2022 -2023 BENEFITS

BENEFITS FOR EVERY STEP OF THE WAY

10/01/2022 – 09/30/2023

Fullerton School District
Personnel Services

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IMPORTANT PLAN INFORMATION

MEDICARE PART D NOTICE

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a federal law gives you more choices about your prescription drug coverage. Please see the *Important Plan Information* section for more details.

The information in this guide is a general outline of the benefits offered under Fullerton School District benefits program. Specific plan details, eligibility definitions, limitations and exclusions are provided in the plan documents, such as the Summary of Benefits and Coverage (SBC), Evidence of Coverage (EOC), Certificate and/or insurance Policies. The plan documents contain the relevant plan provisions. If the information in this guide differs from the plan documents, the plan documents will prevail.

WELCOME TO YOUR BENEFITS GUIDE

2022-2023 BENEFITS

The benefits in this guide are effective October 1, 2022 through September 30, 2023

At Fullerton School District, we value your contributions to our success and want to provide you with a benefits package that protects your health and helps your financial security, now and in the future. This guide provides an overview of your healthcare coverage, life, voluntary benefits, and more.

You'll find tips to help you understand your medical coverage, save time and money on healthcare, reduce taxes, and balance your work and home life.

Review the coverage and tools available to you to make the most of your benefits package.

Who's Eligible for Benefits?

Dependent Verification

Adding dependents is subject to eligibility verification in order to ensure only eligible individuals are participating in our plans. You will be required to provide proof of one or more of the following within 31 days of their eligibility:

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

If you do not supply the proper documentation to add dependents within 31 day period, you will not be able to add the dependent(s) until the next open enrollment period. **Verification of Dependent Eligibility form** found online https://www.fullertonsd.org.

Employees

You are eligible if you are working 50% or more (4 hours for Classified employees).

Eligible dependents

- Legally married spouse or registered domestic partner.
- Your children (including your domestic partner's children) up to age 26.
- Children over age 26 who are disabled and depend on you for support.
- Children named in a Qualified Medical Child Support Order (QMCSO).

Who is not eligible

Family members who are not eligible for coverage include (but are not limited to):

- Parents, grandparents, and siblings.

For additional information, please refer to the plan document for each benefit.

Please note that unless your domestic partner is your tax dependent as defined by the IRS, contributions for domestic partner coverage must be made after-tax. Similarly, the company contribution toward coverage for your domestic partner and his/her dependents will be reported as taxable income on your W-2. Contact your tax advisor for more details on how this tax treatment applies to you. Notify Fullerton School District if your domestic partner is your tax dependent.

Enrolling for Benefits

When can you enroll

Open enrollment is an annual opportunity during which employees can make changes to their benefit elections without a qualifying life event. Life events include (but are not limited to):

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

Changes must be submitted to Insurance Benefits within 31 days of the life event. An employee may be held responsible for substantial charges if services are provided for a person who is found to be ineligible.

Employees with Dual Coverage

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

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

Eligible New Hires

All employees who work 90% or more (7.20 or more hours per day) of the full-time equivalent for the applicable job classification are required to be enrolled as a subscriber in a SISC medical plan offered by the district or WABE.

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

You must complete and return the enrollment forms and dependent verification documentation to Insurance Benefits within 31 days from the date of hire. **Benefit forms are available online at www.fullertonsd.org, under Departments, Human Resources Division, Benefits.**

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

Waiver of Anchor Bronze Enrollment (WABE Option)

To comply with the Self-Insured Schools of California (SISC) participation requirements, employees who prefer to decline SISC medical coverage may elect this option in place of a SISC medical plan. Employees who select this option are not enrolled in a medical/Rx plan. If you elect the WABE option, you will not be able to enroll until the next open enrollment period or as the result of a qualifying event.

Employees taking this option have access to the following SISC Added Value services:

- 24/7 Physician Line (MDLive)
- Employee Assistance Program—EAP (Anthem Blue Cross)
- Expert Medical Opinions (Teladoc Medical Experts)

Changing Your Benefits

LIFE HAPPENS

A change in your life may allow you to update your benefit choices.

Three rules apply to making changes to your benefits during the year:

1. Any change you make must be consistent with the change in status;
2. You must notify Insurance Benefits within 31 days of the date the event occurs; and
3. All proper documentation is required to cover dependents (marriage certificates, birth certificates, etc.)

Outside of open enrollment, you may be able to enroll or make changes to your benefit elections if you have a qualifying life event or qualify for "special enrollment." If you qualify for a mid-year benefit change, you will be required to submit proof of the change.

The following are considered qualifying life events[1]:

- Change in legal marital status
- Change in number of dependents or dependent eligibility status
- Change in employment status that affects eligibility for you, your spouse, or dependent child(ren)
- Change in residence that affects access to network providers
- Change in your health coverage or your spouse's coverage due to your spouse's employment
- Change in an individual's eligibility for Medicare or Medicaid
- Court order requiring coverage for your child
- "Special enrollment event" under the Health Insurance Portability and Accountability Act (HIPAA), including a new dependent by marriage, birth or adoption, or loss of coverage under another health insurance plan
- Event allowed under the Children's Health Insurance Program (CHIP) Reauthorization Act (you have 60 days to request enrollment due to events allowed under CHIP)

You must submit your change within 31 days after the event.

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

MEDICAL

OUR PLANS

Kaiser Permanente HMOs

Blue Shield TRIO HMO

Blue Shield Full Network HMOs

Blue Shield PPO

Blue Shield High Deductible PPO/ HSA

Blue Shield Anchor Bronze High Deductible PPO/HSA

WHICH PLAN IS RIGHT FOR YOU?

That depends on your healthcare needs, favorite doctors, and budget. Here are some considerations.

Do you prefer specific doctors or hospitals?

If you want to stay with your favorite doctors and facilities, check whether they are in the plan's network. If they are not, but you are comfortable paying a bit more to see them, consider a plan with both in-network and out-of-network benefits.

What are your usual healthcare needs?

Do you have frequent doctor or urgent care visits? Do you have a condition that requires a specialist? Do you take prescription medications? Compare how each plan covers the services you need most often.

Consider the bottom line

How much is the monthly payroll deduction? Do you have to meet a deductible? What is the out-of-pocket maximum? How much of the cost is covered by the plan? How much are any copayments for office visits, prescriptions, etc. All of these factors together affect your total cost for healthcare.

Kaiser Medical HMO 15

Benefits	Member Copayments
Calendar Year Deductible	None
Out-of-pocket Maximum	$1,500 individual; $3,000 family
Office Visit	$15 copay (same for specialist)
Preventive Services	No charge
Diagnostic Lab and X-ray	No charge
Advanced Imaging	No charge
Inpatient Hospitalization	No charge
Physician Service	No charge
Outpatient Facility Services	
Surgery	$15 copay per procedure
Urgent Care	$15 copay per visit
Emergency Room (copay waived if admitted)	$100 copay per visit
Ambulance Services	$50 copay per trip
Durable Medical Equipment	No charge
Medically Necessary Acupuncture & Chiropractic Care[1]	$10 copay per visit (up to 30 combined visits per year)

Prescription Drug Coverage	Pharmacy	Mail Order	Supply Limit
Generic	$15 copay	$15 copay	100 days
Brand-name	$15 copay	$15 copay	100 days
Specialty	$15 copay	N/A	30 days

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

This plan is available only in certain California counties and cities ("Service Area") as described in the Evidence of Coverage. You must live and/or work in this select Service Area in order to enroll in this plan.

Find a Primary Care Physician by visiting www.kp.org or call member services.

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

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

Kaiser Medical HMO 30

Benefits	Member Copayments
Calendar Year Deductible	None
Out-of-pocket Maximum	$1,500 individual; $3,000 family
Office Visit	$30 copay (same for specialist)
Preventive Services	No charge
Diagnostic Lab and X-ray	No charge
Advanced Imaging	No charge
Inpatient Hospitalization	No charge
Physician Service	No charge
Outpatient Facility Services	
Surgery	$30 copay per procedure
Urgent Care	$30 copay per visit
Emergency Room (copay waived if admitted)	$100 copay per visit
Ambulance Services	$50 copay per trip
Durable Medical Equipment	No charge
Medically Necessary Acupuncture & Chiropractic Care[1]	$10 copay per visit (up to 30 combined visits per year)

Prescription Drug Coverage	Pharmacy	Mail Order	Supply Limit
Generic	$10 copay	$10 copay	100 days
Brand-name	$30 copay	$30 copay	100 days
Specialty	$30 copay	N/A	30 days

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

This plan is available only in certain California counties and cities ("Service Area") as described in the Evidence of Coverage. You must live and/or work in this select Service Area in order to enroll in this plan.

Find a Primary Care Physician by visiting www.kp.org or call member services.

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

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

Blue Shield Medical TRIO HMO

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

HMO Network: TRIO ACO HMO	Member Copayments
Calendar Year Deductible	None
Out-of-Pocket Maximum	$1,500 individual; $3,000 family
Office Visit	$30 copay per visit
Trio + Self-Referral	$45 copay per visit
MDLive[1]	No charge
Preventive Services	No charge
Diagnostic Lab and X-ray	No charge
Advanced Imaging	No charge
Inpatient Hospitalization (preauthorization required)	20% copay per admit
Physician Service	No charge
Outpatient Facility Services	
Surgery	No charge
Urgent Care[2]	$30 copay per visit
Emergency Room (copay waived if admitted)	$150 copay per visit
Ambulance Services	$100 copay per visit
Durable Medical Equipment	20% coinsurance
Acupuncture & Chiropractic Care (up to 30 combined visits per year)	$10 copay per visit
Prescription Drug Coverage[3]	**RX Copayments**
Brand and Specialty Drug Deductible:	$200 individual; $500 family
Generic Network Pharmacy Costco Pharmacy Costco Mail Order	 $10 copay $0 copay $0 copay
Brand Network Pharmacy Costco Pharmacy Costco Mail Order	 $35 copay after deductible $35 copay after deductible $90 copay after deductible
Specialty – Navitus Mail Order	$35 copay after deductible
Supply Limit	Members may receive up to 30 days and/or up to 90 days supply of medication at participating pharmacies

[1]Virtual access to providers and therapists.

[2]Urgent services Inside the Personal Physician's Service Area and rendered or referred by the Personal Physician or Personal Physician's Medical Group/IPA.

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

Blue Shield Medical Full Network HMOs

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

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

[1]If your PCP participates in our Access+ Specialist program, you may go directly to a specialist in your PCP's medical group or IPA without a referral for a higher copayment.

[2]Virtual access to providers and therapists.

[3]Urgent services Inside the Personal Physician's Service Area and rendered or referred by the Personal Physician or Personal Physician's Medical Group/IPA.

[4]Pharmacy Benefits are administered by Navitus Health Solutions.

Blue Shield Medical PPO

	Member pays	
Benefits	**In-Network**	**Out-of-Network[1]**
Calendar Year Deductible	$100 individual; $300 family	
Out-of-pocket Maximum	$1,000 individual; $3,000 family	
Office Visit	$0 copay for the first three visits then $20 copay (deductible waived) (same for specialist)	50% coinsurance after deductible (same for specialist)
MDLive[2]	No charge	Not applicable
Preventive Services	No charge	Not covered
Diagnostic Lab and X-ray	10% coinsurance after deductible	Not covered
Advanced Imaging	10% coinsurance after deductible	Not covered
Inpatient Hospitalization (preauthorization required)	10% coinsurance after deductible	0% coinsurance after deductible with $600/day max
Physician Service	10% coinsurance after deductible	Not covered
Outpatient Facility Services		
Surgery in an Ambulatory Surgery Center	10% coinsurance after deductible	0% coinsurance after deductible with $350/day max
Urgent Care	$20 copay	50% coinsurance after deductible
Emergency Room (copay waived if admitted)	$100 copay per visit + 10% coinsurance after deductible	
Ambulance Services	$100 copay + 10% coinsurance after deductible	
Durable Medical Equipment	10% coinsurance after deductible	Not covered
Acupuncture (up to 12 visits per year)	10% coinsurance after deductible	50% coinsurance after deductible
Chiropractic Care (up to 20 visits per year)	10% coinsurance after deductible	Not covered
Prescription Drug Coverage[3]		
Brand and Specialty Drug Deductible:	$200 individual; $500 family	
Generic Network Pharmacy Costco Pharmacy Costco Mail Order	 $10 copay $0 copay $0 copay	
Brand Network Pharmacy Costco Pharmacy Costco Mail Order	 $35 copay after deductible $35 copay after deductible $90 copay after deductible	
Specialty – Navitus Mail Order	$35 copay after deductible	
Supply Limit	Members mays receive up to 30 days and/or up to 90 days supply of medication at participating pharmacies.	

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

[2]Virtual access to providers and therapists.

[3]Pharmacy Benefits are administered by Navitus Health Solutions.

Blue Shield Medical High Deductible PPO/HSA

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

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

[2]Virtual access to providers and therapists.

[3]Up to a max combined benefit of $700 per pair every 24 months for the hearing aid and ancillary equipment.

[4]Pharmacy Benefits are administered by Navitus Health Solutions.

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

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

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

HOW THE PLAN WORKS

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

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

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

To file a claim visit www.voya.com

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

Blue Shield Medical Anchor Bronze PPO (HDHP/HSA)

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

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

[2]Virtual access to providers and therapists.

[3]Up to a max combined benefit of $700 per pair every 24 months for the hearing aid and ancillary equipment.

[4]Pharmacy Benefits are administered by Navitus Health Solutions.

Health Savings Account (HSA)

A personal savings account for healthcare

An Health Savings Account (HSA) is an easy way to pay for healthcare expenses that you have today, and save for expenses you may have in the future. You contribute pre-tax money to your account to save for out-of-pocket healthcare expenses. Plus, any money that you don't spend grows year after year and can be used in the future, even after you retire. Please contact Sterling Administration if you have questions/or want to open an HSA.

Are you eligible?

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

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

HSA benefits

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

Qualified expenses

Qualified medical expense are defined in Internal Revenue Code Section 213 [d]. In general they include specified deductibles, co-payments, and other medical expenses not covered under the HDHP or in any other manner. All HSA enrollees will be subject to the plan design and mid-year changes based on Federal/Legislative guidelines. For additional resources on HSA plans, visit www.irs.gov.

REMINDER: You cannot include medical expenses amounts for which you are fully reimbursed by your Flexible Spending Account (FSA).

HSA IRS contributions limits

You can contribute up to the annual limit set by the IRS. **Please see the cost of coverage page for District HSA contributions. You are responsible for ensuring you do not exceed the limit.**

Your HSA account will be credited with the amount you elect to have withheld from your paycheck. For more information contact Sterling Administration member services: www.sterlingadministration.com

HDHP Coverage	Calendar Year 2022	Calendar Year 2023
Self-only limit	$3,650	$3,850
Family limit	$7,300	$7,750
"Catch-up" contribution limit	If you are 55 or older you can make additional "catch-up" contribution up to $1,000 per year.	

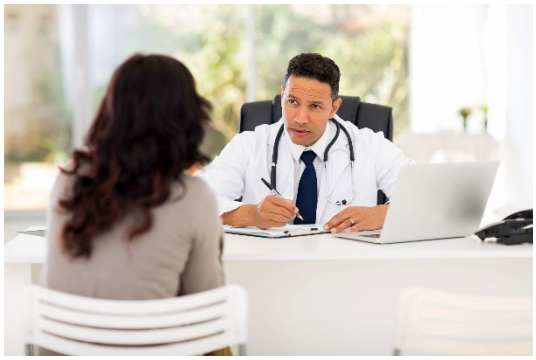
Life event change

When increasing or decreasing coverage level during the plan year, the Health Savings Account contribution is adjusted based on the effective date of the change in coverage level. The contribution (difference between lower tier and higher tier) is available to pay for claims incurred after the effective date of the new coverage level. The deductible and out-of-pocket maximum will also change based on coverage selected. Any deductible/out-of-pocket maximum amounts will move with the individual to the new coverage level.

Non-qualified expenses

If you use HSA funds for non-qualified expenses before you are age 65, you will owe a 20% penalty tax PLUS income tax on the withdrawal. After age 65, if you use HSA funds for non-qualified expenses, you will owe income tax only.

Preventive Care Screening Benefits



TYPICAL SCREENINGS FOR ADULTS

- Blood pressure
- Cholesterol
- Diabetes
- Colorectal cancer screening
- Depression
- Mammograms
- OB/GYN screenings
- Prostate cancer screening
- Testicular exam

You take your car in for maintenance. Why not do the same for yourself?

Annual preventive checkups can help you and your doctor identify your baseline level of health and detect issues before they become serious.

What is Preventive Care?

The Affordable Care Act (ACA) requires health insurers to cover a set of preventive services at no cost to you, even if you haven't met your yearly deductible. The preventive care services you'll need to stay healthy vary by age, sex, and medical history.

Visit cdc.gov/prevention for recommended guidelines.

Preventive care is covered in full only when obtained from an IN-NETWORK provider.

Not all exams and tests are considered preventive

Exams performed by specialists are generally not considered preventive and may not be covered at 100 percent.

Additionally, certain screenings may be considered diagnostic, not preventive, based on your current medical condition. You may be responsible for paying all or a share of the cost for those services.

If you have a question about whether a service will be covered as preventive care, contact your medical plan.

Know Where to Go

Where you get medical care can have a significant impact on the cost. Here's a quick guide to help you know where to go, based on your condition, budget, and time.

Type	Appropriate for	Examples	Access	Cost
Nurse Line 	Quick answers from a trained nurse	• Identifying symptoms • Decide if immediate care is needed • Home treatment options and advice	24/7	$0
Online visit 	Many non-emergency health conditions	• Cold, flu, allergies • Headache, migraine • Skin conditions, rashes • Minor injuries • Mental health concerns	24/7	$
Office visit 	Routine medical care and overall health management	• Preventive care • Illnesses, injuries • Managing existing conditions	Office Hours	$$
Urgent care, walk-in clinic 	Non-life-threatening conditions requiring prompt attention	• Stitches • Sprains • Animal bites • Ear-nose-throat infections	Office Hours, or up to 24/7	$$$
Emergency room 	Life-threatening conditions requiring immediate medical expertise	• Suspected heart attack or • Stroke • Major bone breaks • Excessive bleeding • Severe pain • Difficulty breathing	24/7	$$$$$

SISC Programs and Services

EMPLOYEE ASSISTANCE PROGRAM (EAP)

The Employee Assistance Program (EAP) provides you and eligible family members with no-cost, confidential and user-friendly resources for life management concerns.

EAP can help you with things like stress, anxiety, depression, chemical dependency, relationship issues, legal issues, parenting questions, financial counseling, and dependent care resources.

If you need counseling, EAP includes telephone consultations and face-to-face counseling visits. To access resources and services visit www.anthemEAP.com; Company Code SISC.

The program is available to all District employees.

EAP EMOTIONAL WELL-BEING RESOURCES

The Employee Assistance Program (EAP) provides emotional well-being resources. Learn how to develop resilience, reduce stress, and practice mindfulness at no cost to you. Visit www.anthemEAP.com, enter company code SISC, click on Emotional Well-Being Resources to take a quick assessment and choose the Learn to Live program that's right for you.

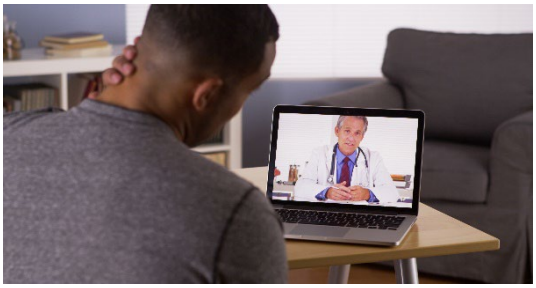
TELADOC MEDICAL EXPERTS

Use Teladoc Expert Medical Opinion when you or your eligible dependents:

- Are unsure about a diagnosis or need help choosing treatment
- Have medical questions or concerns
- Need help finding a specialist
- Have been admitted to the hospital and want expert guidance

This program is sponsored by SISC and available at no cost to all eligible employees and covered dependents. In-person visits/services will be subject to member's plan benefits.

To learn more visit www.teladoc.com/sisc.



SISC Blue Shield Programs

MAVEN

Maven is a value added benefit for SISC PPO members. Maven offers 24/7 virtual access to one-on-one maternity and postpartum support. Eligible SISC PPO members are matched with a Care Advocate who connects them to trustworthy maternity and postpartum content.

Free 6- month diaper subscription for SISC PPO members who:

- Enroll during their first or second trimester
- Have an intro call with a Care Advocate
- Have two appointments with Maven providers during pregnancy
- Complete the exit survey when their baby is born

Enrollment is confidential and will not be shared with your employer.

To activate your membership visit mavenclinic.com/join/SISC.

MDLIVE - TELEHEALTH

Get 24/7 physician access anytime and anywhere with MDLive. Consult with doctors and pediatricians over the phone or using online video for medical conditions such as cold, fever, sore throat, flu, infection, rash, and children's health issues. Physicians can prescribe medication when appropriate. Online behavioral health visits are also available.

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

VIDA HEALTH

Digital Health Coaching App

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

COSTCO GENERIC PRESCRIPTIONS

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

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

To find a Costco location visit www.costco.com.

NAVITUS: SPECIALTY MEDICATIONS

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

CONDITION MANAGEMENT

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

- Diabetes
- Coronary artery disease (CAD)

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

HINGE HEALTH

PPO members have access to Hinge Health at no cost. The program provides personalized, interactive physical therapy using the latest technology to help members conquer pain and recover from injuries. Best of all, it can be done at home.

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

Visit hingehealth.com/sisc to learn more.

VALUE-BASED SITE OF CARE BENEFIT

Hospitals and Ambulatory Surgery Centers (ASCs)

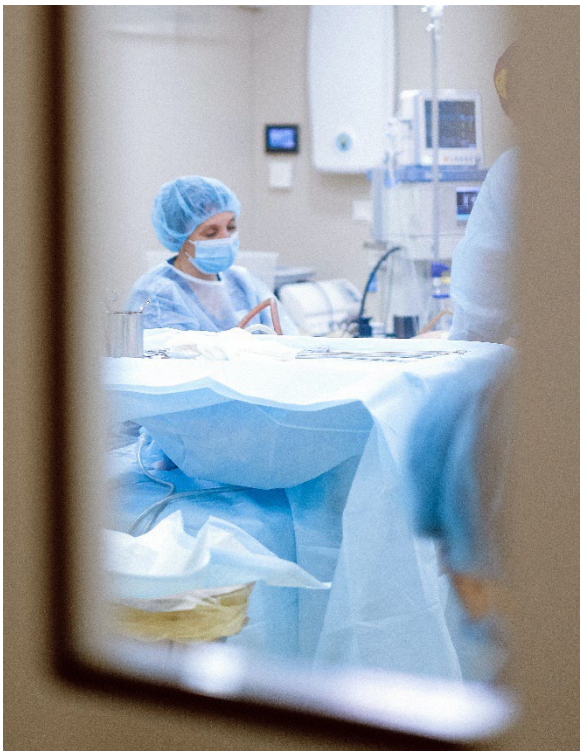
PPO plans limit the maximum benefit amount at an in-network outpatient hospital facility for the following **five** procedures:

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

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

If you use an in-network outpatient hospital facility, you will be responsible for the regular deductible and coinsurance PLUS any amount by which the hospital charge exceeds the maximum benefit. If you use an in-network ASC, you will only be responsible for the regular deductible and coinsurance.

The benefit includes an exemption process. To learn more call member services.



CARRUM HEALTH PROGRAM

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

Covered procedures:

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

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

ENHANCED CANCER BENEFIT

Oncology Center of Excellence Program

PPO members can consult experts who can help you navigate the complex world of cancer treatment. Services include assistance in receiving an accurate initial diagnosis and developing a comprehensive care plan. To learn more go to sisc.contigohealth.com .

Blue Shield Member Programs

WELLNESS DISCOUNT PROGRAMS

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

FITNESS YOUR WAY

Fitness Your Way gives you access to online classes, fitness programs and thousands of participating gyms nationwide and in your area with just one membership. To learn more visit myoptions.blueshieldca.com/sisc.

AWAY FROM HOME CARE PROGRAM

The Away From Home Care® program gives HMO members who are students, long-term travelers, workers on extended out-of-state assignments, and families living apart the convenience and flexibility of coverage for extended periods across the country.

To learn more about Away From Home Care and whether your family is eligible, please call member services. Please note that Away From Home Care is not available in all areas and states, and benefits from the host plan may differ from the benefits in the HMO plan.

BLUECARD OUT OF STATE

Provides you and your eligible family access to covered services, when you are traveling or working outside of California. BlueCard is not applicable to HMO plans or Medicare Supplement plans.

To learn more call member services.

CARE MANAGEMENT FROM SHIELD SUPPORT

With Care Management, you've got a team of nurses, health coaches, and other specialists by your side. They're there to give support, answer questions, and provide expert help – all at no additional cost to you. Care Management can support a number of conditions and illnesses.

Visit myoptions.blueshieldca.com/sisc to learn more.

DENTAL

OUR PLANS

DeltaCare USA DHMO

Delta Dental PPO

Why sign up for dental coverage?

It's important to go to the dentist regularly. Brushing and flossing are great, but regular exams catch dental issues early before they become more expensive and difficult to treat.

That's where dental insurance comes in. Dental insurance makes it easier and less expensive to get the care you need to maintain good oral health.

Dental insurance covers five types of treatments:

- **Preventive** care includes exams, cleanings and x-rays
- **Basic** care focuses on repair and restoration with services such as fillings, root canals, and gum disease treatment
- **Major** care goes further than basic and includes bridges, crowns and dentures
- **Prosthodontics** focus on dental prostheses
- **Orthodontia** treatment to properly align teeth within the mouth

Dental Plans – PPO or DHMO

DeltaCare® USA DHMO Plan

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

Delta Dental PPO Plan

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

	Delta PPO[1,2]		DeltaCare USA DHMO
	In-Network	**Out-Of-Network**	**In-Network**
Calendar Year Deductible (waived for Diagnostic/Preventive Orthodontics)	$25 individual; $75 family		None
Annual Plan Maximum	**Delta Dental PPO dentists:** $2,500 per person each calendar year **Non-Delta Dental PPO dentists:** $2,000 per person each calendar year		Not applicable
Diagnostic & Preventive Services	You pay 20%		Copays vary by service; see contract for fee schedule
Basic Services	You pay 20%		Copays vary by service; see contract for fee schedule
Major Services	You pay 50%		Copays vary by service; see contract for fee schedule
Orthodontic Services Orthodontic Lifetime Maximum (adults and children)	50% up to $1,000		Copays vary by service; see contract for fee schedule

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

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

VISION

OUR PLAN

VSP Choice

When you have an appointment, tell them you have VSP. There's no ID card necessary. If you'd like a card as a reference, you can print one on www.vsp.com.

To find a Provider visit www.vsp.com or call member services.

Why sign up for vision coverage?

Vision coverage helps with the cost of eyeglasses or contacts. But even if you don't need vision correction, an annual eye exam checks the health of your eyes and can even detect more serious health issues such as diabetes, high blood pressure, high cholesterol, and thyroid disease.

Important:

VSP vision coverage is for Blue Shield members and is a voluntary supplemental add-on coverage for Kaiser members.

VSP Special Offers

Log in at www.vsp.com and select discounts for special offers program.

Vision – VSP Choice

	VSP Provider Network: VSP Choice	
	In-Network Copayments	**Out-Of-Network[1] Reimbursements**
WellVision Exam	$25 copay for exam and glasses	Plan reimburses up to $45
Frequency	1 x every 12 months	In-network limitations apply
Lenses		
Single Vision Lens	Combined with exam	Plan reimburses up to $30
Bifocal Lens	Combined with exam	Plan reimburses up to $50
Trifocal Lens	Combined with exam	Plan reimburses up to $65
Progressive Lens	Combined with exam	Plan reimburses up to $81
Frequency	1 x every 12 months	In-network limitations apply
Frames[2]		
Benefit copay combined with exam	Plan pays up to $150 allowance Plan pays up to $170 allowance for Featured Frame Brands 20% savings on the amount over your allowance Plan pays up to $80 allowance for Costco frames	Plan reimburses up to $70
Frequency	1 x every 24 months	In-network limitations apply
Contacts[3] (Elective)		
Benefit (fitting & evaluation)	Plan pays up to $105 allowance, then 15% off any remaining balance	Plan reimburses up to $105
Frequency	1 x every 12 months	In-network limitations apply

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

LIFE INSURANCE

YOUR BENEFICIARY = WHO GETS PAID

If the worst happens, your beneficiary—the person (or people) on record with the life insurance carrier—receives the benefit. Make sure that you name at least one beneficiary for your life insurance benefit, and change your beneficiary as needed if your situation changes.

Employer Paid Life and AD&D Insurance

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

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

Employer Paid Life and AD&D Insurance

EMPLOYER PAID LIFE AND AD&D

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

Important Reminders

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

EMPLOYEE LIFE AND AD&D

- Life benefit amount $100,000
- AD&D benefit amount $100,000

DEPENDENT LIFE

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

VOLUNTARY PLANS

OUR VOLUNTARY PLANS

- **Flexible Spending Account (FSA)**
- **Voluntary Life**

You're unique—and so are your benefit needs

At Fullerton School District, there's more to your benefits than just health insurance, life insurance and retirement savings. We also offer voluntary benefits that can help you care for your loved ones, prepare for the future and manage the unexpected.

Voluntary benefits are just that: voluntary. You have the freedom and flexibility to choose the benefits that make sense for you and your family. Or, you don't have to sign up for voluntary benefits at all. The choice is yours.

Flexible Spending Account (FSA)

A Flexible Spending Account lets you set aside money—before it's taxed—through payroll deductions. The money can be used for eligible healthcare and dependent day care expenses you and your family expect to have over the next year. The main benefit of using an FSA is that you reduce your taxable income, which means you have more money to spend and reimbursements from your FSA accounts are tax-free. The catch is that you have to use the money in your account by September 30th. You must re-enroll in this program each year. WEX (formerly Discovery Benefits) administers this program. Click here to watch FSA 101 video.

Healthcare FSA

Eligible expenses include medical, dental, and vision costs including plan deductibles, copays, coinsurance amounts, and other non-covered healthcare costs for you and your tax dependents. Your spouse or tax dependent children do not have to be covered on the Fullerton School District's health plan. You may access your entire annual election from the first day of the plan year and you can set aside up to $2,850 per year.

Dependent Care FSA

This plan allows you to pay for eligible out-of-pocket dependent care expenses with pre-tax dollars. To qualify, you must pay these expenses so you can work or look for work. Eligible expenses may include daycare centers, in- home childcare, and before or after school care for your dependent children under age 13. Other individuals may qualify if they are your tax dependent and are incapable of self-care. It is important to note that you can access money only after it is placed into your dependent care FSA account.

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

Access your benefits anytime, anywhere. Download the mobile app: Benefits by WEX

Important Considerations

Expenses must be incurred between 10/01/22 and 9/30/2023.

Claims for the reimbursement of expenses incurred in any plan year shall be paid after claim has been filed. If a participant fails to submit a claim within 90 days after the end of the plan year, those expense claims will not be reimbursed. If a participant terminates employment during the plan year claims must be submitted within 60 days after termination of employment.

A participant in the Healthcare FSA can keep (roll-over) up to $570 of unused money for use in the next plan year. Unused amounts are those remaining after expenses have been reimbursed during the runout period. Runout period is 90 days. Amounts under $50 and in excess of $570 will be forfeited.

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

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

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

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

Voluntary Life Insurance

VOLUNTARY LIFE

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

Employee Voluntary Life Amount
$10,000 up to $500,000 in increments of $10,000; Guaranteed issue $50,000

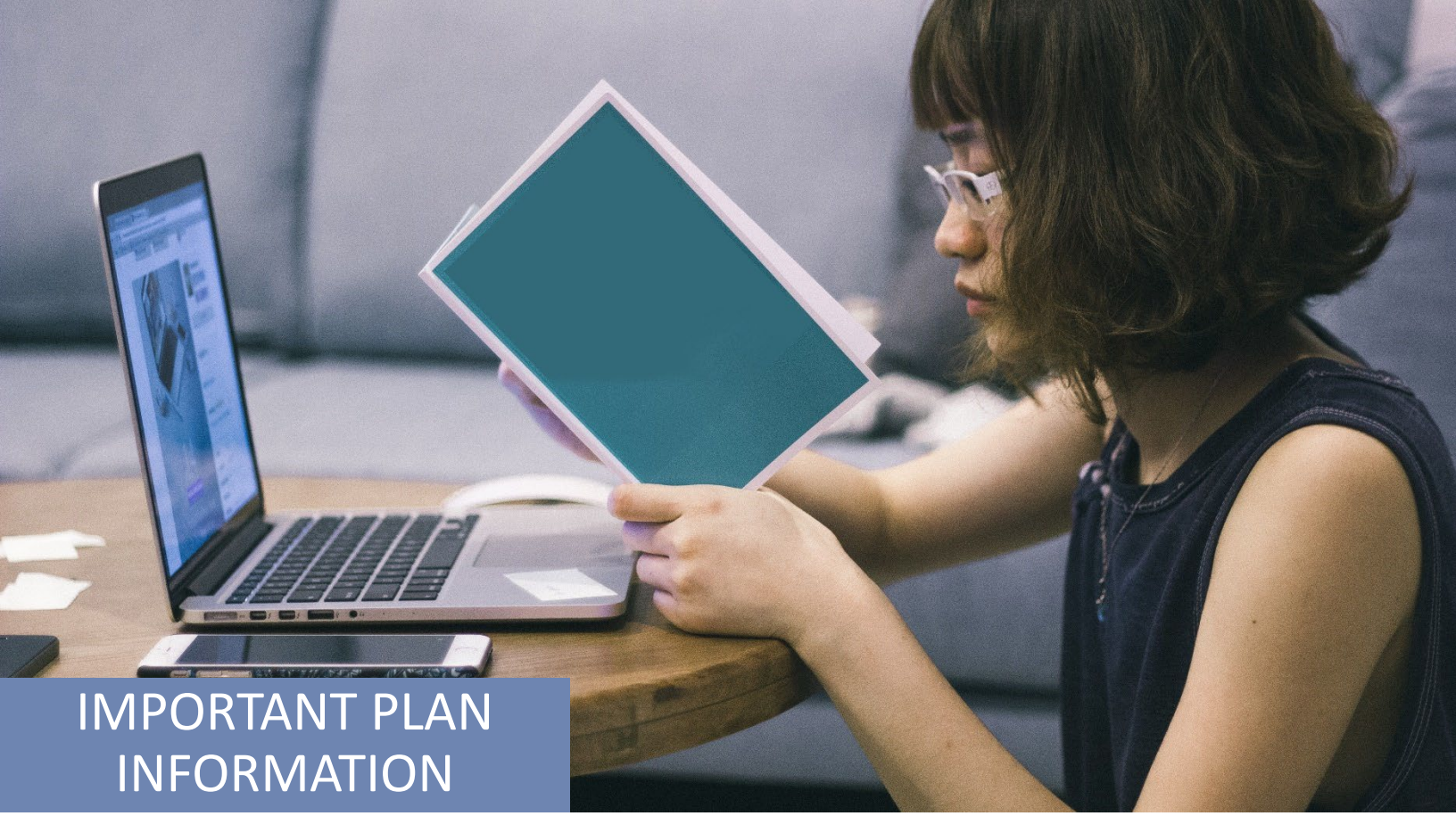
Spouse/Domestic Partner Voluntary Life Amount
$10,000 up to $500,000 in increments of $10,000; Guaranteed issue $50,000 (less than 60)

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

Important Reminders

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

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



IMPORTANT PLAN INFORMATION

In this section, you'll find important plan information, including:

- Your benefit contributions for 2022-2023
- Contact information for our benefit carriers and vendors
- A summary of the health plan notices you are entitled to receive annually, and where to find them
- A Benefits Glossary to help you understand important insurance terms

Fullerton School District
Effective 10-1-2022

2022-2023 Employee Monthly Payroll Deductions Certificated, Classified, and Management

		Blue Shield PPO			Blue Shield HMO 10			Blue Shield HMO 30			Blue Sheild HMO TRIO			KAISER 15		
		SGL	2P	FAM	SGL	2P	FAM	SGL	2P	FAM	SGL	2P	FAM	SGL	2P	FAM
TENTHLY		1,038.00	2,030.40	2,858.40	878.40	1,711.20	2,403.60	808.80	1,573.20	2,205.60	742.80	1,438.80	2,014.80	786.00	1,524.00	2,137.20
ANNUAL		10,380.00	20,304.00	28,584.00	8,784.00	17,112.00	24,036.00	8,088.00	15,732.00	22,056.00	7,428.00	14,388.00	20,148.00	7,860.00	15,240.00	21,372.00
DISTRICT		10,380.00	16,600.00	19,296.00	8,784.00	16,600.00	19,296.00	8,088.00	15,732.00	19,296.00	7,428.00	14,388.00	19,296.00	7,860.00	15,240.00	19,296.00
DIST HSA Contr																
%	HRS	EMPLOYEE PAYROLL DEDUCTION:														
100%	8.00	0.00	370.40	928.80	0.00	51.20	474.00	0.00	0.00	276.00	0.00	0.00	85.20	0.00	0.00	207.60
	7.90	12.98	391.15	952.92	10.98	20.75	498.12	10.11	19.66	300.12	9.28	17.98	109.32	9.82	19.05	231.72
	7.80	25.95	411.90	977.04	21.96	41.50	522.24	20.22	39.33	324.24	18.57	35.97	133.44	19.65	38.10	255.84
	7.70	38.93	432.65	1,001.16	32.94	62.25	546.36	30.33	59.00	348.36	27.86	53.96	157.56	29.48	57.15	279.96
95%	7.60	51.90	453.40	1,025.28	43.92	83.00	570.48	40.44	78.66	372.48	37.14	71.94	181.68	39.30	76.20	304.08
	7.50	64.88	474.15	1,049.40	54.90	103.75	594.60	50.55	98.33	396.60	46.43	89.93	205.80	49.13	95.25	328.20
	7.40	77.85	494.90	1,073.52	65.88	124.50	618.72	60.66	117.99	420.72	55.71	107.91	229.92	58.95	114.30	352.32
	7.30	90.83	515.65	1,097.64	76.86	145.25	642.84	70.77	137.66	444.84	65.00	125.90	254.04	68.78	133.35	376.44
90%	7.20	103.80	536.40	1,121.76	87.84	166.00	666.96	80.88	157.32	468.96	74.28	143.88	278.16	78.60	152.40	400.56
	7.10	116.78	557.15	1,145.88	98.82	186.75	691.08	90.99	176.99	493.08	83.57	161.87	302.28	88.43	171.45	424.68
	7.00	129.75	577.90	1,170.00	109.80	207.50	715.20	101.10	196.65	517.20	92.85	179.85	326.40	98.25	190.50	448.80
	6.90	142.73	598.65	1,194.12	120.78	228.25	739.32	111.21	216.32	541.32	102.14	197.84	350.52	108.08	209.55	472.92
85%	6.80	155.70	619.40	1,218.24	131.76	249.00	763.44	121.32	235.98	565.44	111.42	215.82	374.64	117.90	228.60	497.04
	6.70	168.68	640.15	1,242.36	142.74	269.75	787.56	131.43	255.65	589.56	120.71	233.81	398.76	127.73	247.65	521.16
	6.60	181.65	660.90	1,266.48	153.72	290.50	811.68	141.54	275.31	613.68	129.99	251.79	422.88	137.55	266.70	545.28
	6.50	194.63	681.65	1,290.60	164.70	311.25	835.80	151.65	294.98	637.80	139.28	269.78	447.00	147.38	285.75	569.40
80%	6.40	207.60	702.40	1,314.72	175.68	332.00	859.92	161.76	314.64	661.92	148.56	287.76	471.12	157.20	304.80	593.52
	6.30	220.58	723.15	1,338.84	186.66	352.75	884.04	171.87	334.31	686.04	157.85	305.75	495.24	167.03	323.85	617.64
	6.20	233.55	743.90	1,362.96	197.64	373.50	908.16	181.98	353.97	710.16	167.13	323.73	519.36	176.85	342.90	641.76
	6.10	246.53	764.65	1,387.08	208.62	394.25	932.28	192.09	373.64	734.28	176.42	341.72	543.48	186.68	361.95	665.88
75%	6.00	259.50	785.40	1,411.20	219.60	415.00	956.40	202.20	393.30	758.40	185.70	359.70	567.60	196.50	381.00	690.00
	5.90	272.48	806.15	1,435.32	230.58	435.75	980.52	212.31	412.97	782.52	194.99	377.69	591.72	206.33	400.05	714.12
	5.80	285.45	826.90	1,459.44	241.56	456.50	1,004.64	222.42	432.63	806.64	204.27	395.67	615.84	216.15	419.10	738.24
	5.70	298.43	847.65	1,483.56	252.54	477.25	1,028.76	232.53	452.30	830.76	213.56	413.66	639.96	225.98	438.15	762.36
70%	5.60	311.40	868.40	1,507.68	263.52	498.00	1,052.88	242.64	471.96	854.88	222.84	431.64	664.08	235.80	457.20	786.48
	5.50	324.38	889.15	1,531.80	274.50	518.75	1,077.00	252.75	491.63	879.00	232.13	449.63	688.20	245.63	476.25	810.60
	5.40	337.35	909.90	1,555.92	285.48	539.50	1,101.12	262.86	511.29	903.12	241.41	467.61	712.32	255.45	495.30	834.72
	5.30	350.33	930.65	1,580.04	296.46	560.25	1,125.24	272.97	530.96	927.24	250.70	485.60	736.44	265.28	514.35	858.84
65%	5.20	363.30	951.40	1,604.16	307.44	581.00	1,149.36	283.08	550.62	951.36	259.98	503.58	760.56	275.10	533.40	882.96
	5.10	376.28	972.15	1,628.28	318.42	601.75	1,173.48	293.19	570.29	975.48	269.27	521.57	784.68	284.93	552.45	907.08
	5.00	389.25	992.90	1,652.40	329.40	622.50	1,197.60	303.30	589.95	999.60	278.55	539.55	808.80	294.75	571.50	931.20
	4.90	402.23	1,013.65	1,676.52	340.38	643.25	1,221.72	313.41	609.62	1,023.72	287.84	557.54	832.92	304.58	590.55	955.32
60%	4.80	415.20	1,034.40	1,700.64	351.36	664.00	1,245.84	323.52	629.28	1,047.84	297.12	575.52	857.04	314.40	609.60	979.44
	4.70	428.18	1,055.15	1,724.76	362.34	684.75	1,269.96	333.63	648.95	1,071.96	306.41	593.51	881.16	324.23	628.65	1,003.56
	4.60	441.15	1,075.90	1,748.88	373.32	705.50	1,294.08	343.74	668.61	1,096.08	315.69	611.49	905.28	334.05	647.70	1,027.68
	4.50	454.13	1,096.65	1,773.00	384.30	726.25	1,318.20	353.85	688.28	1,120.20	324.98	629.48	929.40	343.88	666.75	1,051.80
55%	4.40	467.10	1,117.40	1,797.12	395.28	747.00	1,342.32	363.96	707.94	1,144.32	334.26	647.46	953.52	353.70	685.80	1,075.92
	4.30	480.08	1,138.15	1,821.24	406.26	767.75	1,366.44	374.07	727.61	1,168.44	343.55	665.45	977.64	363.53	704.85	1,100.04
	4.20	493.05	1,158.90	1,845.36	417.24	788.50	1,390.56	384.18	747.27	1,192.56	352.83	683.43	1,001.76	373.35	723.90	1,124.16
	4.10	506.03	1,179.65	1,869.48	428.22	809.25	1,414.68	394.29	766.94	1,216.68	362.12	701.42	1,025.88	383.18	742.95	1,148.28
50%	4.00	519.00	1,200.40	1,893.60	439.20	830.00	1,438.80	404.40	786.60	1,240.80	371.40	719.40	1,050.00	393.00	762.00	1,172.40

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

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

Fullerton School District
Effective 10-1-2022

2022-2023 Employee Monthly Payroll Deductions Certificated, Classified, and Management

KAISER 30			VSP	VSP for Kaiser	Delta Dental PPO			Delta Care HMO					Blue Sheild PPO HSA			BLUE SHIELD HIGH DEDUCTIBLE		
SGL	2P	FAM	FAM	FAM	SGL	2P	FAM	SGL	2P	FAM			SGL	2P	FAM	SAVINGS ACCOUNT		
766.80	1,488.00	2,086.80	21.60	27.00	59.56	95.30	160.81	30.66	49.94	74.12	TENTHLY		698.59	1,391.35	1,978.54	SGL	2P	FAM
7,668.00	14,880.00	20,868.00	216.00	270.00	595.56	953.04	1,608.12	306.60	499.44	741.24	ANNUAL		6,985.90	13,913.50	19,785.40	DISTRICT CONTRIBUTION ANNUALLY		
7,668.00	14,880.00	19,296.00	216.00	0.00	595.56	953.04	1,608.12	306.60	499.44	741.24	DISTRICT		10,635.90	16,600.00	19,296.00	3,650.00	2,686.50	0.00
											DIST HSA Contr		3,650.00	2,686.50				
											%	HRS			Pro Rata District HSA Contibution			
0.00	0.00	157.20	0.00	27.00	0.00	0.00	0.00	0.00	0.00	0.00	100%	8.00	0.00	0.00	48.94	3,650.00	2,686.50	0.00
9.58	18.60	181.32	0.27	27.00	0.74	1.19	2.01	0.38	0.62	0.93		7.90	8.73	17.39	24.73	3,604.38	2,652.92	0.00
19.17	37.20	205.44	0.54	27.00	1.49	2.38	4.02	0.77	1.25	1.85		7.80	17.46	34.78	49.46	3,558.75	2,619.34	0.00
28.76	55.80	229.56	0.81	27.00	2.23	3.57	6.03	1.15	1.87	2.78		7.70	26.20	52.18	74.20	3,513.13	2,585.76	0.00
38.34	74.40	253.68	1.08	27.00	2.98	4.77	8.04	1.53	2.50	3.71	95%	7.60	34.93	69.57	98.93	3,467.50	2,552.18	0.00
47.93	93.00	277.80	1.35	27.00	3.72	5.96	10.05	1.92	3.12	4.63		7.50	43.66	86.96	123.66	3,421.88	2,518.59	0.00
57.51	111.60	301.92	1.62	27.00	4.47	7.15	12.06	2.30	3.75	5.56		7.40	52.39	104.35	148.39	3,376.25	2,485.01	0.00
67.10	130.20	326.04	1.89	27.00	5.21	8.34	14.07	2.68	4.37	6.49		7.30	61.13	121.74	173.12	3,330.63	2,451.43	0.00
76.68	148.80	350.16	2.16	27.00	5.96	9.53	16.08	3.07	4.99	7.41	90%	7.20	69.86	139.14	197.85	3,285.00	2,417.85	0.00
86.27	167.40	374.28	2.43	27.00	6.70	10.72	18.09	3.45	5.62	8.34		7.10	78.59	156.53	222.59	3,239.38	2,384.27	0.00
95.85	186.00	398.40	2.70	27.00	7.44	11.91	20.10	3.83	6.24	9.27		7.00	87.32	173.92	247.32	3,193.75	2,350.69	0.00
105.44	204.60	422.52	2.97	27.00	8.19	13.10	22.11	4.22	6.87	10.19		6.90	96.06	191.31	272.05	3,148.13	2,317.11	0.00
115.02	223.20	446.64	3.24	27.00	8.93	14.30	24.12	4.60	7.49	11.12	85%	6.80	104.79	208.70	296.78	3,102.50	2,283.53	0.00
124.61	241.80	470.76	3.51	27.00	9.68	15.49	26.13	4.98	8.12	12.05		6.70	113.52	226.09	321.51	3,056.88	2,249.94	0.00
134.19	260.40	494.88	3.78	27.00	10.42	16.68	28.14	5.37	8.74	12.97		6.60	122.25	243.49	346.24	3,011.25	2,216.36	0.00
143.78	279.00	519.00	4.05	27.00	11.17	17.87	30.15	5.75	9.36	13.90		6.50	130.99	260.88	370.98	2,965.63	2,182.78	0.00
153.36	297.60	543.12	4.32	27.00	11.91	19.06	32.16	6.13	9.99	14.82	80%	6.40	139.72	278.27	395.71	2,920.00	2,149.20	0.00
162.95	316.20	567.24	4.59	27.00	12.66	20.25	34.17	6.52	10.61	15.75		6.30	148.45	295.66	420.44	2,874.38	2,115.62	0.00
172.53	334.80	591.36	4.86	27.00	13.40	21.44	36.18	6.90	11.24	16.68		6.20	157.18	313.05	445.17	2,828.75	2,082.04	0.00
182.12	353.40	615.48	5.13	27.00	14.14	22.63	38.19	7.28	11.86	17.60		6.10	165.92	330.45	469.90	2,783.13	2,048.46	0.00
191.70	372.00	639.60	5.40	27.00	14.89	23.83	40.20	7.67	12.49	18.53	75%	6.00	174.65	347.84	494.64	2,737.50	2,014.88	0.00
201.29	390.60	663.72	5.67	27.00	15.63	25.02	42.21	8.05	13.11	19.46		5.90	183.38	365.23	519.37	2,691.88	1,981.29	0.00
210.87	409.20	687.84	5.94	27.00	16.38	26.21	44.22	8.43	13.73	20.38		5.80	192.11	382.62	544.10	2,646.25	1,947.71	0.00
220.46	427.80	711.96	6.21	27.00	17.12	27.40	46.23	8.81	14.36	21.31		5.70	200.84	400.01	568.83	2,600.63	1,914.13	0.00
230.04	446.40	736.08	6.48	27.00	17.87	28.59	48.24	9.20	14.98	22.24	70%	5.60	209.58	417.41	593.56	2,555.00	1,880.55	0.00
239.63	465.00	760.20	6.75	27.00	18.61	29.78	50.25	9.58	15.61	23.16		5.50	218.31	434.80	618.29	2,509.38	1,846.97	0.00
249.21	483.60	784.32	7.02	27.00	19.36	30.97	52.26	9.96	16.23	24.09		5.40	227.04	452.19	643.03	2,463.75	1,813.39	0.00
258.80	502.20	808.44	7.29	27.00	20.10	32.17	54.27	10.35	16.86	25.02		5.30	235.77	469.58	667.76	2,418.13	1,779.81	0.00
268.38	520.80	832.56	7.56	27.00	20.84	33.36	56.28	10.73	17.48	25.94	65%	5.20	244.51	486.97	692.49	2,372.50	1,746.23	0.00
277.97	539.40	856.68	7.83	27.00	21.59	34.55	58.29	11.11	18.10	26.87		5.10	253.24	504.36	717.22	2,326.88	1,712.64	0.00
287.55	558.00	880.80	8.10	27.00	22.33	35.74	60.30	11.50	18.73	27.80		5.00	261.97	521.76	741.95	2,281.25	1,679.06	0.00
297.14	576.60	904.92	8.37	27.00	23.08	36.93	62.31	11.88	19.35	28.72		4.90	270.70	539.15	766.68	2,235.63	1,645.48	0.00
306.72	595.20	929.04	8.64	27.00	23.82	38.12	64.32	12.26	19.98	29.65	60%	4.80	279.44	556.54	791.42	2,190.00	1,611.90	0.00
316.31	613.80	953.16	8.91	27.00	24.57	39.31	66.33	12.65	20.60	30.58		4.70	288.17	573.93	816.15	2,144.38	1,578.32	0.00
325.89	632.40	977.28	9.18	27.00	25.31	40.50	68.35	13.03	21.23	31.50		4.60	296.90	591.32	840.88	2,098.75	1,544.74	0.00
335.48	651.00	1,001.40	9.45	27.00	26.06	41.70	70.36	13.41	21.85	32.43		4.50	305.63	608.72	865.61	2,053.13	1,511.16	0.00
345.06	669.60	1,025.52	9.72	27.00	26.80	42.89	72.37	13.80	22.47	33.36	55%	4.40	314.37	626.11	890.34	2,007.50	1,477.58	0.00
354.65	688.20	1,049.64	9.99	27.00	27.54	44.08	74.38	14.18	23.10	34.28		4.30	323.10	643.50	915.07	1,961.88	1,443.99	0.00
364.23	706.80	1,073.76	10.26	27.00	28.29	45.27	76.39	14.56	23.72	35.21		4.20	331.83	660.89	939.81	1,916.25	1,410.41	0.00
373.82	725.40	1,097.88	10.53	27.00	29.03	46.46	78.40	14.95	24.35	36.14		4.10	340.56	678.28	964.54	1,870.63	1,376.83	0.00
383.40	744.00	1,122.00	10.80	27.00	29.78	47.65	80.41	15.33	24.97	37.06	50%	4.00	349.30	695.68	989.27	1,825.00	1,343.25	0.00

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

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

GLOSSARY

-A-

AD&D Insurance
An insurance plan that pays a benefit to you or your beneficiary if you suffer from loss of a limb, speech, sight, or hearing, or if you have a fatal accident.

Allowed Amount
The maximum amount your plan will pay for a covered healthcare service.

Ambulatory Surgery Center (ASC)
A healthcare facility that specializes in same-day surgical procedures such as cataracts, colonoscopies, upper GI endoscopy, orthopedic surgery, and more.

Annual Limit
A cap on the benefits your plan will pay in a year. Limits may be placed on particular services such as prescriptions or hospitalizations. Annual limits may be placed on the dollar amount of covered services or on the number of visits that will be covered for a particular service.
After an annual limit is reached, you must pay all associated health care costs for the rest of the plan year.

-B-

Balance Billing
In-network providers are not allowed to bill you for more than the plan's allowable charge, but out-of-network providers are. This is called balance billing. For example, if the provider's fee is $100 but the plan's allowable charge is only $70, an out-of-network provider may bill YOU for the $30 difference (the balance).

Beneficiary
The person (or persons) that you name to be paid a benefit should you die. Beneficiaries are requested for life, AD&D, and retirement plans. You must name your beneficiary in advance.

Brand Name Drug
A drug sold under its trademarked name. For example, Lipitor is the brand name of a common cholesterol medicine.

-C-

COBRA
A federal law that may allow you to temporarily continue healthcare coverage after your employment ends, based on certain qualifying events. If you elect COBRA (Consolidated Omnibus Budget Reconciliation Act) coverage, you pay 100% of the premiums, including any share your employer used to pay, plus a small administrative fee.

Claim
A request for payment that you or your health care provider submits to your healthcare plan after you receive services that may be covered.

Coinsurance
Your share of the cost of a healthcare visit or service. Coinsurance is expressed as a percentage and always adds up to 100%. For example, if the plan pays 70%, your coinsurance responsibility is 30% of the cost. If your plan has a deductible, you pay 100% of the cost until you meet your deductible amount.

Copayment
A flat fee you pay for some healthcare services, for example, a doctor's office visit. You pay the copayment (sometimes called a copay) at the time you receive care. In most cases, copays do not count toward the deductible.

-D-

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

Family coverage may have an ***aggregate*** or ***embedded*** deductible. Aggregate means your family must meet the entire family deductible before any individual expenses are covered. Embedded means the plan begins to make payments for an individual member as soon as they reach their individual deductible.

Dental Basic Services
Services such as fillings, routine extractions and some oral surgery procedures.

Dental Diagnostic & Preventive Generally includes routine cleanings, oral exams, x-rays, and fluoride treatments.
Most plans limit preventive exams and cleanings to two times a year.

Dental Major Services
Complex or restorative dental work such as crowns, bridges, dentures, inlays and onlays.

Dependent Care Flexible Spending Account (FSA)
An arrangement through your employer that lets you pay for eligible child and elder care expenses with tax-free dollars. Eligible expenses include day care, before and after-school programs, preschool, and summer day camp for children under age 13. Also included is care for a spouse or other dependent who lives with you and is physically incapable of self-care.

-E-

Eligible Expense
A service or product that is covered by your plan. Your plan will not cover any of the cost if the expense is not eligible.

Excluded Service
A service that your health plan doesn't pay for or cover.

-F-

Formulary
A list of prescription drugs covered by your medical plan or prescription drug plan. Also called a drug list.

-G-

Generic Drug
A drug that has the same active ingredients as a brand name drug, but is sold under a different name. For example, Atorvastatin is the generic name for medicines with the same formula as Lipitor.

Grandfathered
A medical plan that is exempt from certain provisions of the Affordable Care Act (ACA).

-H-

Health Reimbursement Account (HRA) An account funded by an employer that reimburses employees, tax-free, for qualified medical expenses up to a maximum amount per year. Sometimes called Health Reimbursement Arrangements.

Healthcare Flexible Spending Account (FSA)
A health account through your employer that lets you pay for many out-of-pocket medical expenses with tax-free dollars. Eligible expenses include insurance copayments and deductibles, qualified prescription drugs, insulin, and medical devices, and some over-the-counter items.

GLOSSARY

High Deductible Health Plan (HDHP)
A medical plan with a higher deductible than a traditional insurance plan. The monthly premium is usually lower, but you pay more health care costs (the deductible) before the insurance company starts to pay its share. A high deductible plan (HDHP) may make you eligible for a health savings account (HSA) that allows you to pay for certain medical expenses with money free from federal taxes.

-I-

In-Network
In-network providers and services contract with your healthcare plan and will usually be the lowest cost option. Check your plan's website to find doctors, hospitals, labs, and pharmacies. Out-of-network services will cost more, or may not be covered.

-L-

Life Insurance
An insurance plan that pays your beneficiary a lump sum if you die.

Long Term Disability Insurance
Insurance that replaces a portion of your income if you are unable to work due to a debilitating illness, serious injury, or mental disorder. Long term disability generally starts after a 90-day waiting period.

-M-

Mail Order
A feature of a medical or prescription drug plan where medicines you take routinely can be delivered by mail in a 90-day supply.

-O-

Open Enrollment
The time of year when you can change the benefit plans you are enrolled in and the dependents you cover. Open enrollment is held one time each year. Outside of open enrollment, you can only make changes if you have certain events in your life, like getting married or adding a new baby or child in the family.

Out-of-Network
Out-of-network providers (doctors, hospitals, labs, etc.) cost you more because they are not contracted with your plan and are not obligated to limit their maximum fees. Some plans, such as HMOs and EPOs, do not cover out-of- network services at all.

Out-of-Pocket Cost
A healthcare expense you are responsible for paying with your own money, whether from your bank account, credit card, or from a health account such as an HSA, FSA or HRA.

Out-of-Pocket Maximum
Protects you from big medical bills. Once costs "out of your own pocket" reach this amount, the plan pays 100% of most remaining eligible expenses for the rest of the plan year.

Family coverage may have an *aggregate* or *embedded* maximum. Aggregate means your family must meet the entire family out-of-pocket maximum before the plan pays 100% for any member. Embedded means the plan will cover 100% for an individual member as soon as they reach their individual maximum.

Outpatient Care
Care from a hospital that doesn't require you to stay overnight.

-P-

Participating Pharmacy
A pharmacy that contracts with your medical or drug plan and will usually result in the lowest cost for prescription medications.

Plan Year
A 12-month period of benefits coverage. The 12-month period may or may not be the same as the calendar year.

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

Preventive Care Services
Routine healthcare visits that may include screenings, tests, check-ups, immunizations, and patient counseling to prevent illnesses, disease, or other health problems. Many preventive care services are fully covered. Check with your health plan in advance if you have questions about whether a preventive service is covered.

Primary Care Provider (PCP)
The main doctor you consult for healthcare issues. Some medical plans require members to name a specific doctor as their PCP, and require care and referrals to be directed or approved by that provider.

-S-

Short Term Disability Insurance
Insurance that replaces a portion of your income if you are temporarily unable to work due to surgery and recovery time, a prolonged illness or injury, or pregnancy issues and childbirth recovery.

-T-

Telehealth / Telemedicine / Teledoc
A virtual visit to a doctor using video chat on a computer, tablet or smartphone. Telehealth visits can be used for many common, non-serious illnesses and injuries and are available 24/7. Many health plans and medical groups provide telehealth services at no cost or for much less than an office visit.

-U-

UCR (Usual, Customary, and Reasonable)
The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service. The UCR amount sometimes is used to determine the allowed amount.

Urgent Care
Care for an illness, injury or condition serious enough that care is needed right away, but not so severe it requires emergency room care. Treatment at an urgent care center generally costs much less than an emergency room visit.

-V-

Vaccinations
Treatment to prevent common illnesses such as flu, pneumonia, measles, polio, meningitis, shingles, and other diseases. Also called immunizations.

Voluntary Benefit
An optional benefit plan offered by your employer for which you pay the entire premium, usually through payroll deduction.

IMPORTANT PLAN INFORMATION

HEALTH PLAN NOTICES

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

- **Medicare Part D Notice:** Describes options to access prescription drug coverage for Medicare eligible individuals.
- **Women's Health and Cancer Rights Act:** Describes benefits available to those that will or have undergone a mastectomy.
- **Newborns' and Mothers' Health Protection Act:** Describes the rights of mother and newborn to stay in the hospital 48-96 hours after delivery.
- **HIPAA Notice of Special Enrollment Rights:** Describes when you can enroll yourself and/or dependents in health coverage outside of open enrollment.
- **HIPAA Notice of Privacy Practices:** Describes how health information about you may be used and disclosed.
- **Notice of Choice of Providers:** Notifies you that your plan requires you to name a Primary Care Physician (PCP) or provides for you to select one
- **Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP):** Describes availability of premium assistance for Medicaid eligible dependents.

COBRA CONTINUATION COVERAGE

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

ACA Disclaimer

This offer of coverage may disqualify you from receiving government subsidies for an Exchange plan even if you choose not to enroll. To be subsidy eligible you would have to establish that this offer is unaffordable for you, meaning that the required contribution for employee only coverage under our base plan exceeds 9.61% in 2022 of your modified adjusted household income.

PLAN DOCUMENTS

SUMMARY PLAN DESCRIPTIONS (SPD)

The legal document for describing benefits provided under the plan as well as plan rights and obligations to participants and beneficiaries.

Go online to Kaiser or Blue Shield's website to access these documents. If you would like a paper copy, please contact Insurance Benefits.

SUMMARY OF BENEFITS AND COVERAGE (SBC)

A document required by the Affordable Care Act (ACA) that presents benefit plan features in a standardized format. SBC documents are available by contacting Insurance Benefits:

- **Kaiser Permanente HMO 15**
- **Kaiser Permanente HMO 30**
- **Blue Shield of California Trio HMO**
- **Blue Shield of California HMO 10**
- **Blue Shield of California HMO 30**
- **Blue Shield of California PPO**
- **Blue Shield of California HDHP HSA**
- **Blue Shield of California Anchor Bronze**

STATEMENT OF MATERIAL MODIFICATIONS

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

Medicare Part D Notice

Important Notice from Fullerton School District About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Fullerton School District and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. Fullerton School District has determined that the prescription drug coverage offered by Blue Shield and Kaiser Permanente medical plans are, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your Fullerton School District coverage will be affected. See below for more information about what happens to your current coverage if you join a Medicare drug plan. **Important Retiree Note:** If you are eligible for the District's Retiree Medical Program, when a subscriber and spouse/domestic partner are both age 65 or older and retired, and are remaining on a SISC plan, they will automatically be enrolled in Medicare Part D. Do not enroll in a Medicare Part D plan outside of SISC. This will automatically disenroll you from your SISC Medicare Part D plan.

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

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

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?
You should also know that if you drop or lose your current coverage with Fullerton School District and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage…
Contact the person listed below for further information. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Fullerton School District changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage…
More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:
- Visit medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 800-MEDICARE (800-633-4227). TTY users should call 877-486-2048.

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

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

Date:	October 1, 2022
Name of Entity/Sender:	Fullerton School District
Contact-Position/Office:	Insurance Benefits
Address:	1401 W. Valencia Drive, Fullerton, CA 92833
Phone Number:	(714) 447-2843

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

HIPAA Notice of Special Enrollment Rights

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

- Lose other health insurance or group health plan coverage. You must request enrollment within 31 days after the loss of other coverage.
- Gain a new dependent as a result of marriage, birth, adoption, or placement for adoption. You must request health plan enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.
- Lose Medicaid or Children's Health Insurance Program (CHIP) coverage because you are no longer eligible. You must request medical plan enrollment within 60 days after the loss of such coverage.

If you request a change due to a special enrollment event within the 31 day timeframe, coverage will be effective the date of birth, adoption or placement for adoption. For all other events, coverage will be effective the first of the month following your request for enrollment. In addition, you may enroll in Fullerton School District health plan if you become eligible for a state premium assistance program under Medicaid or CHIP. You must request enrollment within 60 days after you gain eligibility for medical plan coverage. If you request this change, coverage will be effective the first of the month following your request for enrollment. Specific restrictions may apply, depending on federal and state law.

Note: If your dependent becomes eligible for a special enrollment right, you may add the dependent to your current coverage or change to another health plan.

Availability of Privacy Practices Notice

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

Notice of Choice of Providers

The Blue Shield HMO plans generally require the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the insurance carrier directly.

You do not need prior authorization from Blue Shield or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the insurance carrier directly.

Women's Health and Cancer Rights Act

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

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Therefore, the deductibles and coinsurance in the Summary of Benefits and Coverage (SBC) apply. If you would like more information on WHCRA benefits, call your plan administrator.

Newborns' and Mothers' Health Protection Act

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). If you would like more information on maternity benefits, call your plan administrator.

Notice of Certain Deadline Extensions and Summary of Material Modifications

This document provides notice of the potential expiration of the deadline relief that began on March 1, 2020 and an explanation of how that expiration will affect certain deadlines tolled under prior guidance applicable to ERISA plans. Specifically deadlines cannot be tolled for longer than one-year, **so depending on the date an individual action would have been required, some deadline extensions will be expiring on February 28, 2021. Whether deadlines are tolled or resume will depend on the specific date you were required to take action or provide notice to the plan.** This is a Summary of Material Modifications ("Summary") to the extent those extensions applied to ERISA benefits under the Fullerton School District Health Plan ("the Plan"). You should take the time to read this Summary carefully and keep it with the Summary Plan Description ("SPD") document. If you need a copy of the SPD or if you have any questions regarding these changes to the Plan, please contact Insurance Benefits.

End of Relief Period Extending Certain Deadlines in Response to the COVID-19 Crisis will Depend on the Date an Individual Action Would Have been Required with some Deadlines resuming Feb. 28, 2021

On April 28, 2020, Multi-Agency guidance extended certain deadlines that apply to group health plans that fall within the COVID-19 outbreak period beginning **March 1, 2020**. Those deadlines included and were limited to the following:

- The 30-day period to request special enrollment under HIPAA (or 60-day period as applicable to CHIP enrollment requests);
    - employees, spouses, and new dependents are allowed to enroll upon marriage, birth, adoption, or placement for adoption;
    - employees and dependents are allowed to enroll if they had declined coverage due to other health coverage and then lose eligibility or lose all employer contributions towards active coverage;
    - employees and their dependents are allowed to enroll upon loss of coverage under a state Children's Health Insurance Program (CHIP) or Medicaid or who are eligible to receive premium assistance under those programs;
- The 60-day election period for COBRA continuation coverage;
- The deadline for making COBRA premium payments;
- The 60-day deadline for individuals to notify a plan of a COBRA qualifying event or determination of disability;
- The deadline for individuals to file an ERISA benefit claim under the plan's claims procedure (including a H-FSA run out period deadline that ends during the outbreak period); or
- The deadline for claimants to file an appeal of an adverse benefit determination, a request for an external review, and to file information related to a request for external review for an ERISA plan.

Notice of Certain Deadline Extensions and Summary of Material Modifications

The period that these deadlines can be tolled is limited to one year. On Feb. 28, 2021, one year from March 1, 2020, some of the above timelines will no longer be tolled.

Individual timeframes listed above that are subject to deadline relief will have the applicable deadlines disregarded only until the earlier of: (a) 1 year from the date they were first eligible for relief, or (b) 60 days after the announced end of the National Emergency (the end of the Outbreak Period). On those individualized applicable dates, the timeframes for employees/participants with periods that were previously tolled will resume.

Examples and Explanations:

> If a qualified beneficiary would have been required to make a COBRA election by March 1, 2020, the individual can wait until February 28, 2021, which is the earlier of 1 year from March 1, 2020 or the end of the Outbreak Period. Because the individual had 60 days to elect before the start of the Outbreak he or she would need to make an election by February 28, 2021.
>
> If a qualified beneficiary would have been required to make a COBRA election by March 1, 2021, the Notice delays that election requirement until the earlier of 1 year from that date (March 1, 2022) or the end of the Outbreak Period, with the possibility of an additional 60-day extension.
>
> If an individual experienced the birth of a child in February 2021 and the National Emergency was declared over July 1, 2021 **(hypothetically)**, the employee would have 60 days from the end of the National Emergency plus 30 days under HIPAA to give notice of the birth to request enrollment from the plan, September 29, 2021.

Again, if you have any questions regarding these changes to the Plan or your specific circumstances, please contact Insurance Benefits.

Premium Assistance under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

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

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

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call 1-866-444-EBSA (3272).

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2022. Contact your State for more information on eligibility –

ALABAMA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447
ALASKA – Medicaid
The AK Health Insurance Premium Payment Program | Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx
ARKANSAS – Medicaid
Website: http://myarhipp.com/ | Phone: 1-855-MyARHIPP (855-692-7447)
CALIFORNIA – Medicaid
Website: Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp Phone: 916-445-8322 | Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943 | State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991 | State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program HIBI Customer Service: 1-855-692-6442
FLORIDA – Medicaid
Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

GEORGIA – Medicaid
A HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162, press 2
INDIANA – Medicaid
Healthy Indiana Plan for low-income adults 19-64 | Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid | Website: https://www.in.gov/medicaid/ Phone 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)
Medicaid Website: https://dhs.iowa.gov/ime/members | Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki | Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp | HIPP Phone: 1-888-346-9562
KANSAS – Medicaid
Website: https://www.kancare.ks.gov/ | Phone: 1-800-792-4884
KENTUCKY – Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx | Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx | Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov
LOUISIANA – Medicaid
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid
Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-442-6003 | TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 800-977-6740 | TTY: Maine relay 711
MASSACHUSETTS – Medicaid and CHIP
Website: https://www.mass.gov/masshealth/pa | Phone: 1-800-862-4840
MINNESOTA – Medicaid
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739
MISSOURI – Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm | Phone: 573-751-2005
MONTANA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP | Phone: 1-800-694-3084
NEBRASKA – Medicaid
Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 | Lincoln: 402-473-7000 | Omaha: 402-595-1178
NEVADA – Medicaid
Medicaid Website: http://dhcfp.nv.gov | Medicaid Phone: 1-800-992-0900
NEW HAMPSHIRE – Medicaid
Website: https://www.dhhs.nh.gov/oii/hipp.htm | Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 5218
NEW JERSEY – Medicaid and CHIP
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html | CHIP Phone: 1-800-701-0710

NEW YORK – Medicaid
Website: https://www.health.ny.gov/health_care/medicaid/ | Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid
Website: https://medicaid.ncdhhs.gov/ | Phone: 919-855-4100
NORTH DAKOTA – Medicaid
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ | Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP
Website: http://www.insureoklahoma.org | Phone: 1-888-365-3742
OREGON – Medicaid
Website: http://healthcare.oregon.gov/Pages/index.aspx or http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx | Phone: 1-800-692-7462
RHODE ISLAND – Medicaid and CHIP
Website: http://www.eohhs.ri.gov/ | Phone: 1-855-697-4347 or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid
Website: https://www.scdhhs.gov | Phone: 1-888-549-0820
SOUTH DAKOTA – Medicaid
Website: http://dss.sd.gov | Phone: 1-888-828-0059
TEXAS – Medicaid
Website: http://gethipptexas.com/ | Phone: 1-800-440-0493
UTAH – Medicaid and CHIP
Medicaid Website: https://medicaid.utah.gov/ | CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
VERMONT – Medicaid
Website: http://www.greenmountaincare.org/ | Phone: 1-800-250-8427
VIRGINIA – Medicaid and CHIP
Websi Website: https://www.coverva.org/en/famis-select or https://www.coverva.org/en/hipp Medicaid Phone: 1-800-432-5924 | CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid
Website: https://www.hca.wa.gov/ | Phone: 1-800-562-3022
WEST VIRGINIA – Medicaid and CHIP
Website: https://dhhr.wv.gov/bms/ or http://mywvhipp.com/ Medicaid Phone: 304-558-1700 | CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm | Phone: 1-800-362-3002
WYOMING – Medicaid
Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ | Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since January 31, 2022, or for more information on special enrollment rights, contact either:

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

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 1/31/2023)

PLAN CONTACTS

INSURANCE BENEFITS

Andrea Lopez
Andrea_Lopez@myfsd.org
Benefits Coordinator
(714) 447-2834

Jenny Morgan
Jenny_Morgan@myfsd.org
Benefits Technician
(714) 447-7420

MEDICAL

Kaiser Permanente HMO
my.kp.org/sisc
Member Services
(800) 464-4000

Blue Shield SISC Plans
myoptions.blueshieldca.com/sisc
Member Services
(855) 599-2657

Blue Shield MDLive
www.mdlive.com/sisc
Member Services
(800) 657-6169

Teladoc
www.teladoc.com/sisc
Member Services
(808) 835-2362

Navitus
Blue Shield Pharmacy Benefits
www.navitus.com
Member Services
(866) 333-2757

Costco
Blue Shield Pharmacy Benefits
www.costco.com/Pharmacy
Member Services
(800) 607-6861

DENTAL & VISION

DentalCare USA HMO
www.deltadentalins.com
Member Services
(800) 422-4234

Delta Dental PPO
www.deltadentalins.com
Member Services
(866) 499-3001

VSP Vision
www.vsp.com
Member Services
(800) 877-7195

HEALTH SAVINGS ACCOUNT (HSA)

Sterling Administration
sterlingadministration.com
Member Services
(800) 617-4729

FLEXIBLE SPENDING ACCOUNT (FSA)

WEX Inc.
www.wexinc.com
(866) 451-3399
customerservice@wexhealth.com

Fullerton School District
Personnel Services

HR Benefits Website
www.fullertonsd.org

EMPLOYEE ASSISTANCE PROGRAM EAP

Anthem EAP
www.anthemeap.com
Member Services
(800) 999-7222

ADDITIONAL BENEFITS

Voya
Accident Insurance
(HDHP members)
www.voya.com
Member Services
(888) 238-4840

Voya/Reliastar
Life Insurance
www.voya.com
Member Services
(800) 955-7736

UNION PREFERRED DISABILITY INSURANCE VENDORS

American Fidelity
CSEA & FESMA Preferred Vendor
www.americanfidelity.com
Member Services
(800) 365-9180

The Standard
FETA Preferred Vendor
www.standard.com
Member Services
(800) 522-0406