

MORGAN HILL UNIFIED SCHOOL DISTRICT

OPEN ENROLLMENT GUIDE

2019 PLAN YEAR

OPEN ENROLLMENT:

SEPTEMBER 10 – OCTOBER 5, 2018

Elections and changes made during
Open Enrollment are effective
January 1, 2019

CHANGES ONLY OPEN ENROLLMENT

No changes? You don't need to re-enroll. Your medical, dental and vision elections will carry over to next year.

Exception: You must re-enroll with American Fidelity to contribute to the Flex Spending Accounts next year!

DEADLINE TO TURN FORMS IN:

OCTOBER 5, 2018

MARK YOUR CALENDERS

THIS IS YOUR OPPORTUNITY TO ASK QUESTIONS, FILL OUT AND TURN IN FORMS

LOCATION	HR (ALL BENEFIT PLANS)	AMERICAN FIDELITY (FSA, LIFE, DISABILITY, OTHER VOLUNTARY PRODUCTS)
BARRETT	Mon 9/24, 10 – 1 PM	Mon 9/24, 8 - 4 PM
BRITTON	Wed 9/26, 11 – 2 PM	Wed 9/26, 8 – 4 PM
CENTRAL	Wed 9/26, 2:30 – 4 PM	Wed 9/26, 8 – 4 PM
DISTRICT OFFICE	Mon 10/1, 2 – 5 PM	Mon 10/1, 8 – 4 PM
EL TORO	Mon 9/24, 1:30 – 3:30 PM	Mon 9/24, 8 – 4 PM
JACKSON	Tues 9/25, 10:30 – 1 PM	Mon 9/24, 8 – 4 PM
LIVE OAK	Thurs 9/27, 11:30 – 4 PM	Thurs 9/27 & Fri 9/28, 8 – 4 PM
LOS PASEOS	Mon 10/1, 11 – 1:30 PM	Tues 9/25, 8 – 4 PM
MARTIN MURPHY	Fri 9/28, 11:30 – 3 PM	Fri 9/28, 8 – 4 PM
COMMUNITY ADULT	Tues 10/2, 2:30 – 3:30 PM	Fri 9/28, 1 – 4 PM
NORDSTROM	Tues 9/26, 10:30 – 1 PM	Tues 9/25, 8 – 4 PM
PARADISE VALLEY	Tues 9/25, 1:30 - 4 PM	Tues 9/25, 8 – 4 PM
SAN MARTIN/GWINN	Tues 10/2, 10 - 2 PM	Wed 9/26, 8 – 4 PM
SOBRATO	Wed 10/3, 11 – 4 PM	Wed 10/3 & Thurs 10/4, 8 – 4 PM
TRANSPORTATION	Fri 9/21, 11 - 1 PM	Fri 9/28, 8:00 – 12 PM
P.A. WALSH	Thurs 9/27, 11:00 – 1:00 PM	Thurs 9/27, 8 – 4 PM

SUMMARY OF CHANGES

➤ **District Contribution**

- Morgan Hill Unified School District will continue to pay a portion of your medical, dental and vision premiums. The District contribution for Classified employees has increased. The District contribution for Certificated and MHELA has not changed. Please see chart below for the amounts:

Classified Hrs Worked/Day	District Contribution 2018-2019 SY	Certificated / MHELA % FTE	District Contribution 2018-2019 SY
7 or more hours	\$850.00	1.0 FTE	\$750
6 but less than 7 hours	\$637.50	.9 FTE	\$675
5 but less than 6 hours	\$531.25	.8 FTE	\$600
3.5 but less than 5 hours	\$425.00	.7 FTE	\$525
		.6 FTE	\$450
		.5 FTE	\$375

➤ **United Healthcare and Blue Shield Access+**

- United Healthcare and Blue Shield Access+ are no longer offered by CalPERS in the Bay Area. If you are enrolled in either of these plans, you will need to select a new medical plan during open enrollment. Note: If you are currently enrolled in either one of these plans and you do not submit an enrollment change form during open enrollment, you will be automatically enrolled in the lowest cost plan option, PERS SELECT.

➤ **PERS Select** is moving to a value based insurance design (VBID).

- Must have a Primary Care Physician
- Deductible is \$1,000
 - Can earn credit towards the deductible by completing specific healthy activities designated by Anthem¹
 - Flu shot
 - Completion of a smoking cessation program
 - Biometric screening
 - Virtual Second Opinion program
 - ConditionCare Program

¹ Refer to the Summary of Coverage at www.calpers.ca.gov or call Anthem Customer Service at 1-877-737-7776 for detailed information about PERS Select plan.

OVERVIEW OF PLANS

For complete information about plan coverage and changes, see the carrier plan documents/plan summary/evidence of coverage booklet, located at www.calpers.ca.gov or on the MHUSD Intranet.

OVERVIEW OF BENEFIT OPTIONS

Medical Plan Options - CalPERS

Calpers.ca.gov
1-888-225-7377

- The following medical plans will continue to be offered:
 - **Anthem Select HMO**
 - **Anthem Traditional HMO**
 - **HealthNet SmartCare HMO**
 - **Kaiser Permanente HMO**
 - **PERS Choice PPO - Anthem**
 - **PERS Select PPO - Anthem**
 - **PERS Care PPO - Anthem**

Dental - Delta Dental

www.Deltadentalins.com
PPO: 1-800-765-6003
HMO: 1-800-422-4232

- The following dental plans will continue to be offered:
 - **Delta Dental Premier PPO – Low Level**
 - **Delta Dental Premier PPO – High Level**
 - **Delta Dental Premier PPO – Premium Level**
 - **DeltaCare USA HMO**

Vision - VSP

www.VSP.com
1-800-877-7195

- The following vision plans will continue to be offered:
 - **VSP – Low Level**
 - **VSP – Medium Level**
 - **VSP – High Level**

Flexible Spending Account (FSA) – American Fidelity

www.Americanfidelity.com
1-800-365-8306

- The FSA plan allows you to save money by paying for eligible healthcare and dependent care expenses with pre-tax dollars.
- Healthcare account maximum remains \$2,600.
- Dependent Care account maximum remains \$5,000.
- **NOTE:** The plan includes a \$500 carryover provision for the Healthcare FSA plan; you will be able to carryover \$500 into the next plan year.
- This plan does not auto-renew, you need to **enroll** or **re-enroll** with an **American Fidelity rep.**

Voluntary Benefits

- **American Fidelity** – Life, Disability, Accident, Critical Illness, Cancer
- **AXA** – Life, Disability
- **Principal Life** – Voluntary Life (MHCEA Only)
- **CalPERS** – Long Term Care
- **TDS** – 403B and 457b investment plans

My Commuter Check

www.mycommutercheck.com
1-888-235-9223

- The commuter plans allows you to set aside pre-tax dollars to pay for qualified mass Transit and Parking expenses associated with your commute to work.

MEDICAL PLAN DESIGNS

HMO PLAN OPTIONS

- Requires use of a Primary Care Physician (PCP) who will manage your health care
- Requires advance approval for some services
- Requires you to obtain care from providers who are a part of the plan network

PPO PLAN OPTIONS

- Gives you access to a network of health care providers
- Does not require you to select a PCP
- Allows you to access many types of services without receiving a referral
- Encourages you to seek services from preferred providers

HMO PLANS

Basic Plan Benefits	Anthem Select/ Traditional	Health Net Smart Care	Kaiser
Calendar Year Deductible Individual/Family	N/A	N/A	N/A
Max Calendar Year Copay Individual/Family	\$1,500/ \$3,000	\$1,500/ \$3,000	\$1,500/ \$3,000
Hospital Deductible Inpatient	N/A No Charge	N/A No Charge	N/A No Charge
Office Visit Copay	\$15	\$15	\$15
Prescription Drug – No Deductible - Retail Pharmacy – 1st fill			
Generic	\$5	\$5	\$5
Brand Formulary	\$20	\$20	\$20
Non-Formulary	\$50	\$50	N/A

PPO PLANS

Basic Plan Benefits	*Anthem PERS Select In / Out Network	Anthem PERS Choice In / Out Network	Anthem PERS Care In / Out Network
Calendar Year Deductible Individual/Family	\$1,000	\$500 / \$1,000	\$500 / \$1,000
Max Calendar Year Copay Individual/Family	\$3,000 (Co-insurance)	\$3,000/ \$6,000 (Co-insurance)	\$2,000/ \$4,000 (Co-insurance)
Hospital Deductible Hospital Inpatient	N/A 20-30% / 40%	N/A 20% / 40%	\$250 10% / 40%
Office Visit Copay	\$10 - \$35 / 40%	\$35/ 40%	\$35 / 40%
Prescription Drug – No Deductible - Retail Pharmacy – 1st fill			
Generic	\$5	\$5	\$5
Brand Formulary	\$20	\$20	\$20
Non-Formulary	\$50	\$50	\$50

*Anthem PERS Select is changing to a value-based plan.

PLANS AND RATES

DENTAL

Plan Features	Delta Dental PPO			DeltaCare USA HMO
	Low Level	High Level	Premium Level	
Annual Calendar Year Maximum Benefit	\$1,200 In \$1,000 Out	\$2,200 In \$2,000 Out	\$3,200 In \$3,000 Out	Unlimited
Diagnostics, Preventive, Basic, Major	70-100%	70-100%	70-100%	No Cost - \$165
Prosthodontics – Bridges/Dentures	50%	50%	50%	No Cost - \$160
Implants	Not Covered	Not Covered	50%	Not covered
Orthodontia	Not Covered	Child only: 50% to \$1,000 Lifetime Max	Adult & Child: 50% to \$2,000 Lifetime Max	No Cost - \$1,800

VISION

VSP VISION (In-Network Benefits)				
	Low Level	High Level	Premium Level	
Benefit Frequency (Exam / Lenses/Contacts / Frames)	12 / 24 / 24	12 / 12 / 24	12 / 12 / 12	
Exam	\$10	\$10	\$10	
Single Vision Lenses	No Copay	No Copay	No Copay	
Contact Lenses	Up to \$60 copay, \$130 allowance	Up to \$60 copay, \$130 allowance	Up to \$60 copay, \$130 allowance	
Frames	\$130-\$150 allowance	\$130-\$150 allowance	\$130-\$150 allowance	

2019 RATES

		Plan Provider	Employee Only	2-Party	Family	Annual Change
MEDICAL	HMO	Anthem Select	\$831.44	\$1662.88	\$2161.74	-3%
		Anthem Traditional	\$1111.13	\$2222.26	\$2888.94	16.7%
		Health Net Smart Care	\$901.55	\$1803.10	\$2344.03	4.2%
		Kaiser Permanente	\$768.25	\$1536.50	\$1997.45	-1.5%
	PPO	Anthem PERS Choice	\$866.27	\$1732.54	\$2252.30	7.6%
		Anthem PERS Select **	\$543.19	\$1086.38	\$1412.29	-32%
		Anthem PERS Care***	\$1131.68	\$2263.36	\$2942.37	22%
DENTAL	Delta Premier PPO	Low	\$50.39	\$100.78	\$170.37	0%
		High	\$58.49	\$116.96	\$197.76	0%
		Premium	\$64.72	\$129.43	\$218.81	0%
	DeltaCare USA HMO	\$25.34	\$41.87	\$61.65	0%	
VISION	Vision Service Plan (VSP)	Low	\$5.19	\$11.90	\$21.35	0%
		Medium	\$6.19	\$14.19	\$25.43	0%
		High	\$8.56	\$19.60	\$35.16	0%

**** Lowest Cost Plan Offering**

***** Highest rate increase at 22%**

MY "TO DO" LIST

- Review the 2019 benefit options outlined in this memo.
- If you are currently enrolled in **United Healthcare** or **BlueShield Access+**, you **MUST** choose a new medical plan for 2019 by completing the enrollment/change form attached to this packet. If you do not enroll in a new plan, your enrollment will default to PERS Select and you will be automatically enrolled.
- You do not need to re-enroll in medical, dental and vision if you do not want to make any changes to your existing plans, except if you are currently enrolled in United Healthcare or BlueShield Access+ as noted.
- If you are enrolling your dependents for the **first time**, please fill out the **Dependent Eligibility Verification Notice** and provide required documentation.
- If you are waiving medical for the **first time**, please fill complete the **Benefit Decline / Medical Waiver Form**
- Enroll or Re-Enroll** in the Section 125 Flex Spending Accounts by meeting with an American Fidelity rep. Enrollment does not carry over year to year. See insert for dates/times a rep will be at your site.
- Update** your address, phone number, and emergency contacts, if needed.

This will help you calculate your monthly deduction:

Add vision, dental, and medical →	_____	
Subtract the employer contribution (see page 2 of this notice)	-	
Subtotal	_____	(if less than line above, stop calculations)
Then add the summer deduction (subtotal ÷ by 7 to cover July deduction)	+	(only for 10 and 11 month employees)
This is the total monthly cost for benefits	_____	(amount to be deducted from paycheck)

If you have any questions, please contact HR – 1-408-201-6019 or email hillr@mhusd.org.

Deadline to submit changes/forms to HR is Friday, 10/5/18



Open Enrollment Benefit & Change Form

Effective January 1, 2019, I choose to enroll in the following health benefits:

Employee Information			
First Name:	Middle Initial:	Last Name:	
Work Location:	Classification:		

MEDICAL

Employee Group	Plan	Employee Only	2-Party	Family	
<input type="checkbox"/> WAIVE					
Available to all employees Managed by CalPERS Health Program	HMO	Anthem Select	<input type="checkbox"/> \$831.44	<input type="checkbox"/> \$1662.88	<input type="checkbox"/> \$2161.74
		Anthem Traditional	<input type="checkbox"/> \$1111.13	<input type="checkbox"/> \$2222.26	<input type="checkbox"/> \$2888.94
		Health Net Smart Care	<input type="checkbox"/> \$901.55	<input type="checkbox"/> \$1803.10	<input type="checkbox"/> \$2344.03
	PPO	Kaiser Permanente	<input type="checkbox"/> \$768.25	<input type="checkbox"/> \$1536.50	<input type="checkbox"/> \$1997.45
		PERS Choice	<input type="checkbox"/> \$866.27	<input type="checkbox"/> \$1732.54	<input type="checkbox"/> \$2252.30
		PERS Select	<input type="checkbox"/> \$543.19	<input type="checkbox"/> \$1086.38	<input type="checkbox"/> \$1412.29
		PERS Care	<input type="checkbox"/> \$1131.68	<input type="checkbox"/> \$2263.36	<input type="checkbox"/> \$2942.37

DENTAL

Employee Group	Plan	Level	Employee Only	2-Party	Family
<input type="checkbox"/> WAIVE					
Available to all employees	Delta Premier PPO	Low	<input type="checkbox"/> \$50.39	<input type="checkbox"/> \$100.78	<input type="checkbox"/> \$170.37
		High	<input type="checkbox"/> \$58.49	<input type="checkbox"/> \$116.96	<input type="checkbox"/> \$197.76
		Premium	<input type="checkbox"/> \$64.72	<input type="checkbox"/> \$129.43	<input type="checkbox"/> \$218.81
	DeltaCare USA HMO		<input type="checkbox"/> \$25.34	<input type="checkbox"/> \$41.87	<input type="checkbox"/> \$61.65

VISION

Employee Group	Plan	Level	Employee Only	2-Party	Family
<input type="checkbox"/> WAIVE					
Available to all employees	Vision Service Plan (VSP)	Low	<input type="checkbox"/> \$5.19	<input type="checkbox"/> \$11.90	<input type="checkbox"/> \$21.35
		Medium	<input type="checkbox"/> \$6.19	<input type="checkbox"/> \$14.19	<input type="checkbox"/> \$25.43
		High	<input type="checkbox"/> \$8.56	<input type="checkbox"/> \$19.60	<input type="checkbox"/> \$35.16

Turn over to complete side two-

Complete Name (First Last)	Type	Date of Birth	M or F	Vision				Dental				Medical				
				Change	Add	Delete	Keep	Change	Add	Delete	Keep	Change	Add	Delete	Keep	
	Employee															
	Spouse															
	Child															
	Child															
	Child															
	Child															

I hereby request health benefits as indicated on this form. I confirm that my information is accurate and complete. If I choose benefits that cost more than what my employer contributes, I agree to contribute the balance through payroll deductions which will reduce my net pay. I understand that I am not permitted to choose benefits that have out-of-pocket costs exceeding my net pay. I agree to the release of health information about me and my dependents for the purposes of managing and administering my benefits. I understand that my deductions may change periodically for benefit reconciliation. Even if I waive all or some of the health benefits, I understand that I may be enrolled in benefits that do not result in out-of-pocket costs to me. If I waive enrollment in the District's medical plan, I will provide proof of my other coverage each year during Open Enrollment.

I understand that the District highly recommends that all employees be enrolled in vision, dental, and medical plans and that all employees have a disability policy, especially since California State Disability Insurance (SDI) is not available to all employees. It is my responsibility to monitor my vacation and sick leave balances. I will read my union contract for a thorough understanding of allowed leaves of absences and how my pay and benefits might be affected.

If I have enrolled my dependents, I agree to complete the Dependent Verification form and submit proof of eligibility during open enrollment. If all required documentation is not submitted during open enrollment, I understand I have to wait until the next Open Enrollment period to add my dependents unless there is a family status change or qualifying event. I understand that some benefits are only offered at the time of hire and may not be considered as a part of an Open Enrollment period. It is my sole responsibility to report my medical coverage accurately when I file my income tax returns and report information regarding the Affordable Care Act. I have read all benefit forms completely and have had all my questions answered. I agree to follow all District and plan rules for the plans which I have requested enrollment.

Employee's Signature

Date