South Bend Community School Corporation

2016

Employee Benefit Guide

Welcome to South Bend Community School Corporation. Eligible employees have the opportunity to enroll in a variety of benefit plans intended to offer you flexibility to choose the best options for you and your family.

The plans in this booklet offer flexibility in doctor and hospital choice, large networks, and a variety of benefits intended to help you maintain a healthy life.

- Health Insurance
- Dental Insurance
- Vision Insurance
- Life Insurance
- Disability Insurance
- Supplemental Life Insurance
- Supplemental Accident Insurance
- Supplemental Cancer Insurance
- Retirement Plans
- Flexible Spending Plan

If you have questions regarding your benefits, please contact the Benefits Department at 574-283-8189.

This brief summary is not intended to include every benefit and limitation of the plans presented. Please refer to your certificate of coverage or summary plan description for important additional benefits and limitations.

The information in this Benefits Summary is presented for illustrative purposes. While every effort was taken to accurately report your benefits, discrepancies, or errors are always possible. In case of a discrepancy between this Benefits Summary and the actual plan documents, the actual plan documents will prevail. The employer reserves the right to make changes to benefits at any time.

You must meet the eligibility requirements for each plan and be employed in a job classification eligible for insurance benefits.

When You May Enroll or Make Changes to Your Enrollment Status:

- Within 30 days of your date of hire or the date your benefits are effective.
- During the annual open enrollment period for coverage changes effective January 1 (Health Insurance Only)
- Within 30 days of a qualifying life event (Health, Dental and Vision Insurance Only).

Newly Hired

As a new employee, you have the opportunity to enroll in the benefit plans. You must make your benefit elections within 30 days of the end of your new employee waiting period. Your waiting period is based on your employment classification and it will be explained to you during your orientation. Review this guide and complete a Benefit Enrollment Form. Return the completed and signed Benefit Enrollment Form, along with all required documentation, to the Benefits Department no later than 30 days after the end of your new employee waiting period.

Open Enrollment for Plan Changes Effective January 1

If you are an eligible employee, you may make the following changes during Open Enrollment:

- Enroll yourself and/or your eligible dependents in health insurance.
- Drop coverage on yourself and/or dependents for health, dental or vision insurance.
- Switch from one health insurance plan to any health insurance plan (e.g. from the Buy-Up Plan to the Core Plan, or to the Essential Care Plan).
- You may **not** enroll or make changes in dental or vision insurance during Open Enrollment.
- After Open Enrollment ends, you will not be able to enroll or drop coverage unless you request a change within 30 days of a qualifying life event.
- The 2016 Open Enrollment ends on November 16, 2015 for coverage changes effective January 1, 2016.

Within 30 Days of Qualifying Life Event

- Qualifying Life Events include (but are not limited to): your spouse leaves his/her employer, divorce or death of a spouse, loss of eligibility under your parent's plan, loss of eligibility for Medicaid, CHIP or other government health plan.
- New dependents must be enrolled within 30 days of the date of marriage, birth or adoption, even if you already have family coverage.
- **NOTE:** Voluntarily dropping coverage for which you are still eligible is NOT a Qualifying Event. You have to experience a loss of coverage to enroll in coverage through SBCSC.
- **An enrollment form must be completed and returned to the Benefits Department along with the required supporting documentation, within 30 days of the qualifying event.**
- Required supporting documentation may include a marriage license, divorce decree, birth or adoption certificate, letter or other proof of termination of spouse's employment.

Health Insurance

South Bend Community School Corporation offers eligible employees a choice between three health insurance plan options. All plans are administered by Anthem Blue Cross and use the same Anthem Blue Access PPO network.

The **Buy-Up Plan and Core Plan** are traditional PPO plans with copayments for office visits and prescription drugs.

- Both plans include access to the Activate Health & Wellness Center with no out-of-pocket cost for services and medications received at the Health & Wellness Center.

The **Essential Care Plan** is an HSA-qualified high-deductible plan with an accompanying Health Savings Account (see pp. 13-14 for more information on the Health Savings Account – HSA).

- There are **no copayments** on this Essential Care Plan because all covered services, including office visits and prescription drugs, apply to the annual deductible and coinsurance. **This means that no benefits are paid, including prescription drug costs, until the annual deductible has been met.**

- **The Essential Care Plan does NOT include access to the Activate Health & Wellness Center,** and employees and dependents enrolled in this plan are not permitted to receive services or medications at the Health & Wellness Center.

- Spouses may not be enrolled in the Essential Care Plan. If you wish to cover your spouse, you must choose the Buy-Up Plan or Core Plan for yourself and your family. Children may be enrolled in the Essential Care Plan.

ADDITIONAL INFORMATION

Visit the Anthem website at **www.anthem.com** to:

- Find a doctor or other medical provider
- Obtain prescription drug information
- Look up your claims
- Order additional copies of your ID card
- Obtain important cost and quality information for different medical providers in your area
- Research diseases and treatments
- Learn about ways to be healthier and save money

Summary of In-Network Benefits

(Refer to the Certificate of Coverage for in-network benefit levels, and other important details.)

In-Network Benefits:	Buy-Up Plan	Core Plan	Essential Care Plan
Services provided at the Activate Health & Wellness Center	No Out-of-Pocket Cost	No Out-of-Pocket Cost	Not Included/No Access
Benefits for All Other In-Network Covered Services NOT Provided at the Activate Health & Wellness Center:			
Annual Calendar Year Deductible	$750 / Person $1,500 / Family	$1,500 / Person $3,000 / Family	$4,000 / Person $8,000 / Family
PPO Network	Anthem Blue Access	Anthem Blue Access	Anthem Blue Access
After Deductible, the Plan pays Coinsurance of	80%	80%	80%
Annual Out-of-Pocket Maximum **(includes deductible, coinsurance, and copayments except drug copayments)**	$2,500 / Person $5,000 / Family	$4,000 / Person $8,000 / Family	$6,450 / Person $12,900 / Family
Lifetime Maximum Benefit	Unlimited	Unlimited	Unlimited
HSA Qualified Plan **(HSA information on pages 13-14)**	No	No	Yes
Preventive Care	Plan pays 100%, Deductible does not apply	Plan pays 100%, Deductible does not apply	Plan pays 100%, Deductible does not apply
Office Visit – Primary Care Doctor	$30 copay, then paid at 100%	$30 copay, then paid at 100%	Subject to Annual Deductible & Coinsurance
Office Visit – Specialists	$60 copay, then paid at 100%	$60 copay, then paid at 100%	Subject to Annual Deductible & Coinsurance
Urgent Care Center	$40 copay, then paid at 100%	$50 copay, then paid at 100%	Subject to Annual Deductible & Coinsurance
Emergency Room Facility	$250 copay, then paid at 100%	$250 copay, then paid at 100%	Subject to Annual Deductible & Coinsurance
Surgery, Hospital Services and Room & Board, X-rays, MRIs, etc.	Subject to Annual Deductible & Coinsurance	Subject to Annual Deductible & Coinsurance	Subject to Annual Deductible & Coinsurance
Chiropractic Care Office Visit	$60 copay, limited to 20 visits per calendar year	$60 copay, limited to 20 visits per calendar year	Subject to Annual Deductible & Coinsurance limited to 20 visits per calendar year
Prescription Drugs at a Retail Pharmacy – Up to a 30-day supply			
Tier 1 – Most Generics Tier 2 – Preferred Brands Tier 3 – Non-Preferred Tier 4 – Specialty Drugs	Tier 1 - $10 copay Tier 2 - $30 copay Tier 3 - $60 copay Tier 4 – 25% up to $250/fill	Tier 1 - $10 copay Tier 2 - $30 copay Tier 3 - $60 copay Tier 4 – 25% up to $250/fill	Subject to Annual Deductible & Coinsurance
Prescription Drugs through the Mail-Order Pharmacy – Up to a 90-day supply			
Tier 1 – Most Generics Tier 2 – Preferred Brands Tier 3 – Non-Preferred Tier 4 – Specialty Drugs	Tier 1 - $20 copay Tier 2 - $60 copay Tier 3 - $120 copay Tier 4 – 25% up to $750/fill	Tier 1 - $20 copay Tier 2 - $60 copay Tier 3 - $120 copay Tier 4 – 25% up to $750/fill	Subject to Annual Deductible & Coinsurance

Summary of Out-of-Network Benefits

(Refer to the Certificate of Coverage for out-of-network benefit levels, and other important details.)

Out-of-Network Benefits:	Buy-Up Plan	Core Plan	Essential Care Plan
Services provided at the Activate Health & Wellness Center	No Out-of-Pocket Cost	No Out-of-Pocket Cost	Not Included/No Access
Benefits for All Other Out-of-Network Covered Services NOT Provided at the Activate Health & Wellness Center:			
Annual Calendar Year Deductible	$1,500 / Person $3,000 / Family	$3,000 / Person $6,000 / Family	$8,000 / Single Coverage $16,000 / Aggregate Family
PPO Network	Not Applicable	Not Applicable	Not Applicable
After Deductible, the Plan pays Coinsurance of	60%	60%	60%
Annual Out-of-Pocket Maximum **(includes deductible and coinsurance)**	$5,000 / Person $10,000 / Family	$8,000 / Person $16,000 / Family	$12,900 / Single Coverage $25,800 / Aggregate Family
Lifetime Maximum Benefit	Unlimited	Unlimited	Unlimited
HSA Qualified Plan **(HSA information on pages 13-14)**	No	No	Yes
Preventive Care	Subject to Annual Deductible & Coinsurance	Subject to Annual Deductible & Coinsurance	60% After Deductible
Office Visit – Primary Care Doctor	Subject to Annual Deductible & Coinsurance	Subject to Annual Deductible & Coinsurance	60% After Deductible
Office Visit – Specialists	Subject to Annual Deductible & Coinsurance	Subject to Annual Deductible & Coinsurance	60% After Deductible
Urgent Care Center	Subject to Annual Deductible & Coinsurance	Subject to Annual Deductible & Coinsurance	60% After Deductible
Emergency Room Facility	$200 Copay Then Deductible & Coinsurance Apply	$200 Copay Then Deductible & Coinsurance Apply	80% After Deductible
Surgery, Hospital Services and Room & Board, X-rays, MRIs, etc.	Subject to Annual Deductible & Coinsurance	Subject to Annual Deductible & Coinsurance	Subject to Annual Deductible & Coinsurance
Chiropractic Care Office Visit	Subject to Deductible & Coinsurance (Limited to 20 Visits/Cal Year)	Subject to Deductible & Coinsurance (Limited to 20 Visits/Cal Year)	Subject to Deductible & Coinsurance (Limited to 20 Visits/Cal Year)
Prescription Drugs at an Out-of-Network Retail Pharmacy – Up to a 30 Day Supply			
Tier 1 – Most Generics Tier 2 – Preferred Brands Tier 3 – Non-Preferred Tier 4 – Specialty Drugs	50% After Deductible 50% After Deductible 50% After Deductible Not Covered	50% After Deductible 50% After Deductible 50% After Deductible Not Covered	Tiers 1, 2 & 3 - Subject to Annual Deductible & Coinsurance Tier 4 - Not Covered
Prescription Drugs through an Out-of-Network Mail Order Pharmacy			
Tier 1 – Most Generics Tier 2 – Preferred Brands Tier 3 – Non-Preferred	Not Covered	Not Covered	Not Covered

Health Insurance

ADDITIONAL INFORMATION FOR ALL THREE PLANS

Preventive Care such as routine physicals, routine mammograms, routine pap tests, routine PSA tests, and most immunizations are covered at 100%. Claims must be coded by your doctor as "Routine" rather than "Diagnostic".

The Annual Deductible accumulates from January 1, 2016 through December 31, 2016.

Most covered treatment and services, such as hospital room and board, surgery, nursing care, X-rays, MRIs, ambulance, home care, etc.:

- For in-network providers, paid at 80% after the annual in-network calendar year deductible has been met.
- For out-of-network providers, paid at 60% of reasonable and customary after the annual out-of-network calendar year deductible has been met.
- Care must be medically necessary and appropriate treatment.

Pre-Certification and Prior Authorization
The plan requires pre-certification for hospital stays as well as many other tests and procedures. Durable medical equipment also requires pre-approval. Please refer to your Anthem ID card, and provide your ID card to your provider. In-network PPO providers are responsible for obtaining pre-certification and/or prior authorization from Anthem when necessary. If you utilize an out-of-network provider, you are responsible for obtaining prior-authorization.

Health Care Reform Note: All three health insurance plans offered by SBCSC meet the minimum coverage requirement under the individual mandate provision of the Patient Protection and Affordable Care Act. Information about the health insurance marketplace coverage options is located on the SBCSC website; or you can visit www.healthcare.gov for more information.

ADDITIONAL INFORMATION
FOR THE CORE PLAN AND BUY-UP PLANS ONLY

In-Network PPO Office Visits are covered at 100% after the applicable copay for a primary care provider, or the applicable copay for a specialist. *Additional services or treatments you receive may be subject to the annual deductible and coinsurance.*

- A primary care provider is a family doctor, OB/GYN or pediatrician.
- A specialist is any other type of provider; such as a cardiologist, pulmonologist, chiropractor, etc.

In-Network PPO Urgent Care Centers – Such as MedPoint, are covered at 100% after the applicable copay. *Additional services or treatments you receive may be subject to the annual deductible and coinsurance.*

Emergency Room Facility Visits are covered at 100% after a $250 copay. The copay is waived if admitted to the hospital. *Additional services or treatments you receive may be subject to the annual deductible and coinsurance.*

Prescription Drugs

Your medical plan includes coverage for prescriptions. Prescription drug information is on the back of your Anthem medical ID card. Most pharmacies, including all major chain pharmacies, are included in your pharmacy network. ***Please note:***

- The prescription plan provides up to a 30-day supply for a copay.
- Tier 1 are mostly generic medications and are subject to a $10 copay.
- Tier 2 are preferred medications and are subject to a $30 copay.
- Tier 3 are non-preferred medications and are subject to a $60 copay.
- Tier 4 are specialty medications and are subject to a copay of 25% of the cost of the medication up to a maximum copay of $250/fill. Specialty drugs must be obtained from the Accredo Specialty Mail Order Pharmacy in order to be covered. Please call Anthem Customer Service for additional information.
- You may look up your medication to find out in which tier it belongs at www.anthem.com.
- The mail-order pharmacy program provides up to a 90-day supply for a $20, $60, $120, or 25% copay. Mail-order forms are available on the Anthem website at www.anthem.com, or call Anthem at 866-216-4207

For questions about your benefits administered by Anthem, please contact Anthem at **800-295-4119.**

Health Insurance

2016 Employee Payroll Deductions	Buy-Up Plan		Core Plan		Essential Care Plan	
	Bi-Weekly 10/11-month	**Bi-Weekly 12-month**	**Bi-Weekly 10/11-month**	**Bi-Weekly 12-month**	**Bi-Weekly 10/11-month**	**Bi-Weekly 12-month**
Employee Employee Only	$131.51	$104.11	$88.57	$70.12	$58.35	$46.19
Employee & Spouse	$281.68	$223.00	$185.99	$147.24	Not Offered	Not Offered
Employee & Child(ren)	$214.62	$169.91	$141.71	$112.19	$254.23	$201.27
Employee & Full Family	$377.91	$299.18	$256.84	$203.33	Not Offered	Not Offered
Additional Spousal Surcharge Amount[1]	$31.57	$25.00	$31.57	$25.00	Not Applicable	Not Applicable

Payroll deductions are subject to change based on changes in the number of pay periods from which deductions are withheld.

Surcharge for spouses:[1]

Employees that choose to cover their spouse will pay an additional $600 per year surcharge in addition to the payroll deduction amount shown above, if the spouse has health insurance coverage available through his/her own employer. Employees who cover a spouse will be required to sign an affidavit indicating the employment status of their spouse. Failure to complete the Spousal Coverage Verification form during your enrollment period will automatically result in the additional $600.00 annual surcharge.

The $600 annual surcharge is divided equally over each pay period.

Activate Health &Wellness Center

The ***Activate Health & Wellness Center*** is a primary and urgent care center dedicated to South Bend Community School Corporation's employees, spouses and children covered under the Buy-Up and Core Plans. It provides easy access to high quality care with no out of pocket cost. Services at the Health and Wellness Center include:

- Complete adult primary care services
- Urgent Care
- Treatment for minor injuries
- Comprehensive physicals
- Labs
- Flu shots
- Common generic medications for acute and ongoing needs

South Bend Community School Corporation employees, spouses, and children who are covered by the **Buy-Up Plan** or **Core Plan** have access to the ***Activate Health & Wellness Center.***

The Health & Wellness Center provides complete primary care, labs, and many common prescription drugs at **no out-of-pocket cost to you.**

Please make an appointment before visiting the Health & Wellness Center, even for an urgent need. The goal of the Center is to respect your time with little or no waiting when you arrive at your scheduled time. If you have an urgent need, the Center can normally schedule your appointment for the same day or the next morning.

The Center is <u>not</u> a walk-in clinic and is unable to see patients without an appointment.

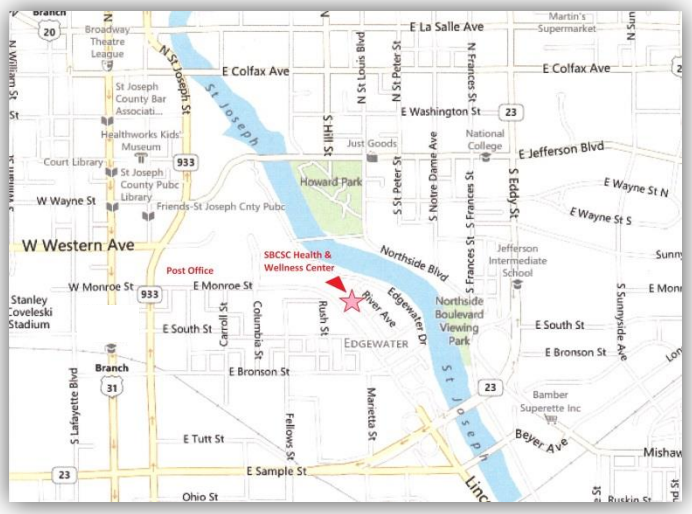
The Health & Wellness Center is open by appointment during the following hours:

Monday	6:00 AM to 5:00 PM
Tuesday	9:00 AM to 7:00 PM
Wednesday	6:00 AM to 5:00 PM
Thursday	9:00 AM to 7:00 PM
Friday	6:00 AM to 4:00 PM

To make an appointment call: 574-855-1090

The Activate Health & Wellness Center is located just southeast of the main Post Office in South Bend:

611 Lincoln Way East
South Bend, IN 46601



Health & Wellness Center

Nurse Line – If you have an urgent need after hours, please call the after-hours nurse line at **877-447-1244**. A nurse will help direct you to the most appropriate provider. Of course, you should always call 911 if the situation is life-threatening.

For news and additional information: **www.activatehealthcare.com/sbcsc**

Things to know about the Health & Wellness Center:

- The goal of the Health & Wellness Center is to help you live a longer, healthier, and more productive life for you and your family.
- It is staffed with two primary care physicians (male & female), a physician assistant, a nurse practitioner, and several medical assistants.
- The level of staffing at the Health & Wellness Center allows for longer visits and more personal attention than what other medical practices typically offer.
- Complete confidentiality is required by law. Your medical information will not be shared with anyone at SBCSC. The privacy requirements are the same as if you were visiting any other doctor's office.
- Information can be shared with other physicians, based on your direction and authorization.

Labs:

The Health & Wellness Center provides lab tests at no cost to you. You can bring in an order from another doctor for lab tests, and the results will be sent to that doctor. There is no cost to you for blood tests done at the Health & Wellness Center, even if they were not ordered by a physician at the Health & Wellness Center.

Medications:

The Health & Wellness Center stocks and dispenses many common generic drugs. There is no cost to you for medications dispensed by the Health & Wellness Center. The Center can dispense up to a 90-day supply at a time.

Due to medication dispensing laws, the Center is unable to fill prescriptions written by an outside doctor. If you would like to know more about obtaining medications at the Health & Wellness Center, please call the Health & Wellness Center.

Care for Children:

Children under age 3 are best served by a pediatrician, and therefore are unable to be seen at the Health & Wellness Center. Children who have reached their 3rd birthday may be seen at the Activate Health & Wellness Center for illnesses and minor injuries.

For several reasons, the Activate Health & Wellness Center does not stock or administer childhood immunizations. For routine well-child visits and immunizations, children are best served by a pediatrician who can follow your child's development and see that the correct immunizations are given at the appropriate times.

We encourage you to maintain your child's relationship with their pediatrician, or primary care physician that administers childhood immunizations, until they are at least 13 years old. Because most physicals required by schools include certification of immunizations, the Active Health & Wellness Center is unable to provide school physicals for children under age 13.

Well-baby/Well-child exams and immunizations are generally covered at 100% under your Anthem health insurance plan, when using a PPO provider. The visit must be coded on the bill as "preventive" by your doctor's office.

Services Provided at the Active Health & Wellness Center for Children ages 3 and up	Services Not Provided at the Activate Health & Wellness Center
• Treatment for Acute Illnesses, such as: Ear infections Respiratory infections Skin rashes Strep Throat Flu/Colds/Viruses • Minor Injuries • Most Sports & Camp Physicals	• Childhood Immunizations • Well Child Care/Check-ups under age 13 • School Physicals under age 13

Wellness Incentives

For Comprehensive Physicals and Health Goals

Employees and spouses who are covered under either the SBCSC Buy-Up or Core health insurance plans have the opportunity to earn up to $150 each by completing a comprehensive physical and health risk assessment, plus participate in a 30-minute coaching session with a health care practitioner who will work with you to tailor your individual health goals. **This reward is available once per lifetime.**

In subsequent years, you may also earn up to $300, after a 12-month period from the date you obtained your physical and coaching session, through the achievement of the health goals established with your health coach, along with a second-year comprehensive physical and health risk assessment.

Once you have completed the requirements for the wellness incentive, your reward will be paid as a health insurance premium credit on a future paycheck, thereby reducing your payroll deduction and increasing your take-home pay. You will receive the entire premium credit earned, even if your medical deduction is less than the full amount of the credit earned.

Throughout the school year, medical assistants from the Center will be systematically visiting each school and other building locations to complete some basic biometric screening tests, such as blood pressure, blood glucose, etc. The medical assistant will also ask you to complete a questionnaire known as a Health Risk Assessment.

The Health & Wellness Center medical assistant will provide you with additional details about the process when meeting with you for your screening. Once your screening is complete, you can schedule a comprehensive physical with a doctor at the Health & Wellness Center.

If you missed the biometric screening at your building location, or if you would like to meet with a physician sooner, rather than wait until your building is scheduled, please feel free to contact the Health & Wellness Center at 574-855-1090

How will your reward be reported to the Payroll Department? Periodically, the Activate Health & Wellness Center sends a report to the SBCSC Payroll Department that includes a list of names and the dollar amount earned. No health information, test results, or health goals will be shared with SBCSC. Please allow 45 days for the reward to appear on your regular paycheck after completing your physical, health risk assessment and health coaching session.

For additional information and important requirements about the healthy incentive financial reward, or to schedule your comprehensive physical, please contact the Activate Health & Wellness Center.

www.activatehealthcare.com/sbcsc

574-855-1090

Health Savings Account (HSA)

What is an HSA? (Note: Only the Essential Care Plan Qualifies for a Health Savings Account)

A health savings account (HSA) is a tax-advantaged checking account that gives you the ability to save for future medical expenses or pay for current ones. You may spend your HSA funds on out-of-pocket medical expenses that are applied to your insurance plan deductible and your coinsurance responsibility. You can also spend your HSA funds on any eligible out-of-pocket dental and vision expenses.

An HSA is not, by itself, health insurance. An HSA is combined with a high-deductible health insurance plan. The rules and laws that allow the tax advantages of an HSA are set by the federal government through the IRS. They are not set by your employer, insurance company, or bank. To be eligible for an HSA, you must:

1) Be covered by a high deductible health insurance plan with no copayments or other benefit provisions that pay before the deductible is met. (The one exception to this rule is for preventive care only.)

2) Not be covered by Medicare, Medicaid, or any other health insurance plan that is not a qualified high deductible health plan (including a spouse's plan). If you do, you are not eligible for an HSA. **This also includes Medicare Part A only**.

3) **Not have a Health Care Flexible Spending Account.** If either you, or your spouse, have a Health Care Flexible Spending Account, you are not eligible for an HSA.

4) Not be eligible to be claimed as a dependent on another person's tax return.

The 2016 contribution limits to your HSA are:

$3,350 if you have single coverage
$6,750 if you have family coverage

Unspent money in your HSA at the end of the year is not lost. It rolls over to the next year. There is no maximum balance on the amount of money you can accumulate in your HSA.

Your HSA account is established by you at the bank of your choice. It is owned by you, and all money in your HSA is always under your control, even if you leave your employer or change insurance plans.

In the future, if your insurance plan or employer changes and you are no longer covered by a qualified high deductible health plan, you can continue to spend down your HSA funds, but you cannot continue to contribute money to your HSA. There is no deadline to spend your HSA money.

Money in your HSA can be spent on any qualified out-of-pocket medical, dental, or vision expenses. Generally, out-of-pocket costs applied to your deductible and coinsurance are eligible expenses.

For more information about Health Savings Accounts, please ask your bank or credit union.

Health Savings Account (HSA)

HSA Frequently Asked Questions & Answers

How do I contribute money to my HSA?

You will need to open your HSA at the bank or credit union of your choice, such as TCU, Key Bank, 1st Source, etc. You can then deposit money into your HSA. You may be eligible for a tax deduction when filing your 2016 tax return. Please discuss this with your financial institution or tax preparer. SBCSC is unable to provide any tax advice regarding your HSA.

Do I have to open an HSA, or contribute money to my HSA, in order to be covered under the Essential Care Plan?

No. You can simply be covered by the Essential Care Plan, and not open an HSA.

Does my premium contribution for the Essential Care Plan fund my HSA?

No. Your premium contribution simply pays your share of the premium for the insurance plan. It does not fund your HSA.

How are claims paid?

All medical claims should first be submitted to Anthem. This will ensure that you receive the PPO discount and also that the appropriate claim amount is applied toward your deductible or coinsurance. Once Anthem has processed the claim, you will receive an Explanation of Benefits (EOB) which will show how much to pay your provider's office. If you have money in your HSA, you can use it to pay for expenses applied to your deductible or coinsurance responsibility.

At the pharmacy, you will want to provide your Anthem ID card. Anthem will apply the full cost of the drug to your deductible or coinsurance, and the pharmacy will ask that you pay when you pick up your medication. You can use any available money in your HSA to pay for your medication.

Important Note: Under the Essential Care Plan, you no longer pay just a portion of the cost with a copay, you are responsible for the full cost until the deductible is met. Some drugs cost as little as $2, others may cost $50, $300, or much more per month. If you are unsure of the full cost of your particular medication, you may want to consult your pharmacist.

Does my bank or Anthem have to approve my HSA claims? What if I spend my HSA money on non-qualified expenses?

Neither your bank, nor Anthem, nor your employer approves your HSA expenses. If you are audited by the IRS you will need to provide receipts showing that your HSA withdrawals were used for qualified medical, dental, or vision expenses. Therefore, it is recommended that you always keep your receipts. HSA money spent on non-qualified expenses is subject to a tax penalty plus income taxes.

Dental Insurance

GUARDIAN®

Important Information

- You may choose any dentist.
- To receive the best benefits and discounts, use a participating dental provider in the Guardian PPO dental network. Go to www.guardiananytime.com for providers.

Predetermination of Benefits – It is recommended that your dentist request a predetermination of benefits from Guardian whenever the cost is expected to exceed $300. This will allow you to find out how much you will be responsible for, and how much the dental plan will pay before treatment begins.

Contact Guardian at 800-541-7846 with any questions.

Dental Benefits Through Guardian	In-Network	Out-of-Network
Annual Deductible – Per Individual **Per Family (3x Individual Ded.)**	**$50** **$150**	**$100** **$300**
Preventive Services – routine exams, x-rays, teeth cleanings (prophylaxis), sealants, fluoride treatment and space maintainers for children	**100%**	**100%**
Basic Services – include fillings, root canal therapy, periodontal surgery and periodontal maintenance procedures, extractions and most oral surgeries; emergency relief of pain and repair of crowns, bridgework and dentures.	**90%**	**90%**
Major Services – crowns, bridges and dentures, to replace natural teeth extracted or lost while covered (Implants Not Included)	**60%**	**60%**
Orthodontia – To Age 19 **Lifetime Maximum Benefit is $1,000**	**50% - No Ded.**	**50% - No Ded.**
Annual Maximum Benefit Per Person	**$2,000**	**$1,000**

	DENTAL PLAN COST PER PAY PERIOD	
	Bi-Weekly Employee 10/11-Month	**Bi-Weekly Employee 12-Month**
Single **Family**	**$3.74** **$9.79**	**$2.96** **$7.75**

Vision Insurance

Important Information

- To receive the best benefits and discounts, you should go to a vision provider who is contracted with VSP. Visit www.vsp.com to find a provider or to make sure your current provider is "in-network". VSP has an extensive list of contracted providers and the website is very user-friendly.

Contact VSP at 800-877-7195 with any questions.

Vision Benefits through VSP	In-Network	Out-of-Network
Exam – (1 Every Calendar Year)	$10 Copay	Reimbursed up to $50
Lenses – (1 Set Every Calendar Year) Single, Bifocal or Trifocal Basic Progressive	Included with Exam Additional $50 Copay	Reimbursed up to $50, $75, $100 Reimbursed up to $75
Frames – (1 Set Every Calendar Year)	$150 Allowance	Reimbursed up to $70
Contacts – (In Lieu of Glasses)	$120 Allowance	$105 Allowance

	VISION PLAN COST PER PAY PERIOD	
	Bi-Weekly Employee 10/11-Month	Bi-Weekly Employee 12-Month
Single Family	$1.47 $3.13	$1.16 $2.48

Life and Disability Insurance

SYMETRA

BASIC LIFE AND ACCIDENTAL DEATH & DISMEMBERMENT (AD&D)

The South Bend Community School Corporation provides Term Life Insurance and Accidental Death & Dismemberment (double indemnity for accidental death) to you when newly eligible for benefits. The amount is based on your Employee Classification. Please contact the Benefits Department if you are unsure of your benefit level.

SUPPLEMENTAL (VOLUNTARY) LIFE AND AD&D

You also have the opportunity to elect Optional Supplemental Term Life and Accidental Death & Dismemberment for yourself and your dependents. This option is available only for employees who are newly eligible for benefits. If you waive coverage when you are newly eligible, you will not be able to elect Supplemental Life in the future. You can choose benefit increments of $50,000 for yourself up to a maximum of $200,000. If you are enrolling, you may also elect $25,000 or $50,000 for your spouse and $10,000 for each dependent child. The premium is based on your age. Please contact the Benefits Department for more information.

LONG TERM DISABILITY INSURANCE

To protect you and your family in the event of a long term disability, South Bend Community School Corporation provides you with Long Term Disability Insurance. If disabled more than 6 months, the plan will pay you two-thirds of your pre-disability salary up to a maximum benefit of $6,000 per month. The plan will continue to pay you as long as you are disabled until you reach age

Flexible Spending Plan (FSA)

American Fidelity Assurance Company

In addition to your benefit premium contributions being deducted pre-tax, you also have the option during the American Fidelity Open Enrollment to have additional money deducted pre-tax and deposited into a flexible spending account for eligible out-of-pocket expenses. You may also set up a dependent care account into which you can make pre-tax deductions and can then be used to pay for child care expenses. American Fidelity will visit each school building in the fall.

How The FSA Works:

- First, you decide how much money you want to put into your Health Care and/or Dependent Care Flexible Spending Account through American Fidelity. The annual maximum contribution to your health care account is $2,500 per year. The maximum for dependent care is $5,000. Your elected contribution is then divided by your number of paychecks and that amount is deducted tax-free each pay period.
- Next, the deducted contributions are then placed into your FSA(s). Not only do you not pay taxes on this money, but it's deducted from your paycheck before you can spend it on anything else, thereby helping you budget for known expenses that you will have throughout the year. You also do not pay income taxes on the money when it is spent.

Examples of Eligible Medical Expenses:

- Any charges not covered by your Medical Plan, including (but not limited to) Deductibles, Copayments, Prescriptions
- Chiropractic or other therapy charges over the plan maximum benefit
- Weight-loss programs
- Dental or vision care copays or charges over the maximum benefits
- Hearing aids and batteries
- In-vitro fertilization
- Laser eye surgery

***** IMPORTANT NOTE*****

Be conservative when determining your Elected Contribution. The IRS requires that you forfeit any unused money in your FSA at the end of the year. You cannot receive any money as cash nor can you carry it over to the next plan year. This is commonly known as the "Use it or Lose It" rule.

For more information on any of these policies, please contact American Fidelity at 1-800-638-4268.

Other Supplemental Benefits

American Fidelity Assurance Company

Disability Income Insurance

The advantage of this plan is that benefits become available on a short-term basis, which would help you during the 6-month period before you would be able to start receiving benefits on your Long Term Disability plan provided to you by South Bend Community School Corporation. Benefits are paid directly to you in the event that you are unable to work due to an illness or accident.

Life Insurance

The life insurance benefits provided to you through South Bend Community School Corporation are term benefits, which means you only get your Basic Life and AD&D while you are employed (unless you convert your coverage when you retire); and if you have elected Supplemental Term Life Insurance, your benefit reduces to 50% at age 70. American Fidelity offers permanent, whole life insurance options, as well as additional term insurance if you are interested in applying for more insurance than is available through Symetra's voluntary group policy.

Accident Only Insurance

Individual and Family plans are available with the Accident Only insurance policy. Benefit payments are made directly to you and there are several options available. As long as you pay your premiums, the policy is guaranteed renewable – you cannot be cancelled for any reason.

Hospital Indemnity Insurance

You choose the amount to be paid to you for an untimely admission to the hospital for you or a family member. Benefits include payment for Intensive Care, Rehabilitation and Ambulance Services.

Cancer Insurance

The Cancer insurance policy covers expenses such as Lost Income, Utilities, Spouse's Lost Income, Meals and Lodging, Transportation Costs, Special Dietary Needs, Housekeeping Expenses and House/Mortgage Payments in the unfortunate event where you or a covered family member is diagnosed with cancer after the policy becomes effective. The money can be used however you need, allowing you to protect yourself from financial hardship.

For more information on any of these policies, please contact American Fidelity at 1-800-638-4268.

*****NOTE: You can ONLY enroll in these plans during Open Enrollment.*****

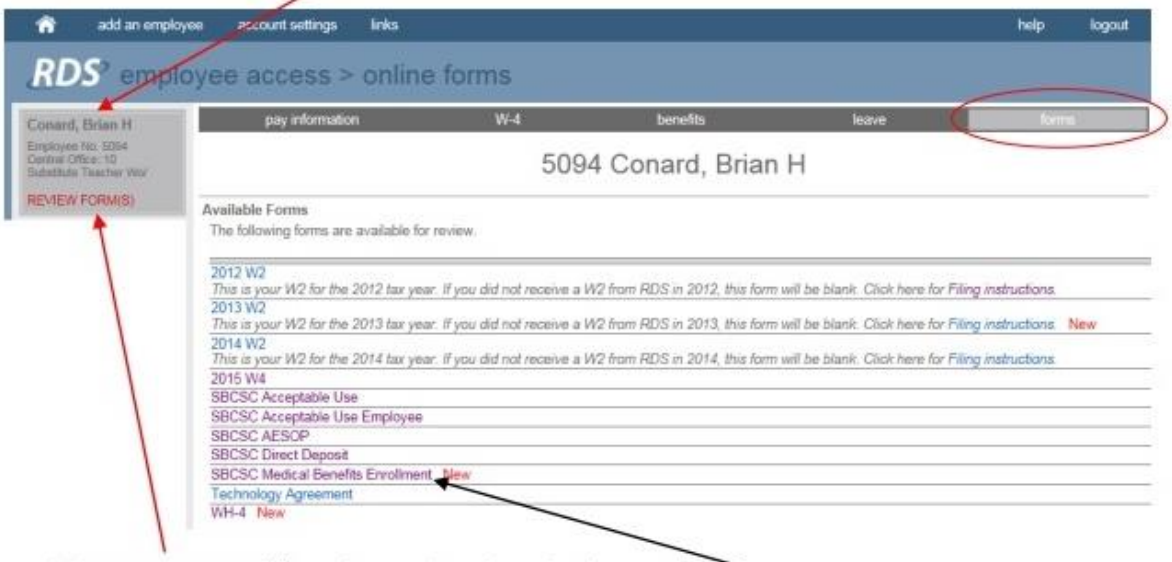
Making Changes During Open Enrollment

All medical enrollment changes you wish to make during Open Enrollment will be made via the RDS online employee portal. Your enrollment must be completed by November 16, 2015.

Please follow the instructions below to add or drop coverage for yourself or a dependent, or to change from one plan to another plan.

Medical Benefits Enrollment - Employee Instructions

Log in, click your employee **Name**, then click on the **forms** tab to view/modify forms.



Or, click **REVIEW FORM(S)** to take you directly to the forms tab.

Click the form name to fill out a form

South Bend Community School Corporation **Medical Benefits Enrollment**

Section 1: Demographic Information

FOR OFFICE USE ONLY

Anthem Group Number: 00235421 Sub-Group _____

Date of Hire _____ Date of Rehire: _____ Coverage Effective Date: _____

New Enrollment ___ Special Enrollment ___ If special, reason? _____

Event Date: _____ Position _____ ☐ Full time ☐ Part Time

Class # _____ Job Code _____ Cert ___ Non-Cert ___ Admin _____ 10 mo cont ___ 10 mo hourly ___ 12 mo ___ Job share ___

Employee Name & Address

Last	First	Middle	Social Security Number	Gender: Male Female
Conard	Brian	H	100-00-4157	
Street: 5157 Delaware Street			Date of Birth	Status: Married Single
City: Crown Point	State: IN	Zip: 46307	Home Phone: 2195559999	Work Phone
Retired / Disabled / Hospitalized				
Email Address				

Use the scroll bar to move down the form.

Medical Plans

	○ Essential Care Plan		○ Core Plan		○ Buy Up Plan		○ Waive
Choose Status	**Bi-Wkly Cost 19 Pay Periods**	**Bi-Wkly Cost 24 Pay Periods**	**Bi-Wkly Cost 19 Pay Periods**	**Bi-Wkly Cost 24 Pay Periods**	**Bi-Wkly Cost 19 Pay Periods**	**Bi-Wkly Cost 24 Pay Periods**	
Employee Only	☐ $58.35	☐ $46.19	☐ $ 88.57	☐ $ 70.12	☐ $131.51	☐ $104.11	
Employee & Spouse	Not Offered	Not Offered	☐ $185.99	☐ $147.24	☐ $281.68	☐ $223.00	
Employee & Child(ren)	☐ $254.23	☐ $201.27	☐ $141.71	☐ $112.19	☐ $214.62	☐ $169.91	
Employee & Family	Not Offered	Not Offered	☐ $256.84	☐ $203.33	☐ $377.91	☐ $299.18	

Use the checkboxes to select your plan.
Or select to Waive coverage.

South Bend Community School Corporation

Section 3: Eligible Dependents

Select Coverage(s) Med				SSN	Last Name	First Name	Date of Birth	Gender (M/F)	Relationship to Employee	Address (if different than employee's)
☐			1						Spouse	
☐			2							
☐			3							
☐			4							
☐			5							
☐			6							
☐			7							
☐			8							
☐			9							
☐			10							
☐			11							
☐			12							

This section will pre-fill with any existing dependent information. If it's blank, fill it in. If corrections are needed, make the changes on the form prior to clicking submit.

Section 3: Eligible Dependents (continued)

Do you or any dependents have other Medical Insurance

Name of Insured Person _____ Policy Number: _____

Section 4: Section 125 Premium Contribution Authorization

I authorize South Bend Community School Corporation to deduct my portion of the medical premiums from my paycheck as follows:

☐ I elect pre-tax deductions
☐ I elect post-tax deductions

I understand that after the first day of the Plan Year (January 1) pre-tax or post-tax status of my deductions for premium contributions cannot change before the next anniversary date (January 1 of the following year) unless a change in family status occurs (see Section 4 above).

Use the checkboxes to indicate your selection.

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Section 5: Declination of Medical Coverage for Employee and/or Eligible Dependents

I have been offered **Medical** coverage and decline to elect or continue it for ☐ **Myself** ☐ **My Dependents** I understand that the Plans do not allow late enrollment unless the late enrollee qualifies for a **Special Enrollment** as defined by the **Health Insurance Portability and Accountability Act (HIPAA)** and requests coverage within 31 days of the event. I understand that, although I or my eligible dependent may qualify for a Special Enrollment, the **Pre-Existing Condition Clause** will apply.

If you chose to waive coverage, make sure to indicate who should be waived by selecting the checkboxes.

Acknowledgement:

I represent that the answers given to all questions are true and accurate to the best of my knowledge and I understand they are being relied upon by South Bend Community School Corporation in accepting this application. I understand that any material misrepresentation or omission found in this application may result in denial, rescission, or cancellation of coverage. I acknowledge that I have received information regarding INPRS, COBRA, 403(b)/457(b), and Section 125.

This election form revokes any prior election form completed and will remain in effect and cannot be revoked or changed during the plan year, unless the revocation and new election are on account of and consistent with a valid status change, or other qualifying event*. Participation will automatically cease upon termination of an employee's employment, or loss of eligibility for a benefit plan.

* **Examples of qualifying events include:**	
Marriage	COBRA Coverage Exhausted
Birth	Termination of Spouse's Employment/Reduction in Work Hours
Adoption/ Placement for Adoption	Benefits Eliminated (Plan No Longer Being Offered)
Divorce	Involuntary Termination of Medicaid
Legal Separation	Dependent Returning to Full-Time Status
Death	Court-Ordered Dependent Coverage
	Reaching Plan's Limiting Age

The undersigned acknowledges that he/she has an affirmative duty to verify the eligibility of enrolled dependents, and immediately inform the employer of any change. Failure to verify eligibility or notify the employer shall be deemed to be an intentional misrepresentation.

Signature (JennaVasaiko3) 10/30/2015 3:29 PM

10.23.2014

Submit Cancel

Click **submit**, when ready. The submitted form will be sent to the Human Resources department AND the form will be available as a PDF for your review under the **Completed Forms** section on the **forms tab.**

Any changes needed for a submitted form, will be allowed up to the closing date of open enrollment.

Health and Rx / Anthem Blue Cross and Blue Shield

www.anthem.com

Customer Service 800-295-4119

Precertification 800-814-4803

Activate Health & Wellness Center

www.activatehealthcare.com/sbcsc

Customer Service 574-855-1090

Dental Insurance / Guardian

www.guardiananytime.com

Customer Service 800-541-7846

Vision Insurance / Vision Service Plan

www.vsp.com

Customer Service 800-877-7195

Life and Disability Insurance / Symetra

www.symetra.com

Customer Service 800-796-3872

Flexible Spending Account / American Fidelity

americanfidelity.com

Customer Service 800-638-4268

Supplemental Benefits / American Fidelity

americanfidelity.com

Customer Service 800-638-4268