

Your 2020 Benefits

Effective January 1, 2020 - December 31, 2020

**OPEN
ENROLLMENT**

.....
September 9, 2019 -
October 4, 2019



Health Benefits, FSA, Parking & Transit Open Enrollment Guide

IMPORTANT NOTICE: READ CAREFULLY

This Benefits Guide briefly describes your benefit choices and your options to enroll. All benefits, and your eligibility for benefits, are subject to the terms and conditions of the benefit plans, including group insurance contracts. The Guide is not intended to be a complete description of the District's benefit plans and it is not a summary plan description or plan document. In the event of any conflict or discrepancy between this Guide and the plan documents, the plan documents will govern. This Guide is not a guarantee of current or future employment or benefits and you are responsible for knowing and understanding the contents of this Guide. If after review you have any questions, you should contact the Office of Risk Management/Benefits Department immediately.

Understanding Your Rights: Read All Notices

Employees and family members eligible for the District's benefits may have rights under applicable federal or state laws. This Guide does not describe all provisions or rights. If eligible, you will receive separate information and notices explaining those rights, such as:

Privacy Rule: The Health Insurance Portability and Accountability Act (HIPAA) includes provisions to protect the privacy of health information for group health plan participants. Provisions are explained in the District's Privacy Notice.

Health Plan Protections: Health plan benefits must meet the requirements of the Women's Health and Cancer Rights Act and the Mothers' and Newborns' Health Protection Act. These provisions are explained in the carrier EOCs and this Guide.

Coverage Continuation: The Consolidated Omnibus Budget Reconciliation Act (COBRA) offers the opportunity to continue your group health coverage after certain qualifying events (such as leaving the District, or a child reaching the plan's age limit). These provisions are explained in the District's General/Initial COBRA Notice.

Summary of Benefits and Coverage (SBC): The SBCs are available on the web at: <https://pcms.plansource.com>. See user name and password on page 2. Additional information regarding the SBCs can be found on page 18 and on the CalPERS website.

If you do not receive the above information or notices, or if you have any questions about this information, please contact the Office of Risk Management/Benefits Department

(510) 644-6666

Cash-in-lieu : Requires Re-Enrollment

You need to take action!

Complete the Cash-in-lieu form and return to Office of Risk Management by October 4th.

Even if you are already getting cash-in-lieu, you need to re-enroll!

Please Note: That Coverage under an individual plan, such as through Covered California, Medi-Cal, Tri-Care or Tri-West is not acceptable proof to receive cash-in-lieu. Please review page 4 and page 7 to determine the form and documents that are needed.

Welcome to Your Benefits Guide

Your benefits are a valuable addition to your overall compensation. Make sure you get the most from them by taking the time to understand your options and by selecting the best coverage for you and your family.

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Where to Obtain Information/Enrollment Forms

Enrollment/Change forms for the CalPERS medical plans are included with the informational packet sent to you by the District. Enrollment/Change forms and the complete CalPERS 2020 *Health Benefit Summary* can be obtained one of the following ways:

- The District's MyBenefits website
<https://pcms.plansource.com>
Username: BUSDEmployee
Password: benefits
Click on "Obtain an Enrollment Form"
- The District's Office of Risk Management/Benefits Department
<http://www.berkeleyschools.net>
Offices/Business Services/Benefits
- The Health Benefits Wellness Fair
September 11, 2019
12:00pm—5:00pm
District Office (Board Room)
1231 Addison Street Berkeley, CA

Important Changes in the 2020 Benefit Offerings

CalPERS Medical— CHANGES TO PLANS AND/OR REGIONS

For specific changes to the medical plans, please review the *CalPERS 2020 Health Benefit Summary*. The complete *2020 Health Benefit Summary* can be obtained through the CalPERS website:

www.calpers.ca.gov Under “I Want To...” Click on “**View Health Plan Rates**”

CalPERS Regional Change

Consolidated the rating regions down to three:

Region 1—Northern California (which includes Alameda County)

Region 2—Central and Southern California

Region 3—Los Angeles, Riverside and San Bernardino

Changes to the medical plans may impact your decisions for coverage during open enrollment. **Please review carefully.** You may need to make a new medical plan choice during this open enrollment.

Delta Dental PPO (Fee-For-Service) and DHMO (DeltaCare USA)— PPO total premium decrease;

DHMO no change in premium

Vision Service Plan (VSP)— Total premium decrease

Health Care Spending FSA—Maximum will be increasing to \$2,700

Voluntary Life Insurance—You will have the opportunity to enroll or increase your coverage up to the guaranteed issue amounts allowed. See page 16 for details

Rates Will Be Changing

Rate sheets for each bargaining unit as well as additional plan information can be found online at: The District’s Office of Risk Management/Benefits Department

- <http://www.berkeleyschools.net>

Click on : Offices, Business Services, Benefits

Reminder: Mobile App—Benefits2Go

Access District benefits information whenever and wherever you carry your smartphone and tablet devices. Download the free Benefits2Go app available through iTunes or the Google Play Store. Download and use the below Company Registration Key to get started!

Company Registration Key: BER0110

Open Enrollment Checklist - IMPORTANT

Review the checklist below to ensure that you have completed all paperwork during this Open Enrollment period as your next opportunity to enroll or change coverage will not occur until next year's Open Enrollment, unless you experience a qualifying event during the year.



All forms are due to the Office of Risk Management/Benefits Department no later than 5:30 pm on Friday, October 4, 2019

PLEASE SEE PAGE 6 "HOW TO SUBMIT YOUR ENROLLMENT FORMS & FSA ELECTION FORMS"

☐ **Medical Plan—CalPERS**

- ***Cash-in-lieu requires re-enrollment, you need to take action even if you are already getting cash-in-lieu. See below.***

If adding coverage, changing plans, or adding dependents to the CalPERS medical plan

- ☐ CalPERS Health Benefit Enrollment Form (PERS-HBD-12)
- ☐ Dependent Certification (if applicable—see additional information below)

If declining CalPERS medical plan

- ☐ CalPERS Health Benefit Enrollment Form (PERS-HBD-12), complete sections A, B, and E.

☐ **Cash in Lieu**, you need to complete and return the Cash in Lieu Form **AND** provide proof of medical coverage as outlined below:

- For employees working greater than 30 hours per week, proof of other employer group medical coverage (required)
- For employees working less than 30 hours per week, proof of any alternative medical coverage (required)

(note: for BFT members, cash in lieu is only available to hourly employees)

☐ **Dental Plan**—adding coverage, changing plans or adding dependents, complete a Delta Dental enrollment/change form

- ***IF YOU ARE NOT MAKING A CHANGE, YOU DO NOT NEED TO DO ANYTHING.***

☐ **Vision Plan**—adding coverage or adding dependents, complete a VSP enrollment/change form

- ***IF YOU ARE NOT MAKING A CHANGE, YOU DO NOT NEED TO DO ANYTHING.***

☐ **Lincoln Voluntary Life Insurance**

- Employees and spouses have the opportunity to enroll in or increase their Voluntary Life benefit up to the guarantee issue amount without Evidence of Insurability (EOI) as long as the applicant has not been previously withdrawn or declined. If you are enrolling for the first time, you will need to complete an Enrollment Form. If electing more than the guarantee issue, complete the EOI Form.

☐ **Flexible Spending Account/Dependent Care Spending Account**—Must complete a BASIC pacific election form for the 2020 plan year. Your current election will not carry forward. Remember to consider any carryover Health Care spending dollars you will have at the end of 2019 when making your election for 2020.

☐ **Parking & Transit Account**—must complete a BASIC pacific enrollment/change form if you wish to change your monthly election amount or enroll in coverage. Changes for this plan can be made outside of open enrollment.

Dependent Certification is REQUIRED!

If you are enrolling dependents, the following applicable certification must be provided. It is the employee's responsibility to obtain certification(s) and to submit such certification(s) to the District in a timely manner. Failure to submit supporting documentation copies will result in dependents being denied coverage. **DO NOT SUBMIT ORIGINAL DOCUMENTS AS THEY WILL NOT BE RETURNED.**

☐ **Spouse**—Marriage Certificate or Affidavit of Marriage/Domestic Partnership

☐ **Domestic Partner**—Declaration of Domestic Partnership from the California Secretary of States office, or Affidavit of Marriage/Domestic Partnership. If your domestic partnership is non-registered, you will need to complete District Domestic Partnership Application/Affidavit

☐ **Children**—Birth certificate, adoption paperwork, legal guardianship papers when applicable. Birth certificates must show the names of the parents.

☐ **Disabled Dependent Child Certification Forms—CalPERS (provide only if child is disabled)**

- ☐ *MEDICAL REPORT for the CalPERS DISABLED DEPENDENT BENEFIT*
- ☐ *MEMBER QUESTIONNAIRE for the CalPERS DISABLED DEPENDENT BENEFIT*

Office of Risk Management/Benefits Department

Open Enrollment Window Hours/Locations

Walk-in submittals will be accepted at the Office of Risk Management/Benefits Department only during the following window hours:

Open Enrollment Window hours	Informational Sessions / Open Enrollment Meetings
<ul style="list-style-type: none">September 9, 10 & 12 (Monday, Tuesday, Thursday) 8:30 am - 4:30 pmSeptember 16 - September 19 (Monday through Thursday) 8:30 am - 4:30 pmSeptember 23 - September 26 (Monday through Thursday) 8:30 am - 4:30 pmSeptember 30 - October 2 (Monday—Wednesday) 8:30 am—4:30 pmOctober 3 (Thursday) 8:30 am—5:30 pmOctober 4 —Last Day (Friday) 8:30 am—5:30 pm	<ul style="list-style-type: none">September 11, 2019 (ACTIVE EMPLOYEE SESSION)<ul style="list-style-type: none">Active meeting 12:00 pm—5:00 pm Board Room 1231 Addison StreetSeptember 11, 2019 (RETIREE SESSION)<ul style="list-style-type: none">Retiree meeting 11:00 am—2:00 pm Board Room 1231 Addison Street

Enrollment: What You Need to Do?

You will need to make choices about which benefits you'd like to participate in during "enrollment windows." Enrollment windows are specific times that will require you to take action and select your benefits:

- When you are first eligible to participate in benefits (you have 30 calendar days to enroll). Elections you make generally become effective first of the month following your date of hire. See page 7 for What Happens if you don't enroll in coverage within 30 days.
- All enrollments and changes you make during this Open Enrollment period become effective January 1, 2020 even if you do not receive a new ID card by this date.**
- When you experience a qualified change-in-status event, such as marriage or the birth of a child, or HIPAA special enrollment event; you must report these events within 30 days in order to make any allowable changes to your benefits. See pages 9 and 10 for more details about reporting qualified change-in-status events and HIPAA special enrollment events.

Each time an enrollment window occurs, use this Guide to familiarize yourself with the most current information on the District's benefit programs and what coverage options are available to you. You can also use this information if:

- You want to enroll or make a change
- You want to submit completed enrollment/change form(s)
- You want to know what to expect after you enroll
- You want to learn what happens if you don't enroll

Enrolling or Making a Change

1. Please review your medical options carefully, ask questions and talk with your family. CalPERS medical provides both HMO and PPO options (see page 3 for important changes). If you're enrolling in a CalPERS medical plan:
 - a. Check with your doctors to find out which plans they participate in.
 - b. If you take any prescription medications regularly, contact the new plan to find out how these drugs are covered (for example, formulary or non-formulary drugs).
 - c. If you have questions call the medical plan's Member Services number or visit its website (contact details can be found in the ***CalPERS 2020 Health Benefit Summary***).
2. Consider not only your current circumstances but also what may be happening in your life in the future. Outside of the Open Enrollment period, you will not be able to make changes to your benefits unless:
 - a. You have a qualified change-in-status or HIPAA special enrollment event (for example, you get married or have a child). HIPAA special enrollment events are explained in more detail on page 10 of this Guide.
 - b. You move out of the HMO service area.
3. Review the ***CalPERS 2020 Health Benefit Summary (see page 3 for important changes)*** to view your medical options and this guide for your dental, vision, life, flexible spending accounts, and parking and transit benefits. Consider the following when choosing a medical plan:
 - a. **What the plans cover;**
 - b. **Your estimated usage.** Does your plan choice adequately cover the services you use most or will need in the future?
 - c. **Flexibility in choice of doctors, hospitals and how you receive care.** Each plan may include a different set of doctors, hospitals or have different rules for how to receive care;
 - d. **Verify service areas and provider availability** since all medical plans make ongoing changes during the year.
4. Use available tools to evaluate your needs and decide what's right for you.
 - a. Go to <https://pcms.plansource.com> (Username: BUSDEmployee Password: benefits) to review medical, dental, vision, flexible spending account information or;
 - b. Visit www.calpers.ca.gov to view medical plan information only. Under "I Want To..." Click on "View Health Plan Rates."
5. **Have the right information handy.** When you start the enrollment process, you'll need:
 - a. Your Social Security number;
 - b. The names, birth dates, and Social Security numbers of any dependents you wish to enroll, or of any beneficiaries you wish to designate;
 - c. Dependent Certification—see page 4 for a complete list of **REQUIRED** documents

How to Submit Completed Enrollment/Change Forms & FSA Election Forms

You may turn in your completed enrollment/change and/or election forms directly to the Office of Risk Management/ Benefits Department by:

1. **Walk-in:** Employees may submit the completed forms during window hours (See page 5).
 - **Employees can walk-in completed forms until 5:30 pm on October 4, 2019.**
2. **Mail:** Employees may submit the completed form(s) through Postal Mail. Forms must be postmarked no later than **5:30 pm on October 4, 2019**. Postmarked submittals received after this date will not be accepted.
3. **E-Mail:** Employees may submit the completed form(s) through E-mail. Please e-mail to openenrollment@berkeley.net. Forms must be received no later than **5:30 pm on October 4, 2019**. E-mailed submittals received after this date will not be accepted.

Forms must be received no later than **5:30 pm on October 4, 2019**. Completed forms will not be accepted after this date.

FAXED FORMS WILL NOT BE ACCEPTED

CHANGE: Waiving Health Coverage, Cash In Lieu of Medical (Limited Eligibility)

1. **You will need to re-enroll and recertify that you are waiving health coverage each year.**
2. Complete the **Cash in Lieu Form** . This waiver will be maintained on file with the District for the calendar year.
3. Return completed *CalPERS Health Benefits Enrollment Form* with your completed *Cash in Lieu* form.
4. Provide proof of other medical coverage when submitting the above forms. See page 4 for additional details.
Cash in lieu will not be provided without a signed Cash in Lieu Form and this proof.
5. Coverage under an individual plan, such as through Covered California, Medi-Cal, Tri-Care or Tri-West is not acceptable proof to receive cash-in-lieu.

You Want to Know What Happens After Enrollment

ID Cards

After you enroll for the first time, you will receive an ID card from the CalPERS medical plan you select. You will not receive an ID card for dental or vision coverage. Coverage is effective January 1, 2020 **even if you do not receive a new ID card by this date.**

When you receive your ID card, confirm that all information is accurate. If not, contact the Office of Risk Management/ Benefits Department right away.

Selecting Primary Care Physicians

You are not required to select a primary care physician (PCP) if you enroll in one of the CalPERS PPO plans. However, most HMOs (medical and dental) require that you and each of your covered dependents select a PCP from the plan's network. Kaiser is the only HMO medical carrier that does not require you to choose a PCP. With Kaiser, you can visit any of the primary care physicians at the facility of your choice. If you enroll in the DeltaCare (dental DHMO) plan, you must select a dental office.

When you first enroll, you'll need to designate your choice of PCP for CalPERS HMO medical plans and DeltaCare dental. If you don't designate your preferred PCP, the HMO will assign one for you. To choose a different PCP, call your plan carrier after you receive your ID card and request that your PCP be changed. PCP changes are not effective immediately. Generally, the change will occur the first of the following month.

You Want to Know What Happens if You Don't Enroll

If You Don't Enroll

If you are an active employee and you don't make any changes during the Open Enrollment period, you will continue to receive your current year's medical, dental, vision and life insurance coverages for yourself and your covered dependents. **You will not participate in any Flexible Spending Accounts (FSA) since you must enroll each year to participate in these plans. You must enroll during the Open Enrollment period: September 9 — October 4, 2019.**

If you are not currently enrolled and don't enroll in District-sponsored benefits during the Open Enrollment period, you will not be able to enroll until the next Open Enrollment period or until you experience a qualified change-in-status event or HIPAA special enrollment event.

Eligibility and Changes

Eligibility

All full-time and part-time employees who work the minimum specified hours as outlined by contract/agreement **AND** receive a STRS or PERS contribution can participate in the CalPERS benefits described in this Guide. Employees not receiving a STRS or PERS contribution are still eligible to enroll in the District's other benefits. Coverage begins based on your contract/agreement with the District unless you are applying for coverage during Open Enrollment in which case your effective date will be January 1, 2020.

Your Dependents

Your eligible dependents include:

- Your spouse (includes same and opposite sex spouses)
- Your same-sex or opposite sex domestic partner who meets certain criteria (listed below)
- Your children who are one of the following:
 - under age 26
 - age 26 or older with a physical or mental disability as defined by the Social Security Administration (provided they were on the plan prior to turning age 26)

Your children include:

- You or your domestic partner's natural or adopted children
- Your stepchildren whom you support and who live with you in a parent-child relationship
- Children placed in your home for adoption
- Any other children you support, you are the legal guardian or you are required to provide coverage as the result of a qualified medical child support order

You are required to provide certification of dependent status. Your dependents cannot be enrolled without providing such proof. See page 4 for details.

Domestic Partner Eligibility Criteria

If you are enrolling a non-registered domestic partner, you are required to have met all eligibility requirements listed below for the previous 6 months and complete a Domestic Partnership application/affidavit.

A Domestic Partnership shall exist between two persons regardless of gender and each of them shall be the domestic partner of the other if both complete and sign the affidavit and attest to the following:

1. The two parties reside together and share the common necessities of life;
2. The two parties are not married to anyone, not related by blood closer than would bar marriage in the State of California, and are mentally competent to consent to contract;
3. The two parties declare that they are each other's sole domestic partner and they are responsible for their common welfare;
4. The two parties agree to notify the Berkeley Unified School District's Office of Risk Management/Benefits Department if there is a change of circumstances attested to in the affidavit;
5. All dependents under Domestic Partnership coverage shall have permanent residency in the Domestic Partnership household and shall meet all other dependent coverage criteria;
6. It has been at least six months since either of the two parties has filed a statement of termination of a previous Domestic Partnership affidavit with the Office of Risk Management/Benefits Department.

Domestic Partner/Same-Sex Spouse Taxation

The cost to cover a domestic partner and his or her dependent children is the same as the cost to cover all other eligible family members. However, employee contributions for domestic partners and/or their dependent children are made on an after-tax basis for federal tax purposes in compliance with Internal Revenue Service (IRS) regulations.

In addition, the cost of employer paid coverage for domestic partners and their children will result in taxable “imputed” income to the employee for federal tax purposes. This means the District’s cost of the coverage is subject to federal income taxes including Federal Insurance Contributions Act (FICA) tax. Imputed income will be reflected on the employee’s paycheck and year-end W-2 form. The additional taxes will be withheld from pay.

Employee contributions for the domestic partner or his or her children may be deducted on a pre-tax basis if the individual meets the IRS definition of a “dependent.” For this purpose, a dependent is defined as a “qualifying relative” of the employee, who is generally someone who resides in, and is a member of, the employee’s household and who receives at least half of his or her support from the employee.

In the event your domestic partnership ends, you must notify the Office of Risk Management/Benefits Department within 30 days to discontinue this coverage.

For additional information regarding the tax implications of covering a domestic partner and their children, employees are strongly encouraged to consult with a tax advisor.

Please Note: The change in DOMA (Defense of Marriage Act) does not impact domestic partner relationships or civil unions. It is important to inform Office of Risk Management/Benefits Department of your marital status or domestic partnership to ensure proper taxation.

Making Changes

You can enroll in benefits as a new hire or during Open Enrollment. When you elect coverage under the medical, dental, vision or FSA plans, coverage stays in effect for the entire plan year (January 1, 2020— December 31, 2020). You cannot change your coverage, start or stop coverage, or add or drop any family members to or from your coverage during the plan year unless you have a **qualified change-in-status event** or a **HIPAA special enrollment event**.

Qualified Change-in-Status Events

Examples of qualified change-in-status events include:

- Change in marital status (marriage, divorce or legal separation)
- Change in the number of dependents (birth, adoption or placement for adoption of a child; death of spouse or child)
- Change in dependent eligibility (dependent child loses eligibility due to age)
- Change in other coverage (spouse or child gains or loses eligibility for coverage under another group plan, such as through spouse’s employment)
- Change in residence resulting in loss of eligibility (such as moving out of the HMO area)
- Significant cost or other coverage changes
- Other changes may qualify. Contact the Office of Risk Management/Benefits Department for more information.

If you experience a qualified change-in-status event, you have **30 days** to report the event and request an enrollment change that is consistent with the type of event. For instance, if the event is marriage, you may request an enrollment change to add your new spouse to your coverage. Enrollment changes due to qualified change-in-status events generally are effective the first of the month following the event, provided that you requested the enrollment change by the 30-day deadline. Coverage for a new child due to birth, adoption or placement of adoption generally is effective on the date of the event.

The plan's official documents govern how and when you can make enrollment changes during the plan year and may allow qualified change-in-status events in addition to those previously listed. The District's Office of Risk Management/Benefits Department can provide complete details.

When you experience any type of family change, you should also consider updating your life insurance and beneficiaries at the same time. In addition, you may need to update your address or update your tax status by completing a new Form W-4. For questions about tax forms or to update your address, contact the District's Office of Risk Management/Benefits Department.

HIPAA Special Enrollment Rights

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), if you decline District-sponsored medical, dental or vision coverage for yourself or your dependents because you have other group health insurance coverage (for example, through your spouse's employment), you may be able to enroll yourself and your dependents in the District's health care plan during the plan year if:

- You or your dependents lose eligibility for the other group coverage;
- The other employer stops contributing toward the other coverage;
- You or your dependents lose eligibility for Medicaid or Children's Health Insurance Program (CHIP) coverage;
- You or your dependents become eligible for a state's premium assistance program under Medicaid or CHIP.

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents in the District's health care plan during the plan year.

For any HIPAA special enrollment event, you must request enrollment within **30 days** after you or your dependent's other group coverage ends (or after the other employer stops making contributions toward the other coverage) or you acquire a new dependent. If the event is gaining or losing eligibility for coverage or premium assistance under Medicaid or CHIP, you have up to **60 days** to request enrollment.

For more information or to request special enrollment, contact the Office of Risk Management/Benefits Department at (510) 644-6666.

If You Leave Your Job

In most cases, your District-sponsored benefits end on the last day of the month in which you terminate your employment with the District, except CalPERS medical. Your CalPERS medical coverage will end on the first day of the second month following the last date you were employed. Keep in mind, depending on your bargaining unit contract/agreement, your coverage may be extended longer. You and the dependents you have covered under your medical, dental and vision coverage have the right to continue participation in group health coverage as allowed under the Consolidated Omnibus Budget Reconciliation Act (commonly referred to as "COBRA"). COBRA generally allows you to continue coverage for up to 18 months by paying the monthly premiums yourself. In some cases, longer extensions may apply. You may request another copy of your COBRA rights notice at any time. For more information, contact the Office of Risk Management/Benefits Department at (510) 644-6666.

You also have the option to continue your District paid Life insurance and/or your Voluntary Life insurance policies. *Please note: you are not able to continue your Basic Life AD&D coverage; however, you may be able to continue your voluntary AD&D coverage.* In addition, you may also continue the group term coverage that you selected for your spouse/domestic partner and dependent child(ren).

It is your responsibility to obtain and make application directly to the insurance carrier if you wish to continue your life insurance policy(ies). **The District cannot do this for you.** You have **31 days** after your termination date to make application directly with the insurance carrier. Failure to submit your application within the **31 day** time limit will result in forfeiture of your rights to continue your insurance. Please contact the District's Office of Risk Management/Benefits Department for an application.

Dental

Your Dental Plans



Choosing the right dental plan is as important as choosing your medical insurance plan. After considering your anticipated dental needs for the coming year, you can determine which dental plan will work best for you and your family by reviewing the deductibles, copays, and services covered under each plan. The following are the available plans offered to you:

- **Delta Dental – DeltaCare USA (DHMO)**
- **Delta Dental – PPO (Fee-For-Service) (in-network and out-of-network)**

DeltaCare USA (DHMO) is based on fixed copays for preventive, basic and major care. You must designate a primary care dentist when you enroll in this plan. The plan utilizes a network of dentists, and you must use a dentist who is a part of the DeltaCare network and who you have been assigned to receive benefits. If you obtain services from a dentist other than your designated primary dentist, you will have no benefits.

Delta Dental PPO (Fee-For-Service) gives you the freedom to choose your own dentist and receive coverage from in-network and out-of-network providers. This plan is a preferred provider organization (PPO) made up of general dentists and specialists who have agreed to provide dental care at discounted fees. If you go to a dentist who participates in the PPO, you qualify for in-network coverage, higher calendar year maximum and benefit from discounted rates.

IN - PPO Network Delta Dental PPO Dentist	Out-of-PPO Network Delta Dental Premier Dentists & Non-Delta Dental Dentists
You will usually pay the lowest amount for services when you visit a Delta Dental PPO dentist.	You are responsible for the difference between the amount Delta Dental pays and the amount your non-Delta Dental dentist bills. You will usually have the highest out-of-pocket costs when you visit a non-Delta Dental dentist.
PPO dentists agree to accept a reduced fee for PPO patients.	Delta Premier dentists may not balance bill above Delta Dental's approved amount, so your out-of-pocket costs may be lower than with non-Delta Dental dentists' charges.
You are charged only the patient's share at the time of treatment. Delta Dental pays its portion directly to the dentist.	Non-Delta Dental dentists may require you to pay the entire amount of the bill in advance and wait for reimbursement. Delta Premier dentists charge you only the patient's share at the time of treatment.
PPO dentists will complete claim forms and submit them for you at no charge.	You may have to complete and submit your own claim forms, or pay your non-Delta Dental dentist a service fee to submit them for you. Delta Premier dentists will complete claim forms and submit them for you at no charge.

Below is a quick summary of the key features and costs for both in-network and out-of-network services.

	DeltaCare In Network	Delta Dental In / Out of Network	
Calendar Year Deductible	None	\$25 single / \$50 Family	
Calendar Year Maximum Benefit	Unlimited	\$1,600	\$1,500
Diagnostic/Preventive	Various copays apply	100% <small>(Not subject to deductible or calendar year max)</small>	100% <small>(Not subject to deductible or calendar year max)</small>
Basic	Various copays apply	100%	100%
Major	Various copays apply	70%	70%
Orthodontia	Various copays apply	50%	50%
Lifetime Orthodontia Maximum	None	\$1,000	
Implants	Not covered	70%	70%
TMJ Treatment	Not covered	Not covered	
Waiting Period	None	None	None

The information presented in the chart is a summary only. The information does not include all of the detailed explanation of benefits, exclusions and limitations. Plan participants should refer to the Evidence of Coverage (EOC) document for coverage details. In the event information in this summary differs from the EOC, the EOC will prevail.

Voluntary Vision



Your Vision Plan

BUSD offers vision coverage through Vision Service Plan (VSP). You, the employee, pay the full premium for this coverage. VSP has one of the most extensive networks of optometrists and ophthalmologists as well as other vision care specialists in the country. Under this plan, you can use a VSP provider or another provider of your choice. However, when you obtain vision care through a non-VSP provider, you will receive a reduced level of benefits.

Here is a summary of covered services and costs:

COPAY		Vision Service Plan	
Exam/Materials		\$10 copay	
BENEFIT FREQUENCY			
Exam		Once every 12 months	
Lenses		Once every 12 months	
Frames		Once every 24 months	
Contact Lenses (in lieu of all other eyewear)		Once every 12 months	
COVERAGE		In - Network	Out-of-Network
Eye Exam		Covered in Full	up to \$50.00
Single Lens		Covered in Full	up to \$50.00
Bi-Focal Lenses		Covered in Full	up to \$75.00
Tri-Focal Lenses		Covered in Full	up to \$100.00
Lenticular Lenses		Covered in Full	up to \$125.00
Frame Allowance		up to \$140.00	up to \$70.00
<u>Contact Lenses</u>			
Medically Necessary		Covered in Full	up to \$210.00
Elective		up to \$140.00	up to \$105.00
Rate Guarantee		Guaranteed until 1/1/20	

***Primary Eyecare** rider is designed for the detection, treatment and management of ocular conditions and/or systemic conditions which produce ocular or visual symptoms. A member can seek care from their vision provider versus their medical primary care physician for - **Symptoms - including but not limited to:**

- ocular discomfort
- transient loss of vision
- flashes or floaters
- red eyes
- swollen lids
- pain in or around the eyes
- diplopia
- ocular trauma

Conditions - including but not limited to:

- ocular hypertension
- glaucoma
- cataracts
- pink-eye
- sty
- corneal abrasion
- corneal dystrophy
- macular degeneration
- retinal nevusble
- blepharitis

Solid Tints and Dyes		
Patient Option	Single Vision*	Multifocal*
Tinted/Photochromic	Covered in Full	Up to \$5
Anti-reflective Coating	\$37	\$37
Polycarbonate for Children	Covered in Full	Covered in Full
Polycarbonate for Adult	\$23	\$28
Standard Progressives	N/A	Covered in Full
Premium & Custom Progressives	N/A	\$80 - \$160+
Tints/Photochromics	Covered in Full	Covered in Full
Scratch-Resistant Coating	\$15	\$15

**Prices shown reflect the standard option price for each respective category. Premium options may vary. Prices are valid only through VSP Preferred Providers and are subject to change without notice.*

You are also eligible for certain discounts on non-covered lens options as well as Lasik vision correction surgery at contracted facilities. Discounts include:

- Average 35-40% savings on non-covered lens options and 30% off additional glasses and sunglasses
- Average of 15% off regularly priced services or procedures or 5% off promotionally priced services or procedures
- Discounts on hearing aids

After surgery, you can use your frame allowance (if applicable) to purchase sunglasses from any VSP network provider.

Flexible Spending Accounts (FSA) - You Must Re-Enroll

Flexible spending accounts (FSAs) help you save money on health care and dependent care expenses by paying for eligible expenses with tax-free dollars. If you are already enrolled, you must re-enroll for the new plan year. If you aren't enrolled and you would like to participate, please complete an enrollment form. Forms must be received no later than **5:30 pm on October 4, 2019**.

Here's how you save:

- The amount you contribute to either or both FSAs is deducted from your paycheck before federal, state, local, and Social Security taxes are withheld.
- When you have an eligible expense, you are reimbursed from your account(s) and the money isn't taxed.

Important!

Estimate your expenses and make your contribution elections wisely. Some of the funds you elect may be subject to forfeiture. Please be sure to review carryover and grace period guidelines. Additional information is available on the District's website or through the District's administrator, BASIC pacific. See page 17 for contact info.

Health Care Spending Account

You can use the Health Care Spending Account to pay for out-of-pocket health plan expenses including copays, coinsurance and deductibles. You can contribute up to \$2,700 each year. You may carryover up to \$500 of unused funds from the 2019 plan year to the 2020 plan year. Amounts in excess of \$500 will be forfeited. This carryover provision does not apply to Dependent Care Spending or Parking and Transit Accounts.

- Deductibles, copays and coinsurance
- Prescription drugs and drug copayments
- Prescription glasses, contact lenses and lens cleaning solution
- Dental and orthodontia expenses
- Laser vision correction
- Much more

Eligible expenses are "medically necessary" expenses not covered by your medical, dental or vision plans, including: Eligible expenses do not include cosmetic procedures, treatments not supervised by a qualified health care professional, premiums for employer-provided health care plans, or other expenses that are not medically necessary.

Dependent Care Spending Account

You may use the Dependent Care Spending Account to pay for the day care expenses of your dependent children under the age of 13, and dependents of any age who are incapable of self-care, live with you at least eight hours per day, and are claimed as dependents on your income tax return. You can contribute up to \$5,000 each year. However, if your spouse has access to a Dependent Care Spending Account, your total combined contribution may not exceed \$5,000. If you are married and file separate tax returns, each spouse may contribute \$2,500.

To be eligible, care must be provided while you (and your spouse, if you are married) work, look for work, or attend school full time. Eligible expenses include care in your home by an eligible provider or at a licensed facility. You will not be reimbursed for residential or "sleep-away" care, nursing home care, or for babysitting when you are not at work.

The Dependent Care Spending Account will not cover services provided by your spouse, a child of yours under age 19, or any dependent you claim as an exemption on your federal income tax.

How to Pay for Eligible Expenses

Health Care Expenses

You'll pay for your eligible out-of-pocket health care expenses using your personal credit card, cash or check. Get a receipt then submit a claim for reimbursement from your Health Care Spending Account.

You may also use your Health Care Spending account debit card to pay for eligible expenses. Be sure to keep the itemized receipt as documentation. A claim is automatically generated when you use your card.

Dependent Care Expenses

You'll pay for your eligible out-of-pocket dependent care expenses using your personal credit card, cash or check. Then, submit a claim for reimbursement from your Dependent Care Spending Account.

Deadline to Submit Claims for Reimbursement

You have 90 days after the end of the plan year to submit claims for reimbursement from your Health Care and Dependent Care Spending Accounts. Reimbursement checks can be mailed to your home or deposited into your bank account if you sign up for direct deposit

Health Care Spending Account— If you have dollars remaining at the end of the plan year (12/31/20), you may Carryover up to \$500 into the next plan year. Any dollars in excess of \$500 will be forfeited if not used by the end of the 90-day run-out period (3/31/21).

Dependent Care Spending Account—If you have dollars remaining at the end of the plan year (12/31/20), you may continue to incur claims for expenses during the “Grace Period.” The Grace Period extends 2 1/2 months after the end of the plan year (3/15/21), during which time you can continue to incur claims and use up all amounts remaining in your Dependent Care Spending Account. Any dollars remaining at the end of the Grace Period (3/31/21) will be forfeited.

To submit claims:

1. **Online Claim Filing:** File your claims online via the participant portal website. If new, login to your account at www.BASICpacific.com.
 - After you have logged on, click on **File A Claim** directly from the Home Page and Create Reimbursement from by selecting an account. Click on the Next button after each section.
 - Click on **Upload Valid Documentation** to continue online filing.
 - A copy of your receipt must be in PDF, JPG, GIF format and cannot exceed 2 MB. Use **Browse** to locate and attach the receipt and/or other supporting documentation of your claim and **Submit**.
 - Add all **Claim Details** (Note: Under “Category” and “Type”, if more than one selection from the drop-down list seems right, select the one that best fits the expense.)
 - Check the box next to **Claims Terms and Conditions** and be sure to click on the **Submit** button.
 - The next screen should show **Accounts/Transaction Confirmation** – Successfully Submitted.
 - If you uploaded all your receipts and/or supporting documentation, there is nothing more you need to do.
 - If you cannot upload your receipt and/or supporting documentation, click on Print the **Claim Confirmation Form** and send the confirmation to BASIC pacific with your documentation via e-mail, fax or mail. This confirmation page serves as your claim form and verifies that all claims have been successfully submitted. Your claim is considered “received” by BASIC pacific only after BASIC pacific receives your supporting documentation
2. **Paper Claim Form Filing:** You may opt to file claims using a paper claim form available on the website under the **Tools & Support** tab.
 - Complete the claim form in full including your certification (signature).
 - Do not highlight, alter or write on your documentation.
 - Consider photocopying colored, carbon or thermal-paper receipts, as they may transmit too light to be legible. They may also fade over time, so photocopying may help to preserve the long-term integrity of the document.
 - Retain a complete copy for your records.
 - Submit your completed claim form and required documentation via e-mail (PDF only), fax or mail.
 - NEVER SUBMIT A “PAPER” CLAIM FOR A CLAIM YOU HAVE ALREADY FILED ONLINE OR FOR AN EXPENSE YOU’VE PAID FOR WITH YOUR BASIC PACIFIC DEBIT CARD.

More details and eligible expenses

For more a list of eligible expenses for the health care or dependent care FSA, refer to IRS guidelines available online at www.irs.gov. You can also contact the District’s administrator, BASIC pacific, by calling (800) 574-5448 or by visiting their website at www.BASICpacific.com.

Parking & Transit Reimbursement Plan

Save money on your parking and transit expenses by utilizing pretax dollars to pay for transit, vanpooling and work-related parking costs. You designate a portion of your salary before taxes (pretax income) to pay for qualified transit, vanpooling or parking expenses. Tax-free benefits are only available through BUSD. You cannot directly take advantage of these tax benefits by taking a tax deduction or credit on your individual tax return.

There are two types of expenses (1) Parking Expenses and (2) Mass Transit Expenses.

Eligible **Parking Expenses** include the costs you incur for parking your car at or near your work premises or at a location that you commute to work to use Mass Transit.

Eligible **Mass Transit** Expenses include your costs for a pass, token, fare card, or voucher used exclusively to pay for mass transportation. The transportation can be on a public or privately owned facility. Vanpools or Commuter Highway Vehicles used for travel to and from your work or to a Mass Transit location that you commute from, are eligible Mass Transit Expenses.

To be eligible, however, a Vanpool must: (a) have a seating capacity of at least six (6) adults excluding the driver; (b) be used 80% for purposes of transporting eligible employees to and from work; and , (c) be used by more than half the riders to commute to and from work.

Toll charges and carpooling expenses do not qualify as a “Mass Transit Expense” and are, therefore, not eligible for reimbursement.

You are permitted to change your elections on the first day of each calendar month. You may also stop making contributions to your accounts as of the first day of each calendar month. If you have a balance in either of your accounts, you may still access your funds even if you are not currently contributing. Your funds are not forfeited while working.

You may not transfer funds between the Parking and Transit accounts.

MAXIMUM AMOUNT THAT CAN BE CONTRIBUTED EACH MONTH:

Parking Spending Account:	\$265 (subject to change by IRS)
Transit & Van Pooling Spending Account:	\$265 (subject to change by IRS)

Life Insurance—Lincoln Life

Basic Life and AD&D Insurance

Life insurance and Accidental Death and Dismemberment (AD&D) insurance provide funds for those who have lost someone or for those who are seriously injured. Life insurance pays funds to your designated beneficiaries after your death, while AD&D pays an additional amount in the event of an accidental death or for certain accidental injuries. Basic Life and AD&D is provided at no cost to employees with FTE's at .50 and greater. You are provided with Life and AD&D Insurance equal to \$15,000.

You are automatically enrolled when you become an employee of Berkeley Unified School District with a minimum .50 FTE. This benefit is 100% paid by the District.

How to Enroll—you do not need to do anything unless you want to enroll in or increase your voluntary life insurance election (see page 16)

Note: The value of any life insurance coverage in excess of \$50,000 may be subject to imputed income taxes.

Voluntary Life Insurance

In addition to the Basic Life insurance plan, you are eligible to purchase additional amounts of individual term life insurance for yourself, your spouse or your domestic partner, and your children. You must elect Voluntary Life insurance for yourself in order to make an election for any eligible dependents. Below are the maximums:

- **Employee Benefit** – purchase up to a maximum of \$300,000 in increments of \$10,000
- **Spouse/Domestic Partner Benefit** - up to \$100,000 in increments of \$5,000 (cannot exceed 50% of employee election)
- **Dependent child(ren) Benefit** – 6 months to 26 years: up to \$10,000 in increments of \$2,500

You may enroll in this benefit when you are first hired and receive up to the following Guarantee Issue (GI) amounts:

- **Employee**— \$200,000
- **Spouse/Domestic Partner**—\$30,000
- **Dependent child(ren) Benefit**—\$10,000

★ 2020 Open Enrollment ★

During Open Enrollment, you will have the opportunity to enroll in or increase benefits up to the guaranteed issue amounts listed above for yourself and your spouse **without Evidence of Insurability (EOI)** as long as you have not been previously withdrawn or declined by Lincoln Financial.

If you wish to enroll or increase your coverage amounts, you will need to complete either the Lincoln Enrollment Form or the Evidence of Insurability (EOI) form.

- Employee Benefit—increase \$10,000 or \$20,000
- Spouse/Domestic Partner Benefit—increase \$5,000 or \$10,000

Employee/Spouse Voluntary Life Insurance Rates per \$1,000 (Rate based on Employee's Age)	
Under age 24	\$0.060
25-29	\$0.072
30-34	\$0.096
35-39	\$0.108
40-44	\$0.120
45-49	\$0.216
50-54	\$0.336
55-59	\$0.564
60-64	\$0.936
65-69	\$1.57
70-74	\$2.66
75-79	\$8.00
80-99	\$17.29
Child(ren) Voluntary Monthly Life Insurance Rates	
\$2,500 Benefit	\$0.72
\$5,000 Benefit	\$1.44
\$7,500 Benefit	\$2.16
\$10,000 Benefit	\$2.88

NAMING YOUR BENEFICIARY

You may name anyone you wish as the beneficiary who will receive your life and AD&D benefits in case of your death. Once you have selected your beneficiary(ies), your designation will remain unchanged until you submit a new beneficiary designation form. You may change your beneficiary(ies) as often as you wish.

PLEASE NOTE:

1. Employee must purchase insurance for themselves, to purchase insurance for dependents.
2. Spouse benefits are based on the employee's age.
3. Child rates are per dependent unit, so the rate is the same for one (1) or multiple children.
4. Rate changes due to age category changes take place on the policy anniversary, January 1st.

EXAMPLE OF EMPLOYEE/SPOUSE TENTHLY RATE CALCULATION

Employee age 45 elects \$200,000
 $\$200,000 / \$1,000 \times \$0.216 = \43.20 tenthly

Employee Assistance Program (EAP) - Claremont EAP

By accessing Claremont Employee Assistance Program you can be assessed and referred to Participating Practitioners who can help you and your eligible family members resolve personal problems that can affect your health, family life, abilities, and desire to excel at work. You and your family members are entitled to up to 8 sessions per member per incident per year. The EAP can help you resolve a broad range of personal problems through assessment of issues and referral to Participating Practitioners including:

- Marriage/Family Issues
- Emotional Problems
- Financial & Legal Problems
- Stress Management
- Alcohol/Drug Dependency
- Childcare & Eldercare Assistance

Contacts

If you have questions, you can contact the District's Office of Risk Management/Benefits Department or the plan carriers. Use this chart to help guide you to the right resource on the first try.

PLAN INFO	WEBSITE	CONTACT	GROUP #
BUSD Office of Risk Management/Benefits Department			
(510) 644-6666	External: www.berkeley.net (click on “Staff Resources”) Internal (Only accessible from a computer within the District): http://intranet.berkeley.net/ (Click on “Risk Management”)		
Medical—CalPERS			
Medical Plans	www.calpers.gov	(888) 225-7377	
Review the CalPERS 2020 <i>Health Benefit Summary</i> for specific carrier contact information			
Dental—Delta Dental			
PPO (Fee-For-Service)	www.deltadentalins.com	(866) 499-3001	7069
DeltaCare USA (DHMO)		(800) 422-4234	5827
Vision—Vision Service Plan (VSP)			
Vision PPO	www.vsp.com	(800) 877-7195	12314888
Life Insurance—Lincoln Financial			
Basic Life/Voluntary Life	www.lfg.com	(800) 423-2765	BERKELEYSD
Flexible Spending Accounts—BASIC pacific			
Administration	www.BASICpacific.com	(800) 574-5448	
Employee Assistance Program (EAP)			
EAP—Claremont	www.claremonteap.com	(800) 834-3773	

Annual Notices

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, contact your health plan.

Patient Protection Act

The CalPERS HMO Plans generally require the designation of a primary care provider. You have the right to designate any primary care provider who participates in the network and who is available to accept you or your family members. Until you make this designation, the plan will designate one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the plan at the phone number on the back of your ID card. For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from the plan 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 the 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 plan at the phone number on the back of your ID card.

Special Enrollment

If an eligible employee declines enrollment in this group health plan for the employee or the employee's spouse or dependents because of other health insurance or group health plan coverage, the eligible employee may be able to enroll him/herself and eligible dependents in this plan if eligibility is lost for the other coverage (or because the employer stops contributing toward this other coverage). However, the eligible employee must request enrollment within **30 days** after the other coverage ends (or after the employer ceases contributions for the coverage).

In addition, if an eligible employee acquires a new dependent as a result of marriage, birth, adoption or placement for adoption, the eligible employee may be able to enroll him/herself and any eligible dependents, provided that the eligible employee requests enrollment within **30 days** after the marriage, birth, adoption, or placement for adoption. If the eligible employee otherwise declines to enroll, he/she may be required to wait until the group's next open enrollment to do so.

Furthermore, eligible employees and their eligible dependents who are eligible for coverage but not enrolled, shall be eligible to enroll for coverage within 60 days after (a) becoming ineligible for coverage under a Medicaid or Children's Health Insurance Plan (CHIP) plan or (b) being determined to be eligible for financial assistance under a Medicaid, CHIP, or state plan with respect to coverage under the plan.

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. If you would like more information on WHCRA benefits, call the plan at the phone number on the back of your ID card.

Summary of Benefits and Coverage (SBC)

As required by the Affordable Care Act (ACA), health plans and employer groups must provide the Summary of Benefits and Coverage (SBC) to eligible employees and family members, who are:

- Currently enrolled in one of the group health plans or
- Eligible to enroll in one of the plans, but not yet enrolled

As such, an SBC for the health plan you are currently enrolled in is available to you and your dependents, if applicable. The SBC provides important information about the Plan's benefits and your rights as a Plan participant.

The Affordable Care Act (ACA) also provides a Uniform Glossary of Insurance and Medical Terms. A paper copy of this Glossary is available upon request. All SBCs and the Glossary can be found on the District's MyBenefits website. Refer to page 2 for login information.

NOTICE OF HIPAA PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices (the "Notice") describes the legal obligations of the self-funded health plan(s) (the "Plan") sponsored by Berkeley Unified School District ("Plan Sponsor") and your legal rights regarding your protected health information held by the Plan under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Health Information Technology for Economic and Clinical Health Act (HITECH Act) and subsequent amending regulations ("HIPAA Privacy Rule"). Among other things, this Notice describes how your protected health information may be used or disclosed to carry out treatment, payment, or health care operations, or for any other purposes that are permitted or required by law. We are required to provide this HIPAA Privacy Notice to you pursuant to HIPAA.

The HIPAA Privacy Rule protects only certain medical information known as "protected health information." Generally, protected health information is health information, including demographic information, collected from you or created or received by a health care provider, a health care clearinghouse, a health plan, or your employer on behalf of a group health plan, from which it is possible to individually identify you and that relates to:

- Your past, present, or future physical or mental health or condition;
- The provision of health care to you; or
- The past, present, or future payment for the provision of health care to you.

If you have any questions about this Notice or about our privacy practices, please contact the individual listed at the end of this notice.

Our Responsibilities

Berkeley Unified School District is required by law to:

- Maintain the privacy of your protected health information;
- Provide you with certain rights with respect to your protected health information;
- Provide you with a copy of this Notice of our legal duties and privacy practices with respect to your Protected health information; and
- Follow the terms of the Notice that is currently in effect.

We reserve the right to change the terms of this Notice and to make new provisions regarding your protected health information that we maintain, as allowed or required by law. If we make any material change to this Notice, we will provide you with a copy of our revised HIPAA Privacy Notice electronically or by first class mail to the last known address on file.

How We May Use and Disclose Your Protected Health Information

Under the law, we may use or disclose your protected health information under certain circumstances without your permission. The following categories describe the different ways that we may use and disclose your protected health information. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

For Payment. We may use or disclose your protected health information to determine your eligibility for Plan benefits, to facilitate payment for the treatment and services you receive from health care providers, to determine benefit responsibility under the Plan, or to coordinate Plan coverage. For example, we may tell your health care provider about your medical history to determine whether a particular treatment is experimental, investigational, or medically necessary, or to determine whether the Plan will cover the treatment. We may also share your protected

health information with a utilization review or precertification service provider. Likewise, we may share your protected health information with another entity to assist with the adjudication or subrogation of health claims or to another health plan to coordinate benefit payments.

For Health Care Operations. We may use and disclose your protected health information for other Plan operations. These uses and disclosures are necessary to run the Plan. For example, we may use medical information in connection with conducting quality assessment and improvement activities; underwriting, premium rating, and other activities relating to Plan coverage; submitting claims for stop-loss (or excess-loss) coverage; conducting or arranging for medical review, legal services, audit services, and fraud and abuse detection programs; business planning and development such as cost management; and business management and general Plan administrative activities. However, we will not use your genetic information for underwriting purposes.

Treatment Alternatives or Health-Related Benefits and Services. We may use and disclose your protected health information to send you information about treatment alternatives or other health-related benefits and services that might be of interest to you.

To Business Associates. We may contract with individuals or entities known as Business Associates to perform various functions on our behalf or to provide certain types of services. In order to perform these functions or to provide these services, Business Associates will receive, create, maintain, transmit, use, and/or disclose your protected health information, but only after they agree in writing with us to implement appropriate safeguards regarding your protected health information. For example, we may disclose your protected health information to a Business Associate to process your claims for Plan benefits or to provide support services, such as utilization management, pharmacy benefit management, or subrogation, but only after the Business Associate enters into a Business Associate contract with us.

As Required by Law. We will disclose your protected health information when required to do so by federal, state, or local law. For example, we may disclose your protected health information when required by national security laws or public health disclosure laws.

To Avert a Serious Threat to Health or Safety. We may use and disclose your protected health information when necessary to prevent a serious threat to your health and safety, or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat. For example, we may disclose your protected health information in a proceeding regarding the licensure of a physician.

To Plan Sponsors. For the purpose of administering the plan, we may disclose to certain employees of the Employer protected health information. However, those employees will only use or disclose that information as necessary to perform plan administration functions or as otherwise required by HIPAA, unless you have authorized further disclosures. Your protected health information cannot be used for employment purposes without your specific authorization.

Special Situations

In addition to the above, the following categories describe other possible ways that we may use and disclose your protected health information without your specific authorization. For each category of uses or disclosures, we will explain what we mean and present some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

Organ and Tissue Donation. If you are an organ donor, we may release your protected health information after your death to organizations that handle organ procurement or organ, eye, or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

Military. If you are a member of the armed forces, we may release your protected health information as required by military command authorities. We may also release protected health information about foreign military personnel to

the appropriate foreign military authority.

Workers' Compensation. We may release your protected health information for workers' compensation or similar programs, but only as authorized by, and to the extent necessary to comply with, laws relating to workers' compensation and similar programs that provide benefits for work-related injuries or illness.

Public Health Risks. We may disclose your protected health information for public health activities. These activities generally include the following:

- to prevent or control disease, injury, or disability;
- to report births and deaths;
- to report child abuse or neglect;
- to report reactions to medications or problems with products;
- to notify people of recalls of products they may be using;
- to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
- to notify the appropriate government authority if we believe that a patient has been the victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree, or when required or authorized by law.

Health Oversight Activities. We may disclose your protected health information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose your protected health information in response to a court or administrative order. We may also disclose your protected health information in response to a subpoena, discovery request, or other lawful process by someone involved in a legal dispute, but only if efforts have been made to tell you about the request or to obtain a court or administrative order protecting the information requested.

Law Enforcement. We may disclose your protected health information if asked to do so by a law-enforcement official: in response to a court order, subpoena, warrant, summons, or similar process; to identify or locate a suspect, fugitive, material witness, or missing person; about the victim of a crime if, under certain limited circumstances, we are unable to obtain the victim's agreement; about a death that we believe may be the result of criminal conduct; and about criminal conduct.

Coroners, Medical Examiners, and Funeral Directors. We may release protected health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about patients to funeral directors, as necessary to carry out their duties.

National Security and Intelligence Activities. We may release your protected health information to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

Inmates. If you are an inmate of a correctional institution or are in the custody of a law-enforcement official, we may disclose your protected health information to the correctional institution or law-enforcement official if necessary: (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

Research. We may disclose your protected health information to researchers when: the individual identifiers have been removed; or when an institutional review board or privacy board has reviewed the research proposal and established protocols to

ensure the privacy of the requested information, and approves the research.

Required Disclosures

The following is a description of disclosures of your protected health information we are required to make.

Government Audits. We are required to disclose your protected health information to the Secretary of the United States Department of Health and Human Services when the Secretary is investigating or determining our compliance with the HIPAA privacy rule.

Disclosures to You. When you request, we are required to disclose to you the portion of your protected health information that contains medical records, billing records, and any other records used to make decisions regarding your health care benefits. We are also required, when requested, to provide you with an accounting of most disclosures of your protected health information if the disclosure was for reasons other than for payment, treatment, or health care operations, and if the protected health information was not disclosed pursuant to your individual authorization.

Other Disclosures

Personal Representatives. We will disclose your protected health information to individuals authorized by you, or to an individual designated as your personal representative, attorney-in-fact, etc., so long as you provide us with a written notice/authorization and any supporting documents (i.e., power of attorney). Note: Under the HIPAA privacy rule, we do not have to disclose information to a personal representative if we have a reasonable belief that:

you have been, or may be, subjected to domestic violence, abuse, or neglect by such person; or treating such person as your personal representative could endanger you; and in the exercise of professional judgment, it is not in your best interest to treat the person as your personal representative.

Spouses and Other Family Members. With only limited exceptions, we will send all mail to the employee. This includes mail relating to the employee's spouse and other family members who are covered under the Plan, and includes mail with information on the use of Plan benefits by the employee's spouse and other family members and information on the denial of any Plan benefits to the employee's spouse and other family members. If a person covered under the Plan has requested Restrictions or Confidential Communications (see below under "Your Rights"), and if we have agreed to the request, we will send mail as provided by the request for Restrictions or Confidential Communications.

Authorizations. Other uses or disclosures of your protected health information not described above will only be made with your written authorization. For example, in general and subject to specific conditions, we will not use or disclose your psychiatric notes; we will not use or disclose your protected health information for marketing; and we will not sell your protected health information, unless you give us a written authorization. You may revoke written authorizations at any time, so long as the revocation is in writing. Once we receive your written revocation, it will only be effective for future uses and disclosures. It will not be effective for any information that may have been used or disclosed in reliance upon the written authorization and prior to receiving your written revocation.

Your Rights

You have the following rights with respect to your protected health information:

Right to Inspect and Copy. You have the right to inspect and copy certain protected health information that may be used to make decisions about your Plan benefits. If the information you request is maintained electronically, and you request an electronic copy, we will provide a copy in the electronic form and format you request, if the information can be readily produced in that form and format; if the information cannot be readily produced in that form and format,

we will work with you to come to an agreement on form and format. If we cannot agree on an electronic form and format, we will provide you with a paper copy.

To inspect and copy your protected health information, you must submit your request in writing to the individual listed at the end of this Notice. If you request a copy of the information, we may charge a reasonable fee for the costs of copying, mailing, or other supplies associated with your request. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to your medical information, you may request that the denial be reviewed by submitting a written request to the individual listed at the end of this Notice.

Right to Amend. If you feel that the protected health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the Plan. To request an amendment, your request must be made in writing and submitted to the individual listed at the end of this Notice. You must provide a reason that supports your request.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- is not part of the medical information kept by or for the Plan;
- was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- is not part of the information that you would be permitted to inspect and copy; or
- is already accurate and complete.

If we deny your request, you have the right to file a statement of disagreement with us and any future disclosures of the disputed information will include your statement.

Right to an Accounting of Disclosures. You have the right to request an "accounting" of certain disclosures of your protected health information. The accounting will not include (1) disclosures for purposes of treatment, payment, or health care operations; (2) disclosures made to you; (3) disclosures made pursuant to your authorization; (4) disclosures made to friends or family in your presence or because of an emergency; (5) disclosures for national security purposes; and (6) disclosures incidental to otherwise permissible disclosures.

To request this list or accounting of disclosures, you must submit it in writing to the individual listed at the end of this Notice. Your request must state the time period you want the accounting to cover, which may not be longer than six years before the date of the request. Your request should indicate in what form you want the list (for example, paper or electronic). The first list you request within a 12-month period will be provided free of charge. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions. You have the right to request a restriction or limitation on your protected health information that we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on your protected health information that we disclose to someone who is involved in your care or the payment for your care, such as a family member or friend. For example, you could ask that we not use or disclose information about a surgery that you had. Except as provided in the next paragraph, we are not required to agree to your request. However, if we do agree to the request, we will honor the restriction until you revoke it or we notify you.

We will comply with any restriction request if (1) except as otherwise required by law, the disclosure is to a health plan for purposes of carrying out payment or health care operations (and is not for purposes of carrying out treatment); and (2) the protected health information pertains solely to a health care item or service for which the health care provider involved has been paid in full by you or another person. To request restrictions, you must send your request in writing to the individual listed at the end of this notice.

In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use,

disclosure, or both; and (3) to whom you want the limits to apply—for example, disclosures to your spouse.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. To request confidential communications, you must make your request in writing the individual listed at the end of this notice. We will not ask you the reason for your request. Your request must specify how or where you wish to be contacted. We will accommodate all reasonable requests

Right to Be Notified of a Breach. You have the right to be notified in the event that we (or a Business Associate) discover a breach of unsecured protected health information.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice.

You may obtain a copy of this notice at our website which is listed at the end of this notice. To obtain a paper copy of this notice, contact the individual listed at the end of this notice.

Complaints

If you believe that your privacy rights have been violated, you may file a complaint with the Plan or with the Office for Civil Rights of the United States Department of Health and Human Services. To file a complaint with the Plan, contact to the individual listed below. All complaints must be submitted in writing.

You will not be penalized, or in any other way retaliated against, for filing a complaint with the Office for Civil Rights or with us.

HIPAA Contact

Kimberle Sanders
Risk Manager and Benefits Supervisors
2020 Bonar St. Ste. 234
Berkeley, CA 94702
(510) 644-6049

Website: <https://pcms.plansource.com>
Username: BUSDEmployee (case sensitive)
Password: benefits (case sensitive)

