Berkeley PUBLIC SCHOOLS
Berkeley Unified School District

Your 2021 Benefits

Effective January 1, 2021 - December 31, 2021

OPEN ENROLLMENT
September 21, 2020 - October 16, 2020

Health Benefits, FSA, Parking & Transit Open Enrollment Guide

Active Employees

IMPORTANT NOTICE: READ CAREFULLY

This 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 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): Information regarding the SBCs can be found on page 21 of this Guide and are 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 Benefits Department
(510) 644-6666 (press 1)

Cash-in-lieu : Requires Re-Enrollment

You need to take action!
Complete the Cash-in-lieu form and return to the Benefits Department
by October 16th
Even if you are already getting cash-in-lieu, you need to re-enroll!

Please Note: Coverage under an individual plan, such as through Covered California or Medi-Cal is not acceptable proof to receive cash-in-lieu. Please review page 11 to determine the form and documents that are needed.

TABLE OF CONTENTS

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.

Open Enrollment 4

Important Changes 5

Eligibility 6

Enrolling or Making a Change 9

Open Enrollment Checklist 11

Dental Benefits 12

Vision Benefits 13

Flexible Spending Accounts (FSAs) 14

Life & Voluntary Life Insurance 17

Employee Assistance Program (EAP) 19

Key Contacts 20

Annual Notices 21

Important Notice

Berkeley Unified School District has made every attempt to ensure the accuracy of the information described in this enrollment guide. Any discrepancy between this guide and the insurance contracts or other legal documents that govern the plans of benefits described in this enrollment guide will be resolved according to the insurance contracts and legal documents. Berkeley Unified School District reserves the right to amend or discontinue the benefits described in this enrollment guide in the future, as well as change how eligible employees and Berkeley Unified School District share plan costs at any time. This enrollment guide creates neither an employment agreement of any kind nor a guarantee of continued employment with Berkeley Unified School District.

WELCOME

OPEN ENROLLMENT is from September 21 to October 16, 2020

During this Open Enrollment, you will have the opportunity to review your coverage needs, consider the benefit plans available to you, and select benefits that will provide the most value to you. All enrollments and changes you make during this Open Enrollment period will become effective January 1, 2021 even if you do not receive a new ID card by this date.

Open Enrollment for 2021 coverage – **your one chance to make changes to your benefits**[1] – begins September 21 and will remain open until October 16. The benefits you choose during open enrollment will become effective on January 1, 2021.

You must participate in Open Enrollment if you wish to do any or all of the following:

- Enroll or make changes to your medical, dental, or vision coverage for the upcoming plan year
- Contribute to a Health Care and/or Dependent Care Flexible Spending Account (FSA)

If you don't enroll or make changes to your benefits, you will default into the same or comparable coverage that you elected last year. However, you won't be automatically enrolled in any FSA account – **you need to make an election to participate each year.**

Where to Obtain Information and Enrollment/Change Forms

- **CalPERS Medical**

  The complete CalPERS *2021 Health Benefit Summary* and other CalPERS open enrollment information including enrollment/change forms can be obtained by accessing the CalPERS website at:

  CalPERS member benefits open enrollment

- **Non-Medical Benefits (Dental, Vision, Life, FSA)**

  This Guide provides a brief overview of these benefits. Detailed information including benefit summaries and enrollment/change forms can be obtained by accessing either of the following websites:

  The District's MyBenefits website
  https://pcms.plansource.com
  Username: BUSDEmployee
  Password: benefits

  The District's Benefits Department
  https://www.berkeleyschools.net/departments/benefits/

[1] You can change your coverage during the year if you experience a "Qualified Status Change," including but not limited to marriage, domestic partnership, divorce, birth or adoption of a child or death of spouse or child.

Important Changes in the 2021 Benefit Offerings

Virtual Meetings

This year, Open Enrollment is different due to COVID-19. A virtual open enrollment meeting will be held via Zoom on Wednesday, September 30, 2020 at 3:00 pm. If you'd like to participate, please register using the link below:

https://epicbrokers.zoom.us/webinar/register/WN_Wbsm8wruT8-BMsbnhkTZtw

In addition to the Zoom meeting being conducted by the District, you can access various CalPERS medical information and carrier webinars at:

CalPERS
CalPERS member benefits open enrollment

Kaiser Permanente:
Register for a webinar at: Kaiser Permanente Virtual Open Enrollment

Anthem:
Link to HMO benefits presentation at: Anthem HMO Benefits Presentation
Link to PPO benefits presentation at: Anthem PPO Benefits Presentation

CalPERS Medical – CHANGES TO PLANS

For specific changes to the medical plans, please review your *CalPERS 2021 Health Benefit Summary*. The complete *2021 Health Benefit Summary* can be obtained through your myCalPERS account or on the CalPERS website:

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

Delta Dental PPO (Fee-For-Service) and DeltaCare USA (DHMO)— no change in benefits or premiums

Vision Service Plan (VSP)— no change in benefits or premiums

Health Care Spending FSA—Maximum will be increasing to $2,750

Voluntary Life Insurance—You will have the opportunity to enroll or increase your coverage up to two increments without evidence of insurability. See page 18 for details

Medical Rates Will Be Changing

Rate sheets for each bargaining unit as well as additional plan information can be found online at:
The Benefits Department
https://www.berkeleyschools.net/departments/benefits/

Mobile App—Benefits2Go Company Registration Key: BER0110

Access District benefits information (app does not contain personal 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 Company Registration Key to get started!

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, 2021.

Eligible dependents include:

- Your spouse (includes same and opposite sex spouses)
- Your state-registered domestic partner (CalPERS Medical)
- Your non-state registered domestic partner for dental, vision, life who meets certain criteria (listed below)[1]
- Child(ren) up to age 26
- Child(ren) of any age with a physical or mental disability as defined by the Social Security Administration (provided they were on the plan prior to turning age 26)

You 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

PROOF OF DEPENDENT ELIGIBILITY

You are required to provide certification of dependent status. Your dependents cannot be enrolled without providing such proof. See page 11 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 Benefits Department.

[1] Due to federal and state tax regulations, benefits provided to domestic partners are generally taxable and therefore deducted from your pay on an after-tax basis. Additionally, any premium contributions made by Berkeley USD on behalf of your domestic partner are generally considered taxable income to you. Contact the Benefits Department if you believe your domestic partner is exempt from federal or state taxes.

ELIGIBILITY

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 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 the Benefits Department of your marital status or domestic partnership to ensure proper taxation.

Making Changes

When you elect coverage under the medical, dental, vision or FSA plans, coverage stays in effect for the entire plan year (January 1, 2021— December 31, 2021). 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 Martial Status (marriage, divorce, or legal separation)
- Change in the number of dependents (birth, adoption or replacement for adoption of a child; death of spouse or child)
- Change in dependent eligibility (dependent 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 service area)
- Significant cost or other coverage changes
- Other changes may qualify. Contact the 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.

ELIGIBILITY

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 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 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 Benefits Department at (510) 644-6666 (press 1).

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 Benefits Department at (510) 644-6666 (press 1).

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 Benefits Department for an application.

Enrolling or Making a Change

Enrolling or Making Changes

1. Please review your medical options carefully, ask questions and talk with your family. CalPERS medical provides both HMO and PPO options (see page 5 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 2021 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 HIPPA special enrollment event (for example, you get married or have a child).
    b) You move outside the HMO service area.
3. Review the CalPERS 2021 Health Benefit Summary (see page 5 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.gove 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 any beneficiaries you wish to delegate.
    c) Dependent Certification – see page 11 for a complete list of **REQUIRED** documents

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

You may submit your completed enrollment/change and/or election forms to the Benefits Department by:

1. **Mail:** Employees may submit the completed form(s) through Postal Mail. Forms must be postmarked no later than **5:30pm on October 16, 2020.** Postmarked submittals received after this date will not be accepted. Mail to: Benefits Department, 2020 Bonar Street, 2nd Floor, Berkeley, CA 94702
2. **Email:** Employees may submit the completed form(s) through Email. Please email to benefits@Berkeley.net. Forms must be received no later than **5:30 pm on October 16, 2020**. Emailed submittals received after this date will not be accepted.

Forms must be received no later than **5:30 pm on October 16, 2020**. Completed forms will not be accepted after this date.

FAXED FORMS WILL NOT BE ACCEPTED

Enrolling or Making a Change Continued

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 11 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 unless enrolling in the DeltaCare DHMO dental plan. Coverage is effective January 1, 2021 **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 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 21 — October 16, 2020.

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.

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 Benefits Department no later than
5:30 pm on Friday, October 16, 2020

PLEASE SEE PAGE 9 "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 area 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 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 2021 plan year. **Your current election will not forward.** Remember to consider any carryover Health Care spending dollars you will have at the end of 2020 when making your election for 2021.
- ❑ **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 certifications to the District in a timely manner. Failure to submit supporting documentation copies will result in dependents being denied coverage. **DO NOT SUBMIT ORIGNAL DOCUMENTS AS THEY WILL NOT BE RETURNED.**

- ❑ **Spouse –** Marriage Certificate
- ❑ **Domestic Partner –** Declaration of Domestic Partnership from the California Secretary of State Offices, 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

DENTAL BENEFITS

BUSD offers dental coverage through Delta Dental and DeltaCare. You have the opportunity to choose from the DHMO or PPO dental plan options. Each type of plan has unique advantages. Understanding the differences between them will help you choose the coverage that best meets the needs of you and your family.

Plan	Plan Features
DHMO	• Provides benefits only if you see an in-network dentist • Requires you to choose a primary care dentist to coordinate all your care • Provides benefits based on a copay schedule
PPO	• Allows you to receive care from a dentist in the network or outside the network • Pays a portion of your expenses after you meet your annual deductible, except for preventive care which is covered at 100% • In-network coverage provides a higher calendar year maximum and a benefit from discounted rates

DENTAL PLAN SUMMARY

Key Features	DeltaCare USA (DHMO)	Delta Dental PPO (Fee-For-Service)	
	In-Network Only	In-Network	Out-of-Network
Calendar Year Deductible (Individual / Family)	None	$25 single / $50 Family	
Calendar Year Maximum Benefit	Unlimited	$1,600	$1,500
Diagnostic/Preventive	Various Copays Apply	100% (Not subject to deductible or calendar year max)	
Basic Services	Various Copays Apply	100%	100%
Major Services	Various Copays Apply	70%	70%
Orthodontics (children up to age 19)	Various Copays Apply	50%	50%
Orthodontics Lifetime Maximum	None	$1,000	
Implants	Not Covered	70%	70%
TMJ Treatment	Not Covered	Not Covered	
Waiting Period	None	None	None

This 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 BENEFITS

BUSD offers vision coverage for you and your dependents through Vision Service Plan (VSP). You, the employee, pay the full premium for this coverage. The plan pays benefits for both in-network and out-of-network services. However, you will receive maximum value from your vision benefits when you choose in-network providers. If you receive care outside the network, you will receive a reduced level of benefits.

VISION PLAN SUMMARY

Key Features	In-Network	Out-of-Network	Frequency
Copay Exam/Materials	$10 copay		
Primary Eye Care*	$20 copay	Not Covered	
Exam	Covered In Full	Up to $50.00	Once every 12 months
Single Lenses	Covered in Full	Up to $50.00	Once every 12 months
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	
Frames	Up to $140.00	Up to $70.00	Once every 24 months
Contact Lenses (in lieu of glasses)	Elective: Up to $140.00 allowance Medically Necessary: Covered 100%	Up to $105.00 UP to $210.00	Once every 12 months

This 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.

*Primary Eye Care 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 Nevus Blue
Blepharitis

FLEXIBLE SPENDING ACCOUNTS (FSA)
You must Re-Enroll

Flexible Spending Accounts (FSAs) allow you to set aside money from your paycheck to pay Health Care and Dependent Care expenses with tax-free dollars. When you contribute to FSAs, your pre-tax contributions reduce your taxable income. IF you are already enrolled, you must re-enroll in for the new plan year.

Account	What it can be used for:	Most you can contribute in 2021
Health Care FSA	To pay medically necessary medical, dental, vision, and hearing expenses not covered by your health care plans, such as deductibles, coinsurance and copayments. **NOTE:** If you contribute to an HSA, you cannot participate in the Health Care FSA.	$2,750
Dependent Care FSA	Dependent care expenses such as day care and after school programs for children under age 13, or elder care expenses, so you and your spouse can work or attend school full time	$5,000, or $2,500 if married and filing separate tax returns

HOW THE FSAs WORK:

- The total amount you choose to contribute to your Health Care FSA is available immediately. You can spend the dollars in your Dependent Care FSA as they are deposited each pay period.
- Health Care and Dependent Care Accounts are separate. The money in one account cannot be used to pay for expenses from the other account.
- If you enroll in the Health Care FSA, you will receive a debit card that you can use to pay for eligible health care expenses at the point of service. Otherwise, you can pay for services and submit a claim for reimbursement or request reimbursement online.
- If you enroll in the Dependent Care FSA, you will pay for services and submit a claim for reimbursement or request reimbursement online.
- FSA elections do not automatically roll over from one year to the next. You must re-enroll each year to participate.
- For a complete list of eligible Health Care and Dependent Care FSA expenses, visit http://www.irs.gov/. You can also contact or call the District Administrator, BASIC pacific at (800) 574-5448 or by visiting their website at www.BASICpacific .com

Use-It or Lose-It

- With the Health Care FSA, you can carry-over up to $500 of unused funds from the 2020 plan year to the 2021 plan year. Amounts in excess of $500 will be forfeited if not used by the end of the 90-day run-out period (3/31/2021).
- With the Dependent Care FSA, if you have dollars remaining at the end of the plan year (12/31/2020), you may continue to incur expenses during the grace period. The grace period extends 2 1/2months after the end of the plan year (3/15/2021). Any dollars remaining at the end of the grace period (3/31/2021 will be forfeited.

FLEXIBLE SPENDING ACCOUNTS (FSAs) Continued

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.

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.

FLEXIBLE SPENDING ACCOUNTS (FSAs) and Parking & Transit Reimbursement Plan

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	$270
Transit & Van Pooling Spending Account	$270

LIFE INSURANCE BENEFITS

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 beneficiary(ies) after your death, while AD&D pays an additional amount in the even of an accidental death or for certain accidental injuries.

BASIC LIFE AND AD&D

Berkeley USD provides you with Basic Life and AD&D insurance at no cost to employees with FTE's at .50 or greater. You are provided with Life and AD&D insurance equal to $15,000. You are automatically enrolled. This benefit is 100% paid by the District.

If your death is the result of an accident, you will receive an additional Accidental Death & Dismemberment (AD&D) benefit. If you experience an accidental injury, the plan may pay a percentage of your AD&D benefit amount depending upon the injury sustained.

VOLUNTARY LIFE AND AD&D

You have the option to supplement your District-paid coverage by purchasing additional Life and AD&D insurance for yourself, your spouse and your children. You are required to purchase coverage for yourself in order to enroll your family members. Below are the maximums:

- Employee Benefit – Purchase up to a maximum of $300,000 in increments of $10,000.
- Spouse/Domestic Partner – Purchase up to a maximum of $100,000 in increments of $5,000 (cannot exceed 50% of the employee's amount)
- Dependent Child(ren) Benefit – Purchase up to $10,000 in increments of $2,500 for children ages 6 months to 26

2021 Open Enrollment

During Open Enrollment, you will have the opportunity to enroll in or increase benefits up to two (2) increments for yourself or your spouse **without Evidence of Insurability (EOI)** as long as you have not been previously declined by Lincoln Financial.

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

You can also choose to increase your coverage by more than the two (2) increments up to the maximums listed above by submitting Evidence of Insurability (EOI).

If you wish to enroll or increase your coverage amounts, you will need to complete the Lincoln Enrollment Form and the Evidence of Insurability (EOI) form (if electing more than two increments).

Dependent Child(ren) coverage is offered without Evidence of Insurability (EOI).

LIFE INSURANCE BENEFITS continued

Employee/Spouse Voluntary Life Insurance Rate per $1,000 (Rate based on Employee's Age)	
Under 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 x $0.216 = $43.20 tenthly

EAP

EMPLOYEE ASSISTANCE PROGRAM (EAP) – Claremont EAP

The Claremont EAP is a counseling and referral service available to you and your eligible family members at no cost. The EAP offers 24/7 telephone access to licensed professionals who can help with concerns regarding marriage and relationships, depression, anxiety, stress, grief, substance abuse, work-related issues, and much more. The EAP may refer you to a local counselor who can address your concerns in person. The EAP provides 8 sessions per member per incident per year.

The program also gives you access to:

- Child care and elder care resources
- Financial and legal consultations and information
- Identity theft prevention and recovery

EAP services are confidential. No information will be shared with the District. To take advantage of the services and resources available through the EAP, call 800-834-3773. You can also access valuable information online at www.claremonteap.com

View a 4-minute video regarding the EAP and the information that is available. Click on the link below:

Benefits Center

KEY CONTACTS

For General Questions				
BUSD Benefits Department **510-644-6666 (press 1)** **External: www.berkeleyschools.net/departments/benefits/** **Internal: (Only accessible from a compute within the District) – http://intranet.Berkeley.net (Click on "Risk Management)**				
For Medical Questions				
CalPERS **888-225-7337** **www.calpers.ca.gov** **Review the CalPERS 2021 Health Benefit Summary for specific carrier contact information**				

For Questions About	Carrier	Phone Number	Website/Email	Plan/Group ID
Dental PPO	Delta Dental	866-499-3001	www.deltadentalins.com	7069
Dental DHMO	DeltaCare	800-422-4234		5827
Vision	VSP	800-877-7195	www.vsp.com	12314888
Flexible Spending Accounts (FSAs)	BASICpacific	800-574-5448	www.BASICpacific.com	
Life and AD&D Insurance	Lincoln Financial	800-423-2765	www.lfg.com	
Employee Assistance Program (EAP)	Claremont	800-834-3773	www.claremonteap.com	

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 CalPERS website. Refer to page 4 for login information.

Prepared By

EPIC®

Insurance Brokers &
Consultants