Benefits

Employee Benefits Guide

2017-2018
2017-2018 Benefits Enrollment

What’s New?

- Employee +1 and Employee +Family Premiums have **decreased** on the HSA 2500 and HSA 1500 plans.
- The Mayo Clinic and Cancer Treatment Centers of America have been added to all district medical plans as in-network providers.
- Dental and Vision premiums have increased slightly.
- You must provide proof of eligibility for all dependents on your plans.

**What happens if I don’t enroll?** Your benefits (excluding District Life Insurance) will be terminated effective June 30, 2017.

Continuing Incentives

- Dysart will continue to match dollar for dollar of your per pay HSA contributions up to $750 if you are enrolled in the HSA 2500 and up to $500 if you are enrolled in the HSA 1500 medical plan.
- A frontload of 50% of the district match will be deposited to your HSA account at the beginning of the year if you have a contribution set up for at least the match amount.
- A deposit of $250 to your HSA account for having an annual physical exam with your primary care physician.
- An additional $150 deposited to your HSA account if you earned 25 points on the Blue Cross Points Portal the previous school year. You must have completed the required Health Assessment and must have earned an additional 20 points by completing Blue Cross or Dysart approved activities. You must also be employed when awarded and enrolled in a district medical plan.
- HSA incentives are not available for those enrolled in Medicare, Social Security (age 65), Tricare, AHCCCS; if you are a dependent on your spouse’s medical plan that is not an HSA or if you are a dependent on someone else’s medical plan that is not your spouse.
- A $150 premium reduction for the current school year if you are enrolled in the PPO 2000 medical plan and you earned 25 points on the Blue Cross Points Portal the previous school year. You must have completed the required Health Assessment and must have earned an additional 20 points by completing Blue Cross or Dysart approved activities. You must also be employed when awarded and enrolled in the PPO 2000 medical plan.
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Who is eligible for Dysart Benefits?
Certified employees are eligible if they work 50% of a contract or more. This is typically 20+ hours per week. Classified employees must work at least one 6 hour position per day to be eligible for full district benefits.

For employees who work under 30 hours per week, including substitutes, and classified employees who work a total of 6 hours per day but one position is not 6 hours or more, the District will follow the Patient Protection and Affordable Care Act (PPACA) tracking requirements and will notify you if and when you become eligible for medical insurance. Employees who become eligible for medical insurance as a PPACA variable hour employee will not be eligible for any other benefits.

When can I enroll?
You may enroll in benefits as a new employee once you start your employment with Dysart. As a new hire, you will receive an email from a Payroll & Benefits Specialist advising you to enroll. You will have 30 days to enroll starting on your hire date. **If after the first 30 days of your hire date, you have not elected or waived coverage, you will only receive District paid life insurance and all other coverage will be waived.** Current employees can make changes during the annual Open Enrollment period or if you meet the requirements of a Life Status Change.

What benefit plans are subject to the enrollment period?
- Medical (and HSA option)
- Short Term Disability*
- Sick Leave Bank
- Dental
- Vision
- Group Life/AD&D/Voluntary Life Insurance*
- Health Care & Dependent Care Flexible Spending Account

*For Short Term Disability and Voluntary Life Insurance, there is a guarantee issue for the first 30 days of employment. Current employees applying for Voluntary Life Insurance coverage during the Open Enrollment period must submit evidence of insurability and wait for approval or denial by the insurance company.

How do I enroll?
Enrollment is done via an on-line system from any computer with internet access. Select the Benefits Enrollment Tab on the Payroll & Benefits Website. See the benefitsCONNECT section at the end of this booklet for more information.

Note: For 2017-2018 Open Enrollment is Mandatory. **ALL employees must re-enroll or they will lose benefits on June 30th.**

How do I pay for my benefits?
Payments for Medical, Dental, Vision, Flexible Spending Accounts and Health Savings Accounts are taken from your pay check on a pre-tax basis. Due to regulations, should you cover a Domestic Partner, their premium cost will be deducted from your check on a post-tax basis. ASRS Retirement and tax-sheltered annuity contributions are deducted before State and Federal taxes, but not Social Security or Medicare taxes. All other payments for insurances are deducted on a post-tax basis. Due to holiday breaks, hourly classified employees paid on the 21 pay schedule will have deductions withheld equally over 18 of the 21 pay periods.

When do my benefits become effective?
For a new employee, benefits are effective the first of the month following or “coincident with” your hire date. For example, if your hire date is August 6th, your benefits become effective September 1st. If your hire date is September 1st, your benefits would become effective September 1st. For current employees going through Open Enrollment, benefit changes become effective July 1st. If you have a qualifying life status change, changes go into effect the first of the month following the date or “coincident with” the date of the qualifying event.
Enrollment Information

Do I have to enroll in each benefit?
The District paid life insurance is mandatory. All other benefits are optional, and you only enroll in the benefit plans that best fit you or your family needs. The employee must enroll in benefits in order to have spouse or dependent coverage.

When will my benefits end?
If you resign or are terminated at any time during the year, your benefits will end the last day of that month. If you work through your contract, but do not renew for the following year or renew then rescind without starting the school year or terminate employment after June 30th, your benefits end on June 30th of the current school year. Should your work hours drop below benefit eligibility, your benefits will end at the end of the month of your full-time assignment’s end date. If you re-new your contract, benefits will continue into the 2017 – 2018 school year as long as you have completed the Mandatory Open Enrollment. Benefits will also end the last day of the month following non-FMLA leave and after 12 weeks of FMLA leave or Workers’ Compensation if the employee has not returned to work. Per Governing Board Policy (Sec. 7.28), the District shall require the repayment of any health care premiums paid by the District for continuing coverage during the period of the FMLA leave if the employee fails to return to work after the FMLA leave expires and the failure to return is not due to circumstances beyond the employee's control.

Who can I enroll as a dependent? **Documents are required if you haven’t already presented them.**
- Spouse under a legally valid existing marriage – marriage certificate required or joint mortgage/bank account records
- Domestic partner – Domestic Partner Affidavit or joint legal or liability documents required (pre-dated by 12 months)
- Biological children up to age 26 – birth certificate(s) required
- Step-children up to age 26 – children of your current spouse only – marriage certificate and birth certificate of children
- Adopted children up to age 26 – court approved adoption papers
- Legal Guardianship – court order
- Dependent children with disabilities – you must be their primary caregiver – disability documents and birth certificate are required.

Children who have reached age 26 will be terminated from all plans the last day of the month after turning 26.

What if I have more questions?
Be sure to review the entire benefits guide. You may also send your questions to benefits@dysart.org or call 623.876.7924.
MEDICAL PLAN OPTIONS

If you move from one medical plan to another during the annual open enrollment period (typically held in April/May for July 1st effective date) Blue Cross will credit the amount of any deductible and out of pocket maximums that were met between January 1 and June 30 to your new medical plan on July 1. In addition, if you are enrolled in a medical plan “without” an HSA Blue Cross will rollover the amount of your deductible you met during the 4th quarter of the calendar year to the new calendar year. The 4th quarter rollover is not authorized on HSA plans due to IRS regulations.

HSA 2500

- Provides benefits at Blue Cross Blue Shield PPO contracted physicians, facilities and providers. Also, it allows out-of-network benefits.
- Must meet the calendar year deductible before BCBS covers any expenses other than preventive.
- In-network preventive care covered at no cost to members.
- After meeting the calendar year deductible, in-network services are covered by BCBS at 80% and 20% is paid by the member. Out-of-network services are covered by BCBS at 60% and 40% by the member after the calendar year deductible is met.
- The employee may contribute pre-tax money into their HSA account (calendar year limits). Dysart will match up to $750 per fiscal year. In addition, employees can receive an additional $250 Dysart contribution to their HSA account should they provide proof of a routine physical*.

Special Medicare note – If you (or your dependents) are 65 or older and enroll in this plan and delay your enrollment in Medicare, it’s important to note that Medicare will more than likely charge you a higher premium for Medicare when you decide to enroll, as this plan is not credible in Medicare terms. Should you have any questions contact Medicare at 1-800-MEDICARE.

Medicare/AHCCCS/Tricare Enrollees – If you are enrolled in Medicare, Social Security, AHCCCS or Tricare, if you are a dependent on a non-HSA plan, or if you are a dependent on someone else’s plan (other than your spouse), you and the District are not allowed to contribute to an HSA Account.

If you (or your dependent) is enrolled in Medicare, Social Security, AHCCCS, or Tricare the Dysart medical plan is primary and Medicare, AHCCCS, or Tricare plan is secondary.
HSA 1500

- Provides benefits at Blue Cross Blue Shield PPO contracted physicians, facilities and providers. Also, it allows out-of-network benefits.
- Must meet the calendar year deductible before BCBS covers any expenses other than preventive.
- In-network preventive care covered at no cost to members.
- After meeting the calendar year deductible in-network services are covered by BCBS at 80%, and 20% is paid by the member. Out-of-network services are covered by BCBS at 60%, and 40% by the member, after the calendar year deductible is met.
- The employee may contribute pre-tax money into their HSA account (calendar year limits). Dysart will match up to $500 per fiscal year. In addition, employees can receive an additional $250 Dysart contribution to their HSA should they provide proof of routine physical.
- **Special Medicare note** – If you (or your dependents) are 65 or older and enroll in this plan and delay your enrollment in Medicare, it’s important to note that Medicare will more than likely charge you a higher premium for Medicare when you decide to enroll as this plan is not credible in Medicare terms. Should you have any questions contact Medicare at 1-800-MEDICARE.
- Medicare/AHCCCS/Tricare Enrollees – If you are enrolled in Medicare, Social Security, AHCCCS or Tricare, if you are a dependent on a non-HSA plan, or if you are a dependent on someone else’s plan (other than your spouse), you and the District are not allowed to contribute to an HSA Account.
- If you (or your dependent) is enrolled in Medicare, Social Security, AHCCCS, or Tricare the Dysart medical plan is primary and Medicare, AHCCCS, or Tricare plan is secondary.

PPO 2000

- Provides benefits at Blue Cross Blue Shield PPO contracted physicians, facilities and providers. Also, it allows out-of-network benefits.
- In-network preventive care covered at no cost to members.
- In-network benefits – Non-preventive visits/specialist office visits, as well as prescriptions, urgent care, emergency room visits, and hospitalizations are subject to co-payments and/or subject to deductible and coinsurance.
- After meeting the calendar year deductible, in-network services are covered by BCBS at 80% and 20% is paid by the member. Out-of-network services are covered by BCBS at 60% after the calendar year deductible is met.
- Out-of-network benefits – Allows benefits if you choose to use a medical care provider that does NOT contract with BSBCAZ. Benefits are subject to a deductible and coinsurance. Also, Out-of-network providers may charge more than BCBSAZ reasonable and customary rates.
- If you (or your dependent) is enrolled in Medicare, Social Security, AHCCCS, or Tricare the Dysart medical plan is primary and Medicare, AHCCCS, or Tricare plan is secondary.

If you were enrolled in the HSA 1500 or HSA 2500 and move to the PPO 2000 during open enrollment, your Health Savings Account will be charged $5.00 per month beginning July 1st, if you have a balance.

Other:

- All three medical plans are broad network based PPO plans. You have access to a national network of providers (you are not restricted to providers in Arizona only). New for 2017-2018 is the addition of the Mayo Clinic and Cancer Treatment Centers of America as in-network providers to all district medical plans.
- If you ever use an out-of-network provider, Blue Cross will reimburse you for what they would have paid for the service if it was in-network. You must pay your out-of-network provider directly.
<table>
<thead>
<tr>
<th>Benefits</th>
<th>In Network</th>
<th>Out of Network</th>
<th>In Network</th>
<th>Out of Network</th>
<th>In Network</th>
<th>Out of Network</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Lifetime Maximum</strong></td>
<td>Unlimited</td>
<td>Unlimited</td>
<td>Unlimited</td>
<td>Unlimited</td>
<td>Unlimited</td>
<td>Unlimited</td>
</tr>
<tr>
<td><strong>Calendar Year Deductible</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual</td>
<td>$2,500 if enrolled as employee only</td>
<td>$5,000 if enrolled as employee only</td>
<td>$1,500 if enrolled as employee only</td>
<td>$3,000 if enrolled as employee only</td>
<td>$2,000 per individual</td>
<td>$3,000 per individual</td>
</tr>
<tr>
<td>Family</td>
<td>$5,000 if enrolled and covering any dependents</td>
<td>$10,000 if enrolled and covering any dependents</td>
<td>$3,000 if enrolled and covering any dependents</td>
<td>$6,000 if enrolled and covering any dependents</td>
<td>$4,000 per family</td>
<td>$6,000 per family</td>
</tr>
<tr>
<td><strong>Coinsurance</strong></td>
<td>20%</td>
<td>40%</td>
<td>20%</td>
<td>40%</td>
<td>20%</td>
<td>40%</td>
</tr>
<tr>
<td><strong>Calendar Year Out-of-Pocket Maximum</strong> (Includes Deductible)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual</td>
<td>$5,000 if enrolled as employee only</td>
<td>$10,000 if enrolled as employee only</td>
<td>$3,000 if enrolled as employee only</td>
<td>$6,000 if enrolled as employee only</td>
<td>$5,500 per individual</td>
<td>$12,290 per individual</td>
</tr>
<tr>
<td>Family (1 + dependents)</td>
<td>$10,000 if enrolled and covering any dependents</td>
<td>$20,000 if enrolled and covering any dependents</td>
<td>$6,000 if enrolled and covering any dependents</td>
<td>$12,000 if enrolled and covering any dependents</td>
<td>$6,000 per family</td>
<td>$24,580 per family</td>
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<tr>
<td><strong>Hospital Services</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient Hospital</td>
<td>20%*</td>
<td>40%*</td>
<td>20%*</td>
<td>40%*</td>
<td>20%*</td>
<td>40%*</td>
</tr>
<tr>
<td>Outpatient Hospital</td>
<td>20%*</td>
<td>40%*</td>
<td>20%*</td>
<td>40%*</td>
<td>20%*</td>
<td>40%*</td>
</tr>
<tr>
<td>Emergency Room</td>
<td>$150 fee per day; then 20%*</td>
<td>$150 fee per day, then 20%*</td>
<td>$200 copay, then 20%*</td>
<td></td>
<td>$200 copay, then 20%*</td>
<td></td>
</tr>
<tr>
<td>Urgent Care</td>
<td>20%*</td>
<td>40%*</td>
<td>20%*</td>
<td>40%*</td>
<td>$50</td>
<td>40%*</td>
</tr>
<tr>
<td><strong>Routine Services</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Preventive Care</td>
<td>0%</td>
<td></td>
<td>0%</td>
<td></td>
<td>0%</td>
<td></td>
</tr>
<tr>
<td>Office Visit</td>
<td>20%*</td>
<td>40%*</td>
<td>20%*</td>
<td>40%*</td>
<td>$30</td>
<td>40%*</td>
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<tr>
<td>Specialist</td>
<td>20%*</td>
<td>40%*</td>
<td>20%*</td>
<td>40%*</td>
<td>$60</td>
<td>40%*</td>
</tr>
<tr>
<td><strong>Prescription Drugs</strong> (1)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Deductible</td>
<td>Yes – Plan Deductible</td>
<td>Yes – Plan Deductible</td>
<td>Yes – Plan Deductible</td>
<td>Deductible</td>
<td>None</td>
<td></td>
</tr>
<tr>
<td>Generic/Level 1</td>
<td>20%*</td>
<td>40%*</td>
<td>20%*</td>
<td>40%*</td>
<td>$15</td>
<td></td>
</tr>
<tr>
<td>Preferred Brand/Level 2</td>
<td>20%*</td>
<td>40%*</td>
<td>20%*</td>
<td>40%*</td>
<td>$35</td>
<td></td>
</tr>
<tr>
<td>Level 3 and 4</td>
<td>20%*</td>
<td>Not Covered</td>
<td>20%*</td>
<td>Not Covered</td>
<td>$60</td>
<td></td>
</tr>
<tr>
<td>Mail Order (90 day supply)</td>
<td>20%*</td>
<td>Not Covered</td>
<td>20%*</td>
<td>Not Covered</td>
<td>2.5 x copay</td>
<td>Not Covered</td>
</tr>
</tbody>
</table>

* = after deductible is met (1) On both the HSA 2500 and 1500 plans specialty medications have a $250 per prescription maximum after the plan deductible is met.
Dysart’s HSA 2500 and HSA 1500 health insurance plans are high-deductible health plans which qualifies enrollees to participate in a Health Savings Account (HSA) with HealthEquity, Inc.

Rules Regarding Health Savings Accounts
If you are enrolled in Medicare, Social Security, AHCCCS, Tricare or claimed as a dependent on someone’s tax return (other than your spouse), or enrolled as a dependent on a non-HSA medical plan, the IRS will NOT allow the District (or you) to make contributions to the Health Savings Account. It is your responsibility to notify the Payroll & Benefits Department if you are not eligible for contributions.

Employees enrolled in an HSA medical plan may contribute to their HSA savings account. All contributions made through payroll deductions are taken on a pre-tax basis. For 2017, the maximum that can be contributed for someone enrolled with “employee only coverage” is $3,400 and $6,750 for employees who are enrolled covering dependents. Employees 55+ of age are eligible to contribute an additional $1,000. The maximum amounts are total contributions which would include both your and the District’s match. See the HSA Contribution Form for a calculation worksheet to determine how much you can contribute in a calendar year. Note that you are responsible for not over-contributing to your HSA account each calendar year.

What exactly is a Health Savings Account (HSA)?
It’s a savings and spending account that offers members a tax-advantaged way to pay for qualified medical, dental and vision expenses, as well as a way to save for future medical and retirement health care expenses that won't be subject to Federal tax. After the age of 65 money can be withdrawn from the account for any purpose with no tax penalty, but if not used for health care, you will pay your regular tax rate.

Who is eligible to open an HSA?
Anyone covered by an HSA-eligible health plan and not covered by any non-eligible plan. Dysart’s eligible plans are the HSA 2500 and HSA 1500. It is important to note the District and employee are “not” eligible to contribute to the HSA if the employee is enrolled in Medicare, AHCCCS, Tricare, if the employee is enrolled in another medical plan that is not a high deductible health plan, or if the employee is listed as a dependent on someone else’s tax return (other than their spouse). It’s important to note for many people when they sign up for social security (at age 65) they are automatically enrolled in Medicare. If you receive social security benefits you will need to provide confirmation in writing to the District that you are not enrolled in any part of Medicare including Part A. It is the responsibility of the employee to notify the Benefits Department if they are not eligible for contributions to the HSA. Employees can use HSA funds for children up to age 19 if not a full time student or up to age 24 if a full time student.

How does an HSA work?
The member can use their account to make payments for qualified health care expenses using their HealthEquity Visa® Health Account Card, online using electronic funds transfer (EFT), or by phone.

Who owns the HSA?
The member owns the account, regardless of who contributes. The money earns interest and returns over time.

What happens to HSA funds if the owner changes jobs or retires?
The account still belongs to the owner.
**Health Savings Account**

Can an HSA ever be used to pay for non-qualified expenses?
Once the member reaches age 65 the funds can be used for non-qualified expenses, but withdrawals will be subject to tax. If the funds are used before age 65 for non-qualified expenses, the amount used will be taxed and incur a 20% penalty. See your account page on healthequity.com for eligible expenses.

Am I allowed to have an HSA and an FSA (Flexible Spending Account)?
Yes, you are able to have an HSA and FSA. However, the FSA will be a special “Limited Purpose” FSA. The “Limited Purpose” FSA will only allow reimbursement for vision, dental, and dependent care expenses (not medical expense reimbursement as medical must be reimbursed through the HSA). It is important to note the HSA allows medical, dental and vision expenses to be reimbursed (but not dependent care).

So individuals can’t contribute to an HSA if they’re on Medicare?
No, the law does not allow those on Medicare or enrolled in Social Security to contribute to an HSA, but they may continue to own and use an HSA if the account was opened before they went on Medicare or Social Security.

Do members lose HSA funds at the end of the year?
No, any remaining funds roll over into the following year and grow tax-free.

Can HSA funds be withdrawn at any time?
Absolutely, as long as they're used to pay qualified medical expenses the money is not taxed at the Federal level. If money is withdrawn before age 65 for other expenses, the regular tax rate would apply as well as a 20% penalty. After age 65 there are taxes, but no penalty regardless of how the money is used.

Does an HSA earn interest?
Yes. Best of all, the interest accumulates tax-free.

Can HSA funds be invested?
Yes, in stocks, bonds, mutual funds, CDs, and annuities.

Which individuals benefit most from HSAs?
Health savings accounts are not just for the healthy or the wealthy. HSAs and qualified high-deductible health plans can work for anyone, regardless of their income or the state of their health. HSAs are the best financial vehicle to save for retirement and pay for medical expenses in the meantime.

What happens if you no longer have an HSA-eligible plan? For example if you move to the PPO 2000 or another medical plan?
You keep your HSA. It's always your money. But you can no longer make contributions to your HSA if you're not enrolled in an HSA medical plan. If you were enrolled in the HSA 1500 or HSA 2500 and move to the PPO 2000 or waive insurance, your Health Savings Account will be charged $5.00 per month.

Additional Questions?
HealthEquity’s Customer Service Number: 866.960.8026 (24/7, 365 days/year) or visit healthequity.com.
Teladoc
800.Teladoc (835.2362)
http://www.teladoc.com

Dysart Unified employees who enroll in medical insurance will be automatically enrolled in Teladoc coverage. Dysart Unified employees must either call or go online to register their dependents for the services. This can be done at the time of service by providing the needed information at the start of the call. The Teladoc phone or video consultation is no cost to the employee (or their dependents). However the employee (or dependents will be responsible for the prescription cost if prescribed).

Talk to a doctor anytime for FREE
Teladoc gives you access to a national network of U.S. board-certified doctors who are available 24/7/365 to treat many of your medical issues.

When can I use Teladoc?
Teladoc does not replace your primary care physician. It is a convenient and affordable option for quality care.
• When you need care now
• If you’re considering the ER or urgent care center for a nonemergency issue
• On vacation, on a business trip, or away from home
• For short-term prescription refills

GET THE CARE YOU NEED
Teladoc doctors can treat many medical conditions, including:
• Cold & flu symptoms
• Allergies
• Sinus problems
• Bronchitis
• Urinary tract infection
• Respiratory infection
• And more!

With your consent, Teladoc is happy to provide information about your Teladoc consult to your primary care physician.
TDA PREPAID DENTAL PLAN (DMO)

- Provides benefits at contracted dental offices only. No out of network coverage.
- Each family member can select a different office.
- Preventive services are paid at 100%.
- Other services, members pay a co-payment and the insurance company pays the remaining fees.
- Members can change dentists during the year by contacting the TDA Member Services Department.

TDA PPO DENTAL PLAN

- Provides benefits at any dental office. Higher benefits for those that contract with TDA.
- Each family member can select a different office.
- Preventive services are paid at 100%.
- Other services are subject to a deductible and then member pays percentage of costs.
- If out-of-network dentist is used, member is responsible for any cost above the ‘Maximum Plan Reimbursement’.

### Dental Benefits At A Glance

<table>
<thead>
<tr>
<th></th>
<th>DHMO/Pre-Paid Benefits</th>
<th>PPO Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>In-Network Only</td>
<td></td>
</tr>
<tr>
<td>Deductible (July 1 – June 30)</td>
<td>None</td>
<td>$50</td>
</tr>
<tr>
<td>Number of Deductibles Per Family</td>
<td>None</td>
<td>3</td>
</tr>
<tr>
<td>Annual Maximum</td>
<td>None</td>
<td>$1,000</td>
</tr>
<tr>
<td>Class I – Preventive /Diagnostic</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Class II – Basic (Includes Endodontics &amp; Periodontics)</td>
<td><strong>Co-Payment Examples</strong>&lt;br&gt;RCT-Molar $395, RCT-Anterior $175</td>
<td>90% 80%</td>
</tr>
<tr>
<td>Class III – Major (Includes Crowns, Bridges, Dentures)</td>
<td><strong>Co-Payment Examples</strong>&lt;br&gt;Crown-Porcelain-high noble metal $455</td>
<td>60% 50%</td>
</tr>
<tr>
<td>Class IV – Orthodontics (Children only)</td>
<td><strong>Co-Payment Examples</strong></td>
<td>50% Children Only</td>
</tr>
<tr>
<td>Class IV – Lifetime Maximum</td>
<td>Limited Ortho – Child $2,800&lt;br&gt;Comprehensive – Child $3,400</td>
<td>$1,000 Children Only</td>
</tr>
<tr>
<td>Emergency Palliative</td>
<td>$15</td>
<td>100%</td>
</tr>
</tbody>
</table>

---

**Total Dental Administrators**
602.266.1995
[www.tdadental.com](http://www.tdadental.com)
(for list of providers by zip code)
In-Network Benefits:
- $10 co-pay for an exam.
- $10 co-pay for materials (frames and lenses) subject to the plan allowance.
- Exam and lenses every 12 months.
- Frames every 24 months.
- Contact lens allowance of $130, including fitting and evaluation, in lieu of frames and lenses.
- Medically necessary contact lenses covered at 100%.
- 20% off the provider’s usual & customary fees for additional purchases or add-ons to standard lenses.
- LASIK benefit of $150 allowance toward LASIK at an Avesis contracted LASIK provider. One time (lifetime) benefit for one or both eyes and it takes the place of all other benefits for that plan period.

Out-of-Network Benefits:
The plan provides allowances towards your exam and materials if you choose an out-of-network provider. However, you will get the most for your money by using in-network contracted providers.
**Employee Dual Credit**

**What if my spouse works for the District?**

If you and your spouse are both employed by the District and are both 100% eligible for District paid benefits, you can take advantage of a dual-employee credit; however, the dual-employee credit is most advantageous with family coverage. The spouse carrying medical and/or dental will be credited with the amount the District would have paid for the spousal employee if they had independently selected that policy. At no time will the District contribute more than 100% of the total BCBS Monthly Plan Cost. Any premium over and above the credit will be payroll deducted from the employee who has opted for the dual credit coverage. The other employee will be required to waive medical and/or dental coverage in the benefitsCONNECT system.

*Note: Dual credit employees are not allowed to select Voluntary Life insurance on their spouse, and only the employee selecting insurance can choose Voluntary Life insurance on the children.*

One employee – selects Medical, Dental, Vision, can select STD and Voluntary Life on self and child(ren). Other employee – waives Medical, Dental, Vision, can select STD and Voluntary Life on self only.

<table>
<thead>
<tr>
<th>Coverage Level</th>
<th>HSA 2500</th>
<th>HSA 1500</th>
<th>PPO 2000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee &amp; Spouse</td>
<td>$0</td>
<td>$8.48</td>
<td>$383.99</td>
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<tr>
<td>Employee &amp; Family</td>
<td>$16.74</td>
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</table>

<table>
<thead>
<tr>
<th>Coverage Level</th>
<th>DHMO Dental</th>
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<tbody>
<tr>
<td>Employee &amp; Spouse</td>
<td>$0</td>
<td>$44.26</td>
</tr>
<tr>
<td>Employee &amp; Family</td>
<td>$9.43</td>
<td>$87.25</td>
</tr>
</tbody>
</table>
Short Term Disability is offset by sick leave. This means you must use your sick days and/or sick bank time before you will receive disability payments.

- Waiting period: 5th day of injury, 5th day of sickness.
- 6 Month Duration.
- Income replacement if you are unable to work because of an injury (non-work related) or illness for up to six months.
- May select a disability benefit up to 66 2/3% of your monthly salary (to a maximum of $7,500 per month).
- Pre-existing conditions treated 12 months prior to the effective date will not be covered in the next 12-months. For example, if you are pregnant on the date your insurance became effective, the pregnancy is considered a pre-existing condition.
- Injury or illness caused during the course of your employment is not covered under this policy.
- All eligible employees are automatically enrolled into Long-Term Disability with Arizona State Retirement System (ASRS).

NEW Employees
- Guaranteed eligibility during the initial eligibility period (30 days from date of hire) up to $5,000 per month. In future years, you will only be authorized to increase your benefit one level (by $100) and the remaining balance will be subject to medical questions/approval.

<table>
<thead>
<tr>
<th>Annual salary</th>
<th>Benefit Amount</th>
<th>Monthly Premium</th>
<th>Annual salary</th>
<th>Benefit Amount</th>
<th>Monthly Premium</th>
<th>Annual salary</th>
<th>Benefit Amount</th>
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<td>$96.00</td>
<td>$134,200</td>
<td>$7,400</td>
<td>$142.08</td>
</tr>
</tbody>
</table>
Dysart Unified School District provides Group Term Life Insurance and Accidental Death and Dismemberment Insurance through Symetra.

**For Most Employees:**
Life Insurance equal to ONE time your annual base salary to a maximum of $100,000. Accidental death and dismemberment insurance in an amount equal to ONE time you annual base salary to a maximum of $100,000.

**For Principals, Assistant Principals, Directors & Cabinet Members:**
Life Insurance equals to two times your annual base salary up to a maximum of $400,000. Accidental death and dismemberment insurance in an amount equal to two times your annual base salary up to a maximum of $400,000.

**Dependent Coverage:**
A dependent life policy of $1,000 is available for your spouse/domestic partner, and dependent children up to age 26. There is an employee cost for dependent coverage of $0.16 per month for each $1,000 of coverage.

**The Fine Print:**
Life and Accidental Death and Dismemberment Insurance benefits will reduce by 35% at age 65, and 50% at age 70, and benefits terminate at retirement. Dependent Life Coverage for employee’s spouse will be reduced by 50% when the spouse reaches age 65.

*Employees must be eligible for all other benefits in order to be eligible for the District-paid life insurance policy.*
Voluntary Selections
- Eligible for up to five times your annual base salary, not to exceed $500,000.
- May cover spouse for up to half the employee amount (excluding dual credit employees).
- May cover your children for $1,000, $5,000 or $10,000 (premium is per policy, NOT per child). Primary dual credit employee can select.

Current employees
- Already enrolled – May increase or decrease coverage, but proof of medical insurability will be required on all life insurance increases.
- New enrollees – Will be required to submit proof of medical insurability.

New employees
- Guaranteed eligibility during your initial eligibility period (30 days from date of hire) up to $150,000 for the employee and $50,000 for spousal/domestic partner coverage.

Terminating employees
- You have 30 days following termination of life insurance benefits to apply for portability or conversion. It is the employee’s responsibility to submit the portability or conversion form to Symetra. Forms are available under Forms/Resources on the Payroll & Benefits website.

<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>AGE</td>
<td>Rate Per $10,000</td>
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<tr>
<td></td>
<td>Employee (Includes AD&amp;D)</td>
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<tr>
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<tr>
<td>30 – 34</td>
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<tr>
<td>35 – 39</td>
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<td>$0.81</td>
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<tr>
<td>65 - 69</td>
<td>$8.26</td>
</tr>
<tr>
<td>70 - 74</td>
<td>$13.37</td>
</tr>
</tbody>
</table>

*Child Premium is per Family
What are Flexible Spending Accounts or FSAs?
Flexible Spending Accounts allow you to put money aside on a before-tax basis; the Health Care Spending Account for eligible health care expenses and the Dependent Care Spending Account for eligible dependent care expenses (e.g. for child day-care). The money is taken from your check on a pre-tax basis and deposited into an account that is managed by a third-party administrator, HealthEquity.

What types of FSAs are available?

HEALTH CARE SPENDING ACCOUNT (Medical Reimbursement Account)
- Set from $100 to $2,500 per year into the account, pre-tax dollars!
- Can cover IRS allowable dependents from this account. They do NOT have to be enrolled on any of our policies. For example, if you could enroll your children into our benefit plans but choose not to, you can still use this account for their out-of-pocket medical expenses as well.
- Money is available immediately from this account. For example, you can set aside $2,500 into an account and have Lasik surgery done in August. You will continue to pay the money into the account on a pre-tax basis, even though you have already spent it!
- A debit card is offered at no cost to you.
- There will be a special “Limited Purpose” FSA available for employees enrolled in an HSA. The “Limited Purpose” FSA will only allow expenses for vision and dental care.

DEPENDENT CARE REIMBURSEMENT ACCOUNT
- Set from $100 to $5,000 per year into the account (married, filing jointly, or head of household) or between $100 and $2,500 per year (married, filing separately).
- Dependent day care expenses for children under age 13 or disabled family members who qualify.
- Only the amount deposited in the account is available for your use.
- When submitting receipts for reimbursement, caregiver must provide their social security number or tax-identification number. The FSA Administrator is required by law to submit this information to the IRS.
- Depending on your personal income tax situation, you may get a greater tax savings with the childcare credit than the Dependent Care Spending Account. Ask your tax advisor which alternative is best for you.

Why should I consider putting money aside in an FSA?
Because the money is put aside BEFORE taxes, you save on every dollar you spend. For example, if you pay your child care or health care provider $100 after you have received your paycheck, you probably had to earn $125, which is taxed, to bring home the $100. Because the money put in these accounts is pre-tax, it is like getting a 20-30% discount on health care or dependent care expenses.

How do I access money once it has been deposited in a Flexible Spending Account?
You may file a claim by submitting receipts to the administrator or use a debit card to access your medical spending account funds.
Am I allowed to have an HSA (Health Savings Account) and an FSA (Flexible Spending Account)?
Yes, you are able to have an HSA and FSA. However, the FSA will be a special “Limited Purpose” FSA. The “Limited Purpose” FSA will only allow reimbursement for vision, dental, and dependent care expenses (not medical expense reimbursement as medical must be reimbursed through the HSA). It is important to note the HSA allows medical, dental and vision expenses to be reimbursed (but not dependent care).

How long do I have to spend this money?
Active or continuing employees may file a claim for any expense incurred from July 1, 2017 – June 30, 2018. If you do not use your funds in the FSA by June 30, 2018, you forfeit your funds. You must submit your claims for reimbursement by September 30, 2018. To avoid forfeiting money, you should carefully estimate your uninsured health care expenses and your employment related dependent care expenses before electing contribution amount(s).

Must I use the Debit Card?
No. You may file claims manually. Claim forms can be emailed to: reimbursementaccounts@healthequity.com or faxed 801-999-7829 and HealthEquity will reimburse you. Claim forms can be found on Health Equity’s website or the benefits portal under Flexible Spending Accounts.

What if I leave employment with Dysart?
You must incur the expense by the last day of your benefit eligibility. This also includes employees who terminate at the end of the school year and employees whose benefits end June 30th. You will have 30 days from the date of your termination or benefit end date (if the benefit is ending at the end of the school year) to request reimbursement.

Can I change my contributions to a Flexible Spending Account during the year?
After Open Enrollment, you may change your election if certain life status events occur and you must make these changes within 31 days of the event.
**Flexible Spending Account**

Can I get more information regarding what is allowable and what is not? Refer to IRS Publication 503 at [www.irs.gov/pub/irs-pdf/p503.pdf](http://www.irs.gov/pub/irs-pdf/p503.pdf) for the most up-to-date description of eligible and ineligible dependent care expenses. You can also view eligible health care and dependent care expenses on Health Equity’s website at [www.healthequity.com](http://www.healthequity.com). If you would rather just talk with a person about allowable expenses, please call HealthEquity, for more clarification. *A reminder, if you enroll in both a HSA and FSA the FSA will be a special “Limited Purpose” FSA which will only allow expenses to be reimbursed for vision and dental.*

<table>
<thead>
<tr>
<th>Description</th>
<th>Regular FSA Eligible Expense <em>without Health Savings Account (HSA) Enrollment</em></th>
<th>Limited Purpose FSA Eligible Expense <em>with Health Savings Account (HSA) Enrollment</em></th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Dental</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Vision</td>
<td>Yes</td>
<td>Yes</td>
</tr>
</tbody>
</table>
FSA Debit Card Information

Do I always send my receipts and the reimbursement form after I use my FSA Debit Card?
The IRS has set specific requirements for receipt submission when the FSA Debit Card is used. There are only a handful of times you will not have to submit receipts. When physician and pharmacy co-pays match your employer’s health care plan, receipts are generally not required. If you use a retailer that is using the IIAS system, you will not be required to submit receipts. All other uses of the card will require you to submit your receipts.

What type of merchant’s will allow me to use the FSA Debit Card?
As of January 1, 2008, grocery, discount and drug stores must have an IIAS inventory control system in place. This allows the merchant to identify over-the-counter purchases as an eligible FSA expense. If you purchase items with your FSA Debit Card at a merchant using the IIAS system, you will NOT need to submit additional documentation. If you try to use your FSA Debit Card at a merchant that does not have the IIAS system your FSA Debit Card will not work. You will have to pay for the items out-of-pocket and submit a claim form for these items.

What should I always remember with the FSA Debit Card?
- Keep your receipts/documentation, just in case.
- Submit the reimbursement form and receipts within 15 days of using your FSA Debit Card if it is for an expense that doesn’t match our medical/pharmacy co-pays.

What are some reasons my FSA Debit Card didn’t work?
- Your provider’s card terminal may not be set up with a medical provider code.
- The merchant may not have an IIAS system in place.
- You may have reached your FSA limit.
- You have outstanding charges for which you have not submitted documentation.

What happens if I forget to send in receipts?
HealthEquity will send you a letter stating that Dysart needs to document your use of the FSA Debit Card. If receipts are not received, your card will be de-activated or ‘turned off’. You will no longer be able to use the card until the documentation is received or you have reimbursed the fund for your expenditures.

This seems like a lot of work, why should I get an FSA Debit Card?
The FSA Debit Card allows you immediate access to your money. For example, you need to purchase new contact lens or have another procedure done at your dentist office that does not fall into a normal co-pay amount. You will have access to your flexible spending account money with the understanding further documentation may be required in the future.

You cannot use a Flexible Spending Account for elective surgery or cosmetic procedures such as laser hair removal, Botox injections, teeth whitening or veneers. Contact our administrator if you are in doubt. (Sorry about that, but we thought you should know.)
1. **OVERVIEW**
   a. The Medical Leave Assistance Program also called Sick Leave Bank is a means by which employees of the Dysart Unified School District #89 can help each other in times of need.
   b. It allows employees to join the Program by contributing one (1) earned leave day annually to be eligible to participate in the Sick Leave Bank.
   c. The days deposited must be from the current year’s earned sick leave.
   d. Enrollment is during benefits open enrollment for continuing employees and open for thirty (30) calendar days following the first scheduled “work” day for new employees.
   e. The Sick Leave Bank is a "blind" bank. A "blind bank" is one in which donated sick leave days are not allocated for a specific employee, but are donated to the bank to be used by any eligible employee.
   f. Employees deposit into an account consistent with their job category. There are three accounts as follow: classified (support), certified, and administrative.
   g. If the Sick Leave Bank runs out of days, the Superintendent or designee may solicit new contributions for the specific account needing replenishment.
   h. For purposes of this program, a day equals the number of hours scheduled in the normal working day of the donor. Days of leave (or for classified (support) employees – hours of leave), not the actual wage of the donor employee, will be donated.
   i. All unused-banked sick leave time in each bank will continue forward to the next school year.

2. **ELIGIBILITY**
   a. Join the Program: Only full-time classified (support), certified or administrative employees are eligible to enroll in and become members of the Sick Leave Bank.
   b. Only members of the sick leave bank may apply for benefits.
   c. Leave may be provided if the following conditions are met:
      i. The employee has a "non-work-related” serious illness or injury as defined by the employee’s licensed health care practitioner/physician." OR
      ii. If requested for the care of a terminally ill immediate family member, or serious medical condition as identified by FMLA and requires the employee to be the primary care giver for their immediate family member. An immediate family member is to be defined as the employee’s spouse and children as well as parents of the employee or spouse, AND
      iii. (3)The employee expects to be out of paid leave for at least 5 consecutive work days or more. Sick leave bank will begin on the sixth (6) consecutive work day.
   d. Exclusions:
      i. It cannot be used for non-complicated maternity leave as child birth is ordinarily not considered a serious illness.
      ii. No benefited employee shall be eligible for the Sick Leave Bank after he/she has qualified for long-term-disability coverage or worker’s compensation.
   e. Application for the program must be supported by health care provider medical certification and must include nature of the illness, diagnosis and prognosis for return to duty.
      i. It must be submitted within ten (10) days following the applicant beginning an “unpaid leave status”.
      ii. This means that there will not be an award to an applicant until he/she has exhausted all earned/accrued leave and is expected to be in an unpaid leave status with the District for five (5) consecutive work days. Sick bank leave will begin on the sixth (6) consecutive work day.
3. **NOTICE OF APPLICATION DECISION AND AWARD OF DAYS:**
   a. Notice to an applicant regarding the decision on their request for a Sick Leave Bank award of days must be made in writing to the applicant and include information about the review process and appeal rights.

   b. Based on continuous membership in the bank, each approved applicant is limited to an award of days no more than:
      - Tier I = 20 days based on 1-2 years of continuous membership or as determined by prior use
      - Tier II = 40 days based on 3-4 years of continuous membership or as determined by prior use
      - Tier III = 60 days based on 5+ years of continuous membership or as determined by prior use

   c. Employee award status will reset at Tier I if the full amount of days the employee is eligible to receive are exhausted prior to June 30, in the academic year for which it was awarded.

4. **APPLICATION REVIEW PROCESS AND APPEALS**
   a. The daily operation of the bank is overseen by the Superintendent or designee for the routine determination and award of benefits.

   b. Periodic summaries of applications and award of benefits will be provided to members of the Review Board and the Governing Board but shall not contain employee names or any information identifying the employee as using the Sick Leave Bank.

   c. Appeal Process:
      - i. Appeals may be made to a Review Board established by the Superintendent or designee.
      - ii. The Review Board consists of employees representing the three employee groups: classified, certified, and administrative.
      - iii. The Review Board shall convene a meeting within fifteen (15) days after receipt of the appeal and the employee may be present.
      - iv. A written decision will be provided to the employee within five (5) working days after the review meeting.

5. **LIMITATIONS**
   a. Employees will not earn or accrue additional sick leave during the use of banked sick leave.

   b. The Medical Assistant Program - Sick Leave Bank and procedures in no way interfere with, limit, or reduce the rights of employees under the federal Family Medical and Leave Act, 29 U.S.C. 2601-2654.

   c. No continuing rights are established by this policy. In compliance with established procedure, the Governing Board reserves the right to modify, change, or delete any policy in accord with its own guidelines.
May I make changes to my benefit elections outside of my initial eligibility period?
After your initial eligibility or Open Enrollment period, you may only change some benefit elections if certain life status events occur. Note: You are not allowed to change plans.

Why can’t I change my benefits at any time?
Because our benefit deductions are taken on a pre-tax basis, we are required to follow the Internal Revenue Service Section 125 rules. The IRS Code is very specific and states that changes can only be made within your initial enrollment period, during our Open Enrollment Period or if the change meets the Life Status Change criteria.

What events are considered a Life Status Change?
- Marriage, divorce, legal separation, or annulment
- Birth, adoption or legal custody
- Death of a dependent, spouse or employee
- Significant change in the health coverage of the employee’s spouse attributable to the spouse’s employment
- Employee or employee’s spouse starts an unpaid leave or returns from an unpaid leave
- Medicare enrollment
- Health Exchange enrollment (open enrollment begins in November for a January effective date)

How do I make a Life Status Change?
Changes must be made within 31 days of the event. However, if you choose to enroll in coverage through the Marketplace (exchange), you must select a plan for yourself and your family within 60 days of the event. When an event occurs, print off the Life Status Change Form on the Benefits Portal and attach proof to the form of the event. Within the 31 days you will be required to submit this documentation to the Benefits Team supporting your request (unless you enroll in the Marketplace you have 60 days to submit the documentation). Once the documentation is received, your request will need to be approved and processed. Documentation can be dropped off at the Benefits Department in the District Office to ensure we receive it. You are discouraged from using Inter-District mail.

When does my Life Status Change become effective?
Life Status Changes take effect the first of the month following the date or “coincident with” the date of the qualifying event.

What if I am unsure if I meet the Life Status Change criteria?
If you are unsure that you have experienced a Life Status Change, please contact the Benefits Team at payroll.benefits@dysart.org or at 623.876.7924 within 31 days of the event (or 60 days if you enroll in the Marketplace).
<table>
<thead>
<tr>
<th>Change of Status</th>
<th>Changes to Coverage</th>
<th>Document Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Birth, Adoption or Legal Guardianship/Custody of Child</strong></td>
<td>• New dependents may be added to existing medical, dental or vision coverage.</td>
<td>• Birth Certification</td>
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<td></td>
<td>• Dependent child life insurance coverage can be added or increased.</td>
<td>• Hospital records or documents</td>
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<td></td>
<td>• Health and Child Care reimbursement accounts may be added.</td>
<td>• Court documents</td>
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<td></td>
<td>• No other changes can be made.</td>
<td></td>
</tr>
<tr>
<td><strong>Spouse or Dependent child becomes eligible under another Group Insurance Plan</strong></td>
<td>• Spouse or child can be dropped from medical, dental and vision coverage.</td>
<td>• Copy of Enrollment Form</td>
</tr>
<tr>
<td></td>
<td>• No other changes can be made.</td>
<td>• Online Enrollment Confirmation</td>
</tr>
<tr>
<td><strong>Dependent Child becomes ineligible due to marriage or reaching age of 26</strong></td>
<td>• Dependent child must be dropped from medical, dental and vision coverage.</td>
<td>• Marriage Certificate</td>
</tr>
<tr>
<td></td>
<td>• Dependent child must be dropped from supplemental life insurance.</td>
<td>• 26th Birthday of dependent</td>
</tr>
<tr>
<td></td>
<td>• Dependent child may be able to continue coverage via COBRA.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• No other changes can be made.</td>
<td></td>
</tr>
<tr>
<td><strong>Divorce, Annulment or Legal Separation</strong></td>
<td>• Spouse and spouse’s children/step-children will be dropped from coverage.</td>
<td>• Court documents</td>
</tr>
<tr>
<td></td>
<td>• Spouse and spouse’s children/step-children may be able to continue coverage via COBRA.</td>
<td>• Divorce Decree</td>
</tr>
<tr>
<td></td>
<td>• Existing dependent or spousal life insurance will be dropped.</td>
<td></td>
</tr>
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<td></td>
<td>• No other changes can be made.</td>
<td></td>
</tr>
<tr>
<td><strong>Marriage</strong></td>
<td>• Employee, spouse and children can be dropped from all medical, dental and vision coverage provided they are added to the spouse’s group coverage.</td>
<td>• Marriage Certificate</td>
</tr>
<tr>
<td></td>
<td>• No other changes can be made.</td>
<td></td>
</tr>
<tr>
<td><strong>Spouse Gains Employment</strong></td>
<td>• Spouse and spouse’s children/step-children can be added to medical, dental or vision coverage.</td>
<td>• Copy of Enrollment Form</td>
</tr>
<tr>
<td></td>
<td>• Dependent supplemental life can be added.</td>
<td>• Online Enrollment Confirmation</td>
</tr>
<tr>
<td></td>
<td>• Spouse supplemental life can be added and may require evidence of insurability.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• No other changes can be made.</td>
<td></td>
</tr>
<tr>
<td><strong>Spouse Terminates/Resigns Job or Loses Benefits Eligibility</strong></td>
<td>• Spouse and/or children can be added to medical, dental and vision coverage.</td>
<td>• Letter from HR Department of spouse’s employer</td>
</tr>
<tr>
<td></td>
<td>• No other changes can be made.</td>
<td>• Resignation Letter</td>
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<tr>
<td></td>
<td></td>
<td>• COBRA Notification</td>
</tr>
<tr>
<td><strong>Starting of an Unpaid Leave for either employee or spouse</strong></td>
<td>• May drop medical coverage if proof of other credible coverage is provided.</td>
<td>• Approval letter or e-mail for the leave</td>
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<td></td>
<td>• May drop dental and vision coverage.</td>
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<tr>
<td></td>
<td>• May drop Short term disability and supplemental life insurance. (Note: if STD or Supp Life is dropped, will be required to submit evidence of insurability to re-enroll.)</td>
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</tr>
<tr>
<td><strong>Returning from an Unpaid Leave for either employee or spouse</strong></td>
<td>• May re-enroll in any benefits in which you were enrolled in prior to going on the leave or add new dependents to the existing coverage.</td>
<td>• Doctor’s release</td>
</tr>
<tr>
<td></td>
<td>• Evidence of insurability required for both Short Term Disability and Supplemental Life Coverage.</td>
<td>• Letter from HR Department confirming return to employment</td>
</tr>
<tr>
<td></td>
<td>• New benefits may be added if the return date is after the beginning of the new fiscal year and Open Enrollment was missed.</td>
<td></td>
</tr>
<tr>
<td><strong>Spouse’s Open Enrollment</strong></td>
<td>• May add or drop medical, dental and vision coverage.</td>
<td>• Enrollment form</td>
</tr>
<tr>
<td></td>
<td>• No other changes can be made.</td>
<td>• Online Benefits Statement</td>
</tr>
<tr>
<td><strong>Death (Dependent Child or Spouse)</strong></td>
<td>• Deceased dependent or spouse will be dropped from all coverage.</td>
<td>• Death Certificate</td>
</tr>
<tr>
<td>Change of Status</td>
<td>Changes to Coverage</td>
<td>Document Examples</td>
</tr>
<tr>
<td>--------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>-------------------</td>
</tr>
</tbody>
</table>
| **Death (Employee)**     | ▪ All coverage will be automatically terminated.  
▪ Dependent may continue health-related coverage through COBRA.  
▪ Life insurance coverage on dependents will be dropped and may be converted to individual policies.                                                                                                                                                                                         | ▪ Death Certificate |
| **Health Exchange Enrollment** | ▪ Employee, spouse and children can be dropped from medical coverage provided they are added to the health exchange coverage.  
▪ Employee must be eligible for a special enrollment period to enroll in a qualified health plan through the marketplace or during the marketplace’s annual enrollment period.  
▪ Proof of enrollment in the marketplace coverage must be provided prior to the start date of the health exchange enrollment.  
▪ No other changes can be made.                                                                                                                                                                                                                 | ▪ Copy of Enrollment Form  
▪ Online Enrollment Confirmation |
What is the Arizona State Retirement System (ASRS)?
The ASRS is a pension program. State employees contribute a percentage of their earnings to the ASRS fund. Dysart Unified School District matches a portion of the employees’ contribution and the district’s portion is calculated into a retiree’s lifetime benefit.

Who has to participate in the ASRS?
All employees who are hired to work 20 or more weeks per year, for 20 or more hours per week must participate in the ASRS. There is not an option to decline enrollment into this benefit. Non-retired substitutes who have reached the 20/20 rule and retired substitutes who terminated employment with the district, if they have reached the 20/20 rule within 365 days of retirement will be required to contribute to the ASRS for the current fiscal year only. Those retirees who did not terminate employment with the district are also required to contribute to the ASRS for each fiscal year when they reach the 20/20 rule.

What services does ASRS provide?
The ASRS provides retirement benefits, long-term disability, retiree health insurance, retiree health insurance premium supplement and survivor benefits.

How much is my contribution into ASRS?
All employees who meet the eligibility requirements will be required to contribute 11.50% of their earnings into their ASRS account. 11.34% of 11.50% contribution rate is for their retirement account. The remaining 0.16% is for the ASRS Long-Term Disability benefit.

What is the Long-Term Disability benefit?
ASRS provides, upon approval, long-term disability coverage for any contributing employee who has been unable to work due to a medical disability for over six (6) months. Benefits are normally 66% of their annual gross salary.

What if I leave employment with Dysart Unified School District (DUSD)?
You can leave the money you have contributed to the ASRS in the system. This is especially beneficial if you may work for another State of Arizona employer in the future. Another option is to roll your contributions into a tax-deferred account such as an IRA account. You may also opt to cash out your account. If you request a refund, you will lose the years of service credited to your account. Before making a decision, you are encouraged to meet with a tax advisor to understand the laws and regulations regarding your contributions.

How do I get more information about ASRS and how it will fit into my retirement planning?
You are encouraged to login to your account at azasrs.gov and review eligibility, calculators available and the road map to retirement.

I'm getting ready to retire, what should I do?
The District has a Route 4 Retirement class the end of February for those retiring the end of the current school year. A Route 3 class is held the end of April, early May for those thinking of retiring the next 2-3 years. View the azasrs.gov website for calculations, manuals and the online retirement instructions.

If I retire (ASRS) and Return to Work?
You must first fill out a return to work form on the ASRS website. You will be told of any restrictions. You must also advise Human Resources of your retirement.

Reminder – Appointments are required for all in-person counseling sessions at the Phoenix and Tucson offices. Please call the Member Advisory Center to set up an appointment.
Phoenix (602) 240-2000
Outside the Metro Area (800) 621-3778
What are 457 and 403(b) Plans?
These are school-sponsored, tax advantaged defined contribution retirement plans that are available for Dysart employees. We provide the plan and the employee defers compensation into it on a pre-tax basis.

What makes a 457 plan different from an IRA or traditional 401(k) plan or 403(b) plan?
If you leave employment with DUSD or decide to retire early, you can draw from a 457 account without an early withdrawal tax-penalty. Remember, the money will be subject to regular taxation but you are not penalized for taking the money early.

When can I enroll into a 457 or 403(b) plan?
Unlike most other benefits, enrollment is open throughout the year. You can begin contributing, change your elections or stop your contributions at any time during the year.

Who manages my account?
Dysart has partnered with TSA Consulting Group, a third-party administrator who will manage 403(b) and 457(b) accounts. Visit www.tsacg.com (select AZ and Dysart) for additional information on accounts and contact information.

How can I sign up for a Plan?
See the attached chart for approved vendors. You must set up an account with one of these vendors before you can begin contributing. Up-to-date vendor lists can be found on www.tsacg.com or on the Payroll & Benefits website. We encourage that you meet with your vendor outside the school or at district office.

What if I already have an account?
For transactions, loans, withdrawals, etc. see the Transaction Routing Request form on the Payroll & Benefits website or on www.tsacg.com. To modify your Salary Reduction Agreement, see the Salary Reduction Agreement Forms on the Payroll & Benefits website.
<table>
<thead>
<tr>
<th>Company</th>
<th>Contact Name</th>
<th>Phone</th>
<th>Email</th>
<th>Contact Name</th>
<th>Phone</th>
<th>Email</th>
</tr>
</thead>
<tbody>
<tr>
<td>AXA Equitable Life Insurance Company</td>
<td>Philip Kim</td>
<td>480.444.3782</td>
<td><a href="mailto:Philip.kim@axa-advisors.com">Philip.kim@axa-advisors.com</a></td>
<td>Lawrence Sanfilipoo</td>
<td>480.444.3772</td>
<td><a href="mailto:Lawrence.sanfilipoo@axa-advisors.com">Lawrence.sanfilipoo@axa-advisors.com</a></td>
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<tr>
<td>403(b), 403(b) Roth &amp; 457(b)</td>
<td></td>
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<td>Kyle Charles</td>
<td>480.444.3702</td>
<td><a href="mailto:Kyle.charles@axa-advisors.com">Kyle.charles@axa-advisors.com</a></td>
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<tr>
<td>Fidelity Investments</td>
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<td></td>
<td>1.800.543.0860</td>
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<tr>
<td>403(b), 403(b) Roth &amp; 457(b)</td>
<td>Kevin Hofberger</td>
<td>602.841.2627 x 215</td>
<td><a href="mailto:Kevin.hofberger@firstinvestors.com">Kevin.hofberger@firstinvestors.com</a></td>
<td>Emmanuel Kandinov</td>
<td>602.841.2627 x 203</td>
<td><a href="mailto:Emmanuel.kandinov@firstinvestors.com">Emmanuel.kandinov@firstinvestors.com</a></td>
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<td>Foresters Financial Services</td>
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<td>403(b), 403(b) Roth &amp; 457(b)</td>
<td>Tim Whitney</td>
<td>602.565.9542</td>
<td><a href="mailto:Tim.whitney@metlife.com">Tim.whitney@metlife.com</a></td>
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<td>MetLife Associates, LLC – MetLife Resources</td>
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<tr>
<td>403(b), 403(b) Roth &amp; 457(b)</td>
<td>Ken McCormick</td>
<td>602.743.4935</td>
<td>kmccormick@t pensions.com</td>
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<tr>
<td>National Life Group (Life Insurance of the Southwest)</td>
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<tr>
<td>403(b), 403(b) Roth &amp; 457(b)</td>
<td>Erica Gargol</td>
<td>480.557.9727</td>
<td><a href="mailto:Erica.gargol@ipl.com">Erica.gargol@ipl.com</a></td>
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<tr>
<td>Oppenheimer Funds</td>
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<td></td>
<td>Robert Young</td>
<td>602.686.5300</td>
<td><a href="mailto:Robert.Young@planmembersec.com">Robert.Young@planmembersec.com</a></td>
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<tr>
<td>403(b) &amp; 403(b) Roth</td>
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<tr>
<td>PlanMember Services</td>
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<td>Robert Young</td>
<td>602.686.5300</td>
<td><a href="mailto:Robert.Young@planmembersec.com">Robert.Young@planmembersec.com</a></td>
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<td>403(b), 403(b) Roth &amp; 457(b)</td>
<td></td>
<td></td>
<td><a href="mailto:young@planmembersec.com">young@planmembersec.com</a></td>
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<tr>
<td>PUTNAM FUNDS</td>
<td></td>
<td></td>
<td>1.800.225.1581</td>
<td><a href="http://www.putnam.com">www.putnam.com</a></td>
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<tr>
<td>403(b)</td>
<td>Participant Service Center</td>
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<tr>
<td>ReliaStar Life Insurance Company (A VOYA Co.)</td>
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</tr>
<tr>
<td>403(b), 403(b) Roth &amp; 457(b)</td>
<td>Ken McCormick</td>
<td>602.743.4935</td>
<td>kmccormick@t pensions.com</td>
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<tr>
<td>Security Benefit Group</td>
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<td>Erica Gargol</td>
<td>480.557.9727</td>
<td><a href="mailto:Erica.gargol@ipl.com">Erica.gargol@ipl.com</a></td>
</tr>
<tr>
<td>403(b), 403(b) Roth &amp; 457(b)</td>
<td>Kim Aranda</td>
<td>480.557.9727</td>
<td><a href="mailto:kim.aranda@ipl.com">kim.aranda@ipl.com</a></td>
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<tr>
<td>The Legend Group</td>
<td></td>
<td></td>
<td></td>
<td>Cameron Cook</td>
<td>602.686.6570</td>
<td><a href="mailto:Cameron.Cook@legendgroup.com">Cameron.Cook@legendgroup.com</a></td>
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<tr>
<td>403(b), 403(b) Roth &amp; 457(b)</td>
<td>Adam Pearce</td>
<td>520.751.9798 x 117</td>
<td><a href="mailto:adampearce@legendequities.com">adampearce@legendequities.com</a></td>
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<tr>
<td>VALIC</td>
<td>Tara Hanson</td>
<td>602.570.7849</td>
<td><a href="mailto:Tara.hanson@valic.com">Tara.hanson@valic.com</a></td>
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<tr>
<td>403(b), 403(b) Roth &amp; 457(b)</td>
<td>Jim Bishopp</td>
<td>520-506-7579</td>
<td><a href="mailto:jbishopp@investsli.com">jbishopp@investsli.com</a></td>
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</tbody>
</table>
What is COBRA?
COBRA is a Federal law that gives employees the opportunity to continue coverage through Dysart’s group insurance plans at the employee’s expense for up to 18 months. Should you wish to compare the Dysart COBRA rates and benefits to benefits and rates offered by the health exchange, contact Jerry Anderson of Anderson Insurance Services for assistance 480.607.7049.

How do I continue coverage with Dysart Unified School District?
When you or a dependent lose medical, dental, or vision plan coverage, P&A Group will send you COBRA enrollment materials to your last known address.

What benefits may I continue via COBRA?
You may continue the pre-tax benefits in which you were enrolled in at the time your coverage was lost. However, at Open Enrollment, you may elect to enroll or change any of the benefits for which you were eligible at the time you lost your coverage.

Who is eligible for benefits under COBRA?
If you or any eligible dependents were covered under our benefits program as an employee, you and your dependents are eligible to continue coverage.

What is the initial enrollment process into COBRA?
When you separate from Dysart or lose benefits due to an employment change, i.e. going from full-time to a part-time status, our COBRA administrator will send you COBRA enrollment materials to continue your coverage. You will then have 60 days from the date your benefits terminated to elect continuing coverage. Your COBRA coverage will be retroactive to the date your coverage would have terminated. You may elect to continue your medical, dental and/or vision coverage. Note: COBRA will not be activated until premiums are paid to P&A Group. Payments must be made on time or you risk having your COBRA coverage terminated.

What if I would like to change plans?
When you elect COBRA, you will be covered under the same plan you had as an employee (unless you move out of the area and your current plan does not have coverage in your new location). You cannot make changes until the next Open Enrollment period, unless you experience a life or family status change.

What if I am late enrolling into COBRA?
It is your responsibility to insure you respond to the COBRA notification and meet all the deadlines referred to in the information. The guidelines and law are very clear regarding the deadlines for enrollment. If you do not meet these deadlines, you will not be allowed to enroll.

What if I do not receive my COBRA notification via U.S. mail?
You should contact P&A Group immediately at the number listed above to request new information be sent or contact the Payroll & Benefits department.

Why is COBRA coverage so expensive?
Because you are now paying the total cost for coverage. This is the cost that the District has paid for the coverage during your employment at Dysart plus the employee premium. In most cases, the cost of the coverage is only increased by 2%, as allowed by Federal law, to recover the administration costs of managing your COBRA policy. In cases where an extension of COBRA has been granted due to a Social Security disability, COBRA coverage can be increased for a total of 150% during the 11 month extension period.
Note that late payments to our COBRA administrator will result in the termination of your COBRA benefits. Reinstatement of benefits will not be allowed.

*Remember* – This is merely an overview regarding COBRA and its related regulations. Other portions of the law may apply to you that are not listed above. You are encouraged to contact P&A Group if you have specific questions regarding your situation.

### COBRA Monthly Rates for 2017-2018

#### Medical, Dental & Vision

<table>
<thead>
<tr>
<th></th>
<th>Blue Cross Blue Shield of AZ</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>HSA 2500</td>
<td>HSA 1500</td>
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<tr>
<td><strong>Employee</strong></td>
<td>$392.78</td>
<td>$459.80</td>
</tr>
<tr>
<td><strong>Employee + 1</strong></td>
<td>$766.89</td>
<td>$911.43</td>
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<tr>
<td><strong>Family</strong></td>
<td>$1,066.12</td>
<td>$1,272.73</td>
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<table>
<thead>
<tr>
<th></th>
<th>TDA Pre-paid HMO</th>
<th>TDA PPO Dental</th>
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<tbody>
<tr>
<td><strong>Employee</strong></td>
<td>$10.55</td>
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<tr>
<td><strong>Employee + Spouse</strong></td>
<td>$20.27</td>
<td>$66.24</td>
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<tr>
<td><strong>Employee + Children</strong></td>
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<td>$81.03</td>
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<tr>
<td><strong>Family</strong></td>
<td>$30.71</td>
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#### AVESIS

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<tbody>
<tr>
<td><strong>Vision</strong></td>
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<tr>
<td><strong>Employee</strong></td>
<td>$6.34</td>
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<tr>
<td><strong>Employee + Spouse</strong></td>
<td>$11.99</td>
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<tr>
<td><strong>Employee + Children</strong></td>
<td>$13.06</td>
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<tr>
<td><strong>Family</strong></td>
<td>$16.82</td>
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</tbody>
</table>
BenefitsCONNECT™ is an online enrollment system customized specifically for the Dysart Unified School District that all employees will use to enroll in their benefits or check what plans they have selected throughout the year.

**Step #1 – Get to the site!** You can go to the website while at the District or from any internet accessible computer.

- Go to www.Dysart.org or type in www.dysart.org/benefits to go to Enrollment Page
- Click on “Staff” and log in if necessary
- Click on “Payroll and Benefits” website
- Click on the Benefits Open Enrollment Tab
- Click on the Link to enroll
- Log In

**Step #2 – Enter your log-on ID!** Your log-on ID follows a specific formula.

The User I.D. consists of:
*First 6 letters of last name (or less- last name is shorter) + First letter of First name + Last 4 digits of SSN*

Your log-in ID has to be ALL lower-case letters. Just say no to capitalization!

**Enter your Password**
Your password is your Social Security Number (with NO dashes) for new hires only. For continuing employees, use the password you previously created. Click Forgot my Password to reset it if you do not remember. Your password must contain at least six (6) numbers or letters. This will be your password for all future enrollment access.

**Getting started!**
Read the employee usage agreement. You can opt to only review this once and not have it appear again. Now you can go through the process step-by-step, one screen at a time. If you need to stop and return back to the system at a later time, simply hit the log-out button.

**Go through the enrollment process**
The website will take you step by step, one screen at a time, to enroll in your benefits for the upcoming year. You must complete all fields that are in bold type. Please be sure to put in the current date when asked for an effective date of change on any page. When electing benefits, you can view an outline of benefits and a benefit summary by clicking on “View Plan Outline of Benefits” under the benefit title. You will be shown information in the following order:

1) **Security Questions (If Applicable):** Select your answers to your security questions (New Hires only)
2) **Password Change (If Applicable):** Change to your new password.
3) **Employee Usage Agreement:** Acknowledgement of electronic signature use.
4) **Personal Information:** Verify your name, date of birth and address. If any of the information is incorrect, please send an e-mail to benefits@dysart.org to request a correction.

5) **Emergency Contact:** Enter at least one emergency contact.

6) **Dependents/Beneficiaries:** Add spouse and child (ren) here. If you do not add your dependents here, they will not be eligible for benefits. All benefit eligible (full-time) employees must add beneficiary for the Company paid Life and AD&D coverage. You may designate an existing dependent or create new ones. You may list primary and contingent beneficiaries. Please be sure to have beneficiary Social Security Number available as well as the beneficiary Date of Birth or you will not be able to complete the on-line enrollment process. For each beneficiary designation, you will be prompted to select the beneficiary on the benefit election page.

7) **Medical Election:** Choose one (1) of the medical plans or waive the benefit.

8) **Dental Election:** Choose one (1) of the dental plans or waive the benefit.

9) **Vision:** Choose vision or waive benefit.

10) **Voluntary Short Term Disability:** Choose voluntary short term disability or waive benefit.

11) **Basic Dependent Life (If applicable):** Choose basic dependent life or waive benefit. This is only available if you entered dependents in the system during step 6.

12) **Voluntary Life:** Choose the amount of term life benefit either with or without accidental death and dismemberment or waive benefit.

13) **Voluntary Dependent Life (If applicable):** If you enroll in Voluntary Life, you are eligible to choose term life coverage on your dependents, if they are present in the system.

14) **Flexible Spending Accounts-Medical:** Elect amount for medical spending account.

15) **Flexible Spending Accounts-Dependent Care:** Elect amount for dependent care spending account.

16) **Sick Leave Bank (SLB):** Elect to donate 1-5 days to the Sick Leave Bank.

**When electing benefits, you can view an outline of benefits and a benefit summary by clicking on “View Plan Outline of Benefits” under the benefits title.**

17) **Consolidated Enrollment Form:**

   *You are not enrolled until you hit the “Finish Elections” button at the bottom of this form.*

**Adobe Acrobat Reader will be required to view benefit summaries. This can be downloaded from the Employee Benefit Website or at http://get.adobe.com/reader/**

To change personal information (Emergency Contact, password): Click on the “Personal Information” option or corresponding option in the menu on the left side of the page. Make the appropriate changes and save your information. Remember the “Profile” information changed must be emailed to HR.

To change dependent information: Click on the “Dependent Information” icon in the center of the page and select to add a spouse or child or click on the dependent your wish to change.

To change your benefit elections: Click on the “My Benefits” icon in the center of the page, click on “Benefit Plan Enrollment”, choose the FUTURE ELECTIONS tab at the top of the page and click EDIT under the benefit you wish to change and update your enrollment.

If you have further questions or system problems, please contact Benefits by calling 623-876-7924 or send an E-mail to benefits@dysart.org.
Premium Assistance Under Medicaid & 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).

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

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

OMB Control Number 1210-01
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.

Certain employer-sponsored health plans are required by the privacy regulations issued under the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”) to maintain the privacy of your health information that the plan creates, requests, or is created on the Plan's behalf, called Protected Health Information (“PHI”) and to provide you, as a participant, covered dependent, or qualified beneficiary, with notice of the plan's legal duties and privacy practices concerning Protected Health Information.

The terms of this Notice of Privacy Practices (“Notice”) apply to the following plans (collective and individually reference in this Notice as the “Plan”):

Blue Cross Blue Shield of Arizona – Group Medical Insurance Plans
Health Equity, Inc. – Health Savings Account and Flexible Spending Account Administration
P&A Group – COBRA Administration
Total Dental Administrators – Group Dental Insurance (PPO and Prepaid Plan)
Avesis – Group Vision Benefits
Symetra Financial Corporation – Group Term Life; Accidental Death and Dismemberment; Voluntary Life; Voluntary Accidental Death and Dismemberment; and Dependent Life.
MHN – Employee Assistance Plan
Assurant Employee Benefits - Short Term Disability
Teladoc – Teladoc

This Notice describes how the Plan may use and disclose your PHI to carry out payment and health care operations, and for other purposes that are permitted or required by law.

The Plan is required to abide by the terms of this Notice so long as the Plan remains in effect. The Plan reserves the right to change the terms of this Notice as necessary and to make the new Notice effective for all PHI maintained by the Plan. Copies of revised Notices in which there has been a material change will be mailed to all participants then covered by the Plan. Copies of our current Notice may be obtained by calling the Privacy Office at the telephone number or address below.

DEFINITIONS

Plan Sponsor means Dysart USD and any other employer that maintains the Plan for the benefit of its associates.

Protected Health Information (“PHI”) means individually identifiable health information, which is defined under the law as information that is a subset of health information, including demographic information, that is created or received by the Plan and that relates to your past, present, or future physical or mental health or condition; the health care services you receive; or the past, present, or future payment for the health care services you receive; and that identifies you, or for which there is a reasonable basis to believe the information can be used to identify you.

USES AND DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION

The following categories describe different ways that the Plan may use and disclose your PHI. For each category of uses and disclosures we will explain what we mean and, where appropriate, provide examples for illustrative purposes. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted or required to use and disclose PHI will fall within one of the categories.

Your Authorization – Except as outlined below or otherwise permitted by law, the Plan will not use or disclose your PHI unless you have signed a form authorizing the Plan to use or disclose specific PHI for an explicit purpose to a specific
person or group of persons. Uses and disclosures of your PHI for marketing purposes and/or the sale of your PHI require your authorization. You have the right to revoke any authorization in writing except to the extent that the Plan has taken action in reliance upon the authorization.

**Uses and Disclosures for Payment** – The Plan may use and disclose your PHI as necessary for benefit payment purposes without obtaining an authorization from you. The persons to whom the Plan may disclose your PHI for payment purposes include your health care providers that are billing for or requesting a prior authorization for their services and treatments of you, other health plans providing benefits to you, and your approved family member or guardian who is responsible for amounts, such as deductibles and co-insurance, not covered by the Plan.

For example, the Plan may use or disclose your PHI, including information about any medical procedures and treatments you have received, are receiving, or will receive, to your doctor, your spouse's or other health plan under which you are covered, and your spouse or other family members, unless you object, in order to process your benefits under the Plan. Examples of other payment activities include determinations of your eligibility or coverage under the Plan, annual premium calculations based on health status and demographic characteristics of persons covered under the Plan, billing, claims management, reinsurance claims, review of health care services with respect to medical necessity, utilization review activities, and disclosures to consumer reporting agencies.

**Uses and Disclosures for Health Care Operations** – The Plan may use and disclose your PHI as necessary for health care operations without obtaining an authorization from you. Health care operations are those functions of the Plan it needs to operate on a day-to-day basis and those activities that help it to evaluate its performance. Examples of health care operations include underwriting, premium rating or other activities relating to the creation, amendment or termination of the Plan, and obtaining reinsurance coverage. Other functions considered to be health care operations include business planning and development; conducting or arranging for quality assessment and improvement activities, medical review, and legal services and auditing functions; and performing business management and general administrative duties of the Plan, including the provision of customer services to you and your covered dependents.

**Use or Disclosure of Genetic Information Prohibited.** The Genetic Information Nondiscrimination Act of 2009 (GINA), and regulations promulgated thereunder, specifically prohibit the use, disclosure or request of PHI that is genetic information for underwriting purposes. Genetic information is defined as (1) your genetic tests; (2) genetic tests of your family member; (3) family medical history, or (4) any request of or receipt by you or your family members of genetic services. This means that your genetic information cannot be used for enrollment, continued eligibility, computation of premiums, or other activities related to underwriting, even if those activities are for purposes of health care operations or being performed pursuant to your written authorization.

**Family and Friends Involved in Your Care** – If you are available and do not object, the Plan may disclose your PHI to your family, friends, and others who are involved in your care or payment of a claim. If you are unavailable or incapacitated and the Plan determines that a limited disclosure is in your best interest, the Plan may share limited PHI with such individuals. For example, the Plan may use its professional judgment to disclose PHI to your spouse concerning the processing of a claim. If you do not wish us to share PHI with your spouse or others, you may exercise your right to request a restriction on our disclosures of your PHI (see below), including having correspondence the Plan sends to you mailed to an alternative address. The Plan is also required to abide by certain state laws that are more stringent than the HIPAA Privacy Standards, for example, some states give a minor child the right to consent to his or her own treatment and, under HIPAA, to direct who may know about the care he or she receives. There may be an instance when your minor child would request for you not to be informed of his or her treatment and the Plan would be required to honor that request.

**Business Associates** – Certain aspects and components of the Plan’s services are performed through contracts with outside persons or organizations. Examples of these outside persons and organizations include our third party administrator, reinsurance carrier, agents, attorneys, accountants, banks, and consultants. At times it may be necessary for us to provide certain of your PHI to one or more of these outside persons or organizations. However, if the Plan does provide your PHI to any or all of these outside persons or organizations, they will be required, through contract or by law, to follow the same policies and procedures with your PHI as detailed in this Notice.

**Plan Sponsor** – The Plan may disclose a subset of your PHI, called summary health information, to the Plan Sponsor in certain situations. Summary health information summarizes claims history, claims expenses, and types of claims
experienced by individuals under the Plan, but all information that could effectively identify whose claims history has been summarized has been removed. Summary health information may be given to the Plan Sponsor when requested for the purposes of obtaining premium bids, for providing coverage under the Plan, or for modifying, amending or terminating the Plan. The Plan may also disclose to the Plan Sponsor whether you are enrolled in or have disenrolled from the Plan.

Other Products and Services – The Plan may contact you to provide information about other health-related products and services that may be of interest to you without obtaining your authorization. For example, the Plan may use and disclose your PHI for the purpose of communicating to you about health benefit products or services that could enhance or substitute for existing coverage under the Plan, such as long term health benefits or flexible spending accounts. The Plan may also contact you about health-related products and services, like disease management programs that may add value to you, as a covered person under the Plan. However, the Plan must obtain your authorization before the Plan sends you information regarding non-health related products or services, such as information concerning movie passes, life insurance products, or other discounts or services offered to the general public at large.

Other Uses and Disclosures – Unless otherwise prohibited by law, the Plan may make certain other uses and disclosures of your PHI without your authorization, including the following:

- The Plan may use or disclose your PHI to the extent that the use or disclosure is required by law.
- The Plan may disclose your PHI to the proper authorities if the Plan suspects child abuse or neglect; the Plan may also disclose your PHI if we believe you to be a victim of abuse, neglect, or domestic violence.
- The Plan may disclose your PHI if authorized by law to a government oversight agency (e.g., a state insurance department) conducting audits, investigations, or civil or criminal proceedings.
- The Plan may disclose your PHI in response to a court order specifically authorizing the disclosure, or in the course of a judicial or administrative proceeding (e.g., to respond to a subpoena or discovery request), provided written and documented efforts by the requesting party have been made to (1) notify you of the disclosure and the purpose of the litigation, or (2) obtain a qualified protective order prohibiting the use or disclosure of your PHI for any other purpose than the litigation or proceeding for which it was requested.
- The Plan may disclose your PHI to the proper authorities for law enforcement purposes, including the disclosure of certain identifying information requested by police officers for the purpose of identifying or locating a suspect, fugitive, material witness or missing person; the disclosure of your PHI if you are suspected to be a victim of a crime and you are incapacitated; or if you are suspected of committing a crime on the Plan (e.g., fraud).
- The Plan may use or disclose PHI to avert a serious threat to health or safety.
- The Plan may use or disclose your PHI if you are a member of the military, as required by armed forces services, and the Plan may also disclose your PHI for other specialized government functions such as national security or intelligence activities.
- The Plan may disclose your PHI to state or federal workers' compensation agencies for your workers' compensation benefit determination.
- The Plan may, as required by law, release your PHI to the Secretary of the Department of Health and Human Services for enforcement of the HIPAA Privacy Rules.

Verification Requirements -- Before the Plan discloses your PHI to anyone requesting it, the Plan is required to verify the identity of the requester and the requester's authority to access your PHI. The Plan may rely on reasonable evidence of authority such as a badge, official credentials, written statements on appropriate government letterhead, written or oral statements of legal authority, warrants, subpoenas, or court orders.

RIGHTS THAT YOU HAVE

To request to inspect, copy, amend, or get an accounting of PHI pertaining to your PHI in the Plan, you may contact the Privacy Officer at Dysart Unified School District #89; 15802 N. Parkview Place, Surprise, AZ 85374; 623-876-7998.

Right to Inspect and Copy Your PHI – You have the right to request a copy of and/or inspect your PHI that the Plan maintains, unless the PHI was compiled in reasonable anticipation of litigation or contains psychotherapy notes. In certain limited circumstances, the Plan may deny your request to copy and/ or inspect your PHI. In most of those limited circumstances, a licensed health care provider must determine that the release of the PHI to you or a person authorized by you, as your “personal representative,” may cause you or someone else identified in the PHI harm. If your request is
denied, you may have the right to have the denial reviewed by a designated licensed health care professional that did not participate in the original decision. Requests for access to your PHI must be in writing and signed by you or your personal representative. You may ask for a Participant PHI Inspection Form from the Plan through the Privacy Office at the address below. If you request that the Plan copy or mail your PHI to you, the Plan may charge you a fee for the cost of copying your PHI and the postage for mailing your PHI to you. If you ask the Plan to prepare a summary of the PHI, and the Plan agrees to provide that explanation, the Plan may also charge you for the cost associated with the preparation of the summary.

**Right to Request Amendments to Your PHI** – You have the right to request that PHI the Plan maintains about you be amended or corrected. The Plan is not obligated to make requested amendments to PHI that is not created by the Plan, not maintained by the Plan, not available for inspection, or that is accurate and complete. The Plan will give each request careful consideration. To be considered, your amendment request must be in writing, must be signed by you or your personal representative, must state the reasons for the amendment request, and must sent to the Privacy Office at the address below. If the Plan denies your amendment request, the Plan will provide you with its basis for the denial, advise you of your right to prepare a statement of disagreement which it will place with your PHI, and describe how you may file a complaint with the Plan or the Secretary of the US Department of Health and Human Services. The Plan may limit the length of your statement of disagreement and submit its own rebuttal to accompany your statement of disagreement. If the Plan accepts your amendment request, it must make a reasonable effort to provide the amendment to persons you identify as needing the amendment or persons it believes would rely on your un-amended PHI to your detriment.

**Right to Request an Accounting for Disclosures of Your PHI** – You have the right to request an accounting of disclosures of your PHI that the Plan makes. Your request for an accounting of disclosures must state a time period that may not be longer than six years and may not include dates before April 14, 2004. Not all disclosures of your PHI must be included in the accounting of the disclosures. Examples of disclosures that the Plan is required to account for include those pursuant to valid legal process, or for law enforcement purposes. Examples of disclosures that are not subject to an accounting include those made to carry out the Plan’s payment or health care operations, or those made with your authorization. To be considered, your accounting requests must be in writing and signed by you or your personal representative, and sent to the Privacy Office at the address below. The first accounting in any 12-month period is free; however, the Plan may charge you a fee for each subsequent accounting you request within the same 12-month period.

**Right to Place Restrictions on the Use and Disclosure of Your PHI** – You have the right to request restrictions on certain of the Plan’s uses and disclosures of your PHI for payment or health care operations, disclosures made to persons involved in your care, and disclosures for disaster relief purposes. For example, you may request that the Plan not disclose your PHI to your spouse. Your request must describe in detail the restriction you are requesting. The Plan is not required to agree to your request, but will attempt to accommodate reasonable requests when appropriate. The Plan retains the right to terminate an agreed-to restriction if it believes such termination is appropriate. In the event of a termination by the Plan, it will notify you of the termination. You also have the right to terminate, in writing or orally, any agreed-to restriction. Requests for a restriction (or termination of an existing restriction) may be made by contacting the Plan through the Privacy Office at the telephone number or address below.

**Request for Confidential Communications** – You have the right to request that communications regarding your PHI be made by alternative means or at alternative locations. For example, you may request that messages not be left on voice mail or sent to a particular address. The Plan is required to accommodate reasonable requests if you inform the Plan that disclosure of all or part of your information could place you in danger. The Plan may grant other requests for confidential communications in its sole discretion. Requests for confidential communications must be in writing, signed by you or your personal representative, and sent to the Privacy Office at the address below.

**Right to a Copy of the Notice** – You have the right to a paper copy of this Notice upon request by contacting the Privacy Office at the telephone number or address below.

**Right to Notice of Breach** - You have the right to receive notice if your PHI is improperly used or disclosed as a result of a breach of unsecured PHI.

**Complaints** – If you believe your privacy rights have been violated, you can file a complaint with the Plan through the Privacy Office in writing at the address below. You may also file a complaint in writing with the Secretary of the U.S.
Department of Health and Human Services in Washington, D.C., within 180 days of a violation of your rights. There will be no retaliation for filing a complaint.

FOR FURTHER INFORMATION

If you have questions or need further assistance regarding this Notice, you may contact our Privacy Office by writing to:

Payroll & Benefits Department
Dysart USD
15802 North Parkview Place
Surprise, AZ 85374
623.876.7924

This Notice is effective September 1, 2015.
USERRA Notice

Your right to continued participation in the Plan during leaves of absence for active military duty is protected by the Uniformed Services Employment and Reemployment Rights Act (USERRA). Accordingly, if you are absent from work due to a period of active duty in the military for less than 31 days, your Plan participation will not be interrupted. If the absence is for more than 31 days and not more than 12 weeks, you may continue to maintain your coverage under the Plan by paying premiums.

If you do not elect to continue to participate in the Plan during an absence for military duty that is more than 31 days, or if you revoke a prior election to continue to participate for up to 12 weeks after your military leave began, you and your covered family members will have the opportunity to elect COBRA Continuation Coverage only under the medical insurance policy for the 24-month period (18-month period if you elected coverage prior to December 10, 2004) that begins on the first day of your leave of absence. You must pay the premiums for Continuation Coverage with after-tax funds, subject to the rules that are set out in that plan.
New Health Insurance Marketplace Coverage Options and Your Health Coverage

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 Ms. Janis Peel.

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.

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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.

<table>
<thead>
<tr>
<th>3. Employer name</th>
<th>4. Employer Identification Number (EIN)</th>
</tr>
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<tbody>
<tr>
<td>Dysart Unified School District #89</td>
<td>86-6000520</td>
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</table>

<table>
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<tr>
<th>5. Employer address</th>
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</thead>
<tbody>
<tr>
<td>15802 N. Parkview Place</td>
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</table>

<table>
<thead>
<tr>
<th>6. Employer phone number</th>
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</thead>
<tbody>
<tr>
<td>(623) 876-7968</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>7. City</th>
<th>8. State</th>
<th>9. ZIP code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surprise</td>
<td>Arizona</td>
<td>85374</td>
</tr>
</tbody>
</table>

10. Who can we contact about employee health coverage at this job?
Ms. Janis Peel

11. Phone number (if different from above) (623) 876-7950
12. Email address janis.peel@dysart.org

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

- As your employer, we offer a health plan to:
  - All employees. Eligible employees are:

    Certified Staff min of 20 hours per week; includes PPACA variable hr EE - 1st of month following date of hire
    Support Staff min of 30 hours per week; included PPACA variable hr EE - 1st of month following date of hire
    Board members - 1st of month following date sworn in

- With respect to dependents:
  - We do offer coverage. Eligible dependents are:

    Legal Spouse
    Same/Opposite sex domestic partners
    Child(ren) to age 26

 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 will guide you through the process. Here's the employer information you'll enter when you visit HealthCare.gov to find out if you can get a tax credit to lower your monthly premiums.
The information below corresponds to the Marketplace Employer Coverage Tool. Completing this section is optional for employers, but will help ensure employees understand their coverage choices.

13. Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible in the next 3 months?

- Yes (Continue)
- No (STOP and return this form to employee)

13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage? _______________ (mm/dd/yyyy) (Continue)

14. Does the employer offer a health plan that meets the minimum value standard*?

- Yes (Go to question 15)  
- No (STOP and return form to employee)

15. For the lowest-cost plan that meets the minimum value standard* offered only to the employee (don’t include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/she received the maximum discount for any tobacco cessation programs, and didn’t receive any other discounts based on wellness programs.

   a. How much would the employee have to pay in premiums for this plan? $____________
   b. How often? □ Weekly  □ Every 2 weeks  □ Twice a month  □ Monthly  □ Quarterly  □ Yearly

   If the plan year will end soon and you know that the health plans offered will change, go to question 16. If you don’t know, STOP and return form to employee.

16. What change will the employer make for the new plan year?

- Employer won’t offer health coverage
- Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)

   a. How much would the employee have to pay in premiums for this plan? $____________
   b. How often? □ Weekly  □ Every 2 weeks  □ Twice a month  □ Monthly  □ Quarterly  □ Yearly

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* 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 (Section 5005(c)(1)(C)(ii) of the Internal Revenue Code of 1986).