

Phoenix Union High School District

NEW HIRE BENEFITS ENROLLMENT GUIDE

Plan Year July 1, 2017 – June 30, 2018



*Preparing Every Student for Success
in College, Career and Life*

For Employees of the Phoenix Union High School District



Dear Colleague,

Welcome to the Phoenix Union High School District (PUHSD). As a new member of the PUHSD staff, you are eligible for a wide range of valuable benefits designed to:

- Promote the health and wellness of you and your family;
- Protect your income while you are working;
- Build financial security for retirement; and
- Help balance your personal responsibilities and work life.

The District provides some insurance benefits automatically at no cost to you. You must actively enroll in others through the District's iVisions Self Service portal @ <https://ivisions.phoenixunion.org/ess>.

This Benefits Enrollment Guide gives you a brief overview of the benefits available to you. Some of your benefits require enrollment within 30 days of your contracted date of employment so please review this information at your earliest opportunity.

Additional information about the insurance benefits can be viewed once you begin the On-Line Enrollment Process. A video demonstrating the process is available on the 2017/2018 Benefit Enrollment page on the District's website @ <http://www.phoenixunion.org/Page/21247>. This page also includes links to all of the plan information. If you need one-on-one assistance making your benefit elections for the coming year, please email me at nelke@phoenixunion.org to set up an appointment.

If you have any questions, please call Cyndy Nelke at 764-1538. Thank you for your cooperation and welcome to PUHSD.

Sincerely,

Cyndy Nelke

Cyndy Nelke
Employee Benefits Specialist

ENROLLING FOR BENEFITS

You have **30 days** from your contracted date of hire to enroll in the following benefits:

- Medical Coverage
- Dental Coverage
- Vision Coverage
- Short Term Disability Coverage
- Supplemental Life Insurance
- Medical Reimbursement Account (MRA)
- Dependent Care Account (DCA)

In addition to the benefits listed above, you will also need to elect a beneficiary for your District provided life Insurance policy as well as acknowledge other important information provided to you during the enrollment process.

You enroll in your benefits online using the District's IVisions Self Service (IVisions/ESS) portal @ <https://ivisions.phoenixunion.org/ess>.

If your contract/work agreement starts between the 1st and the 15th of the month, your insurance will be effective the first day of the following month. If your contract/work agreement starts between the 16th and the end of the month, your insurance will be effective the first day of the second following month.

As a PUHSD employee, you have access to many other benefits and perks that you will find described in this guide. Some of these benefits are available to you immediately, others have waiting periods.

How to enroll in the District's insurance

- ✓ Read through this Guide carefully. This Guide gives you important information to help you understand all of your benefit options.
- ✓ Decide which benefits are best for you and your family.

The District offers you a choice of three medical plan options, two dental plan options, vision coverage, voluntary life insurance, a short-term disability (STD) plan, and pre-tax flexible spending accounts.

- ✓ Complete your online enrollment within 30 days of your contract/work agreement start date.
- ✓ Note: All medical, dental and vision benefit deductions will be **pre-tax**. If you want to pay your premiums with **after-tax dollars**, please contact Cyndy Nelke at nelke@phoenixunion.org and ask for the "Flex Plan Option Form".
- ✓ If applicable, return your completed and signed Short Term Disability form to Cyndy Nelke @ CEE-5th Floor or Fax # 602-274-0484 or email to nelke@phoenixunion.org within your 30-day enrollment period. Failure to do so will result in the disqualification of this insurance election.

This form will be available for download during the online enrollment process and is on the 2017/2018 Benefit Enrollment page on the District website.

- ✓ If you applied for supplemental life insurance in excess of the Guaranteed Issue (GI) amounts (\$50,000 Employee & \$50,000 Spouse), you must complete the Evidence of Insurability (EOI) questionnaire on-line @ www.standard.com/mhs within 30 days of your election. Failure to do so will result in the cancellation of the additional amount requested over the GI.

Note: completion of the EOI questionnaire does not guarantee coverage. If applicable, your additional life insurance election over the GI will be subject to medical underwriting for approval.

- ✓ Verify that all applicable insurance deductions are being taken from your check. Please contact the Employee Benefits Office with any discrepancies.
- ✓ ***Note: If you fail to complete your online enrollment within your 30-day election period, you will be defaulted into the free Medical Insurance on the Middle Option only. You will have to wait until the next Open Enrollment to elect any additional insurance benefits.***

Who's eligible?

You are eligible to elect benefits if you are:

- ✓ A permanent classified or contracted employee of the District working a minimum of 24 hours of service per week.
- ✓ You are also eligible to elect benefits for your dependents.

Under our plan, legal dependents include your:

- ✓ lawful spouse; and
- ✓ the following children under age 26 whether married or unmarried: natural children, adopted children or children placed for adoption, stepchildren, children under a QMCSO, children under a legal guardianship order and/or foster children. Disabled adult children who are age 26 or older and unmarried can continue coverage if they otherwise meet the eligibility requirements of the plan. Note: If a child whose coverage has already terminated under this Plan due to reaching the age limit becomes disabled, said child is not eligible to re-enroll as a disabled adult dependent child under this Plan.

Changing your coverage during the Year

Medical, dental and vision premiums are deducted from your paycheck on a pre-tax basis—giving you the advantage of not paying tax on your healthcare premium dollars (unless you let us know that you want to pay premiums with after tax dollars by completing the Flex Plan Options form).

With the pre-tax feature, IRS rules require that you cannot change your elections until the next Open Enrollment period unless you have a qualified change in status that affects your benefits, such as a birth, adoption, dependent losing dependent status, marriage, divorce or death. You must notify the Plan in writing within 31 days of a qualifying change in status. For more information, contact the District Employee Benefits Office.

MEDICAL INSURANCE PLANS

The District gives you a choice of three medical plan options. Understanding the differences between the medical plan options can help you decide which plan is best for you and your dependents. These plan options are preferred provider organization (PPO) plans accessing the Blue Cross Blue Shield of Arizona (BCBSAZ) network of providers. With PPO plans, you can see any provider you wish, but you get greater cost savings by using in-network PPO physicians, hospitals, labs and urgent care centers. This is important to consider since you share in the cost of care in the form of deductibles, co-pays and coinsurance.

The 2017-2018 Summaries of Benefits and Coverage (SBC) and other important information is available Online @ www.phoenixunion.org. You can also request hard copies of these, as well as the Plan Document, by contacting the District's Employee Benefits Specialist at 602-764-1538.

Below are ways you can be a wise health care consumer and get value out of the medical plan you elect.

How Can You Be a Wise Health Care Consumer AND Get The Most Value Out Of The Medical Plan?

- ✓ **Use in-network BCBSAZ (PPO) providers.** They charge less, and you pay less. And, Preventive Care is free when provided by in-network PPO providers.
- ✓ **Choose Generic drugs when possible.** Ask your Doctor if a generic drug is appropriate for you. You'll pay less for generic drugs than for brand name drugs.
- ✓ **Have a chronic health condition like diabetes, asthma, arthritis, heart disease, etc.?** One of the best things you can do for that condition is to take the medication your Doctor recommends for you. Make medication compliance your habit to a healthier life.
- ✓ **Keep current with your Preventive/Wellness care** to help identify any health risk factors (like high blood pressure, high blood sugar, weight creeping above the recommended range) and to stay current on recommended immunizations.
- ✓ **Not feeling well?** Call your in-network Doctor's office for help. Or, use an in-network Urgent Care facility instead of an emergency room (ER), if medically appropriate.
- ✓ **Precertify** your elective hospital admission, certain prescription drugs, and other services, as explained in the BCBSAZ medical plan booklets to help avoid a financial penalty.

These six tips will help you make the most of your District-sponsored medical plan benefits.

Medical coverage options

High Option Plan

This is the option with the lowest deductible, but also the most expensive plan that the District offers. You must meet an annual deductible before the plan begins to pay certain eligible expenses. You may also have additional costs in coinsurance and co-pays.

Middle Option Plan

This is the District's default plan. The District pays 100% of the employee's premium for this plan. You must meet an annual deductible before the plan begins to pay certain eligible expenses. You may also have additional costs in coinsurance and co-pays.

Low Option Plan

This plan option may be preferred if you need medical coverage for your family and desire a lower monthly premium. The District pays 100% of the employee premium in addition to a portion of the dependent premium. You have an annual deductible to meet and you share in the cost with higher coinsurance and co-pays.

Prescription drug benefits (Retail and Mail Order)

For each medical plan, you have outpatient prescription drug coverage utilizing the BCBSAZ tiered co-pay pharmacy benefit. BCBSAZ classifies outpatient prescription drugs in 4 levels. Your co-pay is lowest at Level 1.

Tip: *For the greatest cost savings, verify that your prescribed medication is on the Prescription Medication Guide (a formulary of preferred drugs). A copy of the listing is available online at www.azblue.com. Also, remember to discuss generic equivalents with your provider; they are your least expensive drug option.*

Terms to Know

Co-pay. A set amount you pay for a covered health-related service or supply.

Access Fees. Like a co-pay, this is a specific dollar amount you pay at the point of care at provider facilities, such as emergency room visits at hospitals.

Co-insurance. Co-insurance is how you and the plan split the cost for covered services. For example, 80% co-insurance means the plan pays 80% and you would be responsible for 20%.

Deductible. The amount you must pay each plan year for certain covered services/supplies before benefits are paid by the plan.

Out-of-pocket Maximum (OOP Max). The maximum amount of co-insurance you pay each year in covered healthcare expenses (excluding deductibles, co-pays and access fees) before the plan starts paying 100% of most covered expenses.

MEDICAL PLAN COMPARISON

The following chart compares the highlights of our three medical plans. For more detailed information, please refer to the 2017-2018 Summaries of Benefits and Coverage (SBC) on the District website @ www.phoenixunion.org.

PPO Plan Comparison for the 2017-2018 Plan Year

In-Network Only

	High	Middle	Low
Individual Annual Deductible	\$200	\$500	\$1,000
Office Visit Co-pays: PCP/Specialist	\$15/\$25	\$15/\$25	\$25/\$35
OOP Max Individual/Family	\$1000/\$2000	\$1000/\$2000	\$3000/\$6000
Emergency Room co-pay	\$150	\$150	\$150
Urgent Care co-pay	\$35	\$35	\$50
Coinsurance	90%	80%	80%
Prescription Drugs (Retail)	\$10/\$40/\$60/\$80	\$10/\$40/\$60/\$80	\$10/\$40/\$60/\$80

Coinsurance is based on the allowed amount for covered services after the plan year deductible is met.

Paying for your benefits

The chart below shows what you would pay in premiums for medical coverage for the 2017/2018 plan year. Note: the biweekly payroll deduction amount is based on 24 deductions per plan year if you are a 12 month employee and 21 deductions per plan year if you have a less than 12 month work contract.

2017-2018 Employee Premiums for Medical Plans

Medical Plans (BCBSAZ)	Monthly	Biweekly Deduction 12 Month Contracts	Biweekly Deduction < 12 Month Contracts
High Option			
Employee	\$ 59.91	\$ 29.96	\$ 34.23
Employee + 1	\$ 701.44	\$ 350.72	\$ 400.82
Employee + 1 - Dual Spouse *	\$ 119.21	\$ 59.61	\$ 68.12
Employee + 2 or more	\$ 1,157.77	\$ 578.89	\$ 661.58
Employee + 2 or more - Dual Spouse *	\$ 789.52	\$ 394.76	\$ 451.15
Middle Option			
Employee	\$ -	\$ -	\$ -
Employee + 1	\$ 581.71	\$ 290.86	\$ 332.41
Employee + 1 - Dual Spouse *	\$ -	\$ -	\$ -
Employee + 2 or more	\$ 978.39	\$ 489.20	\$ 559.08
Employee + 2 or more - Dual Spouse *	\$ 610.14	\$ 305.07	\$ 348.65
Low Option			
Employee	\$ -	\$ -	\$ -
Employee + 1	\$ 441.48	\$ 220.74	\$ 252.27
Employee + 1 - Dual Spouse *	\$ -	\$ -	\$ -
Employee + 2 or more	\$ 768.27	\$ 384.14	\$ 439.01
Employee + 2 or more - Dual Spouse *	\$ 400.02	\$ 200.01	\$ 228.58

*Dual Spouse Subsidy (Medical Only)

*To utilize this premium subsidy, both you and your spouse must be benefit eligible employees of PUHSD, but only one of you would enroll in a medical plan as an employee while the other "waives" medical coverage and becomes a dependent on the other employee's medical plan. **Note: Eligibility will be verified. Ineligible employees will be changed to the appropriate non-Dual Spouse premium that corresponds to their coverage election.***

DENTAL INSURANCE PLANS

Total Dental Administrators (TDA)

TDA has an extensive network of dental providers throughout Arizona. The Prepaid Dental Plan provides coverage for services and treatment for diagnostic, preventive, restorative, and routine oral surgery. There is no co-pay for most preventive and diagnostic services. Additional services are paid according to the TDA fee schedule. For more detailed information on the fee schedule, please refer to the TDA Summary of Benefits on the District website @ www.phoenixunion.org. **Note: To receive benefits, you must use TDA dental providers.**

Delta Dental's Indemnity Plan

The Indemnity Dental Plan utilizes the Delta Dental of Arizona network of dentists, or you can see any dentist and submit a claim form for reimbursement. Reimbursement is based on Delta Dental's fee schedule. This plan covers preventive dental services such as oral cleanings, examinations, and X-rays. Preventive care is covered at 100% with no deductible. Basic services are covered at 80% and major services are covered at 50% after you have been on the plan for 6 months (continuous). Orthodontic services are available for children, 8 to 18 years old, after 12 months (continuous) on the plan.

Paying for your benefits

The chart below shows what you would pay in premiums for dental coverage for the 2017/2018 plan year. Note: the biweekly payroll deduction amount is based on 24 deductions per plan year if you are a 12 month employee and 21 deductions per plan year if you have a less than 12 month work contract.

2017-2018 Employee Premiums for Dental Plans

Dental Plans	Monthly	Biweekly Deduction 12 Month Contracts	Biweekly Deduction < 12 Month Contracts
Total Dental Administrators			
Employee	\$ 9.56	\$ 4.78	\$ 5.46
Employee + 1	\$ 19.13	\$ 9.57	\$ 10.93
Employee + 2 or more	\$ 25.20	\$ 12.60	\$ 14.40
Delta Dental of AZ			
Employee	\$ 32.90	\$ 16.45	\$ 18.80
Employee + 1	\$ 65.76	\$ 32.88	\$ 37.58
Employee + 2 or more	\$ 86.82	\$ 43.41	\$ 49.61

VISION INSURANCE PLAN

The following chart highlights the benefits of our vision insurance via VSP. For more detailed information, please refer to the VSP Summary of Benefits on the District website @ www.phoenixunion.org.

VSP Plan Details for the 2017-2018 Plan Year

<p>Plan Name VSP Choice Plan</p> <p>Provider Network VSP Network Providers</p> <p>Copays Total (eye exam/glasses) \$10 Contact Lens Exam \$60</p> <p>Out-of-Network Schedule Exam Lenses: Single vision Lined bifocal Lined trifocal Progressives Frame Elective contact lenses (in lieu of lenses & frame) Necessary contact lenses (in lieu of lenses & frame)</p> <p>Additional Plan Features Scratch Resistant Coating=\$0 copay; Diabetic Eyecare Plus Program = \$20 Copay</p>	<p>Frequency of Benefits Eye Exam..... once every plan year Lenses once every plan year Frame..... once every plan year Contacts (in lieu of glasses)once every plan year * Plan year begins July 1st</p> <p>Allowances (glasses or contacts) Frame..... \$140 Contact Lenses \$140 Costco Frame \$75</p> <p>Up to \$45 Up to \$30 Up to \$50 Up to \$65 Up to \$50 Up to \$70 Up to \$105 Up to \$210</p>
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Paying for your benefits

The chart below shows what you would pay in premiums for vision coverage for the 2017/2018 plan year. Note: the biweekly payroll deduction amount is based on 24 deductions per plan year if you are a 12 month employee and 21 deductions per plan year if you have a less than 12 month work contract.

2017-2018 Employee Premiums for Vision Plan

	Monthly		Biweekly Deduction	
	\$	8.06	12 Month Contracts	< 12 Month Contracts
Employee	\$	8.06	\$ 4.03	\$ 4.61
Employee + 1	\$	16.09	\$ 8.05	\$ 9.19
Employee + 2 or more	\$	25.92	\$ 12.96	\$ 14.81

LIFE & AD&D INSURANCE

Basic Life Insurance

Basic life insurance coverage via the Standard Insurance Company is provided to all eligible employees. This coverage is automatic and paid 100% by the District. You receive one times your base annual earnings with a minimum benefit of \$25,000 (maximum benefit restrictions may apply).

Note: This policy has an automatic age reduction provision whereby the payable benefit referenced above will be reduced to the following percentages:

Age of Employee	Payable Percentage
70	65%
75	45%
80	30%

***Minimum benefit of \$25,000 still applies**

Note: The District's Life Insurance Policy is available on the District's website @ www.phoenixunion.org.

Beneficiary Designation

The beneficiary you designate for your Basic Life insurance will also be the beneficiary for your Voluntary Life insurance if applicable - see next section for details on our voluntary policy.

Voluntary Life Insurance

In addition to your District-paid life insurance, you have the option to purchase additional (voluntary/supplemental) life insurance, underwritten by the Standard Insurance Company. You can purchase coverage for yourself, your spouse and your dependent child(ren).

Coverage options for Voluntary Life Insurance

Voluntary life insurance coverage is available for you and your spouse in increments of \$10,000, to a maximum of \$300,000. **Note: You must have employee coverage to elect spouse coverage and your spouse cannot have higher coverage than you. Also, employees cannot have personal coverage and be covered as a spouse through another District employee.**

Voluntary life insurance coverage is available for your dependent child(ren) up to age 26: \$2,500, \$5,000, \$7,500 or \$10,000. You must have employee coverage to elect child(ren) coverage. You pay only one premium to cover all your children.

Evidence of Insurability (EOI)

If you apply for more than the guaranteed issue amount of \$50,000 for you and your spouse, you must provide proof of good health (evidence of insurability) and be approved for the additional coverage.

The Evidence of Insurability (EOI) questionnaire is available on-line @ www.standard.com/mhs and should be completed within 30 days of your election.

Voluntary life insurance rates for you and your spouse are based on your age as of July 1st. The monthly rates are listed below. Premiums for voluntary life insurance benefits are set up through payroll deductions on an after-tax basis. The monthly premiums for each age band and insurance level are available on the District website @ www.phoenixunion.org.

2017-2018 Standard Supplemental Life Insurance Rates

<u>Employee Age</u>	<u>Under 30</u>	<u>30-34</u>	<u>35-39</u>	<u>40-44</u>	<u>45-49</u>	<u>50-54</u>	<u>55-59</u>	<u>60-64</u>	<u>65+</u>
Rate per \$1000 For Spouse	\$.039	\$.050	\$.061	\$.088	\$.139	\$.233	\$.345	\$.519	\$.743
<u>Employee Age</u>	<u>Under 30</u>	<u>30-34</u>	<u>35-39</u>	<u>40-44</u>	<u>45-49</u>	<u>50-54</u>	<u>55-59</u>	<u>60-64</u>	<u>65+</u>
Rate per \$1000	\$.039	\$.050	\$.061	\$.088	\$.139	\$.233	\$.345	\$.519	\$.743
Cost for Child(ren) \$2,500 = \$.13, \$5,000 = \$.27, \$7,500=\$.40, \$10,000=\$.53									

Note: This policy has an automatic age reduction provision whereby the insurance amount elected will be reduced to the following percentages:

Age of Employee	Payable Percentage
70	65%
75	45%
80	30%

In the future, if you fall within these parameters, you will have two choices: 1) you can apply for an increased benefit during Open Enrollment (EOI will apply) or 2) you can convert the amount lost due to age reduction to an individual policy.

Note: The District's Life Insurance Policy is available on the District's website @ www.phoenixunion.org.

DISABILITY INSURANCE

Short Term Disability

Short-term disability (STD) insurance through Sun Life Financial provides you with income of up to two-thirds of your base monthly salary if you are totally disabled and unable to work. Benefits start on the sixth day of disability and are payable for up to 90 calendar days. ***This benefit has a workers' compensation exclusion and pre-existing condition limitations apply to all applications (new and increases).***

STD Enrollment Form Requirement

If you are applying for STD coverage, you must apply online and complete the STD enrollment form. If you fail to complete the enrollment form, your coverage will be cancelled. Forms should be returned to Cyndy Nelke @ CEE-5th Floor, faxed to 602-274-0484 or emailed to nelke@phoenixunion.org within your 30-day eligibility period.

You pay for the STD benefit through payroll deductions and rates are based on the amount of the benefit you elect and are shown on the following STD rate chart. You can elect any benefit level up to your maximum gross annual salary.

2017-2018 Employee Premiums for STD Plan

Minimum Gross <u>Annual Salary</u>	Maximum Monthly <u>Benefit</u>	Monthly <u>Premium</u>	Biweekly Deduction	
			<u>12 Month Contract</u>	<u><12 Month Contract</u>
\$6,480.00	\$360.00	\$5.83	\$2.92	\$3.33
\$9,180.00	\$510.00	\$8.26	\$4.13	\$4.72
\$13,500.00	\$750.00	\$12.15	\$6.08	\$6.94
\$18,000.00	\$1,000.00	\$16.20	\$8.10	\$9.26
\$21,600.00	\$1,200.00	\$19.44	\$9.72	\$11.00
\$27,000.00	\$1,500.00	\$24.30	\$12.15	\$13.89
\$30,600.00	\$1,700.00	\$27.54	\$13.77	\$15.74
\$36,000.00	\$2,000.00	\$32.40	\$16.20	\$18.51
\$40,500.00	\$2,250.00	\$36.45	\$18.23	\$20.83
\$45,000.00	\$2,500.00	\$40.50	\$20.25	\$23.14
\$49,500.00	\$2,750.00	\$44.55	\$22.28	\$25.46
\$54,000.00	\$3,000.00	\$48.60	\$24.30	\$27.77
\$58,500.00	\$3,250.00	\$52.65	\$26.33	\$30.09
\$63,000.00	\$3,500.00	\$56.70	\$28.35	\$32.40
\$67,500.00	\$3,750.00	\$60.75	\$30.38	\$34.71
\$72,000.00	\$4,000.00	\$64.80	\$32.40	\$37.03

Additional Levels of Coverage are available.

Mid-Term Disability

Mid-term disability insurance through the Standard Insurance Company provides a weekly income of up to 66 2/3% of your base weekly pay (maximum of \$2,500) for a maximum of 90 calendar days if you cannot work due to a non-occupational, accidental injury or illness (including pregnancy). Benefits are available after a 90-day waiting period and after you have exhausted any remaining sick leave. **This coverage is provided automatically for employees and paid for by the District.**

Long-Term Disability

Long-term disability (LTD) insurance provides a weekly income of up to 66 2/3% of your base monthly pay if you are disabled and unable to work. Coverage is provided through the Arizona State Retirement System (ASRS) and is available after six months of disability and after you have exhausted any remaining sick leave. **This coverage is provided automatically for employees as part of their ASRS enrollment.** Please call Broadspire with any questions you have regarding LTD benefits at 1-877-232-0596.

FLEXIBLE SPENDING ACCOUNTS (FSAs)

Flexible Spending Accounts (FSAs) allow you to set aside a portion of your pay on a pre-tax basis to be used at a later date to reimburse yourself for certain out-of-pocket expenses. By taking advantage of pre-tax deductions, you minimize your taxes paid thereby maximizing your take-home pay.

FSA options

- ✓ Medical Reimbursement Account (MRA) – a general purpose account
- ✓ Dependent Care Spending Account (DCA)

How FSAs work

You contribute with pre-tax deductions from your pay into one or both accounts up to the maximum permitted (as outlined below). Then you use the money in your accounts to reimburse yourself for eligible expenses you incur between your benefit's eligibility date and June 30, 2018.

Medical Reimbursement Account Max: \$2500/year
Dependent Care Spending Account Max: \$5000/year

Debit Card – The District will be utilizing the Debit Card Option for the 2017/2018 plan year. This card will enable you to pay for certain eligible expenses up-front rather than going thru the reimbursement process.

Note: If you enroll in a MRA and/or DCA for the 2017/2018 plan year and will be re-enrolling for the 2018/2019 plan year, do not destroy your Debit Card once your funds are exhausted. You will be using the same card for future plan years.

Because FSA deductions are taken from your pay before taxes are withheld, you avoid paying taxes on that money.

The following are some examples of eligible medical and dependent care expenses that can be reimbursed from your Medical Reimbursement Account or Dependent Care Spending Account:

MRA

- ✓ Annual deductibles
- ✓ Coinsurance
- ✓ Co-pays for medical care and prescription drugs
- ✓ Dental expenses that are not covered by the Dental plan (excluding cosmetic)
- ✓ Vision expenses that are not covered by the Vision plan
- ✓ Hearing aid expenses
- ✓ Over the counter (OTC) drugs/medications (these require a physician prescription, except for insulin).
- ✓ Special equipment for the handicapped that are not covered

DCA

- ✓ Child or elder care, when care is provided to allow you to work

If you have any questions as to whether an expense is eligible for coverage, call our FSA administrator BASIC at (800) 444-1922 ext 1 or visit them online, www.basiconline.com.

FSA Contributions

Your elected FSA contributions will be deducted automatically each pay period. Maximum contributions are shown below. Employees who have spouses that are enrolled in a HSA Qualified Plan are subject to different limitations. If you fall in this category, please contact Glenda Steucy at BASIC (800) 444-1922 ext. 297 or gsteucy@basiconline.com for clarification.

To estimate how much you want deducted each pay period; calculate your eligible expenses for the new plan year. The following worksheet is designed to help you do this.

Worksheet: Estimate Your FSA Expenses for 2017/2018			
Medical		Dependent Care	
Deductibles/Co-pays	\$ _____	Childcare Expenses	\$ _____
Prescription Drugs	\$ _____	Elder Care Expenses	\$ _____
Glasses, Contact lenses, etc.	\$ _____	Other Eligible Expenses	\$ _____
Hearing Aids and Batteries	\$ _____		
Dental Expenses	\$ _____		
Other Eligible Expenses	\$ _____		
Total per Year*	\$ _____	Total Per Year*	\$ _____

Medical Reimbursement Account Max: \$2500/year
Dependent Care Spending Account Max: \$5000/year

Use-it-or-lose-it rule for the FSAs

The amount you choose to contribute each year to your MRA and DCA accounts should reflect your best estimate of expected eligible out-of-pocket expenses—and maybe a little less—because this plan does not have a carryover provision so unused funds in your account at the end of the plan year shall be forfeited, so estimate your expenses carefully.

Note: You can continue to file claims until September 28, 2018, for expenses incurred between your benefit’s eligibility date and June 30, 2018.

EMPLOYEE ASSISTANCE PROGRAM

The employee assistance program (EAP) is an employer-paid benefit for employees and their dependent family members.

The EAP provides a full range of counseling, educational, and referral services for individuals and families, such as:

- ✓ marriage concerns
- ✓ stress and job-related issues
- ✓ child and domestic abuse issues
- ✓ chemical dependency assessments.

You receive up to six counseling sessions per person per problem per plan year. Any services you receive are kept strictly confidential. Please refer to the District website @ www.phoenixunion.org for current carrier information or contact Cyndy Nelke @ nelke@phoenixunion.org.

This Enrollment Guide contains highlights of the Phoenix Union High School District benefits program. Complete information can be found in the plan's legal documents (Plan Document). If there is a conflict between this Guide and the plan's legal document(s), the legal documents will prevail. Phoenix Union High School District reserves the right to amend, replace or terminate any benefit program at any time for any reason. If one of these events occurs, you will be notified. Receipt of this Guide does not guarantee benefits eligibility.

FOR MORE INFORMATION

- ✓ Phoenix Union High School District Employee Benefits Office
4502 N. Central Avenue, Phoenix, AZ 85012
(602) 764-1538 nelke@phoenixunion.org
- ✓ Medical Plan Provider Network
(PPO Preferred and Participating Only In-Network Providers)
Blue Cross and Blue Shield of Arizona (BCBSAZ)
(602) 864-4861 www.azblue.com
- ✓ Total Dental Administrators Health Plan, Inc. (TDA)
(602) 266-1995 www.totaldentaladmin.com
- ✓ Delta Dental of AZ
(602) 938-3131 www.deltadentalaz.com
- ✓ Vision Service Plan (VSP)
(800) 877-7195 www.vsp.com
- ✓ District Life Insurance – Employee Benefits Office
(602) 764-1538 www.phoenixunion.org
- ✓ Voluntary Life Insurance - Standard
(602) 764-1538 www.phoenixunion.org
- ✓ Mid-term Disability Coverage – Employee Benefits Office
(602) 764-1538 www.phoenixunion.org
- ✓ Short-term Disability Coverage - Assurant
Eleanor Brockhurst and Associates
(602) 263-9265 meredithmoore@brockhurstassociates.com
- ✓ Long-term Disability Coverage - Broadspire through the ASRS
(877) 232-0596
- ✓ Flexible Spending Accounts - BASIC
(800) 444-1922 ext 1 www.basiconline.com
- ✓ Employee Assistance Program (EAP) Employee Benefits Office
(602) 764-1538 www.phoenixunion.org

Phoenix Union High School District (PUHSD)

Important Employee Benefit Program Notices

Updated 4-05-17

This document contains important employee benefit program notices of interest to you and your family. Please share this information with your family members. Some of the notices in this document are required by law and other notices contain helpful information. These notices are updated from time to time and some of the federal notices are updated each year. Be sure you are reviewing an updated version of this important notices document.

MID-YEAR CHANGES TO YOUR HEALTH CARE BENEFIT ELECTIONS

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

- **Special Enrollment Event:**

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if your employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within **31 days** after your or your dependents' other coverage ends (or after the employer stops contributing towards the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within **31 days** after the marriage, birth, adoption, or placement for adoption.

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

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

To request special enrollment or obtain more information, contact the District's Employee Benefits Specialist at 602-764-1538.

- **Mid-Year Change in Status Event:**

Because the District pre-taxes benefits for active employees, we are required to follow Internal Revenue Service (IRS) regulations on if and when benefits can be changed in the middle of a plan year. The following events **may** allow certain changes in benefits mid-year, **if** permitted by the IRS:

- Change in legal marital status (e.g. marriage, divorce/legal separation, death).
- Change in number or status of dependents (e.g. birth, adoption, death).
- Change in employee/spouse/dependent's employment status, work schedule, or residence that affects their eligibility for benefits.

- Coverage of a child due to a QMCSO.
- Entitlement or loss of entitlement to Medicare or Medicaid.
- Certain changes in the cost of coverage, composition of coverage or curtailment of coverage of the employee or spouse's plan.
- Changes consistent with Special Enrollment rights and FMLA leaves.

You must notify the plan in writing within **31 days** of the mid-year change in status event by contacting the District's Employee Benefits Specialist at 602-764-1538. The Plan will determine if your change request is permitted and if so, changes become effective prospectively, on the first day of the month, following the approved change in status event (except for newborn and adopted children, who are covered back to the date of birth, adoption, or placement for adoption).

Failure to give this Plan a timely notice (as noted above) may:

- a. cause you, your Spouse and/or Dependent Child(ren) to lose the right to obtain COBRA Continuation Coverage,
- b. cause the coverage of a Dependent Child to end when it otherwise might continue because of a disability,
- c. cause claims to not be able to be considered for payment until eligibility issues have been resolved,
- d. result in your liability to repay the Plan if any benefits are paid to an ineligible person.

IMPORTANT REMINDER TO PROVIDE THE PLAN WITH THE TAXPAYER IDENTIFICATION NUMBER (TIN) OR SOCIAL SECURITY NUMBER (SSN) OF EACH ENROLLEE IN A HEALTH PLAN

Employers are required by law to collect the taxpayer identification number (TIN) or social security number (SSN) of each medical plan participant and provide that number on reports that will be provided to the IRS each year. Employers are required to make at least two consecutive attempts to gather missing TINs/SSNs.

If a dependent does not yet have a social security number, you can go to this website to complete a form to request a SSN: <http://www.socialsecurity.gov/online/ss-5.pdf>. Applying for a social security number is FREE.

If you have not yet provided the social security number (or other TIN) for each of your dependents that you have enrolled in the health plan, please contact the District's Employee Benefits Specialist at 602-764-1538.

CAUTION: IF YOU DECLINE MEDICAL PLAN COVERAGE OFFERED THROUGH PUHSD

The medical plan options offered by the District are considered to be minimum essential coverage (MEC) and meet the government's minimum value standard. Additionally, the cost of medical plan coverage is intended to be affordable to employees, based on employee wages.

If you are in a benefits-eligible position and choose not to be covered by one of the District's medical plan options, you must maintain medical plan coverage elsewhere or you can purchase health insurance through a Marketplace (www.healthcare.gov), typically at the Marketplace annual enrollment is in the fall each year.

Individuals without medical plan coverage could have to pay a penalty when they file their personal income taxes. Visit the Health Insurance Marketplace for detailed information on individual shared responsibility payment penalty at <https://www.healthcare.gov/fees-exemptions/fee-for-not-being-covered/>.

If you choose to not be covered by a medical plan sponsored by the District at this enrollment time, your next opportunity to enroll for PUHSD's medical plan coverage is at the next annual open enrollment time, unless you have a mid-year change event that allows you to add coverage in the middle of the District's plan year. For questions, contact the District's Employee Benefits Specialist at 602-764-1538.

IRS FORMS TO BE PROVIDED TO YOU IN 2017

Under the Affordable Care Act, employers (and in some cases insurance companies) are required to provide full-time employees, as well as other employees enrolled in a medical plan, with IRS Form 1095. The 1095 form should be provided to you annually.

For each month of the calendar year that you were enrolled in a medical plan, this 1095 form documents that you (and any enrolled family members) met the federal requirement to have “minimum essential coverage or MEC,” meaning group medical plan coverage. **Having minimum essential coverage means you and your family members may not have to pay a penalty when you file your personal income taxes.** Visit the Health Insurance Marketplace at <https://www.healthcare.gov/fees-exemptions/fee-for-not-being-covered/> for detailed information on the individual shared responsibility payment penalty.

If you receive a 1095 form, you do not need to attach the form to your personal income tax return or wait to receive the form before filling your tax return. If you receive a form this year, **you should keep it in a safe place** with your other tax records because you may need to produce it if requested by the IRS. (For large employers, a copy of the form 1095 will also be provided to the IRS.)

PRIVACY NOTICE REMINDER

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 requires health plans to comply with privacy rules. These rules are intended to protect your personal health information from being inappropriately used and disclosed. The rules also give you additional rights concerning control of your own healthcare information.

This Plan’s HIPAA Privacy Notice explains how the group health plan uses and discloses your personal health information. You are provided a copy of this Notice when you enroll in the Plan and the Notice is also in this enrollment guide. You can get another copy of this Notice from the District’s Employee Benefits Specialist at 602-764-1538.

MEDICARE NOTICE OF CREDITABLE COVERAGE REMINDER

If you or your eligible dependents are currently Medicare eligible, or will become Medicare eligible during the next 12 months, you need to be sure that you understand whether the prescription drug coverage that you elect under the Medical Plan options available to you are or are not creditable with (as valuable as) Medicare’s prescription drug coverage.

To find out whether the prescription drug coverage under the medical plan options offered by the District are or are not creditable you should review the Plan’s Medicare Part D Notice of Creditable Coverage available in this enrollment guide and also available from the District’s Employee Benefits Specialist at 602-764-1538.

WOMEN’S HEALTH AND CANCER RIGHTS ACT OF 1998 (WHCRA) ANNUAL NOTICE REMINDER

You or your dependents 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.

Plan limits, deductibles, copayments, and coinsurance apply to these benefits. For more information on WHCRA benefits, contact the District's Employee Benefits Specialist at 602-764-1538.

NOTICE OF GRANDFATHER STATUS

This group health plan (sponsored by Phoenix Union High School District) believes that the High, Middle and Low **medical plan options** are considered to be "**grandfathered health plans**" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that the above noted plan options may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the District's Employee Benefits Specialist at 602-764-1538.

AVAILABILITY OF SUMMARY HEALTH INFORMATION: THE SUMMARY OF BENEFIT AND COVERAGE (SBC) DOCUMENT(S)

The health benefits available to you represent a significant component of your compensation package. They also provide important protection for you and your family in the case of illness or injury.

As required by law, across the US, insurance companies and group health plans like ours are providing plan participants with a consumer-friendly SBC as a way to help understand and compare medical plan benefits. Choosing a health coverage option is an important decision. To help you make an informed choice, the Summary of Benefits and Coverage (SBC), summarizes and compares important information in a standard format.

Each SBC contains concise medical plan information, in plain language, about benefits and coverage, including, what is covered, what you need to pay for various benefits, what is not covered and where to go for more information or to get answers to questions. SBC documents are updated when there is a change to the benefits information displayed on an SBC.

Government regulations are very specific about the information that can and cannot be included in each SBC. Plans are not allowed to customize very much of the SBC documents. There are detailed instructions the Plan had to follow about how the SBCs look, how many pages long the SBC should be, the font size, the colors used when printing the SBC and even which words were to be bold and underlined.

To get a free copy of the most current Summary of Benefits and Coverage (SBC) documents for our medical plan options, go to www.phoenixunion.org or for a paper copy, contact the District's Employee Benefits Specialist at 602-764-1538.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT NOTICE

Hospital Length of Stay for Childbirth: Under federal law, group health plans, like this Plan, generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or the newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, the Plan may pay for a shorter stay if the attending Physician (e.g., Physician, or Health Care Practitioner), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, plans may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, the Plan may not, under federal law, require that a Physician or other Health Care Practitioner obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain precertification. For information on precertification for a length of stay longer than 48 hours for vaginal birth or 96 hours for C-section, contact Blue Cross Blue Shield of Arizona (BCBSAZ) at 877-864-4899 to precertify the extended stay. If you have questions about this Notice, contact the District's Employee Benefits Specialist at 602-764-1538.

FAMILY AND MEDICAL LEAVE ACT (FMLA) REMINDER

The FMLA entitles eligible employees of covered employers to take unpaid, job-protected leave for specified family and medical reasons with continuation of group health insurance coverage under the same terms and conditions as if the employee had not taken leave. Employees are eligible if they have worked for a covered employer for at least 12 months, have 1,250 hours of service in the previous 12 months, and if at least 50 employees are employed by the employer within 75 miles. Eligible employees are entitled to twelve (12) workweeks of leave in a 12-month period for:

- the birth of a child and to care for the newborn child within one year of birth;
- the placement with the employee of a child for adoption or foster care and to care for the newly placed child within one year of placement;
- to care for the employee's spouse, child, or parent who has a serious health condition;
- a serious health condition that makes the employee unable to perform the essential functions of his or her job;
- any qualifying exigency arising out of the fact that the employee's spouse, son, daughter, or parent is a covered military member on "covered active duty;" or

Twenty-six (26) workweeks of leave during a single 12-month period to care for a covered servicemember with a serious injury or illness if the eligible employee is the servicemember's spouse, son, daughter, parent, or next of kin (military caregiver leave).

All covered employers are required to display and keep displayed a poster prepared by the Department of Labor summarizing the major provisions of The Family and Medical Leave Act (FMLA) and telling employees about their rights and responsibilities and how to file a complaint. We display the FMLA poster at our worksite. More information on FMLA is available at: <http://www.dol.gov/whd/fmla/> or contact the District's Employee Benefits Specialist at 602-764-1538.

Certain Employee Responsibilities Related to FMLA: Employees must provide 30 days advance notice of the need to take FMLA leave when the need is foreseeable. When a 30-day notice is not possible, the employee must provide notice as soon as practicable and generally must comply with an employer's normal call-in procedures.

Employees must provide sufficient information for the employer to determine if the leave may qualify for FMLA protection and the anticipated timing and duration of the leave. Sufficient information may include that the employee is unable to perform job functions, the family member is unable to perform daily activities, the need for hospitalization or continuing treatment by a health care provider, or circumstances supporting the need for military family leave.

Employees also must inform the employer if the requested leave is for a reason for which FMLA leave was previously taken or certified. Employees also may be required to provide a certification and periodic recertification supporting the need for leave.

COBRA COVERAGE REMINDER

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

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

Qualifying events include termination of employment, reduction in hours of work making the employee ineligible for coverage, death of the employee, divorce/legal separation, or a child ceasing to be an eligible dependent child.

In addition to considering COBRA as a way to continue coverage, there may be other coverage options for you and your family. You may want to look for coverage through the Health Care Marketplace. See <https://www.healthcare.gov/>. In the Marketplace, you could be eligible for a tax credit that lowers your monthly premiums for Marketplace coverage, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Being eligible for COBRA does not limit your eligibility for coverage for a tax credit through the Marketplace. Additionally, you may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a spouse's plan) if you request enrollment within 30 days, even if the plan generally does not accept late enrollees.

The maximum period of COBRA coverage is generally either 18 months or 36 months, depending on which qualifying event occurred.

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

If you have questions about COBRA contact the District's Employee Benefits Specialist at 602-764-1538.

FLEXIBLE SPENDING ACCOUNT PLAN DOCUMENT/SUMMARY PLAN DESCRIPTION

The Flex Plan Documents and Summaries of Benefits and Coverage for each medical plan option are available on the Employee Benefit Documents page of the District website @ www.phoenixunion.org. You can also request a copy of any of the above and/or a copy of the Summary Plan Description from the District's Employee Benefits Specialist at 602-764-1538.

KEEP THE PLAN NOTIFIED OF CHANGES IN ELIGIBILITY FOR BENEFITS

YOU ARE REQUIRED TO PROVIDE TIMELY NOTICE

You or your Dependents must promptly furnish to the District information regarding change of name, address, marriage, divorce or legal separation, death of any covered family member, change in status of a Dependent Child, Medicare enrollment or disenrollment, an individual meets the termination provisions of the Plan, or the existence of other coverage. Proof of legal documentation will be required for certain changes.

Notify the District preferably within 31 days, but no later than 60 days, after any of the above noted events.

Failure to give your employer, the District, a timely notice of the above noted events may:

- a. cause you, your Spouse and/or Dependent Child(ren) to lose the right to obtain COBRA Continuation Coverage,
- b. cause the coverage of a Dependent Child to end when it otherwise might continue because of a disability,
- c. cause claims to not be able to be considered for payment until eligibility issues have been resolved,
- d. result in your liability to repay the Plan if any benefits are paid to an ineligible person. The Plan has the right to offset the amounts paid against the participant's future medical, dental, and/or vision benefits.

In accordance with the requirements in the Affordable Care Act, your employer will not retroactively cancel coverage (a rescission) except when premiums contributions are not timely paid, or in cases when an individual performs an act, practice or omission that constitutes fraud, or makes an intentional misrepresentation of material fact that is prohibited by the terms of the Plan. Keeping an ineligible dependent enrolled (for example, an ex-spouse, overage dependent child, etc.) is considered fraud. If you have questions about eligibility contact District's Employee Benefits Specialist at 602-764-1538.

IMPORTANT NOTICES ATTACHED

The following pages include important notices for you and your family:

- Health Insurance Marketplace Notice
- Medicare Part D Notice
- The District's HIPAA Privacy Notice
- Premium Assistance Under Medicaid and CHIP Notice



New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 2-28-2017)

PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.¹

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution -as well as your employee contribution to employer-offered coverage- is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact **Phoenix Union High School District's Employee Benefits Department at 602-764-1538.**

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

¹ An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer name Phoenix Union High School District		4. Employer Identification Number (EIN) 86-6000534	
5. Employer address 4502 N. Central Ave.		6. Employer phone number 602-764-1538	
7. City Phoenix	8. State AZ	9. ZIP code 85012	
10. Who can we contact about employee health coverage at this job? Cyndy Nelke, Employee Benefits Specialist			
11. Phone number (if different from above) 602-764-1538		12. Email address nelke@phoenixunion.org	

Here is some basic information about health coverage offered by this employer:

- **As your employer, we offer a health plan to:**

All employees.

Some employees. Eligible employees are:

A permanent classified or contracted employee of the District working a minimum of 24 hours of service per week. If said contract starts between the 1st and the 15th of the month, insurance will be effective the first day of the following month. If said contract starts between the 16th and the end of the month, insurance will be effective the first day of the second following month.

- **With respect to dependents:**

We do offer coverage. Eligible dependents are:

Lawful spouse and the following categories of children under age 26 whether married or unmarried: natural child, adopted child or child placed for adoption, stepchild, child under a QMCSO, child under a legal guardianship order and foster children. Adult disabled children meeting the eligibility requirements of the plan may continue beyond age 26. Dependents are eligible to enroll at the same time as the employee.

We do not offer coverage.

If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, [HealthCare.gov](https://www.healthcare.gov) will guide you through the process. Here's the employer information you'll enter when you visit [HealthCare.gov](https://www.healthcare.gov) to find out if you can get a tax credit to lower your monthly premiums.

Phoenix Union High School District

Center for Educational Services
4502 North Central Avenue
Phoenix, Arizona 85012
(602) 764-1538

Superintendent
Chad Gestson

Executive Director, Talent
Laura Telles

ATTN: EMPLOYEE AND FAMILY

Important Notice from Phoenix Union High School District about Prescription Drug Coverage for People with Medicare

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

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

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

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

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

Phoenix Union High School District has determined that the prescription drug coverage is "creditable" under the following medical plan options: High Option Plan, Middle Option Plan and Low Option plan.

"Creditable" means that the value of this Plan's prescription drug benefit is, on average for all plan participants, expected to pay out as much as or more than the standard Medicare prescription drug coverage will pay.

Because the plan options noted above are, on average, at least as good as the standard Medicare prescription drug coverage, **you can elect or keep prescription drug coverage under the High, Middle and Low Option plans and you will not pay extra if you later decide to enroll in Medicare prescription drug coverage.** You may enroll in Medicare prescription drug coverage at a later time, and because you maintain creditable coverage, you will not have to pay a higher premium (a late enrollment fee penalty).

REMEMBER TO KEEP THIS NOTICE

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

WHEN CAN YOU JOIN A MEDICARE DRUG PLAN?

Medicare-eligible people can enroll in a Medicare prescription drug plan at one of the following 3 times:

- when they first become eligible for Medicare; or
- during Medicare's annual election period (from October 15th through December 7th); or
- for beneficiaries leaving employer/union coverage, you may be eligible for a two month Special Enrollment Period (SEP) in which to sign up for a Medicare prescription drug plan.

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

YOUR RIGHT TO RECEIVE A NOTICE

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

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

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

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

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

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

WHAT ARE MY CHOICES?

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

Your Choices:	What you can do:	What this option means to you:
<p>Option 1</p>	<p>You can select or keep your current medical and prescription drug coverage with High, Middle and Low plans, and you do not have to enroll in a Medicare prescription drug plan.</p>	<p>You will continue to be able to use your prescription drug benefits through High, Middle and Low plans.</p> <ul style="list-style-type: none"> • You may, in the future, enroll in a Medicare prescription drug plan during Medicare’s annual enrollment period (during October 15th -December 7th of each year). • As long as you are enrolled in creditable drug coverage you will not have to pay a higher premium (a late enrollment fee) to Medicare when you do choose, at a later date, to sign up for a Medicare prescription drug plan.
<p>Option 2</p>	<p>You can select or keep your current medical and prescription drug coverage with High, Middle and Low plans and also enroll in a Medicare prescription drug plan.</p> <p>If you enroll in a Medicare prescription drug plan you will need to pay the Medicare Part D premium out of your own pocket.</p>	<p>Your current coverage pays for other health expenses in addition to prescription drugs.</p> <p>If you enroll in a Medicare prescription drug plan, you and your eligible dependents will still be eligible to receive all of your current health and prescription drug benefits. Having dual prescription drug coverage under this Plan and Medicare means that this Plan will coordinate its drug payments with Medicare, as follows:</p> <ul style="list-style-type: none"> • for Medicare eligible Retirees and their Medicare eligible Dependents, Medicare Part D coverage pays primary and this group health plan pays secondary. • for Medicare eligible Active Employees and their Medicare eligible Dependents, this group health plan pays primary and Medicare Part D coverage pays secondary. <p>Note that you may not drop just the prescription drug coverage under the High, Middle and Low plans. That is because prescription drug coverage is part of the entire medical plan. Generally, you may only drop medical plan coverage at this Plan’s next Open Enrollment period.</p> <p>Note that each Medicare prescription drug plan (PDP) may differ. Compare coverage, such as:</p> <ul style="list-style-type: none"> • PDPs may have different premium amounts • PDPs cover different brand name drugs at different costs to you; • PDPs may have different prescription drug deductibles and different drug copayments; • PDPs may have different networks for retail pharmacies and mail order services.

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

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

For more information about Medicare prescription drug plan coverage:

- Visit www.medicare.gov.
- Call your State Health Insurance Assistance Program (see your copy of the Medicare & You handbook for their telephone number), for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Para más información sobre sus opciones bajo la cobertura de Medicare para recetas médicas.

Revise el manual "Medicare Y Usted" para información más detallada sobre los planes de Medicare que ofrecen cobertura para recetas médicas. Visite www.medicare.gov por el Internet o llame GRATIS al 1 800 MEDICARE (1-800-633-4227). Los usuarios con teléfono de texto (TTY) deben llamar al 1-877-486-2048. Para más información sobre la ayuda adicional, visite la SSA en línea en www.socialsecurity.gov por Internet, o llámeles al 1-800-772-1213 (Los usuarios con teléfono de texto (TTY) deberán llamar al 1-800-325-0778).

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information about this extra help is available from the Social Security Administration (SSA). For more information about this extra help, visit SSA online at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

For more information about this notice or your current prescription drug coverage contact:

Phoenix Union High School District
ATTN: Employee Benefits Specialist
4502 N. Central Ave., Phoenix, AZ 85012
Phone Number: 602-764-1538

As in all cases, Phoenix Union High School District reserves the right to modify benefits at any time, in accordance with applicable law. This document (dated April 05, 2017) is intended to serve as your Medicare Notice of Creditable Coverage, as required by law.

Phoenix Union High School District: HIPAA Notice of Privacy Practices

Este aviso está disponible en Español si lo solicitas. Por favor contacte el oficial de privacidad indicado a continuación.

Purpose of This Notice

**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 is required by law.

The Phoenix Union High School District group health plan including the administration of the self-funded Medical Plan options, Medical/Health Reimbursement Account (also known as a Health Flexible Spending Account) and COBRA, (hereafter referred to as the "Plan"), is required by law to take reasonable steps to maintain the privacy of your personally identifiable health information (called Protected Health Information or PHI) and to inform you about the Plan's legal duties and privacy practices with respect to protected health information including:

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

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

You may receive a Privacy Notice from a variety of the insured group health benefit plans offered by the District. Each of these notices will describe your rights as it pertains to that plan and in compliance with the Federal regulation, HIPAA. This Privacy Notice however, pertains to your protected health information related to the District's self-funded medical plan options, administration of the Medical/Health Reimbursement Account (also known as a Health Flexible Spending Account) and COBRA (the "Plan") and outside companies contracted to help administer Plan benefits, also called "business associates."

Effective Date

The effective date of this Notice is **April 05, 2017** and this notice replaces notices previously distributed to you.

Privacy Officer

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

Privacy Officer for Phoenix Union High School District (PUHSD)
Attn: Human Resources Department
4502 N. Central Ave. Phoenix, AZ 85012
Telephone: 602-764-1538 Confidential fax #: 602-274-0484

Your Protected Health Information

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

PHI does not include health information contained in employment records held by Phoenix Union High School District in its role as an employer, including but not limited to health information on disability, work-related illness/injury, sick leave, Family or Medical Leave (FMLA), life insurance, dependent care flexible spending account, drug testing, etc.

When the Plan May Disclose Your PHI

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

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

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

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

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

When the Disclosure of Your PHI Requires Your Written Authorization

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

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

You have the right to revoke an authorization.

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

The Plan generally will require an authorization form for uses and disclosure of your PHI for marketing purposes (meaning a communication that encourages you to purchase or use a product or service) if the Plan receives direct or indirect financial remuneration (payment) from the entity whose product or service is being marketed. The Plan generally will require an authorization form for the sale of protected health information if the Plan receives direct or indirect financial remuneration (payment) from the entity to which the PHI is sold. The Plan does not intend to engage in fundraising activities.

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

Disclosure of your PHI to family members, other relatives and your close personal friends without your written consent or authorization is allowed if:

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

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

- In the event of your death while you are covered by this Plan, when the Plan is notified it will automatically communicate this information to the following internal departments: Payroll, Human Resources, Technology and Community Relations.
- In the event the Plan is notified of a work-related illness or injury, the Plan will automatically communicate this information to the District's Workers' Compensation Insurance Carrier, District Workers' Compensation Coordinator, Site Workers' Compensation Coordinator and Safety Department to allow the processing of appropriate paperwork.
- In the event the Plan is notified of a condition that may initiate a short term disability benefit, the Plan will automatically communicate this information to the Employee Benefits Specialist to allow the processing of appropriate paperwork.
- In the event the Plan is notified of a situation where it may be possible to initiate a medical leave under the Family and Medical Leave Act (FMLA) benefit, the Plan will automatically communicate this information to the Assistants to the Human Resource Administrators to allow the processing of appropriate FMLA paperwork.

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

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

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

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

10. For **research**, subject to certain conditions.
11. When, consistent with applicable law and standards of ethical conduct, the Plan in good faith believes the use or disclosure is necessary to prevent or lessen a serious and **imminent threat to the health or safety** of a person or the public and the disclosure is to a person reasonably able to prevent or lessen the threat, including the target of the threat.
12. When authorized by and to the extent necessary to comply with **workers' compensation** or other similar programs established by law.
13. When required, for **specialized government functions**, to military authorities under certain circumstances, or to authorized Federal officials for lawful intelligence, counter intelligence and other national security activities.

Any other Plan uses and disclosures not described in this Notice will be made only if you provide the Plan with written authorization, subject to your right to revoke your authorization, and information used and disclosed will be made in compliance with the minimum necessary standards of the regulation.

Your Individual Privacy Rights

A. You May Request Restrictions on PHI Uses and Disclosures

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

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

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

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

B. You May Inspect and Copy Your PHI

You have the right to inspect and obtain a copy (in hard copy or electronic form) of your PHI (except psychotherapy notes and information compiled in reasonable contemplation of an administrative action or proceeding) contained in a "designated record set," for as long as the Plan maintains the PHI. You may request your hard copy or electronic information in a format that is convenient for you, and the Plan will honor that request to the extent possible. You may also request a summary of your PHI.

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

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

You or your personal representative will be required to complete a form to request access to the PHI in your Designated Record Set. Requests for access to your PHI should be made to the Plan's Privacy Officer at their address listed on the first page of this Notice. The Plan reserves the right to charge a reasonable cost-based fee for creating or copying the PHI or preparing a summary of your PHI.

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

C. *You Have the Right to Amend Your PHI*

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

If the Plan denied your request in whole or part, the Plan must provide you with a written denial that explains the basis for the decision. You or your personal representative may then submit a written statement disagreeing with the denial and have that statement included with any future disclosures of your PHI. You should make your request to amend PHI to the Privacy Officer at their address listed on the first page of this Notice.

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

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

At your request, the Plan will also provide you with an accounting of disclosures by the Plan of your PHI during the six years (or shorter period if requested) before the date of your request. The Plan will not provide you with an accounting of disclosures related to treatment, payment, or health care operations, or disclosures made to you or authorized by you in writing. The Plan has 60 days after its receipt of your request to provide the accounting. The Plan is allowed an additional 30 days if the Plan gives you a written statement of the reasons for the delay and the date by which the accounting will be provided. If you request more than one accounting within a 12-month period, the Plan will charge a reasonable, cost-based fee for each subsequent accounting.

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

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

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

To obtain a paper or electronic copy of this Notice, contact the Plan's Privacy Officer at their address listed on the first page of this Notice. This right applies even if you have agreed to receive the Notice electronically.

G. *Breach Notification*

If a breach of your unsecured protected health information occurs, the Plan will notify you.

Your Personal Representative

You may exercise your rights to your protected health information (PHI) by designating a person to act as your Personal Representative. Your Personal Representative will generally be required to produce evidence (proof) of the authority to act on your behalf **before** the Personal Representative will be given access to your PHI or be allowed to take any action for you.

Under this Plan, proof of such authority will include (1) a completed, signed and approved Appoint a Personal Representative form; (2) a notarized power of attorney for health care purposes; (3) a court-appointed conservator or guardian; or, (4) for a Spouse under this Plan, the absence of a Revoke a Personal Representative form on file with the Privacy Officer.

This Plan will automatically recognize your legal Spouse as your Personal Representative and vice versa, without you having to complete a form to Appoint a Personal Representative. However, you may request that the Plan not automatically honor your legal Spouse as your Personal Representative by completing a form to Revoke a Personal Representative (copy attached to this notice or also available from the Privacy Officer).

If you wish to revoke your Spouse as your Personal Representative, please complete the Revoke a Personal Representative form and return it to the Privacy Officer and this will mean that this Plan will NOT automatically recognize your Spouse as your Personal Representative and vice versa.

The recognition of your Spouse as your Personal Representative (and vice versa) is for the use and disclosure of PHI related to treatment, payment and health care operations purposes under this Plan and is not intended to expand such designation beyond what is necessary for this Plan to comply with HIPAA privacy regulations.

You may obtain a form to Appoint a Personal Representative or Revoke a Personal Representative by contacting the Privacy Officer at their address listed on this Notice. The Plan retains discretion to deny access to your PHI to a Personal Representative to provide protection to those vulnerable people who depend on others to exercise their rights under these rules and who may be subject to abuse or neglect.

Because HIPAA regulations give adults certain rights and generally children age 18 and older are adults, if you have **dependent children age 18 and older** covered under the Plan, and the child wants you, as the parent(s), to be able to access their protected health information (PHI), that child will need to complete a form to Appoint a Personal Representative to designate you (the employee/retiree) and/or your Spouse as their Personal Representatives.

The Plan will consider a parent, guardian, or other person acting *in loco parentis* as the Personal Representative of an unemancipated minor (a child generally under age 18) unless the applicable law requires otherwise. **In loco parentis** may be further defined by state law, but in general it refers to a person who has been treated as a parent by the child and who has formed a meaningful parental relationship with the child for a substantial period of time. Spouses and unemancipated minors may, however, request that the Plan restrict PHI that goes to family members as described above under the section titled "Your Individual Privacy Rights."

The Plan's Duties

The Plan is required by law to maintain the privacy of your PHI and to provide you and your eligible dependents with Notice of its legal duties and privacy practices. The Plan is required to comply with the terms of this Notice. However, the Plan reserves the right to change its privacy practices and the terms of this Notice and to apply the changes to any PHI maintained by the Plan. In addition, the Plan may not (and does not) use your genetic information that is PHI for underwriting purposes.

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

Notice Revisions: If a privacy practice of this Plan is changed affecting this Notice, a revised version of this Notice will be provided to you and all participants covered by the Plan at the time of the change. Any revised

version of the Notice will be distributed within 60 days of the effective date of a material change to the uses and disclosures of PHI, your individual rights, the duties of the Plan or other privacy practices stated in this Notice.

Material changes are changes to the uses and disclosures of PHI, an individual's rights, the duties of the Plan or other privacy practices stated in the Privacy Notice. Because our health plan posts its Notice on its website (www.phoenixunion.org), we will prominently post the revised Notice on that website by the effective date of the material change to the Notice. We will also provide the revised notice, or information about the material change and how to obtain the revised Notice, in our next annual mailing to individuals covered by the Plan.

Disclosing Only the Minimum Necessary Protected Health Information

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

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

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

As described in the amended Plan document, the Plan may share PHI with the Plan Sponsor for limited administrative purposes, such as determining claims and appeals, performing quality assurance functions and auditing and monitoring the Plan. The Plan shares the minimum information necessary to accomplish these purposes.

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

Your Right to File a Complaint

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

You may also file a complaint (within 180 days of the date you know or should have known about an act or omission) with the Secretary of the U.S. Department of Health and Human Services by contacting their nearest office as listed in your telephone directory or at this website (<http://www.hhs.gov/ocr/office/about/rgn-hqaddresses.html>) or this website: <http://www.hhs.gov/ocr/privacy/hipaa/complaints/index.html> or contact the Privacy Officer (noted on the first page) for more information about how to file a complaint.

If You Need More Information

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

Attachment (Form to Revoke a Personal Representative)

Phoenix Union High School District Form to Revoke a Personal Representative

Complete the following chart to indicate the name of the Personal Representative to be revoked:

	Plan Participant:	Person to be Revoked as my Personal Representative:
Name (print):		
Address (City, State, Zip):		
Phone:	()	()

I, _____ (Name of Participant or Beneficiary) hereby
revoke the authority of _____ (Name of Personal
Representative)

to act on my behalf,

to act on behalf of my dependent child(ren), named:

_____ ,

in receiving any protected health information (PHI) that is (or would be) provided to a personal representative, including
any individual rights regarding PHI under HIPAA, effective _____, 20__.

I understand that PHI has or may already have been disclosed to the above named Personal Representative prior to the
effective date of this form.

Participant or Beneficiary's Signature

Date

Acknowledgement by the Privacy Officer: _____ Date: _____, 20__

Once completed, please return this form to the:
Privacy Officer for Phoenix Union High School District (PUHSD)
 Attn: Human Resources Department
 4502 N. Central Ave. Phoenix, AZ 85012
 Telephone: 602-764-1538 Confidential fax #: 602-274-0484

Premium Assistance Under Medicaid and the Children’s Health Insurance Program (CHIP)

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2017. Contact your State for more information on eligibility –

ALABAMA – Medicaid	FLORIDA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: http://flmedicaidplrecovery.com/hipp/ Phone: 1-877-357-3268
ALASKA – Medicaid	GEORGIA – Medicaid
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Website: http://dch.georgia.gov/medicaid - Click on Health Insurance Premium Payment (HIPP) Phone: 404-656-4507
ARKANSAS – Medicaid	INDIANA – Medicaid
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: http://www.indianamedicaid.com Phone 1-800-403-0864
COLORADO – Health First Colorado (Colorado’s Medicaid Program) & Child Health Plan Plus (CHP+)	IOWA – Medicaid
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: Colorado.gov/HCPF/Child-Health-Plan-Plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711	Website: http://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp Phone: 1-888-346-9562
KANSAS – Medicaid	NEW HAMPSHIRE – Medicaid
Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512	Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf Phone: 603-271-5218

<p align="center">KENTUCKY – Medicaid</p> <p>Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570</p>	<p align="center">NEW JERSEY – Medicaid and CHIP</p> <p>Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710</p>
<p align="center">LOUISIANA – Medicaid</p> <p>Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447</p>	<p align="center">NEW YORK – Medicaid</p> <p>Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831</p>
<p align="center">MAINE – Medicaid</p> <p>Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711</p>	<p align="center">NORTH CAROLINA – Medicaid</p> <p>Website: https://dma.ncdhs.gov/ Phone: 919-855-4100</p>
<p align="center">MASSACHUSETTS – Medicaid and CHIP</p> <p>Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-462-1120</p>	<p align="center">NORTH DAKOTA – Medicaid</p> <p>Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825</p>
<p align="center">MINNESOTA – Medicaid</p> <p>Website: http://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/medical-assistance.jsp Phone: 1-800-657-3739</p>	<p align="center">OKLAHOMA – Medicaid and CHIP</p> <p>Website: http://www.insureoklahoma.org Phone: 1-888-365-3742</p>
<p align="center">MISSOURI – Medicaid</p> <p>Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005</p>	<p align="center">OREGON – Medicaid</p> <p>Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075</p>
<p align="center">MONTANA – Medicaid</p> <p>Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084</p>	<p align="center">PENNSYLVANIA – Medicaid</p> <p>Website: http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancpremiumpaymenthippprogram/index.htm Phone: 1-800-692-7462</p>
<p align="center">NEBRASKA – Medicaid</p> <p>Website: http://dhhs.ne.gov/Children_Family_Services/AccessNebraska/Pages/accessnebraska_index.aspx Phone: 1-855-632-7633</p>	<p align="center">RHODE ISLAND – Medicaid</p> <p>Website: http://www.eohhs.ri.gov/ Phone: 401-462-5300</p>
<p align="center">NEVADA – Medicaid</p> <p>Medicaid Website: https://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900</p>	<p align="center">SOUTH CAROLINA – Medicaid</p> <p>Website: https://www.scdhhs.gov Phone: 1-888-549-0820</p>
<p align="center">SOUTH DAKOTA - Medicaid</p> <p>Website: http://dss.sd.gov Phone: 1-888-828-0059</p>	<p align="center">WASHINGTON – Medicaid</p> <p>Website: http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program Phone: 1-800-562-3022 ext. 15473</p>
<p align="center">TEXAS – Medicaid</p> <p>Website: http://gethipptexas.com/ Phone: 1-800-440-0493</p>	<p align="center">WEST VIRGINIA – Medicaid</p> <p>Website: http://www.dhhr.wv.gov/bms/Medicaid%20Expansion/Pages/default.aspx Phone: 1-877-598-5820, HMS Third Party Liability</p>
<p align="center">UTAH – Medicaid and CHIP</p> <p>Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669</p>	<p align="center">WISCONSIN – Medicaid and CHIP</p> <p>Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002</p>
<p align="center">VERMONT – Medicaid</p> <p>Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427</p>	<p align="center">WYOMING – Medicaid</p> <p>Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531</p>

VIRGINIA – Medicaid and CHIP	
Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm CHIP Phone: 1-855-242-8282	

To see if any other states have added a premium assistance program since January 31, 2017, or for more information on special enrollment rights, contact either:

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

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

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512. The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 12/31/2019)