurance	www.LifeBenefits.com MINNESOTA LIFE A Securian Company	Basic Life and AD&D – provided to all benefits eligible employees (District paid). Supplemental Life and AD&D for you, your spouse, or eligible children (employee paid).	(866) 293-6047
Short Term Disability		This is an Income replacement plan should you become unable to work due to illness or injury.	(800) 858-6506
Critical Illness Insurance		If you experience one of the covered conditions within any category and meet all the group policy and certificate requirements, you will receive a lump-sum payment to use as you see fit.	1 800 GET-MET 8 (1-800-438-6388)
Employee Assistance Program		Confidential, no cost short-term counseling needs (mental health, financial, and legal concerns) for employees & family members.	(520) 575-8623 Tucson (888) 520-5400 Out of Area
Wellness		Wellness tools and programs, exercise classes, one-on-one coaching, and online tools are available.	Wellness Council of Arizona and AmeriBen
403b/457 Plans		Employees are encouraged to save for retirement via a 403b or 457 plan in addition to the ASRS. All transactions are managed by TSA Consulting Group.	(888) 796-3786
Payroll rapid! Pay Card		TUSD is providing you with a great new benefit, the rapid! PayCard® Visa® Payroll Card. You can automatically deposit your paycheck onto a debit card so you have instant access to your cash on payday!	TUSD Payroll (520) 225-6150



*Human Resources
Employee Benefits*

1010 E. 10th Street
Tucson, AZ 85719

Benefits@tusd1.org

(520) 225-6144 – phone

(520) 225-6181 - fax

www.tusd1.org/benefits

Welcome to TUSD! In the pages that follow, we are pleased to provide you with information about the TUSD Benefits package. I encourage you to take some time to review this booklet as it contains important information about your benefits.

- **If you are a newly hired benefits eligible employee or an employee returning from a Governing Board approved Leave of Absence**, please review all information and submit your benefit enrollment forms to the Benefits Office **no later than 30 days after your date of hire (or return to work)**. If you do not submit these forms by your deadline, you will not be able to enroll in any non-mandatory benefits until the next Open Enrollment period or upon a permissible mid-year status change.
- Remember that establishing and maintaining good overall health is the best medical plan of all. Once you receive your AmeriBen ID card, please register at www.myameriben.com. You will find wellness programs and tools in the My Personal Health Suite area.
- Want a more personal experience? You can take advantage of free health coaching, access to Global Fit discount gym memberships, participate in the TUSD HealthStakes million dollar drawings, and other wellness activities from the Wellness Council of Arizona team for TUSD. You may also visit the TUSD Wellness website to learn more: www.tusd1.org/wellness.

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

Sincerely,

Janet Underwood
Benefits Manager



Share your feedback with us.

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

Phone (520) 225-6144

AN EQUAL OPPORTUNITY EMPLOYER

Fax (520) 225-6181



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



AmeriBen Third Party Services

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

What is A Third Party Administrator (TPA)?

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

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

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

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

How does this affect me?

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

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

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

Sincerely,

AmeriBen

Boise, ID

Portland, OR

Salt Lake City, UT

Phoenix, AZ

New Employee -Technology Information (Login and Web Access)

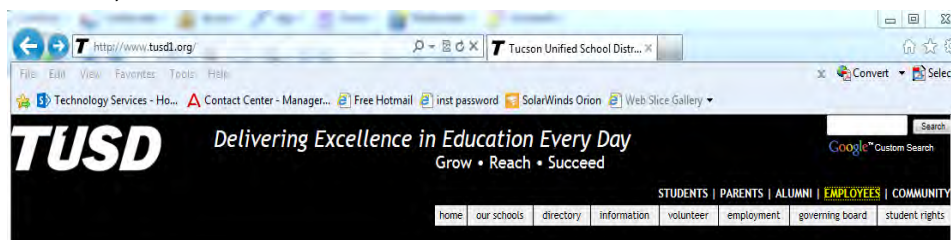
- You will log on to a District computer the first time with your 6-digit employee ID as the username and the password will be the last 4 digits of your Social Security number with your 4-digit year of birth (i.e. 10101960). You will be prompted to change your password at this time. For security reasons, do not share your password with anyone else.
- Your email, Microsoft Outlook, will be available once you log on.
- You will have access to the TUSD intranet and the Internet for District information
 - The intranet is the District's internal website and can only be accessed from a District computer.
 - This is where Employee Self- Service is located
 - Allows you to view and/or print paystubs
 - Update personal information (address, phone number, etc.)
 - The Internet has District information, including TUSD web email Employee Self-Service. They are accessible from home or any computer that has Internet access.

Access From Home

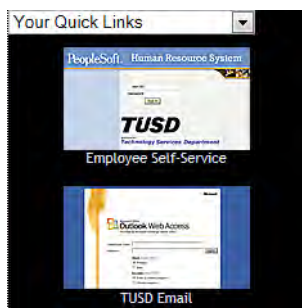
If you have Internet access from your computer at home, you can check your TUSD email using Outlook Web access and/or Employee Self-Service access.

Connect to the Internet through your Internet Service Provider (ISP) and then follow these directions to access your TUSD email and Employee Self-Service from your home computer.

- Open your Internet Browser
- In the Address or Location text box, type: <http://www.tusd1.org>
- Click on the word, EMPLOYEES



- In the YOUR QUICK LINKS box, click on either the TUSD Email link or the Employee Self-Service link.



If you have questions or concerns, please call the Technology Services **Help Desk** at **225-6333**.

ACA, Eligibility at TUSD, Cafeteria Plan, Deductions

Special Note regarding the Affordable Care Act (ACA): Active employees can enroll in the ACA Marketplaces, regardless of the availability of employer health coverage. While federal premium subsidies are available in all ACA Marketplaces, eligibility for those subsidies depends on several factors. First, the household income of the individual must be less than 400% of the federal poverty level. However, individuals eligible for employer coverage are only eligible for Marketplace subsidies if additional requirements are met. Active employees and their dependents are not eligible for Marketplace subsidies if they are **eligible** for an employer plan that satisfies both affordability (employee contribution for self-only coverage is less than 9.5% of household income) and minimum value (value of at least 60%).

- **Am I eligible for coverage?**

You are a TUSD Benefits-Eligible employee if:

- you work at least 30 hours per week (full-time)
- you were hired before 9/1/14 and you work at least 20-29.9 hours per week (part-time)

- **Who is not eligible?**

At this time, these employee types are not eligible for TUSD benefits:

- Employees hired on 9/1/14 or after, who work less than 20 hours per week
- Retirees of the Arizona State Retirement system
- Temporary employees
- Substitutes

If you are eligible for TUSD benefits, you are also eligible to enroll your eligible dependents. If you acquire an eligible dependent after you have submitted your forms, you may be able to enroll them based on a permissible mid-year status change. The list of permissible status changes and eligible dependents is available in this handbook. Note that you have 30 days from the event date of a change such as marriage, divorce, child reaches maximum age, etc. to make changes.

- **Section 111 of the Medicare, Medicaid and SCHIP Extension Act of 2007 (MMSEA),**

- This is a federal law that became effective January 1, 2009. It requires that group health insurers, claims processing third-party administrators, and certain employer self-funded/self-administered plans report specific information about Medicare beneficiaries who have other group coverage.

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

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

- Section 125 of the Internal Revenue Code allows employers to offer a cafeteria plan and deduct premiums before taxes are calculated. Deducting premiums with pre-tax dollars means that the cost of your premium is taken from the paycheck before federal, state and Social Security taxes are calculated. Not all coverage is available for pre-tax. At this time, pre-tax applies to medical, dental and vision coverage.
- **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.** As such, you are not permitted to make changes to your coverage elections outside of Open Enrollment, unless you experience a permissible mid-year status change.

Coverage Effective Dates, Cost on Enrollment Form, How to Enroll

▪ ***When does my insurance begin or end?***

Begin Dates:

- **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 the first day of the plan year.
- **Permissible Mid-Year Status Change** – effective on the 1st of the month following receipt of the completed TUSD Enrollment/Change form and all required and supporting documentation

End Date:

- If you separate from the District (i.e. resignation, retirement, Governing Board leave of absence), your benefits will terminate at the end of the month in which the qualifying event occurs (and a refund of any overpayments will be issued to you) unless your separation date is in May, June, July or August:
 - If you separate from the District (i.e. resignation, retirement, end of a Temp Teacher Contract in May, June, July or August), your benefits will terminate at the end of the Benefits Plan Year on August 31st. NO refunds will be issued.
 - Be sure to complete and submit the TUSD Intent to Separate form to Human Resources. The form can be located at <http://www.tusd1.org/tusdforms/documents/HR1005IntentToSeparate.pdf>
- **Alert!** You must turn in ALL company property (keys, ID badge, laptops, etc.) to School Safety/Key Control. See the Payroll section for information on how your last paycheck is handled.

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

Medical Costs shown on the form:

The medical premiums on the benefit enrollment form are per pay employee costs for each of the 20 pay periods used for benefits deductions. **The District is paying an additional amount per pay above what you see on the form.**

ADJUSTMENTS: Employees may be charged an additional catch-up amount for adding dependents after the 20-deduction schedule begins (for a mid-year status change), or beginning employment after the first Benefits Deduction date. See the Cost Calculation sheet to estimate your per pay costs. Please be sure that you can afford the coverage you are signing up for, as we will make all efforts to collect the premiums.

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

You may bring the benefit enrollment forms to the Benefits Office at 1010 E. 10th St. at the Morrow Ed Center, Building A, during regular business hours and a Benefit Associate will assist you if needed. **You may also fax your form(s) to us at (520) 225-6181. (Be sure to fax the back page also.)**

Interoffice mail can be used – send to the Benefits Office at 1010. Be sure to keep a copy of ALL your forms, and please call us in five (5) days to verify your forms were received. We are not responsible for lost or mis-directed forms.

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

If you do not turn in a benefit enrollment form, you will be enrolled in Basic Life/AD&D coverage and in the Employee Assistance Program (EAP) at no cost to you. You will also be enrolled in the Avesis Vision Discount program at no charge. Remember, if you do not enroll, you will have to wait until the next Open Enrollment period, unless you experience a permissible mid-year status change (per IRS rules).

Summer Coverage, Other Coverage, Making Changes, Leave of Absence

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

Yes. Since all premium payments are collected by the end of the school year, your benefits remain in effect for the summer even if you resign or retire in May, June, July or August.

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

If you elect medical insurance through TUSD, then this coverage will be your **primary** insurance. **Please be aware:** If you elect insurance with TUSD **and** have insurance through another company (e.g., with your spouse's employer), **Coordination of Benefits** may apply.

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

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

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

A status change is a change to an employee's family or employment status. A list of permissible mid-year status changes is included in this booklet.

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

- ***If I take a leave of absence from work, how do I pay my premiums while I am on leave?***

For a Short-Term leave of absence and/or a Family Medical Leave of Absence: If you are enrolled in the medical plan, TUSD will continue to pay its portion while you are FMLA eligible. If you remain on Payroll using your accrued time, your premiums will continue to be deducted from your paychecks. ***For any premiums not deducted via payroll, the TUSD Benefits Office will either bill you on a per-pay-period basis or collect the missed premiums upon your return – be sure you budget accordingly. All premiums must be paid in full. If your leave is non-FMLA, you must pay your premiums by the due date on the TUSD billing notice that is sent to you. We will also accept a check or money order payment. In all cases, all missed premiums must be paid by the due date and before the end of the applicable benefit (plan) year. Contact the Benefits Office if you have questions. Please also see the Short Term Disability Section and the Payroll section for important information.***

For a Governing Board leave of absence: Your benefits will be terminated at the end of the month in which your leave is approved. You will receive a COBRA notice (mailed to your home) and may elect to continue your medical, dental, vision and EAP coverage. If you elect, you must pay the COBRA Administrator monthly in order to continue your coverage while you are out on leave. For Life Insurance, you will receive a Conversion & Portability notice from the Life Insurance carrier, which allows you to continue your life insurance coverage on an individual basis, at non-group rates. You may also be eligible for Waiver Of Premium; the life insurance vendor can assist you in these matters.

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

Eligible Dependents

- **Eligible dependents can include:**

- Spouse or Domestic Partner
 - **Spouse** means a person to whom the employee is legally married. A marriage certificate may be required.
 - **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 before your Domestic Partner can be added. Imputed income for the Domestic Partner will apply (post-tax for medical/dental/vision).
 - The Affidavit of Domestic Partnership is available on the benefits website: http://intranet/hr/ben_forms.asp.
- Children (to age 26)
 - Natural Children
 - Stepchildren
 - Children of a Domestic Partner (if you enroll your Domestic Partner)
 - *Adopted Children
 - *Foster Children
 - *Guardianship of Children i.e. grandchildren

*Court documentation required

- Disabled Child - Unmarried child who is 26 years of age or older and is mentally or physically disabled (as that term is defined in this Plan); the child is incapable of self-sustaining employment as a result of that disability; and that disability existed before the attainment of this Plan's age limit. This Plan may require initial and periodic proof of disability.
 - A Dependent Child who is not covered under the Plan but becomes disabled after reaching the Plan's Dependent age limit is not eligible to enroll as a Dependent under this Plan.
- A dependent child also includes a child for whom health care coverage is required through a "Qualified Medical Child Support Order" or other court or administrative order, even if the child does not reside within the service area.

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 Special Enrollment or Permissible Mid-Year Status Change occurs or until next year's Open Enrollment period.

You are not permitted to provide dependent coverage for a spouse, domestic partner or child if they also work for Tucson Unified School District in a benefit-eligible position. During periodic audits, if your enrollment includes an ineligible dependent, we will remove the dependent. No premium refunds will be processed to you.

Medical Coverage – Differences in Plans

- *What are the differences between the Preferred Provider Organization (PPO) and the High Deductible Health Plan (HDHP)?*

Preferred 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 used. Members pay a deductible (separate deductibles for in-network versus out-of-network) before most benefits become payable under the plan, as well as a fixed co-pay after the deductible is met using in-network providers, or a percentage of covered health care costs (called co-insurance) when using non-network providers.

High Deductible Health Plan (HDHP) – This is a high deductible PPO plan that allows contributions to a Health Savings Account (HSA). A **Health Savings Account (HSA)** is a tax-advantaged, personal savings account that works in conjunction with an HSA-compatible health plan. The Wells Fargo HSA offers an interest-bearing, FDIC-insured deposit account and the option to invest in mutual funds once the deposit account reaches a minimum balance as defined by Wells Fargo. You can use your HSA to pay for qualified medical expenses now or later in life—all tax-free. **NOTE: You may not be eligible for the HSA contribution if you have other coverage that is not also an HSA-compatible plan. You are responsible to go online and create an account at Wells Fargo before HSA contributions can begin; instructions for this are below. If you delay in creating the account, you may forfeit District contributions until your account is ready.**

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

To learn more about how an HSA can help you save for current and future healthcare costs, go to wellsfargo.com/hsa or call Wells Fargo HSA Customer Service at 1-866-884-7374. An employee can contribute additional pre-tax money to this HSA up to the limit allowed by the Internal Revenue Service. The HSA is only available to employees who elect the HDHP.

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

NOTE! Wells Fargo will charge \$3.00 per month out of your account until your account reaches a balance of \$5000.

Enroll online in your Wells Fargo HSA

Getting started is easy

Once you have enrolled in HSA-qualified health plan, it is easy to set up your Wells Fargo Health Savings Account (HSA). You can enroll online in your HSA quickly with Wells Fargo.

Step 1

Please type the following URL into your internet browser

[:https://healthbenefits.wellsfargo.com/hsa/enroll/welcomeViewActionEOE.do](https://healthbenefits.wellsfargo.com/hsa/enroll/welcomeViewActionEOE.do)

Step 2

Complete your application by following the simple steps online. Please note that fields with an asterisk (*) require a response.

On the first screen, you will be asked to fill in your 15 digit Employer HSA ID number. This is important, as it will associate you with your company's HSA program. Please type carefully to ensure accuracy.

Your Employer HSA ID number: **000596000000000**

- You will be asked to read and accept the "E-Sign Consent to use Electronic Records and Signatures." Once you've read this, accept the terms by simply clicking on the box next to "I agree."
- You will be asked to review and agree to the HSA Custodial Agreement, Fee Schedule, Card Terms and Conditions, as well as some other disclosures. You should print and keep a copy of these documents for your records.
- As part of the application process, you will be asked a few questions from your personal history that may be used for account security and identification purposes.
- The last of the application screens is the enrollment confirmation, which will verify if your HSA has been opened. Once your account is opened, you will receive a confirmation number and an account number. If not opened right away, Wells Fargo will contact you regarding your account.

Step 3:

Print the confirmation page for your records.

Once your HSA is opened, you will receive a welcome packet with information that helps you use and manage your account. Your Wells Fargo Visa® HSA debit card and Personal Identification Number (PIN) will be sent in two separate mailings. Please look for these mailings and activate your debit card immediately upon receipt.

Remember once your account is opened, you should go to wellsfargo.com and sign on to Wells Fargo Online® Banking. First time users will need their Health Savings Account number or Wells Fargo Visa HSA debit card and Personal Identification Number (PIN). Once you are signed-on, click your HSA balance to enter the *Wells Fargo Health Account Manager's* portal – your online account gateway. You can view account activity and transaction history, set up a recurring monthly contribution, set up an investment account, and opt out of receiving paper statements for your HSA.

Step 4:

If you are interested in contributing to your HSA account (having deductions taken from your paychecks), please complete the *Authorization for HSA Deduction-Employee* form located at the very end of this handbook. Complete the form and submit it to the TUSD Benefits Office.

How can Wells Fargo help?

We are here to answer any questions you have about your HSA. Contact our HSA Customer Service Center at 1-866-884-7374, Monday through Friday, from 7:00 a.m. to 8:00 p.m. Central Time or visit us online at wellsfargo.com/hsa.

¹INVESTMENT PRODUCTS; NOT FDIC INSURED • NO BANK GUARANTEE • MAY LOSE VALUE

Deposit products offered by Wells Fargo Bank, N.A. Member FDIC
©2013 Wells Fargo Health Benefit Services, A Division of Wells Fargo Bank, N.A. All rights reserved.
MC-2953 (ADA) - 08/13

Prescription Coverage, Network, Copay & Co-Insurance

- **Prescription Coverage is managed by CVS Caremark.**

If you enroll in the PPO Plan, you will pay a fixed co-pay for your medication(s) but this is NOT the case in the HDHP. The prescription may be subject to generic and/or step-therapy restrictions. Medications categories and information is as follows:

<u>PPO Plan</u>		<u>High Deductible Health Plan</u>
Generic	\$10 co-pay (tier one)	You pay the FULL cost of the medication until you reach your Deductible. After the Deductible, you pay co-insurance until you reach the Out-of-Pocket Maximum.
Preferred Brand	\$40 co-pay (tier two)	
Non-Preferred Brand	\$80 co-pay (tier three)	
Specialty Medications	\$80 co-pay (tier three)	
Note: in both plans, we have established a Zero Copay program for certain generic maintenance medications. Caremark will notify you periodically if you can benefit by switching to a generic medication under this program. The current lists are located at www.tusd1.org/benefits .		
Mail Order is also available. Be sure to check prices at different pharmacies – they do not all charge the same amounts. You can also register at the pharmacy carrier website to learn more: www.caremark.com .		

- **Blue Cross Blue Shield Network - Arizona**

The Blue Cross Blue Shield of Arizona network is used when you are in Arizona. The provider directory can be accessed from the TUSD Benefits Intranet. <http://intranet/hr/benefits.asp> - click on the AmeriBen link, and then the BCBS PPO directory link.

- **PHCS Network – Outside of Arizona**

Employees can access the PHCS network while outside of Arizona. Also, your dependent children who live in another state can access care through the PHCS network if the employee is enrolled in your coverage; just call AmeriBen to designate this network for your out-of-state child. To obtain a provider listing for another area, contact AmeriBen Customer Service toll free at (877) 955-1570. For after-hours assistance, check the PHCS website through www.myameriben.com. You will need your AmeriBen ID number to register.

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

- **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. Co-insurance applies in both the PPO plan and the HDHP.

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

These are co-insurance costs paid by the member and include the deductibles and medical co-payments. These items are never part of the Out-of-Pockets Maximum: Failure to obtain or follow pre-certification, mental illness and substance abuse, infertility and charges in excess of eligible expenses.

PPO Plan Example: 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 an individual, the member does not pay any more (not even medical co-payments). The out of pocket maximum amounts are different based on whether you are enrolled as an individual or with dependents. Beginning on 9/01/2014, the deductible and any medical co-pays or co-insurance will apply toward the out of pocket maximum.

Bariatric Surgery

BARIATRIC SURGERY AND OTHER INVASIVE TREATMENTS FOR OBESITY MEDICAL COVERAGE

Questions? Please contact AmeriBen at (877) 955-1570

Coverage for services, procedures, medical devices and drugs are dependent upon benefit eligibility as outlined in the Preferred Provider Organization (PPO) and High-Deductible Health Plan (HDHP) Benefit Options Medical Plan Document/Summary Plan Description.

The Medical Coverage Guideline must be read in its entirety to determine coverage eligibility, if any. The **full** guidelines are posted at www.tusd1.org.

***THIS IS ONLY A PORTION OF THE GUIDELINES ***

Criteria

This section defines criteria set forth by the TUSD Plan to determine whether a service, procedure, medical device or drug is considered medically necessary or experimental or investigational. **Bariatric surgery (as listed in paragraph A. 1.) is limited to one procedure in an individual's lifetime unless determined medically necessary for revision.**

Bariatric Surgery:

Bariatric surgery for the treatment of morbid obesity in adults is considered *medically necessary* with documentation of **ALL** of the following:

The surgical procedure is ONE of the following eligible procedures:

- Adjustable gastric banding (Lap-Band®; Realize™ Band)
- Gastric Bypass (Roux-en-Y)
- Biliopancreatic Diversion with Duodenal Switch
- Sleeve gastrectomy as a sole procedure or in combination with another medically necessary bariatric procedure
- Individual is morbidly obese as defined by **ONE** of the following:
 - Body Mass Index (BMI)** of 40 or greater
 - Body Mass Index (BMI)** of 50 or greater for biliopancreatic diversion with duodenal switch procedure
 - Body Mass Index (BMI)** of 35 or greater with **ANY** of the following comorbid conditions that are generally expected to be ameliorated (improved), reversed, or limited by this surgical treatment, for any eligible procedure:

Comorbid conditions include, *but are not limited to*:

- Cardiovascular disease
- Coronary artery disease
- Degenerative joint disease of weight bearing joints
- Diabetes mellitus
- Documented sleep apnea
- Pseudotumor cerebri
- Gastroesophageal reflux disease (GERD) not responsive to other treatment

** Refer to the BMI Index Table in the guideline

Bariatric surgery is considered **medically necessary** with documentation of **ALL** of the following:

1. Diagnosis of morbid obesity for **the past consecutive** 5 years
2. Individual must provide written documentation of participation in a weight loss program for 8 weeks or longer within 12 months preceding weight loss surgery. Weight loss programs include:
 - recognized commercial weight loss programs, (i.e. Weight watchers, Jenny Craig etc.)
 - nutritional counseling or hospital based weight loss programs.
3. Patient is receiving treatment in multidisciplinary program experienced in obesity surgery that can provide **ALL** of the following:
 - Surgeons experienced with procedure
 - Preoperative medical consultation and approval
 - Preoperative psychiatric consultation and approval
 - Nutritional counseling
 - Exercise counseling
 - Psychological counseling
 - Support group meetings
4. Individual is 18 years of age or older
5. Individual has no treatable condition that may be responsible for the morbid obesity, e.g., endocrine, metabolic, etc.

Bariatric surgery for the treatment of gastroesophageal reflux disease (GERD) in an individual who has not responded to alternative treatments (e.g., medication, Nissen or other fundoplication, hiatal hernia repair, weight loss) is considered **medically necessary** if current TUSD guidelines for bariatric surgery are met.

Early Learning Center

High quality affordable childcare and expert instruction in early learning are now available to Tucson families through TUSD's new Infant & Early Learning Centers (ELC). Tucson families are invited to enroll children ages two to five. Currently, infant care and care for toddlers up through 24 months is available only to TUSD employees.

Our Infant & Early Learning Centers foster positive relationships among children and adults. We provide multiple approaches to serve all learning styles. Our curriculum promotes social, emotional, physical, language, and cognitive development. At our centers, learning takes place in a safe and healthy environment.

The TUSD Infant & Early Learning Centers provide excellent care for our community's young children. The centers were developed to provide quality care to the children of TUSD employees, and now that same opportunity is being provided to all families of the Tucson area. While infant care and care for toddlers up through 24 months is available only to TUSD employees, community members are invited to enroll children ages two to five.

Our east and westside centers provide excellent care for young children.

To register, complete the [registration packet](#) and return it to **TUSD's School Community Services, at 1010 E. Tenth St., Building B.** School Community Services is for family-friendly hours, 7:45 a.m. - 7:00 p.m., Monday through Friday, and 8:00 a.m. to 12:00 noon on Saturdays.

If you have questions about the TUSD Infant & Early Learning Centers, please call the Elementary Leadership Office at 225-6415 or email earlylearning@tusd1.org.

- **Brichta** – 2110 W. Brichta Drive
- **Schumaker** – 501 N. Maguire Avenue

Emergency Room, Urgent Care, Walk-in Clinic, Pre-Existing Conditions, Pre-Certification, Exclusions

▪ ***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 select CVS and Walgreens locations 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.

▪ ***Are there any pre-existing condition exclusions in the TUSD medical plans?***

No, there are no pre-existing condition exclusions in the Medical Plans. **However, TUSD plans do have a list of services that need to be pre-certified prior to utilization.** Examples of services that need to be pre-certified are MRI's, CT Scans, and In-Patient surgery. For specific details, please contact AmeriBen or review the TUSD Medical Plan Document at www.tusd1.org/benefits under the Medical link (AmeriBen).

▪ ***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" in the TUSD Plan Documents even if of the following is true:

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

▪ ***Where can I locate the TUSD Plan Document and Summary of Benefit Coverage (SBC)?***

The TUSD Plan Document can be located at: www.tusd1.org/benefits, and click on Plan Documents/SBCs

Wellness Programs

TUSD EMPLOYEE WELLNESS PROGRAM

Discover  2014 - 2015

August: National Immunization Awareness Month

- Open Enrollment
- Get to Know your Health Coach

September: National Obesity Awareness Month

- Hike the Arizona Trail Challenge

October: National Breast Cancer Awareness Month

- MOM & Wellness & Health Fair
- Biometric Screenings & Flu Shots

November: National Diabetes Month

- Maintain, Don't Gain

December: World AIDS Day

- Managing Holiday Stress

January: Healthy Living Month

- Team Weight Loss Challenge

February: American Heart Health Month

- Take 5 with a Health Coach

March: National Nutrition Month

- Healthy Lunch Box

April: National Stress-Relief Month

- Massage Days

May: Asthma and Allergy Awareness Month

- Take a Breathe Break

June: Men's Health

- Summer Wellness Celebration

July: Sun Safety Month

- Staying Hydrated

Commit to your Health and Graduate with Honors

Earn Points towards your Wellness GPA by participating in:

- Onsite Fitness Classes
- Challenges
- The Health & Wellness Fair
- One on One Health Coaching
- The Wellness Incentive Program

For every point earned you even have a chance to win

\$1,000,000

Wellness Council of Arizona
\$1,000,000
HEALTHSTAKES!

Meet Your Health Coaches



Andrea

Chantal

Anisa

Elizabeth

Your Health Coaches are certified professionals who are onsite to motivate you! They offer one-on-one consultations where you can meet privately with one of them and discuss your specific health goals.

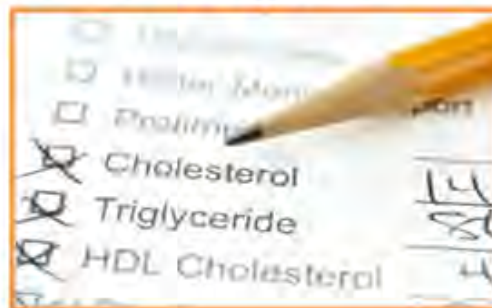
Contact one of your Health Coaches today!

andrea.curlless@tusd1.org chantal.pilon@tusd1.org anisa.shukayr@tusd1.org elizabeth.sheppard@tusd1.org

For more information check www.tusd1.org/wellness

TUSD Wellness Incentive Program

Participating in the **TUSD Wellness Incentive Program** in 2014-2015 will qualify you for rewards and premium rebates the following plan year, plus assure that you are taking positive steps towards preventing disease and living healthier.



To receive your 2015-2016 incentive, submit the following by June 30, 2015:

Required:

- Complete an Annual Physical Exam with your Primary Care Physician. Complete and sign Healthcare Provider Verification Form. Submit to the Wellness Council of Arizona.
- Complete blood lab work. Send a copy of Lab Work Results and Lab Work Results Verification Form. Submit to the Wellness Council of Arizona.
- Complete the Health Risk Assessment at www.myameriben.com.

Required: Pick 2 out of 7 Options

- Complete and sign Non-Tobacco User Affidavit Form
- Complete and sign the Activity Verification Form for the following:
 - Review Health Risk Appraisal (HRA) Health Profile with onsite or online Health Coach
 - Complete a Disease Management Program through the Wellness Council of Arizona or AmeriBen if you have a chronic condition, for example: Diabetes, Heart Disease/Hypertension, or Asthma/COPD.

Earn a chance to win \$1,000,000



5 e-Tickets

- Verified Annual Physical Exam
- Verified Lab Work
- Complete Health Risk Appraisal (HRA) at www.myameriben.com
- Complete a Multi-Session Education Program

3 e-Tickets

- Complete a Disease Management Program through Welcoaz or AmeriBen

1 e-Ticket

- Review Health Risk Appraisal (HRA) Health Profile with Health Coach
- Participation in Ongoing Health Coaching

- Participate in verified ongoing Health Coaching either onsite or telephonic with the Wellness Council of Arizona. 4 session min.
- Complete a multi-session Health Education program offered by the Wellness Council of Arizona
- Show receipt of payment for gym membership, fitness facility or program (approved by Health Coach), or home use fitness accessories (minimum of \$150 approved by Health Coach, purchased in the last 12 months).
- Show receipt of participation in fund raising fitness activity (walks, rides and runs that benefit local and national non-profits)
- Submit to the Wellness Council of Arizona:
 - Mailing Address: 1670 N. Kolb Rd. Ste. 246, Tucson, AZ 85715
 - Secure Fax: 520-293-3368
 - Secure Email: secure@welcoaz.org

Confidentiality Assured

Verified by Welcoaz

All Personal Health Information will be maintained and protected by Wellness Council of Arizona

Questions?

Wellness Council of Arizona

520-293-3369

contact@welcoaz.org



TUSD encourages you to participate in the Wellness Incentive Program. In doing so, you can qualify for rewards, PPO premium reduction, or increased HDHP HSA contribution for the following plan year (9/1/15-8/31/16).

You can also join GlobalFit, now available to TUSD employees on 9/1/2014. Be sure to access the correct link at www.GlobalFit/welcoaz.

Visit www.globalfit.com/welcoaz TODAY!



LOOK GREAT Save Big!

Why Use GlobalFit?

Wellness Council of Arizona and the TUSD Employee Wellness Program have made it easier for you to reach out to GlobalFit directly. GlobalFit helps make it easy and affordable to look and feel your best.

- Choose** from 10,000 gyms, including big chain and local favorites.
- Save** with GlobalFit's Lowest Price Guarantee!
- Transfer** to other network gyms.
- Freeze** your membership for up to 2 months a year.
- Travel** with access to other network gyms nationwide.

Plus, through the GlobalFit Store, you'll get exclusive member discounts on a variety of nutrition programs and home equipment, including Nutrisystem®/Total Gym®, and Zumba® DVDs.

LOWEST PRICE GUARANTEE



globalfit.com/welcoaz
800-294-1500



Please Note: Some Exclusions apply for the Freeze, Travel, and Transfer options. Call GlobalFit at 800-294-1500 for details.

Comparison Chart of Medical Plans (3 pages)

The medical plan comparison charts that follow contain a partial listing of the benefits offered to employees and eligible dependents. Benefits are subject to plan limitations and exclusions.

Network providers are those hospitals and physicians contracted with Blue Cross Blue Shield of Arizona or PHCS.

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

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

Benefit Description	PPO		HDHP	
	In-Network	Out-of-Network	In-Network	Out-of-Network
	Co-Insurance (90/10) (Plan/Employee)	Co-Insurance (70/30) (Plan/Employee)	Co-Insurance (80/20) (Plan/Employee)	Co-Insurance (60/40) (Plan/Employee)
Deductible - Individual	\$500	\$1,000	\$1,500	
Deductible - Family	\$1,000	\$2,000	\$3,000	
Out of Pocket Max - Individual	*\$1,000	*\$4,500	\$5,500	\$9,500
Out of Pocket Max - Family	*\$2,000	*\$9,000	\$11,000	\$19,000
Physician Office Services (PCP/Specialist)	\$25/\$40 co-pay	*30%	*20%	*40%
Preventive Care (see link below for Eligible Preventive Care Services)	100%	*30%	100%	*40%
Walgreen's Take Care Clinic & CVS Minute Clinics	\$25 co-pay	Not Covered	*20%	*40%
Routine Eye Examinations	\$30 co-pay, 1 visit per 24 months	*30%	Not Covered	Not Covered
Urgent Care	\$85 co-pay	*30%	*20%	*40%
Emergency Room	*\$225 co-pay	Same as in-network care	*20%	Same as in-network care
Prescription Drugs	May be subject to generic and step-therapy restrictions, or Prior Authorization Note: both plans offer certain meds at zero copay. See www.tusd1.org/benefits - Prescription coverage.			
Retail (up to a 30-day supply) Tier 1 Generic	\$10	Reimbursement will be according to the network price, so your total out-of-pocket cost may be greater than the co-payment you would have paid if you had used a network pharmacy.	*20%	*40%
Tier 2 Formulary Brand	\$40		*20%	*40%
Tier 3 Non-Formulary Brand & Specialty Drugs	\$80		*20%	*40%
Mail Order	2x the co-pay price for a 31-90 day supply	N/A	*20%	Not Covered
* After Deductible				
Preventive Services Guide:	http://www.uspreventiveservicestaskforce.org/uspstf/uspstabrecs.htm			

Medical Plan Comparison Chart (continued)

Benefit Description	PPO		HDHP	
	In-Network	Out-of-Network	In-Network	Out-of-Network
	Co-Insurance (90/10) (Plan/Employee)	Co-Insurance (70/30) (Plan/Employee)	Co-Insurance (80/20) (Plan/Employee)	Co-Insurance (60/40) (Plan/Employee)
Hospital - Inpatient Stay	*10%	*30%	*20%	*40%
Outpatient Procedure	*10%	*30%	*20%	*40%
Ambulance Services	*10%	*10%	*20%	*40%
Durable Medical Equipment	*10%	*30%	*20%	*40%
Lab/Radiology/X-Ray	*100% covered after Deductible	*30%	*20%	*40%
Mammograms (may be covered 100% if preventive)	*100% covered after Deductible	*30%	*100%	*40%
CT Scans, Pet Scans, MRI, Nuclear Medicine	*100% covered after Deductible	*30%	*20%	*40%
Outpatient Short Term Rehab (i.e.: Physical Therapy)	\$30 Limited to 60 visits per plan year (combined in- and out-of-network)	*30% Limited to 60 visits per plan year (combined in- and out-of-network)	*20% Limited to 60 visits per plan year (combined in- and out-of-network)	*40% Limited to 60 visits per plan year (combined in- and out-of-network)
Chiropractic Care	\$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	*30%	*20%	*40%
Mental Health - Inpatient	*10%	*30%	*20%	*40%
* After Deductible				
Preventive Services Guide: http://www.uspreventiveservicestaskforce.org/uspstf/uspabrecs.htm				

The TUSD Medical Plan Document and forms can be located at: www.tusd1.org/benefits page.

If you cannot access this information, please contact the Benefits Office at 520-225-6144 and we will provide you with a copy free of charge.

If I enroll in the HDHP, what else do I need to do? How do I set up my HSA account?

- You are required to create an account at Wells Fargo to open your HSA account. Please log onto the Wells Fargo website at: <https://healthbenefits.wellsfargo.com/hsa/enroll/welcomeViewActionEOE.do> to establish your account. Please refer to page 14 of this handbook for further instructions. If you are approved by Wells Fargo, TUSD will begin contributions on the next available pay cycle.
- If you wish to contribute a portion of your own money (pre-tax) to your HSA, please complete the Authorization for HSA Deduction – Employee form in the back on this handbook, and submit to the TUSD Benefits Office.
- Wells Fargo will charge \$3.00 per month out of your account until your account reaches a balance of \$5000.



Medical Plan Comparison Chart (continued)

PPO			HDHP		
NETWORK PROVIDERS			NETWORK PROVIDERS		
NON-NETWORK PROVIDERS			NON-NETWORK PROVIDERS		
Deductible per Plan Year The <i>network</i> and <i>non-network deductible</i> do <u>not</u> cross apply			Deductible per Plan Year The Teladoc consultation fee applies to the <i>deductible</i> . The <i>network</i> and <i>non-network deductible</i> cross apply		
Per <i>plan participant</i>			\$1,500		
Per <i>family unit</i>			\$3,000		
Out-of-Pocket Maximum Amount per Plan Year The <i>out-of-pocket-maximum</i> amount includes Medical <i>co-payments</i> and <i>deductibles</i> . The <i>network</i> and <i>non-network out-of-pocket maximums</i> do <u>not</u> cross apply.			Out-of-Pocket Maximum Amount per Plan Year The <i>out-of-pocket-maximum</i> amount includes <i>co-payments</i> (when applicable), <i>deductibles</i> , and <i>co-insurance</i> . The <i>network out-of-pocket maximums</i> apply to the <i>non-network out-of-pocket maximums</i> . The Teladoc consultation fee applies to the <i>out-of-pocket-maximum</i> .		
Per <i>plan participant</i>			\$5,500		
Per <i>family unit</i>			\$11,000		
The <i>Plan</i> will pay the designated percentage of <i>covered charges</i> until <i>out-of-pocket</i> amounts are reached, at which time the <i>Plan</i> will pay 100% of the remainder of <i>covered charges</i> for the rest of the <i>plan year</i> unless stated otherwise. The following charges do not apply toward the <i>out-of-pocket maximum</i> and are never paid at 100%. <ul style="list-style-type: none"> • amounts over <i>allowed charges</i> • non-covered expenses • <i>prescription drug</i> charges, including <i>co-payments</i> • <i>pre-certification</i> penalties 			The <i>Plan</i> will pay the designated percentage of <i>covered charges</i> until <i>out-of-pocket</i> amounts are reached, at which time the <i>Plan</i> will pay 100% of the remainder of <i>covered charges</i> for the rest of the <i>benefit year</i> unless stated otherwise. The following charges do not apply toward the <i>out-of-pocket maximum</i> and are never paid at 100%. <ul style="list-style-type: none"> • amounts over <i>allowed charges</i> • non-covered expenses • out-of-pocket, non-covered <i>prescription drug</i> charges • <i>pre-certification</i> penalties 		

Benefits Deduction Schedule

- The Benefits Deduction Schedule refers to the paydates (pay periods) that TUSD uses to deduct benefit costs from your paychecks.
- Benefits Extension in Summer for non-leave of absence separations: If you separate from the District (i.e. resignation, retirement, or end of a Temp Teacher Contract in May, June, July or August, your benefits will terminate at the end of the Benefit Plan Year on August 31st. No refunds will be issued.

*Benefits Deduction Schedule

Pay Period Begin Date	Pay Period End Date	Paydate	Benefits Begin:		Deductions Remaining
			on the 1 st of the mth following 30 days	Coverage begins in :	
8/17/2014	8/30/2014	9/12/2014			20
8/31/2014	9/13/2014	9/26/2014	9/1/2014	Sept	19
9/14/2014	9/27/2014	10/10/2014			18
9/28/2014	10/11/2014	10/24/2014	10/1/2014	Oct	17
10/12/2014	10/25/2014	11/7/2014			16
10/26/2014	11/8/2014	11/21/2014	11/1/2014	Nov	15
11/9/2014	11/22/2014	12/5/2014			14
11/23/2014	12/6/2014	12/19/2014	12/1/2014	Dec	13
12/7/2014	12/20/2014	1/2/2015			12
12/21/2014	1/3/2015	1/16/2015			11
1/4/2015	1/17/2015	1/30/2015	1/1/2015	Jan	10
1/18/2015	1/31/2015	2/13/2015			9
2/1/2015	2/14/2015	2/27/2015	2/1/2015	Feb	8
2/15/2015	2/28/2015	3/13/2015			7
3/1/2015	3/14/2015	3/27/2015	3/1/2015	Mar	6
3/15/2015	3/28/2015	4/10/2015			5
3/29/2015	4/11/2015	4/24/2015	4/1/2015	Apr	4
4/12/2015	4/25/2015	5/8/2015			3
4/26/2015	5/9/2015	5/22/2015	5/1/2015	May	2
5/10/2015	5/23/2015	6/5/2015	6/1/2015	June	1
Payroll Deductions do not occur during summer months				July & Aug	0

*Paydates subject to change due to Payroll processing, holidays, etc.

▪ **Why are insurance premiums taken over a limited number of pay periods?**

The cost of your coverage is based on the number of months of coverage that will be needed, and the spread over a limited number of payroll deductions since a majority of employees are not paid over the summer months. Benefit deductions are not taken during the summer months of: the second part of June, and the months of July and August. This means that employees may see adjustments (higher amounts added) to their paychecks if they make a change to their benefits elections, begin employment after we start the Benefits Deductions, or amounts owed due to a leave of absence.

Cost of Coverage – Medical

2014-2015			
Plan Year begins 9/1/14			
Full-Time Employees working a minimum of 30 hours per week are eligible.			
	PPO	**HDHP	**HDHP HSA Contribution from TUSD
EE Only	\$28.73	\$0.00	*\$75 per pay
EE + Spouse	\$340.39	\$241.85	*\$100 per pay
EE + Child(ren)	\$300.12	\$218.22	*\$100 per pay
EE + Family	\$582.00	\$430.74	*\$100 per pay
All rates subject to rounding in the PeopleSoft system.			
*HSA Contributions are subject to IRS Annual Calendar Limits.			
*TUSD contributes using the “20 Deductions Per Pay” schedule.			
<p>TUSD can only contribute to your HSA if you create an HSA account with Wells Fargo. At this time, we do not have other banks available to you.</p> <p>To create an account, go to www.wellsfargo.com/hsa. Use the TUSD employer number when you create the account but do not use the <u>spaces</u> shown in this number: 000 596 000 000 000</p> <p style="text-align: center;"><i>- Page 13 is a full page on how to create your HSA account -</i></p>			

If you are eligible for the Health Savings Account Benefit described above is a great way to offset expenses. You can also contribute a portion of your wages to your HSA. Please also see the presentation “Medical Plan Education Workshop” on the Benefits website for detailed information to assist you in choosing a plan.

If you are interested in enrolling in the HDHP with HSA plan, and wish to contribute from your paycheck in addition to what the District provides, please submit the Employee Contribution form to the Benefits office as soon as possible. The form is included at the back of this booklet, or online at:

http://www.tusd1.org/tusdforms/documents/BEN1200_14HDHP_HSA.pdf.

How Do I Calculate My Cost?

Follow these directions to estimate your Per Pay cost. If you wish to use the Excel calculator, please request it to be emailed to you by calling 225-6144 or emailing Benefits@tusd1.org.

You will need to also use Page 23-24 of this booklet for Per Pay Cost and Deductions Available.

INSTRUCTIONS (Using your Benefits Handbook)		Medical Cost Calculator Employee Benefits (520) 225-6144	
1. Determine which MEDICAL plan you want (PPO or HDHP)			
2. Determine if you want Single, or Emp+Spouse, or Emp+Children, or Family.			
3. Locate the Per Pay Cost for the type and level you want on the "Cost" pages	SAMPLE		Your Calc:
4. Enter the Per Pay Cost shown for the coverage you have chosen: ----->	\$ 28.73		
5. Multiply the Per Pay Cost by 20 (this will be annual cost for 12 months) ----->	\$ 574.60		
6. Divide the result in #5 by 12 (this will be the monthly cost) ----->	\$ 47.88		
7. Based on the day your benefits BEGIN, enter the number of months left for this Benefit year. (See the Months/Deduction Schedule in the Benefits handbook)--->	6		
8. Multiply the number of months (from #7 by the amount in #6. This will be the TOTAL COST of that coverage for your months. ----->	\$ 287.30		
9. Look at the Deduction Schedule on Page 21 of the Enrollment Booklet. Locate the Month in the far left column that matches when your benefits begin. For example, for March 1, there are "7 "deductions" remaining (far right column, since the paydate following March 1 equals 7 deductions. Now that you have located the number of deductions, enter the Per Pay amount seven (7) times as shown in the example.	\$ 28.73	1	
	\$ 28.73	2	
	\$ 28.73	3	
	\$ 28.73	4	
	\$ 28.73	5	
	\$ 28.73	6	
	\$ 28.73	7	
		8	
		9	
		10	
		11	
		12	
		13	
		14	
		15	
		16	
		17	
		18	
		19	
		20	
11. Total collected in regular payroll deductions ----->	\$ 201.11		
12. Subtract the total in #11 from the total in #8. This is the extra amount owed.-->	\$ 86.19		

(Extra amounts owed will be taken from the first 2 or 3 deductions, in addition to regular ded.)

HSA Pro-Rated Amounts

The HSA amounts are pro-rated as the benefit year progresses therefore a new hire will receive a reduced overall annual amount depending on his/her benefits effective date and the number of remaining deductions.

FULL TIME Employee Only Coverage				FULL TIME Employee/Dependent Coverage		
Paydate	Per Pay	Cumulative Annual		Paydate	Per Pay	Cumulative Annual
09/12/14	\$ 75.00	\$ 75.00		09/12/14	\$ 100.00	\$ 100.00
09/26/14	\$ 75.00	\$ 150.00		09/26/14	\$ 100.00	\$ 200.00
10/10/14	\$ 75.00	\$ 225.00		10/10/14	\$ 100.00	\$ 300.00
10/24/14	\$ 75.00	\$ 300.00		10/24/14	\$ 100.00	\$ 400.00
11/07/14	\$ 75.00	\$ 375.00		11/07/14	\$ 100.00	\$ 500.00
11/21/14	\$ 75.00	\$ 450.00		11/21/14	\$ 100.00	\$ 600.00
12/05/14	\$ 75.00	\$ 525.00		12/05/14	\$ 100.00	\$ 700.00
12/19/14	\$ 75.00	\$ 600.00		12/19/14	\$ 100.00	\$ 800.00
01/02/15	\$ 75.00	\$ 675.00		01/02/15	\$ 100.00	\$ 900.00
01/16/15	\$ 75.00	\$ 750.00		01/16/15	\$ 100.00	\$ 1,000.00
01/30/15	\$ 75.00	\$ 825.00		01/30/15	\$ 100.00	\$ 1,100.00
02/13/15	\$ 75.00	\$ 900.00		02/13/15	\$ 100.00	\$ 1,200.00
02/27/15	\$ 75.00	\$ 975.00		02/27/15	\$ 100.00	\$ 1,300.00
03/13/15	\$ 75.00	\$ 1,050.00		03/13/15	\$ 100.00	\$ 1,400.00
03/27/15	\$ 75.00	\$ 1,125.00		03/27/15	\$ 100.00	\$ 1,500.00
04/10/15	\$ 75.00	\$ 1,200.00		04/10/15	\$ 100.00	\$ 1,600.00
04/24/15	\$ 75.00	\$ 1,275.00		04/24/15	\$ 100.00	\$ 1,700.00
05/08/15	\$ 75.00	\$ 1,350.00		05/08/15	\$ 100.00	\$ 1,800.00
05/22/15	\$ 75.00	\$ 1,425.00		05/22/15	\$ 100.00	\$ 1,900.00
06/05/15	\$ 75.00	\$ 1,500.00		06/05/15	\$ 100.00	\$ 2,000.00



Three ways to complete your medical history disclosure (MHD)



Online

The fastest and easiest option. Log in to your Teladoc account at Teladoc.com and complete the "My Medical History" section.

Mobile app

Log into your account on your mobile device and complete the "My Health Record" section. Visit Teladoc.com/mobile to download the app.

Call Teladoc

Call Teladoc if you would like a customer service representative to help you complete your MHD over the phone.

Why should I fill out the MHD?

Your MHD must be completed prior to requesting a consult and updated each year. The Teladoc doctor will review your MHD prior to a consult, just like the clipboard of medical questions answered at your primary care physician's office.

Can my company view my MHD?

No. All information is confidential, HIPAA compliant, and will not be shared. Only you and the consulting doctor can view your medical data.

How quiddy can I talk to a doctor?

A Teladoc doctor will call you back within an hour, guaranteed.

Can I get a prescription or a prescription refill?

Yes. When medically appropriate, Teladoc doctors prescribe medication for treatment of your illness and also can prescribe short term prescription refills. Teladoc doctors do not prescribe DEA controlled substances.

With your consent, Teladoc is happy to provide information about your Teladoc consult to your primary care physician.

Talk to a doctor anytime for \$40

 Teladoc.com

 [Facebook.com/Teladoc](https://www.facebook.com/Teladoc)

 1-800-Teladoc

 Teladoc.com/mobile

Download the app:



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10E-131
0414

Cost of Coverage – Dental & Vision

Costs are shown per pay, for the 20 Benefit Deductions dates.
If 20 deductions are no longer available due to a late hire,
the cost is higher than what is shown here.

	<i>Pre-Paid Discount Plan</i>	<i>Preferred Provider Traditonal Dental</i>	
	EMPLOYERS DENTAL SERVICES (EDS)	DELTA DENTAL	
		HIGH OPTION	LOW OPTION
EE Only	\$5.31	\$25.77	\$15.57
EE+ Spouse	\$11.13	\$61.89	\$37.38
EE + Child(ren)	\$15.44	\$56.14	\$33.93
EE + Family	\$16.70	\$89.03	\$53.79

VISION		
	Avesis PPO Plan	Avesis Discount Plan
EE Only	\$4.14	\$0.00
EE + Spouse	\$7.26	\$0.00
EE + Child(ren)	\$8.39	\$0.00
EE + Family	\$10.81	\$0.00

Delta Dental Low Plan



TUCSON UNIFIED SCHOOL DISTRICT
Low Plan Group #4215

Delta Dental PPO plus PremierSM Provider Network
Benefits Effective: September 1, 2014

Covered Services	Delta Dental		Non Delta Dental Dentist
	PPO Dentist	Premier Dentist	
Annual Maximum Benefit (Combination of in and out-of-network)	\$1,000	\$1,000	\$1,000
Lifetime Orthodontia Maximum (Combination of in and out-of-network)	\$1,000	\$1,000	\$1,000
Annual Deductible (Individual/Family) (Combination of in and out-of-network)	\$50/150	\$50/150	\$50/150
Preventive Services			
<ul style="list-style-type: none"> Exams, evaluations or consultations: Two in a benefit year. Full mouth/Panorex or vertical bitewings X-rays: Once in a 3-year period. Bitewing X-rays: Two in a benefit year. Periapical X-rays: As needed. Routine Cleanings: Limited to two in a benefit year. One difficult cleaning may be exchanged for one routine cleaning. However, the difficult cleaning is limited to once in a 5-year period. Topical Application of Fluoride: For children to age 18 - Two in a benefit year. Space Maintainers: For missing posterior primary (baby) teeth up to age 14. 	100%	100%	100%
Basic Services (Waiting period 6 months)			
<ul style="list-style-type: none"> Sealants: For children up to age 19 - Once in a 3-year period for permanent molars and bicuspsids. Fillings: Silver amalgam and for front teeth only, synthetic tooth color fillings. One per surface every two years. Stainless Steel Crowns Emergency (Palliative Treatment): Treatment for the relief of pain. Endodontics: Root canal treatment (permanent teeth). Pulpotomy primary (baby) teeth. Periodontics: Treatment of gum disease - Non-surgical once every two years. Surgical once every three years. Oral Surgery: Simple extractions. Oral Surgery: Surgical extractions. 	60%*	60%*	60%*
Major Services (Waiting period 6 months)			
<ul style="list-style-type: none"> Prosthodontics: Bridges, partial dentures, complete dentures - 5-year waiting period for replacement last performed. Bridge and Denture Repair: Repair of such appliances to their original condition, including relining of dentures. Implants: Implants are only a benefit to replace a single missing tooth bounded by teeth on each side. Limited to \$1000 per tooth, per lifetime and is applied to the patient's annual maximum benefit. Restorative: Crowns and onlays - 5-year waiting period for replacement last performed. 	40%*	40%*	40%*
Orthodontic Services (Waiting period 6 months)			
<ul style="list-style-type: none"> Benefit for adults and children age 8 and older. Payable in two payments - upon initial banding and 12 months after. The orthodontic maximum is separate from the annual maximum for your other dental benefits. 	50%	50%	50%

*Deductible applies to these services. / Dependent Age Limit: 26 / Predetermination recommended for services over \$250.

BENEFITS ARE SUBJECT TO ALL PROVISIONS, TERMS & CONDITIONS OF THE GROUP CONTRACT

You are enrolled in a Delta Dental PPO plus Premier plan. You and your family members may visit any licensed dentist. There are three levels to choose from:

- PPO Dentist** -- Payment is based on the PPO dentist's allowable fee or the actual fee charged, whichever is less.
- Premier Dentist** -- Payment is based on the Premier Maximum Reimbursable Amount (MRA), filed fee, or the fee actually charged, whichever is less.
- Non-Participating Dentist** -- Payment is based on the non-participating dentist Table of Allowance. Members are responsible for the difference between the non-participating dentist Table of Allowance and the full fee charged by the dentist.

To Find A Dentist - www.deltadentalaz.com

Customer Service Phone # 1.800.352.6132

Delta Dental High Plan



TUCSON UNIFIED SCHOOL DISTRICT
High Plan Group #4215

Delta Dental PPO plus PremierSM Provider Network
Benefits Effective: September 1, 2014

Covered Services	Delta Dental		Non Delta Dental Dentist
	PPO Dentist	Premier Dentist	
Annual Maximum Benefit (Combination of in and out-of-network)	\$2,000	\$2,000	\$2,000
Lifetime Orthodontia Maximum (Combination of in and out-of-network)	\$1,500	\$1,500	\$1,500
Annual Deductible (Individual/Family) (Combination of in and out-of-network)	\$50/150	\$50/150	\$50/150
Preventive Services			
<ul style="list-style-type: none"> Exams, evaluations or consultations: Two in a benefit year. Full mouth/Panorex or vertical bitewings X-rays: Once in a 3-year period. Bitewing X-rays: Two in a benefit year. Periapical X-rays: As needed. Routine Cleanings: Limited to two in a benefit year. One difficult cleaning may be exchanged for one routine cleaning. However, the difficult cleaning is limited to once in a 5-year period. Topical Application of Fluoride: For children to age 18 - Two in a benefit year. Space Maintainers: For missing posterior primary (baby) teeth up to age 14. 	100%	100%	100%
Basic Services			
<ul style="list-style-type: none"> Sealants: For children up to age 19 - Once in a 3-year period for permanent molars and bicuspids. Fillings: Silver amalgam and for front teeth only, synthetic tooth color fillings. One per surface every two years. Stainless Steel Crowns Emergency (Palliative Treatment): Treatment for the relief of pain. Endodontics: Root canal treatment (permanent teeth). Pulpotomy primary (baby) teeth. Periodontics: Treatment of gum disease - Non-surgical once every two years. Surgical once every three years. Oral Surgery: Simple extractions. Oral Surgery: Surgical extractions. 	80%*	80%*	80%*
Major Services			
<ul style="list-style-type: none"> Prosthodontics: Bridges, partial dentures, complete dentures - 5-year waiting period for replacement last performed. Bridge and Denture Repair: Repair of such appliances to their original condition, including relining of dentures. Implants: Implants are only a benefit to replace a single missing tooth bounded by teeth on each side. Limited to \$1000 per tooth, per lifetime and is applied to the patient's annual maximum benefit. Restorative: Crowns and onlays - 5-year waiting period for replacement last performed. 	50%*	50%*	50%*
Orthodontic Services			
<ul style="list-style-type: none"> Benefit for adults and children age 8 and older. Payable in two payments - upon initial banding and 12 months after. The orthodontic maximum is separate from the annual maximum for your other dental benefits. 	50%	50%	50%

*Deductible applies to these services. / Dependent Age Limit: 26 / Predetermination recommended for services over \$250.

BENEFITS ARE SUBJECT TO ALL PROVISIONS, TERMS & CONDITIONS OF THE GROUP CONTRACT

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- Non-Participating Dentist** -- Payment is based on the non-participating dentist Table of Allowance. Members are responsible for the difference between the non-participating dentist Table of Allowance and the full fee charged by the dentist.

To Find A Dentist - www.deltadentalaz.com

Customer Service Phone # 1.800.352.6132

EDS Schedule of Benefits

This is a PARTIAL listing of the EDS Schedule. To see the FULL schedule of Benefits for EDS, please visit the TUSD Benefits website: <http://intranet/hr/Documents/eds2.pdf>

Schedule of Benefits EDS 700R

General dentists: Member costs listed below are for services provided by your chosen EDS general dentist.

Specialists: Endodontists, oral surgeons, pediatric dentists, periodontists, prosthodontists and TMD dentists.

EDS specialists offer up to 25% off their normal fees for services specifically described in this schedule of benefits. All fees will be paid to the specialist at the time of treatment. A referral is not required.

ADA* Code	CDT - Procedure description	Average cost	Member cost	ADA* Code	CDT - Procedure description	Average cost	Member cost
DIAGNOSTIC — Procedures that aid the dentist in evaluating existing conditions and determining required dental care.				PREVENTIVE — Procedures that prevent the occurrence of oral diseases.			
09431	Office visit – per patient/per visit		5.00	D1110	Cleaning adult (prophylaxis)	74.00	7.00
D0120	Periodic oral evaluation	40.00	No charge	D1120	Cleaning child (prophylaxis)	56.00	5.00
D0140	Limited oral evaluation - problem focused	65.00	20.00	D1203	Topical application of fluoride (prophylaxis not included) - child	26.00	No charge
D0145	Comprehensive oral evaluation - new or established patient under age 3		No charge	D1204	Topical application of fluoride (prophylaxis not included) - adult	26.00	No charge
D0150	Comprehensive oral evaluation - new or established patient	70.00	No charge	D1310	Nutritional counseling for control of dental disease	30.00	No charge
D0160	Detailed and extensive oral evaluation - problem focused, by periodontist's report		55.00	D1330	Oral hygiene instructions	48.00	No charge
D0170	Re-evaluation - limited, problem focused (established patient)	72.00	15.00	D1351	Sealant - per tooth	43.00	12.00
D0180	Comprehensive periodontal evaluation - new or established patient	90.00	No charge	D1510	Space maintainer - fixed - unilateral	321.00	25.00+Lab
D0210	X-rays - complete series (including bitewings)	105.00	No charge	D1515	Space maintainer - fixed - bilateral	450.00	25.00+Lab
D0220	X-rays - first film	22.00	No charge	D1520	Space maintainer - removable - unilateral	225.00	25.00+Lab
D0230	X-rays - each additional film	18.00	No charge	D1525	Space maintainer - removable - bilateral	389.00	25.00+Lab
D0240	X-rays - occlusal	30.00	No charge	D1550	Recementation of space maintainer	50.00	20.00
D0270	X-rays - bitewing - single film	24.00	No charge	D1555	Removal of fixed space maintainer by dentist who did not place	45.00	25.00
D0272	X-rays - bitewings - two films	34.00	No charge	RESTORATIVE — Procedures for restoring lost tooth structure.			
D0273	X-rays - bitewings - three films	42.00	No charge	D2140	Amalgam filling - one surface, primary or permanent	125.00	13.00
D0274	X-rays - bitewings - four films	49.00	No charge	D2150	Amalgam filling - two surfaces, primary or permanent	160.00	17.00
D0330	X-rays - panoramic film	88.00	No charge	D2160	Amalgam filling - three surfaces, primary or permanent	185.00	21.00
D0460	Pulp vitality tests	45.00	No charge				
D0470	Diagnostic casts	85.00	10.00				

Vision Plan – Avesis

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

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.

Limitations

This plan is designed to cover routine eye examinations and corrective eyewear. It is also designed to cover visual needs rather than cosmetic options. Should the member select options that are not covered under the plan, as shown in the schedule of benefits, the member will pay a discounted fee to the Avesis participating provider. Benefits are payable only for expenses incurred while the group and the individual member's coverage are in force.

Exclusions

There are no benefits under the plan for professional services or materials connected with or arising from:

- 1) Orthoptics or vision training
- 2) Subnormal vision aids and any supplemental testing
- 3) Plano (non-prescription) lenses or non-prescription sunglasses
- 4) Two pairs of glasses in lieu of bifocals
- 5) Any medical or surgical treatment of the eye(s)
- 6) Replacement of lost or broken lenses, contact lenses or frames, except when the member is normally eligible for services
- 7) Any eye examination or corrective eyewear required by an employer as a condition of employment
- 8) Services or materials provided as a result of any Worker's Compensation Law or similar legislation, required by any governmental agency whether Federal, State or subdivisions thereof.

For more information, visit
www.avesis.com
or call 800-828-9341

This is a benefit summary only. For more information, please refer to the Certificate of Insurance.

Underwritten by:
Fidelity Security Life Insurance Company
Kansas City, Missouri 64141

Benefits administrator and
provider network:
Avesis Third Party Administrators, Inc.
3030 N. Central Avenue, #300
Phoenix, Arizona 85012

Avesis Plus Plan Benefits

The following services are available to members who choose to receive services from an Avesis participating provider:

Vision Examination	Covered 100%	After \$10 Co-pay
Spectacle Lenses*	Covered 100%	After \$15 Co-pay
Frames within plan allowance	Covered 100%	
Contact Lens Benefit**		
Elective	\$130 Allowance	
Medically Necessary	Covered 100%	
LASIK Surgery	5% to 25% discount plus onetime \$150 allowance	

* standard single vision, bifocal, trifocal or lenticular

** contact lens benefit is in lieu of spectacle lenses and frame for the plan period.

Benefit Frequency

Exam	once every 12 Months
Frames	once every 12 Months
Lenses	once every 12 Months
Contact Lenses**	once every 12 Months

Avesis Plus Plan (cont'd)

There is a \$15 optical materials co-pay (frames and spectacle lenses).

In-Network Benefit Frame Benefit

The member may choose from a wide variety of frames at the participating provider's office. The member has the choice of staying within the plan frame allowance* with no additional out of pocket expense.

If the member chooses a frame that is not covered in full by the plan's frame allowance, then the member would pay a designated co-insurance amount. The co-insurance amount is based on Avesis Preferred Pricing contract with participating providers, and varies by frame.

(*The Avesis plan frame allowance is \$50 towards the wholesale cost. This equates to an approximate retail value of \$100 - \$150 for a covered frame. As with most products, retail prices may vary.)

In-Network Benefit Spectacle Lenses Benefit

Covered spectacle lenses include a choice of plastic or glass lenses (standard single vision, bifocal or trifocal). If the member chooses to upgrade to specialty lenses (i.e. high index, progressive, etc.) the member would pay a discounted fee to the participating provider.

In-Network Benefit Contact Lens Benefit

Elective - In addition to the routine eye exam benefit Avesis provides a \$130 allowance applied toward contact lenses and associated professional fees (fitting fees).

Medically Necessary Contacts - Covered in full

Contact lenses would be considered medically necessary for: a) post-cataract surgery; b) keratoconus; c) certain conditions of anisometropia; and d) to correct extreme visual conditions that cannot be corrected with spectacle lenses.

Determination of medical necessity will be approved by Avesis.

In-Network Benefit LASIK Benefit

Avesis membership provides access to the Avesis preferred pricing through an Avesis participating LASIK surgery center only. On a one-time/lifetime basis, Avesis will apply a \$150 allowance toward the cost of LASIK

surgery for one or both eyes. This will take the place of all other benefits for that plan period. The remaining charges are the responsibility of the member. Refractive surgery is an elective procedure and may involve potential risks to patients. Avesis is not responsible for the outcome of any refractive surgery.

Additional Options

Members receive up to 20% savings from Avesis providers on fees for options such as scratch coating, anti-reflective coating, etc.) that are not covered under the Avesis Advantage Vision Care Plan.

Additional Eyewear

After members have received their covered eyewear, additional eyewear savings may still be obtained at the Avesis participating provider offices at already discounted fees. The members would be responsible for payment of the discounted fees directly to the providers.

Out-Of-Network Reimbursement Schedule

Vision Examination	\$35.00
Spectacle Lenses	
Single Vision Lenses	\$25.00
Bifocal Lenses	\$40.00
Trifocal Lenses	\$50.00
Lenticular Lenses	\$80.00
Progressive Lenses	\$40.00
Frame	\$45.00
Contact Lenses*	
Elective Contact Lenses	\$130.00
Medically Necessary	\$250.00
LASIK Surgery	\$150.00

*The contact lens benefit takes the place of exam, spectacle lenses and a frame for that plan period.

If an Avesis member chooses to receive services from a non-participating provider, the member would pay the provider and submit an itemized statement to Avesis for reimbursement according to the Out-of-Network Reimbursement Schedule.

The member must submit the claim within 3 months from the date of service. When filing a claim, the member must provide the following information: member's identification number; member's name; patient's name; patient's date of birth, member's mailing address and the group number. Out-of-network benefits are subject to the same eligibility, availability, frequency of benefits and limitation and exclusion provisions of the plan and are in place of services provided by Avesis participating providers.

Avesis Discount Plan

In Network Benefits	
Exam	Member pays \$45
Lenses Standard Single Vision Standard Bifocal Standard Trifocal Standard Lenticular Non Standard Lenses	Member pays \$35 Member pays \$50 Member pays \$65 Member pays \$80 20% off the providers retail fees
All optical items and lens options (tints, coatings, etc.)	20% off the providers retail fees
Frame	20% - 50% off the providers retail fees
Contact Lenses	10% - 20% off the providers retail fees
LASIK	Up to 25% off the providers retail fees
No benefits available outside of the Avesis network	

How to use your vision benefits

When you need to see an eye care professional, simply visit www.avesis.com or call Avesis, Monday through Friday, 7AM to 8PM (EST) at 1-800-828-9341. Avesis' Customer Service Representatives and its website have the most current listing of participating providers. You may also verify eligibility or print ID cards online at www.avesis.com. To use your benefit, simply 1) Select a participating provider. 2) Call up and identify yourself as an Avesis member. 3) Schedule an appointment. 4) Pay the discounted fees.

LASIK - Avesis has contracted with participating providers to offer discounts for LASIK surgery. You may call 1-800-828-9341 for additional information or help in locating a participating provider in your area.

Note: Refractive Surgery is an elective procedure and may involve potential risks to patients. Avesis is not responsible for the outcome of any refractive surgery.

Life Insurance and Accidental Death & Dismemberment

Minnesota Life Insurance Company is the provider for Basic Life Insurance/Accidental Death & Dismemberment [AD&D] (District paid) and Supplemental Life Insurance (Employee paid). Both are term life insurance policies. A Minnesota Life Insurance brochure will be available at Open Enrollment meetings or from the TUSD Benefits office. For further information, contact **Minnesota Life at (866) 293-6047**, or online at www.LifeBenefits.com

What is the purpose of life insurance?

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

What is the Basic Life Insurance benefit?

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

- Full-Time - equal to the employee's annual base salary as of the beginning of the benefit year, but not less than \$10,000 and subject to a maximum of \$200,000.

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

Is Supplemental Life Insurance available?

Yes. You may elect supplemental life insurance for yourself and your covered dependents (see next sections). The employee must have Supplemental Life Insurance for her/himself in order to elect supplemental life insurance for a dependent child. While Dependents Life Insurance is in effect, each newly enrolled child becomes insured immediately. **More than one employee may not insure the same child under the TUSD plan.**

Do I have to submit a health application?

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

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

Accidental Death and Dismemberment

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

Spouse/Domestic Partner Life Insurance

Spouse/Domestic Partner Additional Life Insurance is available in units of \$5,000 to a maximum of \$200,000, but not to exceed 100% of the employee's Additional Life Insurance coverage. Upon hire, employees may elect \$25,000 of "Guaranteed Issue" for the spouse/domestic partner. **Employees must have elected Supplemental Life Insurance for themselves in an amount equal to or greater than the amount elected for their spouses/domestic partners.**

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

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

Child Life Insurance

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

Cost of Life Insurance

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

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

Effective Dates

- Basic Life and Supplemental Life within the Guaranteed Issue range will go into effect on the first day of the month following 30 days of employment.
- Supplemental Life over the Guaranteed Issue amount will go into effect the 1st day of the month following notice from Minnesota Life to TUSD of their approval.
- Child Life Insurance goes into effect immediately once Employee Supplemental Life Insurance is approved.

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

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

LifeSuite Services

- **Travel Assistance Services** – Global Rescue provides 24-hour travel assistance, emergency medical and security transport services, and pre-travel resources to employees and retirees covered under the group life insurance plan. The spouses and dependent children of those covered under the group life plan may also access the services. Global Rescue's services are available when traveling for business or pleasure 100 or more miles away from home. Contact Global Rescue at **1-855-516-5433** (toll free U.S. and Canada), **+1-617-426-6603** (international), or visit **LifeBenefits.com/travel**.
- **Beneficiary Financial Counseling** – Beneficiaries who receive at least \$25,000 in policy benefits will be invited to use independent beneficiary counseling services from PricewaterhouseCoopers LLP.
- **Legacy Planning Services** – Employees and dependents can access resources designed to help individuals and families work through end-of-life issues when dealing with the loss of a loved one or planning for their own passing. These resources are available at **LegacyPlanningServices.com**.
- **Legal Services** – Ceridian provides employees and their dependents telephone access to a national network of 22,000+ accredited attorneys for consultation on simple wills, estate planning documents and other legal issues. Discounts are available for participating attorneys. Contact Ceridian at **1-877-849-6034** or visit **LifeWorks.com** (user name: *will*) (password: *preparation*).

Services provided by Ceridian, Global Rescue LLC, and PricewaterhouseCoopers LLP are their sole responsibility. The services are not affiliated with Minnesota Life or its group contracts and may be discontinued at any time. Certain terms, conditions and restrictions may apply when utilizing the services. To learn more, visit the appropriate website.

Employee Assistance Program (EAP)

What is EAP?

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

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

What is the cost?

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

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

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

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



Will anyone find out that I used EAP services?

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

How do I make an appointment?

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

Short Term Disability (STD) / Leave of Absence

This section is a general enrollment guide/summary of the STD benefits. Refer to the Summary of Coverage on the TUSD benefits website: www.tusd1.org/benefits, and click on Short Term Disability.

ALERT! If you are off work more than 10 consecutive work days for a medical or personal reason, you must submit a TUSD Leave of Absence request. You can also apply for Short Term Disability if your absence is due to sickness or injury. You must return ALL company property to the School Safety department if you go on Leave of Absence and Payroll will hold your paycheck until you do so.

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

MetLife underwrites the Short Term Disability income protection insurance.
Customer Service is (800) 858-6506.

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

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

Short-Term Disability (STD) insurance provides a weekly benefit if the eligible employee cannot work and 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, subject to continuing medical certification as requested by the carrier.

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.

- **Am I eligible to enroll?**

You are eligible if you meet the Eligibility on page 8, and have a minimum of \$6500 annual salary.

Three types of Short Term Disability (STD) plans are available.

What are the differences between the STD Plan Options?

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 – this is a “Grandfathered” plan that is no longer available for 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. Because of the longer waiting period, the premium is lower than both the 0/3 and 7/14 plan premiums. NOTE: under the new carrier, you may use your accrued sick leave and also be paid the 66 2/3 benefit at the same time.

Services to Help You Get Back to Work Can Include:

Nurse Consultant or Case Manager Services:

Specialists who personally contact you, your physician and your employer to coordinate an early return-to-work plan when appropriate.

Vocational Analysis: Help with identifying job requirements and determining how your skills can be applied to a new or modified job with your employer.

Job Modifications/Accommodations: Adjustments (e.g., redesign of work station tools) that enable you to return to your previous job or a similar one.

Retraining: Development programs to help you return to your previous job or educate you for a new one.

Financial Incentives: Allow employees to receive Disability benefits or partial benefits while attempting to return to work.

The Services of Social Security Specialists:

Once you are approved for Disability benefits, MetLife can help you obtain Social Security Disability benefits. Our specialists can guide you through the initial application and appeals processes and may also help you access assistance from attorneys or vendors to pursue Social Security benefits.

Answers to Some Important Questions...

Q. Are there any exclusions for pre-existing conditions?

A. Yes. Your plan may not cover a sickness or accidental injury that arose in the 12 months prior to your participation in the plan (unless you were already enrolled under the prior TUSD carrier). A complete description of the pre-existing condition exclusion is included in the Certificate of Insurance/Summary Plan Description provided by your Employer.

Q. Are there any exclusions to my coverage?

A. Yes. Your plan does not cover any Disability, which results from or is caused or contributed to by:

- Elective treatment or procedures, such as cosmetic surgery, sex-change surgery, reversal of sterilization, liposuction, visual correction surgery, in-vitro fertilization, embryo transfer procedure, artificial insemination or other specific procedures. *However, pregnancies and complications from any of these procedures will be treated as a sickness.*
- War, whether declared or undeclared, or act of war, insurrection, rebellion or terrorist act;
- Active participation in a riot;
- Intentionally self-inflicted injury or attempted suicide;
- Commission of or attempt to commit a felony.

Additionally, no payment will be made for a Disability caused or contributed to by any injury or sickness for which you are entitled to benefits under Workers' Compensation or a similar law.

ASRS Long Term Disability Information

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

Long Term Disability (LTD) is a mandatory disability program through the Arizona State Retirement System and 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. This plan has a six-month waiting period which means you must be off work due to a medical condition for at least six (6) months.

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** who meet ASRS membership criteria are automatically enrolled in Long Term Disability provided through the Arizona State Retirement System.

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

After being off work for six months due to disability, eligible employees whose claim is approved will receive benefits under ASRS' Long Term disability Income Plan equal to 66 2/3% of their monthly earnings. LTD is partially funded by TUSD, 50% of any benefits that are received are subject to taxes.

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

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

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

To obtain the application packet necessary to file an LTD claim, you need to contact Human Resources at (520) 225-6144. 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 TUSD Human Resources, Benefits at (520) 225-6144
- 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.

Retirement Savings Plans FAQs

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

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

TUSD also offers employees the ability to set aside money through payroll deductions on a tax-deferred basis under Internal Revenue Code options: **403(b), Roth 403(b) and 457**. The Internal Revenue Code limits the amount employees can contribute annually to the 403(b) and 457 plans.

Both plans allow employees to set aside money from their paycheck on a pre-tax basis to save for retirement, subject to annual calendar year limits set by the IRS. These limits are not coordinated so you can contribute up to the maximum in both plans in the same year.

Taxes are paid on the savings when a distribution is taken from the plan. IRS rules **restrict** plan distributions of the Plan if you are still currently employed. For detailed information on taxation rules, please go to www.tsacg.com and click on the online video presentation.

To view the limits for the current calendar year, please visit the TUSD Benefits website at www.tusd1.org/benefits

- ***TUSD has contracted with TSA Consulting Group to manage all elective 403(b) and 457 transactions including enrollment, stopping enrollment, loans, distributions and rollovers. Only TSA can sign off on all forms.***

To enroll in a 403(b) or 457 plan please follow these steps:

1. **Review the list of TUSD approved vendors.** The list is located at www.tusd1.org/benefits, Retirement Savings Plans
2. **Contact that vendor to establish your account**
3. **Locate and complete the TSA CG Salary Reduction Agreement form and fax it to TSA CG.** This form is available on the website: www.tusd1.org/benefits, Retirement Savings Plans
4. **Loans, Distributions and Rollovers.** To submit a transaction, please visit www.tusd1.org/benefits, Retirement Savings Plans, and then Transaction Routing Request. TSA will review 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.

Contact your provider directly if you have questions about account fees.


NOTE! If you wish to close your account or move to a new 403b or 457 provider, do NOT do so until after you have notified TSA CG by submitting another Salary Reduction Agreement form to “stop” or “change.”

If you do not notify TSA CG of your intent we will not know to stop or change the deductions from your paycheck. This results in lost time of your money as the vendor will send a check back to TUSD; we then must refund it to you as taxable income, or redirect to your new vendor.

Payroll Information

This section contains information about Tucson Unified School District Payroll.

Please visit the TUSD Payroll Intranet site at http://intranet/financedept/index_payroll.asp for:

<ul style="list-style-type: none">• Employee Self Service	<ul style="list-style-type: none">• Employee Payroll Forms
<ul style="list-style-type: none">• Direct Deposit	<ul style="list-style-type: none">• Printable Tax Forms and Information
<ul style="list-style-type: none">• Work Schedules	<ul style="list-style-type: none">• Work Logs, Time Sheets and Instructions
<ul style="list-style-type: none">• Payroll Deadline Schedules	
<ul style="list-style-type: none">• Pay Card Option through rapid! PayCard	

Address and Phone – Keep us up to date!

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

Employee Self Service

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

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

Once you have logged in, Self-Service functions are available at the same page. Through Self-Service, you can change your address or contact information.

How to log in

1. Go to <http://hrweb.admin.tusd.local/psp/HRPROD/?cmd=login>
2. Your user ID is your employee ID number, which can be found in the top middle of your pay statement.
3. Your password is the last four digits of your social security number and the four digits of your birth year (for example, 55551964).

You can view Self Service Instructions on the site also.

Paycheck for Exiting Employee

If you separate from TUSD, you must turn in ALL company property or your paycheck will have a hold on it. Also, your final check will be a live check (direct deposit will not be used on a final paycheck).



1010 E. 10th Street
Tucson, AZ 85719

REQUIRED NOTICE: Medicare Part D Notice

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

**This notice is for people with Medicare.
Please read this notice carefully and keep it where you can find it.**

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

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

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

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

TUSD has determined that the prescription drug coverage under the following prescription drug plan options are "creditable:" PPO Plan is "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 PPO medical plan 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 or
- for beneficiaries leaving employer/union coverage, you may be eligible for a two month Special Enrollment Period (SEP) in which to sign up for a Medicare prescription drug plan.

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

YOUR RIGHT TO RECEIVE A NOTICE

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

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

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

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

If you go 63 continuous days or longer without creditable prescription drug coverage (meaning drug coverage that is at least as good as Medicare's prescription drug coverage), your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have either Medicare prescription drug coverage or coverage under a creditable prescription drug plan. You may have to pay this higher premium (the penalty) as long as you have Medicare prescription drug coverage.

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

WHAT ARE MY CHOICES?

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

Your Choices:	What you can do:	What this option means to you:
Option 1	You can select or keep your current medical and prescription drug coverage with the PPO medical plan offered by TUSD and you do not have to enroll in a Medicare prescription drug plan.	<p>You will continue to be able to use your prescription drug benefits through the PPO medical plan offered by TUSD.</p> <ul style="list-style-type: none"> You may, in the future, enroll in a Medicare prescription drug plan during Medicare's annual enrollment period. 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	<p>You can select or keep your current medical and prescription drug coverage with the PPO or HDHP medical plan(s) offered by TUSD and also enroll in a Medicare prescription drug plan.</p> <p>If you enroll in a Medicare prescription drug plan you will need to pay the Medicare Part D premium out of your own pocket.</p>	<p>Your current coverage pays for other health expenses in addition to prescription drugs. If you enroll in a Medicare prescription drug plan, you and your eligible dependents will still be eligible to receive all of your current health and prescription drug benefits.</p> <p>Having dual prescription drug coverage under this Plan and Medicare means that you will still be able to receive all your current health coverage and this Plan will coordinate its drug payments with Medicare, as follows:</p> <ul style="list-style-type: none"> 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. <p>Note that you may not drop just the prescription drug coverage under the PPO or HDHP medical plan(s) offered by TUSD. That is because prescription drug coverage is part of the entire medical plan. Generally, you may only drop medical plan coverage at this Plan's next Open Enrollment period.</p> <p>Note that each Medicare prescription drug plan (PDP) may differ. Compare coverage, such as:</p> <ul style="list-style-type: none"> 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. <p>IMPORTANT NOTE: If you are enrolled in the High Deductible Health Plan (HDHP) with the Health Savings Account (HSA) you may not continue to make contributions to your HSA once you are enrolled in Medicare including being enrolled in a Medicare Part D drug plan.</p>

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

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

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- 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 June 26, 2013) is intended to serve as your Medicare Notice of Creditable Coverage, as required by law.

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REQUIRED NOTICE: Mid-Year Changes To Your Medical Plan Elections

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

• **Special Enrollment:**

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

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

You and your dependents may also enroll in this plan if you (or your dependents):

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

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

- ***Mid-Year Changes / Status Event Changes:***

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

- Change in legal marital status (e.g. marriage, divorce/legal separation, death).
- Change in number or status of dependents (e.g. birth, adoption, death).
- Change in employee/spouse/dependent's employment status, work schedule, or residence that affects their eligibility for benefits.
- Coverage of a child due to a QMCSO.
- Entitlement or loss of entitlement to Medicare or Medicaid.
- Certain changes in the cost of coverage, composition of coverage or curtailment of coverage of the employee or spouse's plan.
- Changes consistent with Special Enrollment rights and FMLA leaves.

You must notify the plan in writing within 30 days of the mid-year change in status event and submit required documentation and forms.

The Plan will determine if your change request is permitted and if so, changes become effective prospectively, on the first day of the month, following the approved change in status event (except for newborn and adopted children, who are covered back to the date of birth, adoption, or placement for adoption).

Medicare Secondary Payer Rules

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

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

COBRA Coverage

In compliance with the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) this plan offers its eligible employees and their covered dependents (known as qualified beneficiaries) the opportunity to elect temporary continuation of their group health coverage, referred to as COBRA Continuation Coverage, when that coverage would otherwise end because of certain events (called qualifying events).

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

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

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

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

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

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

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

HIPAA Privacy Notice for Dental and Vision Plans

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

The Medical plans including outpatient retail prescription drugs and COBRA Administration

To obtain a copy of this Plan’s HIPAA Notice of Privacy Practice for the above noted group health plan benefits, write or call the Benefits Department at 1010 E. 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 and vision benefits offered by Tucson Unified School District can be obtained by contacting those insurance companies directly.

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

Permissible Mid-Year Status Changes

Government regulations generally require that your Plan coverage remain in effect throughout the Plan Year (from September 1 through August 31), but you may be able to make some changes during the year if you have a permissible mid-year status change affecting your benefit needs. Any permissible mid-year status change in elections must be on account of and corresponding with the IRC approved status change. Election changes ***must be submitted with appropriate documentation on a TUSD enrollment form to the TUSD Benefits Office within 30 days of the change event.***

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

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

A Brief Summary of Common Change of Status Events and the Mid-Year Enrollment Changes Allowed Under the Medical Plan

Mid-year changes are only those permitted in accordance with Section 125 of the Internal Revenue Code.

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

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

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

A Brief Summary of Common Change of Status Events and the Mid-Year Enrollment Changes Allowed Under the Medical Plan

Mid-year changes are only those permitted in accordance with Section 125 of the Internal Revenue Code.

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

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

If you experience the following Event...	You may make the following change(s)* within 31 days (*where applicable 60 days) of the Event...	YOU MAY <u>NOT</u> make these types of changes...
Spouse or domestic partner's Open Enrollment.	<ul style="list-style-type: none"> Make corresponding changes to TUSD health benefits (for example, spouse enrolls in medical at own employer allowing TUSD employee to remove spouse from TUSD medical coverage). 	<ul style="list-style-type: none"> Drop or add any non-corresponding coverage for yourself or any other covered dependents
Start or Return from an Unpaid Leave of Absence.	<ul style="list-style-type: none"> Add or remove coverage for yourself or your dependents. 	
Increase or Decrease in Hours that impacts Benefits eligibility.	<ul style="list-style-type: none"> Add or remove coverage for yourself or your dependents. 	

Proof of a status change is required to make a corresponding change in coverage/enrollment.

Note: Loss of coverage due to non-payment of COBRA or an Individual Health Policy is not a Qualifying Event.

Tucson Unified School District (TUSD)

HIPAA Notice of Privacy Practices

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

Purpose of This Privacy Notice

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

Please review this information carefully.

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

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

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

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

Effective Date

The effective date of this Notice is June 26, 2014 and this notice replaces the notice(s) previously distributed to you.

Privacy Officer

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

TUSD Privacy Officer
ATTN: Benefits Office
1010 E. Tenth St. Tucson, AZ 85719
(520) 225-6155

Your Protected Health Information

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

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

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

When the Plan May Disclose Your PHI

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

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

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

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

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

When the Disclosure of Your PHI Requires Your Written Authorization

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

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

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

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

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

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

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

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

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

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

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

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

the public and the disclosure is to a person reasonably able to prevent or lessen the threat, including the target of the threat.

11. When authorized by and to the extent necessary to comply with **workers' compensation** or other similar programs established by law.
12. When required, for **specialized government functions**, to military authorities under certain circumstances, or to authorized federal officials for lawful intelligence, counter intelligence and other national security activities.

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

Your Individual Privacy Rights

A. You May Request Restrictions on PHI Uses and Disclosures

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

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

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

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

B. You May Inspect and Copy Your PHI

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

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

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

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

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

C. You Have the Right to Amend Your PHI

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

If the Plan denied your request in whole or part, the Plan must provide you with a written denial that explains the basis for the decision. You or your personal representative may then submit a written statement disagreeing with the

denial and have that statement included with any future disclosures of your PHI. You should make your request to amend PHI to the Privacy Officer at their address listed on the first page of this Notice.

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

D. You Have the Right to Receive an Accounting of the Plan's PHI Disclosures

At your request, the Plan will also provide you with an accounting of disclosures by the Plan of your PHI during the six years (or shorter period if requested) before the date of your request. The Plan will not provide you with an accounting of disclosures related to treatment, payment, or health care operations, or disclosures made to you or authorized by you in writing.

The Plan has 60 days after its receipt of your request to provide the accounting. The Plan is allowed an additional 30 days if the Plan gives you a written statement of the reasons for the delay and the date by which the accounting will be provided. If you request more than one accounting within a 12-month period, the Plan may charge a reasonable, cost-based fee for each subsequent accounting.

E. You have the Right to Request that PHI be Transmitted to You Confidentially

The Plan will permit and accommodate your reasonable request to have PHI sent to you by alternative means or to an alternative location (such as mailing PHI to a different address or allowing you to personally pick up the PHI that would otherwise be mailed), if you provide a written request to the Plan that the disclosure of PHI to your usual location could endanger you. If you believe you have this situation, you should contact the Plan's Privacy Officer to discuss your request for confidential PHI transmission.

F. You Have the Right to Receive a Paper or Electronic Copy of This Notice Upon Request

To obtain a paper or electronic copy of this Notice, contact the Plan's Privacy Officer at their address listed on the first page of this Notice or go to the website: www.tusd1.org/benefits.

Your Personal Representative

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

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

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

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

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

The Plan's Duties

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

Notice Distribution: The Notice will be provided to each person when they initially enroll for benefits in the Plan (the Notice is provided in the Plan's New Employee packets). The Notice is also available on the Plan's website at: www.tusd1.org/benefits. The Notice will also be provided upon request. Once every three years the Plan will notify the individuals then covered by the Plan where to obtain a copy of the Notice. This Plan will satisfy the requirements of the HIPAA regulation by providing the Notice to the named insured (covered employee) of the Plan; however, employees are encouraged to share this Notice with other family members covered under the Plan.

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

Disclosing Only the Minimum Necessary Protected Health Information

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

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

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

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

Your Right to File a Complaint

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

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

If You Need More Information

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

Buck 062613

Supplemental Life Insurance Premiums

Minnesota Life Insurance Company is the provider for Basic Life Insurance and AD&D (District paid) and the Additional Life and AD&D Insurance (employee paid). Both are term life insurance policies. A Minnesota Life Insurance brochure will be available at the Open Enrollment Benefit meetings or the TUSD Benefits intranet site. A full summary plan description of the benefits is available on the TUSD Benefits intranet site. For further information, contact **Minnesota Life at 1-800-293-6047** or online at **www.LifeBenefits.com**.

Accidental Death and Dismemberment

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

MINNESOTA LIFE

Employee Supplemental Life and AD&D - Costs Per 20 Benefits Deductions

Age	\$10,000	\$20,000	\$30,000	\$40,000	\$50,000	\$60,000	\$70,000	\$80,000	\$90,000	\$100,000
<30	\$0.34	\$0.68	\$1.03	\$1.37	\$1.71	\$2.05	\$2.39	\$2.74	\$3.08	\$3.42
30-34	\$0.42	\$0.84	\$1.26	\$1.68	\$2.10	\$2.52	\$2.94	\$3.36	\$3.78	\$4.20
35-39	\$0.46	\$0.91	\$1.37	\$1.82	\$2.28	\$2.74	\$3.19	\$3.65	\$4.10	\$4.56
40-44	\$0.61	\$1.21	\$1.82	\$2.42	\$3.03	\$3.64	\$4.24	\$4.85	\$5.45	\$6.06
45-49	\$0.90	\$1.80	\$2.70	\$3.60	\$4.50	\$5.40	\$6.30	\$7.20	\$8.10	\$9.00
50-54	\$1.42	\$2.84	\$4.27	\$5.69	\$7.11	\$8.53	\$9.95	\$11.38	\$12.80	\$14.22
55-59	\$2.47	\$4.93	\$7.40	\$9.86	\$12.33	\$14.80	\$17.26	\$19.73	\$22.19	\$24.66
60-64	\$2.76	\$5.52	\$8.28	\$11.04	\$13.80	\$16.56	\$19.32	\$22.08	\$24.84	\$27.60
65-69	\$6.74	\$13.49	\$20.23	\$26.98	\$33.72	\$40.46	\$47.21	\$53.95	\$60.70	\$67.44
70-74*	\$5.23	\$10.46	\$15.69	\$20.92	\$26.15	\$31.38	\$36.61	\$41.84	\$47.07	\$52.30
75-79*	\$6.24	\$12.48	\$18.72	\$24.96	\$31.20	\$37.44	\$43.68	\$49.92	\$56.16	\$62.40
80+*	\$3.12	\$6.24	\$9.36	\$12.48	\$15.60	\$18.72	\$21.84	\$24.96	\$28.08	\$31.20

Age	\$110,000	\$120,000	\$130,000	\$140,000	\$150,000	\$160,000	\$170,000	\$180,000	\$190,000	\$200,000
<30	\$3.76	\$4.10	\$4.45	\$4.79	\$5.13	\$5.47	\$5.81	\$6.16	\$6.50	\$6.84
30-34	\$4.62	\$5.04	\$5.46	\$5.88	\$6.30	\$6.72	\$7.14	\$7.56	\$7.98	\$8.40
35-39	\$5.02	\$5.47	\$5.93	\$6.38	\$6.84	\$7.30	\$7.75	\$8.21	\$8.66	\$9.12
40-44	\$6.67	\$7.27	\$7.88	\$8.48	\$9.09	\$9.70	\$10.30	\$10.91	\$11.51	\$12.12
45-49	\$9.90	\$10.80	\$11.70	\$12.60	\$13.50	\$14.40	\$15.30	\$16.20	\$17.10	\$18.00
50-54	\$15.64	\$17.06	\$18.49	\$19.91	\$21.33	\$22.75	\$24.17	\$25.60	\$27.02	\$28.44
55-59	\$27.13	\$29.59	\$32.06	\$34.52	\$36.99	\$39.46	\$41.92	\$44.39	\$46.85	\$49.32
60-64	\$30.36	\$33.12	\$35.88	\$38.64	\$41.40	\$44.16	\$46.92	\$49.68	\$52.44	\$55.20
65-69	\$74.18	\$80.93	\$87.67	\$94.42	\$101.16	\$107.90	\$114.65	\$121.39	\$128.14	\$134.88
70-74*	\$57.53	\$62.76	\$67.99	\$73.22	\$78.45	\$83.68	\$88.91	\$94.14	\$99.37	\$104.60
75-79*	\$68.64	\$74.88	\$81.12	\$87.36	\$93.60	\$99.84	\$106.08	\$112.32	\$118.56	\$124.80
80+*	\$34.32	\$37.44	\$40.56	\$43.68	\$46.80	\$49.92	\$53.04	\$56.16	\$59.28	\$62.40

*Premiums are based on age reductions. Benefits reduce by 35% at age 70, 50% at age 75, and 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 (\$4.56) plus the premium for \$200,000 (\$9.12) and your premium would be \$13.68 per pay check for \$300,000 of Life and AD&D.

Spouse/Domestic Partner Life Insurance

Spouse/Domestic Partner Supplemental Life Insurance is available in units of \$5,000 to a maximum of \$250,000, but not to exceed 100% of the employee's Supplemental Insurance coverage. **Employees must have elected Supplemental Life Insurance for themselves in an amount equal to or greater than the amount elected for their spouse/domestic partner.**

Employees must have elected Supplemental Life Insurance for themselves in order to enroll in Child Life.

NOTE: A benefit eligible employee cannot also be covered as a dependent of another TUSD employee.

Supplemental Life Insurance Premiums (cont'd)

MINNESOTA LIFE

Spouse Supplemental Life and AD&D - Costs Per 20 Benefits Deductions

Age	\$5,000	\$10,000	\$15,000	\$20,000	\$25,000	\$30,000	\$35,000	\$40,000	\$45,000	\$50,000
<30	\$0.17	\$0.34	\$0.51	\$0.68	\$0.86	\$1.03	\$1.20	\$1.37	\$1.54	\$1.71
30-34	\$0.21	\$0.42	\$0.63	\$0.84	\$1.05	\$1.26	\$1.47	\$1.68	\$1.89	\$2.10
35-39	\$0.23	\$0.46	\$0.68	\$0.91	\$1.14	\$1.37	\$1.60	\$1.82	\$2.05	\$2.28
40-44	\$0.30	\$0.61	\$0.91	\$1.21	\$1.52	\$1.82	\$2.12	\$2.42	\$2.73	\$3.03
45-49	\$0.45	\$0.90	\$1.35	\$1.80	\$2.25	\$2.70	\$3.15	\$3.60	\$4.05	\$4.50
50-54	\$0.71	\$1.42	\$2.13	\$2.84	\$3.56	\$4.27	\$4.98	\$5.69	\$6.40	\$7.11
55-59	\$1.23	\$2.47	\$3.70	\$4.93	\$6.17	\$7.40	\$8.63	\$9.86	\$11.10	\$12.33
60-64	\$1.38	\$2.76	\$4.14	\$5.52	\$6.90	\$8.28	\$9.66	\$11.04	\$12.42	\$13.80
65-69	\$3.37	\$6.74	\$10.12	\$13.49	\$16.86	\$20.23	\$23.60	\$26.98	\$30.35	\$33.72
70-74*	\$2.61	\$5.23	\$7.84	\$10.46	\$13.07	\$15.69	\$18.30	\$20.92	\$23.53	\$26.15
75-79*	\$3.12	\$6.24	\$9.36	\$12.48	\$15.60	\$18.72	\$21.84	\$24.96	\$28.08	\$31.20
80+*	\$1.56	\$3.12	\$4.68	\$6.24	\$7.80	\$9.36	\$10.92	\$12.48	\$14.04	\$15.60

*Premiums are based on age reductions. Benefits reduce by 35% at age 70, 50% at age 75, and 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 (\$2.28) plus the premium for \$25,000 (\$1.14) and your premium would be \$3.43 per pay check for \$75,000 of Life and AD&D.

Child Life and AD&D - Costs Per 20 Benefits Deductions

Child(ren) Life and AD&D Benefit Options - Cost per 20 Benefits Deductions

Option	Cost
\$1,000	\$0.07
\$5,000	\$0.36
\$10,000	\$0.72

NOTE: Rounding may occur once placed into the TUSD benefits/payroll system.

When will my life insurance go into effect?

Please refer to the Minnesota Life Supplemental Life Employee Brochure available during the Open Enrollment meetings or on the TUSD Benefits intranet site for more information regarding the following requirements that must be satisfied for the life insurance to become effective.

A Personal Health Application (PHA) New hire employees must complete a Personal Health Application (Evidence of Insurability) if requesting Supplemental Employee Life insurance that exceeds the guaranteed issue of the lesser of \$250,000 or three times their annual salary and if requesting Supplemental Spouse Life insurance that exceeds the guarantee issue of \$25,000. If you previously waived coverage or are looking to increase coverage, you must complete the Personal Health Application. Coverage that requires a Personal Health Application will not become effective until the later of or the 1st of the following month following the date Minnesota Life approves the application.

If a Personal Health Application is required, the Benefits staff will notify Minnesota Life, who will then contact you.

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.

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 within 31 days of your coverage terminating, depending on your situation. If you are applying for Long Term Disability, you may qualify for a Waiver of Premium. Contact the Benefits Office at (520) 225-6144 or benefits@tusd1.org for detailed information.



Critical Illness Insurance

Critical Illness Insurance complements your medical and disability income coverage and can ease the financial impact of a critical illness by providing a lump-sum benefit to help you pay some of your additional expenses. Thanks to advancements in modern medicine, chances of recovery from a critical illness like a heart attack, cancer, or stroke have greatly improved.

Living with a critical illness may affect your financial security and that of your family. Despite having good medical insurance, there are still expenses associated with a critical illness that many medical plans are not designed to pay. Think about such expenses as co-pays, deductibles, out-of-pocket network treatments, prescription drug co-pays, childcare, mortgage, and utility payments. Also, if you are out of work on disability, your income will be less than you make when you are at work. MetLife Critical Illness Insurance can help keep your finances on track if you experience a covered condition.

➤ What is MetLife Critical Illness Insurance?

MetLife Critical Illness Insurance provides you with a lump-sum benefit payment of \$10,000 in the event a covered family member¹ experiences one of the medical conditions (as they are defined by the group Certificate) in three distinct categories and meet the Policy and Certificate Requirements:

- Category 1 incorporates certain cancer-related conditions²
 - Full Benefit Cancer
 - Partial Benefit Cancer³
 - Bone Marrow Transplant
- Category 2 incorporates certain heart-related conditions
 - Heart Attack
 - Heart Transplant
 - Stroke⁴
 - Coronary Artery Bypass Graft³
- Category 3 incorporates certain other covered conditions
 - Major Organ Transplant (other than bone marrow and heart)
 - Kidney Failure

➤ 5 year age banded rates:

COST PER PAY PERIOD (20 DEDUCTION DATES USING THE BENEFITS DEDUCTION SCHEDULE)														
AGE =	<25	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75-79	80-84	85+
Employee	\$0.66	\$0.78	\$1.32	\$2.22	\$3.96	\$6.84	\$10.68	\$16.20	\$23.88	\$35.52	\$51.96	\$75.48	\$96.54	\$104.58
Spouse/ Domestic Partner	\$0.66	\$0.72	\$1.20	\$2.22	\$3.96	\$7.02	\$11.70	\$18.78	\$29.22	\$45.18	\$64.98	\$90.06	\$111.24	\$118.68
Child(ren)	\$0.42													

➤ Critical Illness Insurance Features

Enhanced coverage to traditional medical plans, consumer-driven health plans, and disability income coverage

A lump-sum benefit payment to use as you see fit

- Dependent coverage for your spouse/domestic partner and children
- No obligation to submit expense receipts
- Coverage that can go with you if you leave your employer under certain circumstances

➤ **Use lump-sum payment as you see fit**

MetLife's Critical Illness Insurance pays a lump-sum benefit payment you can use to help bridge the financial gap between what your existing medical insurance covers and the additional expense associated with certain critical illnesses. The payment can be used at the discretion of the insured to help pay for such things as:

- Medical co-pays and deductibles
- Prescription drug co-pays
- Mortgage and rent payments
- Utility payments and other household bills
- Out-of-network treatments
- Childcare bills
- Car payments
- Travel to treatment centers

➤ **Can you explain how the *Category Benefit Payments* work?**

You enroll for a Category Benefit Amount of \$10,000. If you are diagnosed with a Covered Condition in any of the three categories (cancer, heart and other), and meet the policy and certificate requirements, you will receive a lump-sum benefit payment. The lump-sum benefit payment you will receive works like this:

- 1) For Coronary Artery Bypass Graft and Partial Benefit Cancer, you will receive 25% of the Category Benefit Amount. The remaining 75% will be available should you experience another Covered Condition within the same category.
- 2) For all Covered Conditions, other than Coronary Artery Bypass Graft and Partial Benefit Cancer, you will receive 100% of the Category Benefit Amount (unless you have already received a partial benefit payment for a Covered Condition in the same category, in which case you would receive the remaining 75% of the Category Benefit Amount.
- 3) After 100% of a Category Benefit Amount has been paid, that category will close and you will not receive any additional payments within that category.

- MetLife Critical Illness Insurance does not replace your current medical insurance; rather it provides a lump-sum benefit payment if you experience certain covered conditions.

If you would like to know more about Group Critical Illness Insurance or have specific questions about your coverage and options, please contact **1 800 GET-MET 8** (1-800-438-6388), * Coverage for domestic partners, civil union partners and reciprocal beneficiaries varies by state. Please contact MetLife for more information.

MetLife Critical Illness Insurance (CII) is a limited group policy. Like most group accident and health insurance policies, MetLife's CII policies contain certain exclusions, limitations and terms for keeping them in force. Product features and availability vary by state. In most states, there is a 30 to 90 day waiting period after the effective date of coverage and preexisting condition exclusion. In some states there is a benefit suspension period between covered conditions in different categories or a limit on the total benefit payments per calendar year. A more detailed description of the benefits, limitations, and exclusions applicable to you can be found in the Disclosure Statement or Outline of Coverage/Disclosure Document available at the time of enrollment. Please contact MetLife for more information.

TUSD 2014-2015 - Authorization for HSA Deduction-Employee

Instructions:

- TUSD will contribute \$75.00 for each of the Benefits Deduction Schedule (20 pays) for full-time employees enrolled in the High Deductible Health Plan (HDHP) employee only coverage. The contribution for full-time employees enrolled in HDHP employee and dependent coverage will be \$100.00.
- Any amount you authorize on this form is in **ADDITION** to the District contribution to your HSA.
- You may authorize either a one-time transaction or a periodic payroll deduction.
- You **must** be enrolled in the High Deductible Health Plan (HDHP) with the Tucson Unified School District in order to contribute to the HSA account.
- Your deduction will begin on the payroll following your submission of this form in accordance with payroll processing schedules for Benefits.
- Keep a copy of this form for your files.
- Submit the completed form to the TUSD Benefits Office (mail, in person, or fax to (520) 225-6181).

☐ **NEW DEDUCTION** ☐ **CHANGE AMOUNT** ☐ **CANCEL DEDUCTION**

Account Holder Information:

Name: (Print) Last First MI Employee ID# Date of Birth

Street Address City State Zip

() - () -
Daytime Phone Number Evening Phone Number Email Address

Payroll Deduction

Please check the following that applies:

☐ **Lump Sum:** I wish to authorize a **one time** contribution to my HSA in the amount of \$_____

☐ **Periodic Deduction:** I wish to authorize a bi-weekly contribution to my HSA in the amount of \$_____

I hereby authorize the Tucson Unified School District to deduct the amount(s) above from my pay and remit such amount(s) for deposit into my HSA. I understand that the timing of deductions will be established by the Tucson Unified School District. If I have authorized periodic deductions, I may terminate that authorization on at least one month's prior written notice to the Benefits office. I understand that all deductions made within the calendar year will be reported for that calendar tax year. I understand it is my responsibility to review the IRS tax rules and how they may affect me. I understand that Wells Fargo will deduct \$3.00 from my account on a monthly basis until I reach a balance of \$5000. I understand that this authorization is only in effect during the Benefits Plan year of my enrollment.

Signature

Print Name

Date

Please note: 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.

After completing benefit selections, the employee is responsible for making a copy of this form. Please retain the copy for your records.

BEN1200-14

Benefits | Tucson Unified School District
1010 E. 10th St., Tucson, AZ 85719 | Phone (520) 225-6144 | Fax (520) 225-6181

Revised: 06/20/14
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