



SAN LUIS COASTAL
UNIFIED SCHOOL DISTRICT

2023

Open Enrollment Presentation



Benefit Period

October 1, 2023 – September 30, 2024

This presentation and the materials provided are designed to explain the district benefits program, in brief summary only.

Questions:

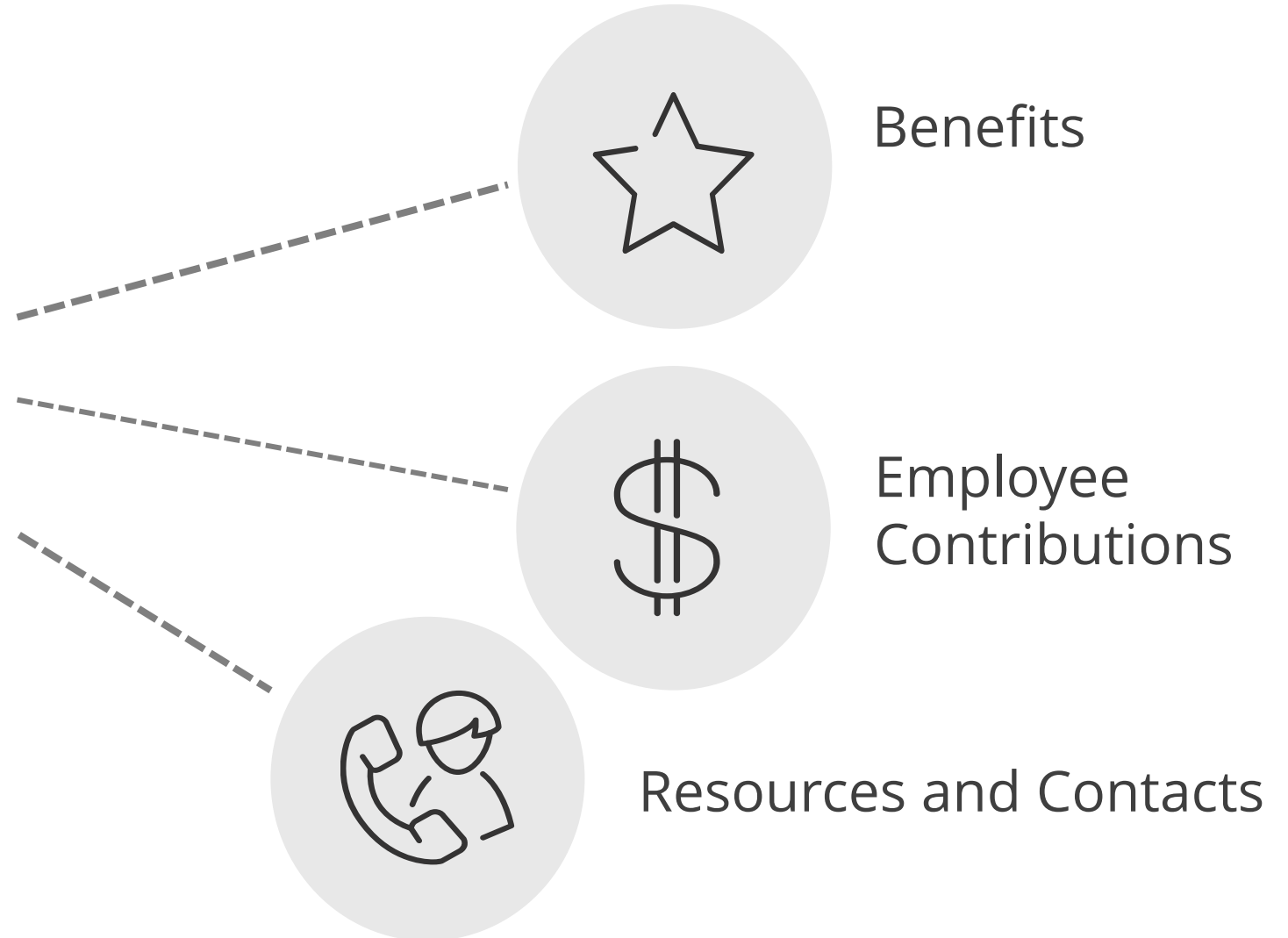
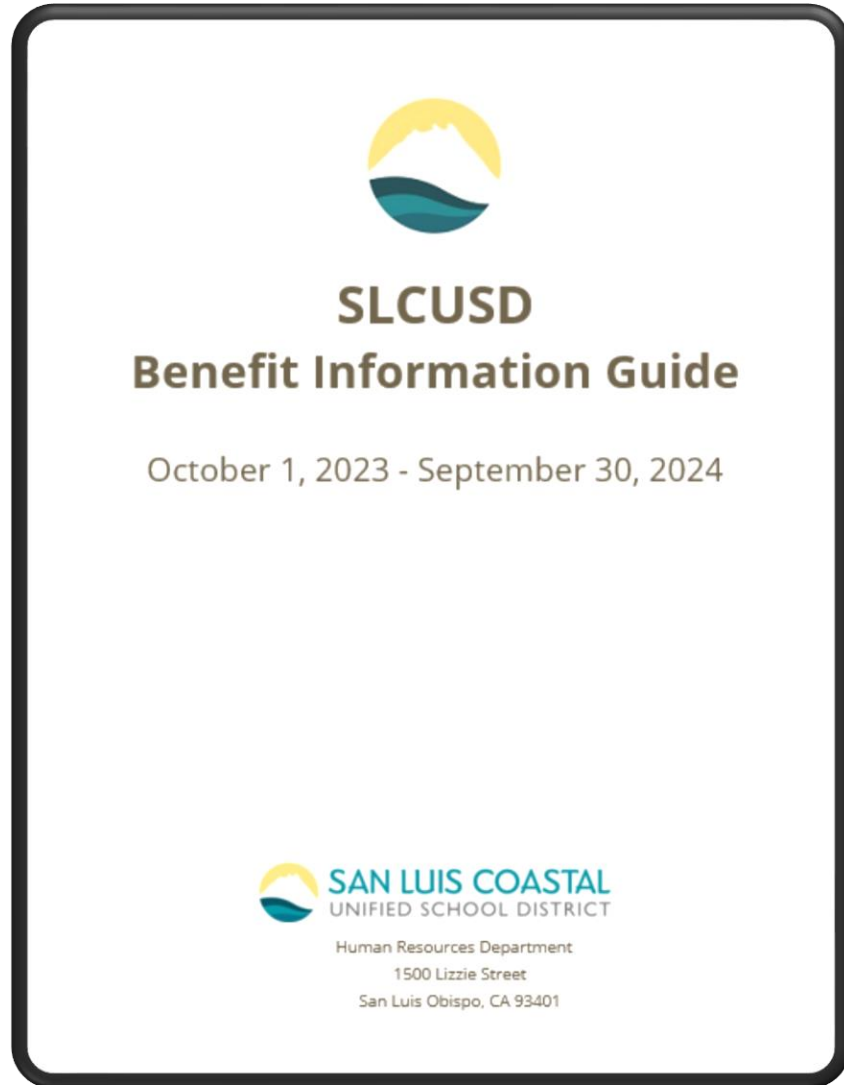
Contact Traci Moreno



Enrollment Information



Benefit Information Guide



Eligibility

New Hire

- First of the month following date of date of hire
- **20 hours per week or 0.50 FTE** or above are eligible for Health Benefits
- Employees working **7.2 to 8 hours per day or FTE .90** required to enroll

Eligible Dependents

- Legally married spouse
- Dependent children under age 26
- Registered Domestic partners

Qualifying Events

- Marriage, divorce, legal separation or annulment
- Birth or adoption of a child
- A qualified medical child support order
- Death of a spouse or child
- Loss of coverage from another health plan

Notify Traci Moreno within 30 days of a qualifying event



Qualifying Life Event

Documentation Required

- Marriage Certificate
- 1040 Form
- Birth Certificate or Hospital Record
- Copy of Spouse's Open Enrollment
- Loss of Coverage letter
- Adoption Paperwork

**30
Days**



Go Online to Notify HR of your qualifying event.

Document required no later than 30 days from date of qualifying event.

Enrolling Dependents

Documentation Required

- **To Enroll a Spouse**

- ✓ **Prior year's 1040 Federal Tax form** (face page only) that shows the couple was married (financial information may be blocked out). If taxes were not filed jointly, you can complete an Affidavit of Marriage with a copy of the **marriage certificate**. A marriage certificate will be accepted for newly married couples (within 1 year) where prior year tax return is unavailable.

- **To Enroll a Domestic Partner**

- ✓ **Certificate of Registered Domestic Partnership** issued by the State of California

- **To Enroll a Child**

- ✓ **Legal Birth Certificate or Hospital Birth Certificate.**

- **To Enroll a Child of which you are Legal Guardian (up to age 18)**

- ✓ **Legal U.S. Court Documentation** establishing Guardianship

- **To Enroll a Disabled Dependent (over age 26)**

- ✓ Anthem members need to complete the ***Request to Continue Dependent Coverage*** form.



Premium Only Plan “POP”

Automatic Enrollment

- The “Premium Only Plan” allows you to save money by using tax-free dollars to pay for your medical, dental, and vision group premiums.
- Your contributions toward the cost of premiums will automatically be deducted, pre-tax, from your payroll check.
- As specifically authorized by your collective bargaining agreement, your enrollment in the “Premium Only Plan” is considered an automatic election to pay for those premiums with pre-tax dollars.

If you would like to opt-out of the “Premium Only Plan” plan you must file a written election within 31 days of the date of hire. During open enrollment, you can change your option to either opt out or change to the tax-free benefit.

You must email, fax or hand-deliver the completed opt out form to Traci Moreno at the District Office.



Enrollment Forms

2022-23 INSURANCE PLAN REQUEST FORM
SLCTA
Please use the Insurance Request form to make changes only.

Employee Name: _____
Position/Site: _____

Packages 11-20 include medical, dental and vision insurance.
Packages 11 - 14 and 19 include Delta Dental Incentive. Packages 15 - 18 and 20 include Delta Dental PPO.
The Anchor Bronze plans are medical plans only. Spouses cannot enroll in Anchor Bronze plans.
There is no dental, no vision and no life insurance included with the Anchor Bronze plans.

MONTHLY Rates effective October 1, 2022
These are full time rates for SLCTA

Pkg	Plan	Rate
80M (Pkg 11)	Blue Cross PB 80% \$30	
	Delta Dental <i>Incentive</i>	
	VSP	
	Cost	
	11 pay:	\$ 443.15
	12 pay:	\$ 406.22

Pkg	Plan	Rate
80G (Pkg 12)	Blue Cross PB 80% \$30	
	Delta Dental <i>Incentive</i>	
	VSP	
	Cost	
	11 pay:	\$ 626.96
	12 pay:	\$ 574.72

Pkg	Plan	Rate
90C (Pkg 13)	Blue Cross PB 90% \$20	
	Delta Dental <i>Incentive</i>	
	VSP	
	Cost	
	11 pay:	\$ 744.78
	12 pay:	\$ 682.72

Pkg	Plan	Rate
100A (Pkg 14)	Blue Cross PB 100% \$20	
	Delta Dental <i>Incentive</i>	
	VSP	
	Cost	
	11 pay:	\$ 818.42
	12 pay:	\$ 750.22

Pkg	Plan	Rate
80M (Pkg 15)	Blue Cross PB 80% \$40	
	Delta Dental <i>PPO</i>	
	VSP	
	Cost	
	11 pay:	\$ 452.04
	12 pay:	\$ 414.37

Pkg	Plan	Rate
80G (Pkg 16)	Blue Cross PB 80% \$30	
	Delta Dental <i>PPO</i>	
	VSP	
	Cost	
	11 pay:	\$ 635.85
	12 pay:	\$ 582.87

Pkg	Plan	Rate
90C (Pkg 17)	Blue Cross PB 90% \$20	
	Delta Dental <i>PPO</i>	
	VSP	
	Cost	
	11 pay:	\$ 753.67
	12 pay:	\$ 690.87

Pkg	Plan	Rate
100A (Pkg 18)	Blue Cross PB 100% \$20	
	Delta Dental <i>PPO</i>	
	VSP	
	Cost	
	11 pay:	\$ 827.31
	12 pay:	\$ 758.37

Affordable Care Act Plans - HSA compatible

Plan	Rate
NEW!!! HSA-A (Pkg 19)	
Single	
Family	
Blue Cross PB 90%	
Delta Dental <i>Incentive</i>	
VSP	
Cost	
11 pay:	\$ 529.87
12 pay:	\$ 485.72

Plan	Rate
NEW!!! HSA-A (Pkg 20)	
Single	
Family	
Blue Cross PB 90%	
Delta Dental <i>PPO</i>	
VSP	
Cost	
11 pay:	\$ 538.76
12 pay:	\$ 493.87

Plan	Rate
Anchor Bronze-A	
Blue Cross PB 70%	
Employee Only	
Cost	
11 pay:	\$ 124.55
12 pay:	\$ 114.17

Plan	Rate
Anchor Bronze-B	
Blue Cross PB 70%	
Employee + Child(ren)	
Cost	
11 pay:	\$ 325.27
12 pay:	\$ 298.17

☐ **WABE: Anchor Bronze-A**
WABE is an option for full time employees in place of a SISC medical plan. This is used only to satisfy the medical participation requirements of a FT employee and are not enrolled in a medical/Rx plan

Note: If you are employed as of the first day of school, your insurance coverage begins September 1st. There will be two deductions taken for insurance coverage on your August paycheck; one deduction is for coverage for September at the current rate; the second deduction begins the eleven monthly payments at the new rate for insurance coverage from October 1 through September 30.

SISC III ENROLLMENT FORM – (DO NOT use for Kaiser members, use Kaiser Permanente enrollment form for Kaiser members)
(Type or print clearly in black ink)

SECTION I: SELECTED COVERAGE – REQUIRED (DISTRICT USE ONLY)
ENROLLMENT REASON: ☐ NEW HIRE ☐ OPEN ENROLLMENT ☐ EMPLOYEE STATUS CHANGE ☐ LOSS OF COVERAGE (COBRA)
QUALIFYING DATE: _____ EFFECTIVE DATE: _____ HIRE DATE: _____ DISTRICT APPROVED INITIALS: _____
DISTRICT NAME (DO NOT ABBREVIATE): _____ EMPLOYEE GROUP (BARGAINING UNIT): _____ HOURS WORKED PER WEEK: _____ 27% OPTION - PROVIDE SPOUSE SOCIAL SECURITY NO: _____
MEDICAL GROUP NO: _____ DELTA DENTAL GROUP NO: _____ VISION GROUP NO: _____ LIFE GROUP NO: _____

SECTION II: EMPLOYEE / APPLICANT INFORMATION - REQUIRED
☐ MEDICAL ☐ DENTAL ☐ VISION ☐ LIFE
SOCIAL SECURITY NO: _____ LAST NAME (PRINT): _____ FIRST NAME (PRINT): _____ MI: _____ DATE OF BIRTH: ____/____/____ ☐ MALE ☐ FEMALE
STREET ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____
TELEPHONE NO: _____ EMAIL ADDRESS: _____ P1 (RMO ONLY-REQUIRED): _____ PCP (RMO ONLY-REQUIRED): _____ CURRENT PROVIDER: ☐ YES ☐ NO
Are you retired? ☐ YES ☐ NO
If yes, do you have Medicare? ☐ YES ☐ NO (Copy of Medicare card required)
Do any of your dependents have Medicare? ☐ YES ☐ NO (Copy of Medicare card required)

SECTION III: DEPENDENT INFORMATION Proof of eligibility required (i.e. birth/marriage/domestic partner certificate)
☐ MEDICAL ☐ DENTAL ☐ VISION
LAST NAME (PRINT): _____ FIRST NAME (PRINT): _____ MI: _____ SOCIAL SECURITY NO: _____
DATE OF BIRTH: ____/____/____ TOTALY DISABLED? ☐ YES ☐ NO
IPR (RMO ONLY-REQUIRED): _____ PCP (RMO ONLY-REQUIRED): _____ IS THIS YOUR CURRENT PROVIDER? ☐ YES ☐ NO
☐ SON ☐ DAUGHTER
LAST NAME (PRINT): _____ FIRST NAME (PRINT): _____ MI: _____ SOCIAL SECURITY NO: _____
DATE OF BIRTH: ____/____/____ TOTALY DISABLED? ☐ YES ☐ NO
IPR (RMO ONLY-REQUIRED): _____ PCP (RMO ONLY-REQUIRED): _____ IS THIS YOUR CURRENT PROVIDER? ☐ YES ☐ NO
☐ SON ☐ DAUGHTER
LAST NAME (PRINT): _____ FIRST NAME (PRINT): _____ MI: _____ SOCIAL SECURITY NO: _____
DATE OF BIRTH: ____/____/____ TOTALY DISABLED? ☐ YES ☐ NO
IPR (RMO ONLY-REQUIRED): _____ PCP (RMO ONLY-REQUIRED): _____ IS THIS YOUR CURRENT PROVIDER? ☐ YES ☐ NO
☐ SON ☐ DAUGHTER
LAST NAME (PRINT): _____ FIRST NAME (PRINT): _____ MI: _____ SOCIAL SECURITY NO: _____
DATE OF BIRTH: ____/____/____ TOTALY DISABLED? ☐ YES ☐ NO
IPR (RMO ONLY-REQUIRED): _____ PCP (RMO ONLY-REQUIRED): _____ IS THIS YOUR CURRENT PROVIDER? ☐ YES ☐ NO
☐ SON ☐ DAUGHTER

SECTION IV: SIGNATURE OF UNDERSTANDING – APPLICANT MUST SIGN
I have read and understood the provisions outlined on this form. All information on this form is correct and true. I understand that it is the basis on which coverage may be issued under the plan. Any misstatements or omissions may result in future claims being denied under the policy being requested. You are entitled to a copy of this signed authorization for your files. Additionally, any person who knowingly and with intent to injure, defraud, or deceive the district, SISC, or plan service provider, by filing a statement or claim containing false or misleading information may be guilty of a criminal act punishable under law. I attest by signing below that I have reviewed the information provided on this application and to the best of my knowledge and belief, it is true and accurate with no omissions or misstatements.
ARBITRATION AGREEMENT: I UNDERSTAND THAT ANY AND ALL DISPUTES BETWEEN MYSELF (AND/OR ANY ENROLLED FAMILY MEMBER) AND SISC III (INCLUDING CLAIMS ADMINISTRATOR OR AFFILIATE) INCLUDING CLAIMS FOR MEDICAL MALPRACTICE, MUST BE RESOLVED BY BINDING ARBITRATION, IF THE AMOUNT IN DISPUTE EXCEEDS THE JURISDICTIONAL LIMIT OF THE SMALL CLAIMS COURT, AND NOT BY LAWSUIT OR RESORT TO COURT PROCESS, EXCEPT AS CALIFORNIA LAW PROVIDES FOR JUDICIAL REVIEW OF ARBITRATION PROCEEDINGS. UNDER THIS COVERAGE, BOTH THE MEMBER AND SISC III ARE GIVING UP THE RIGHT TO HAVE ANY DISPUTE DECIDED IN A COURT OF LAW BEFORE A JURY. SISC III AND THE MEMBER ALSO AGREE TO GIVE UP ANY RIGHT TO PURSUE ON A CLASS BASIS ANY CLAIM OR CONTROVERSY AGAINST THE OTHER. (FOR MORE INFORMATION REGARDING BINDING ARBITRATION, PLEASE REFER TO YOUR EVIDENCE OF COVERAGE BOOKLET.)
Applicant Signature Required _____ Date: _____
<http://www.sisc-kern.org/law>
Rev. 2014-01

SISC Flex Plan – Enrollment Form
Plan Year: 1/1/2022-12/31/2022, with Grace Period through 3/15/2023
Last Day to Submit Claims: 3/31/2023

Employer Code: SIS

Employer _____ **Effective Date** _____

Employee Information – Please write legibly to ensure proper enrollment
First Name, Last Name _____ SSN _____
Home Address (Street, City, State, Zip Code) _____ Date of Hire _____
Date of Birth _____ Phone Number _____ E-mail Address (Mandatory for Debit Card) _____

Benefit Elections

Section 125 Benefit	Yes/No	Annual Election	# of Deductions	Paycheck Deduction
Health Care Expense Account Maximum of \$2,750.00 per plan year	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$ _____	_____	\$ _____
Limited Purpose Health Care Expense Account Maximum of \$2,750.00 per plan year <i>This account is for employees enrolled in a High Deductible Medical Plan and enrolled in a Health Savings Account (HSA).</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$ _____	_____	\$ _____
Dependent Care Expense Account Maximum of \$5,000.00 per plan year (or \$2,500 if you're married and filing taxes separately)	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$ _____	_____	\$ _____

List any month(s) payroll deductions will not be taken for account(s) listed above. _____

Debit Card & Direct Deposit

Navia Debit Card – You may use the card to pay for expenses directly from the funds in your Health Care, Limited Purpose and Dependent Care Expense Account. There is no cost for debit cards. Cards are valid for a 3 year period; if you've previously received a card then it will be reloaded with your new election. You must provide a valid e-mail address to use the card. Automatic _____

Direct Deposit – Reimbursements are electronically deposited into your bank account. If you've previously signed up for direct deposit with Navia your information will remain on file and you do not need to complete this section.

☐ Checking Routing #: _____
☐ Savings Account #: _____

Signature
This election form will remain in effect and cannot be revoked or changed during the plan year unless the revocation and new election are on account of and consistent with federal regulations. I understand that Health or Limited Purpose Expense Account reimbursements will be available only for qualifying medical care expenses for myself, spouse, and dependents. I also understand that Dependent Care reimbursements will be available only for qualifying day care and adult care expenses. I agree to notify the Plan Administrator if I have reason to believe that any expense for which I have obtained reimbursement is not a qualifying expense. I also agree to indemnify and reimburse the Plan Administrator or Employer on demand for any liability it may incur for failure to withhold federal, state or local income tax or Social Security tax from any reimbursement I receive of a non-qualifying expense, up to the amount of additional tax actually owed by me. I understand the benefits and I have read the reverse page. I hereby authorize and direct my employer to reduce my salary by the amount necessary to pay for the benefit(s) as shown above for the plan year indicated above.

Employee Signature _____ **Date** _____
X Employer Signature _____ **Date** _____
X

Completed Enrollment Forms must be returned to Employer
Please see the reverse side for important information regarding the above benefits

#1 - Insurance Plan Request Form(s)
To indicate your plan package selection and confirm payroll deduction amount

#2 - SISC III Enrollment Form
For enrollment in Medical, Dental, Vision, and Life coverage or WABE

#3 - SISC Flex Plan Enrollment Form
For enrollment in the Navia FSA
Optional

Deductions

A note regarding your initial enrollment

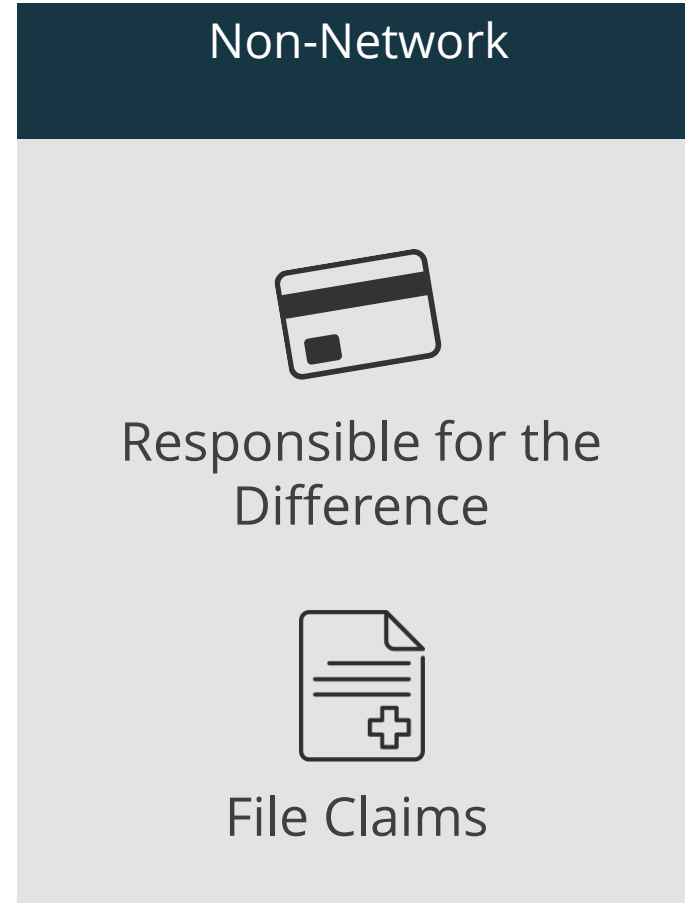
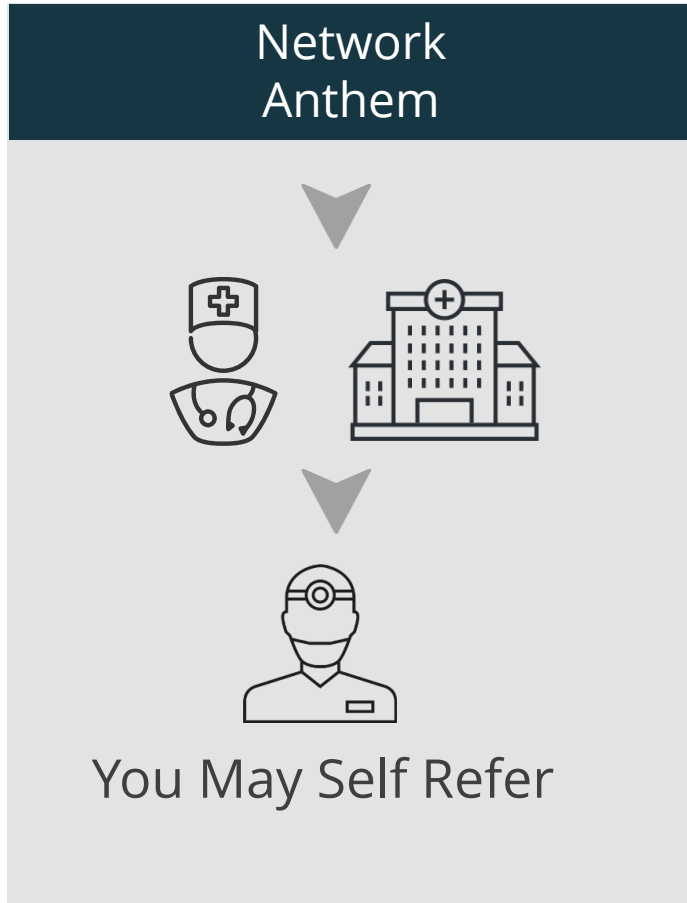
- If you are employed as of the first day of school, your insurance coverage begins **September 1st**
- There will be **two** deductions taken for insurance coverage on your **August paycheck**
 - ✓ One deduction is for coverage for **September** at the current year's rate
 - ✓ The second deduction begins the regular monthly payments at the new year's rate for insurance coverage from **October 1 through September 30**
- **Late hires are subject to pro-rated deductions.**



Medical Benefits



Medical Plans



Medical Plans



	Anthem PPO 80-M In-Network	Anthem PPO 80-G In-Network	Anthem PPO 90-C In-Network	Anthem PPO 100-A In-Network	Anthem HSA \$1,500 In-Network	Anthem 2-Tier HSA \$5,000 In-Network
Health Benefits						
Deductible (calendar year)						
– Individual / Individual wDeps	\$3,000	\$500	\$200	none	\$1,500 / \$3,000 w/deps	\$5,000
– Family	\$6,000	\$1,000	\$500	none	\$3,000	\$10,000
Out of pocket maximum						
– Individual / Family	\$4,000 / \$8,000	\$2,000 / \$4,000	\$1,000 / \$3,000	\$1,000 / \$3,000	\$3,000 / \$6,000	\$6,350 / \$12,700
Office visit copay (PCP / Specialist)	\$40* / \$40	\$30* / \$30	\$20* / \$20	\$20* / \$20	10% after ded	30% after ded
Inpatient Hospital	20% after ded	20% after ded	10% after ded	100% Covered	10% after ded	30% after ded
Outpatient surgery	20% after ded	20% after ded	10% after ded	100% Covered	10% after ded	30% after ded
Emergency Room (copay waived if admitted)	\$100 copay + 20% after ded	\$100 copay + 20% after ded	\$100 copay + 10% after ded	\$100 Copay	10% after ded	30% after ded
Urgent Care	\$40	\$30	\$20	\$20	10% after ded	30% after ded
Prescription Drug (Retail)	\$10 / \$35, \$200 ded	\$9/\$35	\$9/\$35	\$9/\$35	\$9/\$35, after medical ded	\$9/\$35, after medical ded

**First 3 primary care visits are covered with \$0 Copay*

Medical Plans

Understanding the Health Savings Account (HSA) option.

Watch this short video to learn all about Health Savings Accounts.

<https://www.brainshark.com/burnhambis/vu?pi=zGYzfJ06fzNYr9z0&intk=502107144>



WABE – Waiver of Benefits



SISC requires 100% participation of full-time employees (FTE \geq .90 FTE or employees working **7.2 to 8 hours per day**) in the SISC sponsored medical plans or **WABE** and adherence to SISC Health Benefit Manual Guidelines. When electing WABE, you are **opting out of Medical, Dental, Vision, and Life** benefits.

Included with WABE Enrollment

- ✓ Employee Assistance Program
- ✓ Expert Medical Opinion - Teladoc Medical Experts
- ✓ 24/7 Physician Access - MDLive
- ✓ Health Screening Program - Health Smarts
- ✓ Flu Shot Program - Health Smarts

Important Note

When opting out of the district's health benefits, you must provide proof of other Medical coverage.

SISC Value Adds

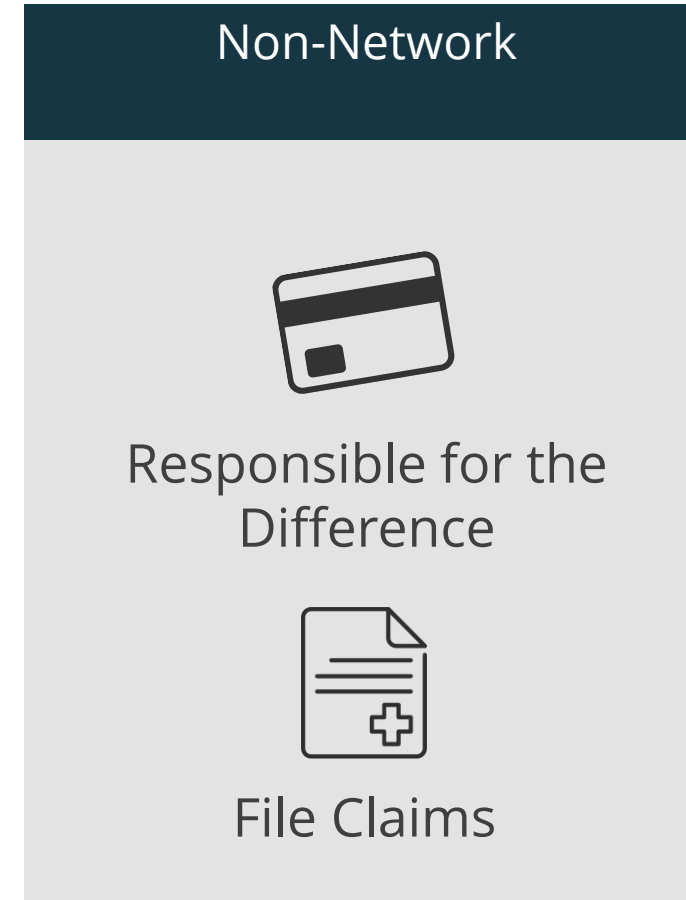
Watch this short video to learn all about the Value Added programs available to SISC members: <https://www.brainshark.com/burnhambis/vu?pi=zHoz7lOubzNYr9z0>



Dental Benefits



Dental Plans



Dental Plans



Delta Dental PPO

	Network	Non-Network
Maximum Benefit	\$3,000	\$1,000
Deductible - Individual - Family	none	\$25 \$75
Preventive Service (plan pays)	100%	50%
Basic Services (plan pays)	100%	50%
Major Services (plan pays)	100%	50%
Prosthodontics (plan pays)	50%	50%
Orthodontia - Adult and Children	100%, \$1,500 Lifetime Maximum	

PPO Network Only

Delta Dental Incentive

Network	Non-Network
\$1,700 (PPO) \$1,500 (Premier)	\$1,500
None	None
70-100%	70-100%
70-100%	70-100%
70-100%	70-100%
50%	50%
None	

PPO & Premier Network

Dental Cleanings

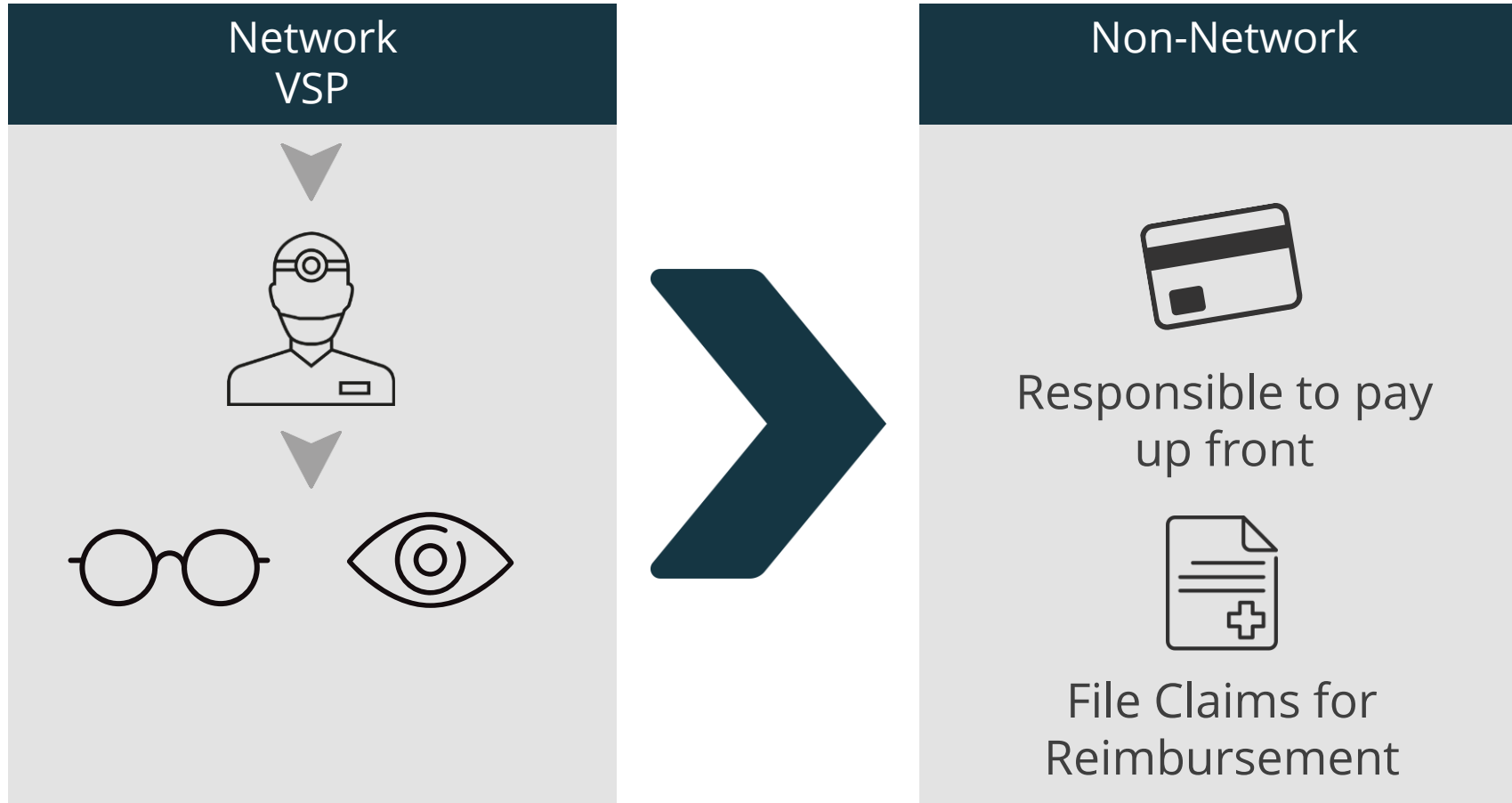
- Take advantage of your **free** teeth cleanings
- Our PPO dental plan covers cleanings **twice a year!**
- Oral health relates to **total health**
- Can **reduce risk** for heart attack and stroke



Vision Benefits



Vision Plan



Vision Plan

Examination



Exam

Network: \$0 Copay
Non-Network: up to \$50
Reimbursement
Every 12 months

+

Glasses



Lenses

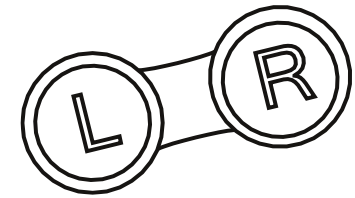
Network: \$0 Copay
Non-Network: up to \$100
Reimbursement
Every 12 months

Frames

Network: \$150 Allowance
Non-Network: up to \$70
Reimbursement
Every 24 months

OR

Contact Lenses



Contact Lenses

Network: \$150 Allowance
15% off fitting exam
Non-Network: up to \$105
Reimbursement
Every 12 months



Basic Life Benefits



Basic Life and AD&D

Financial protection for your family if
you die or become seriously injured

Benefit: **\$10,000**

*This benefit is offered to **Classified Employees***



Basic Life and AD&D

Financial protection for your family if
you die or become seriously injured

Benefit: **\$100,000**

*This benefit is offered to **Confidential and
Management Employees***



Tax Savings Benefits

Flexible Spending
Accounts



TAX FREE



Health Care FSA
\$3,050



Medical



Dental

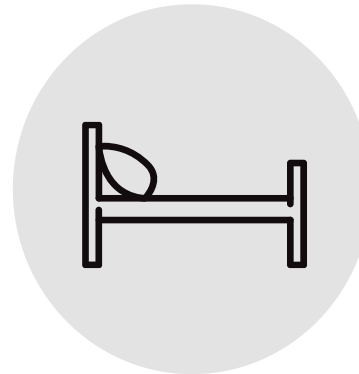


Vision

TAX FREE

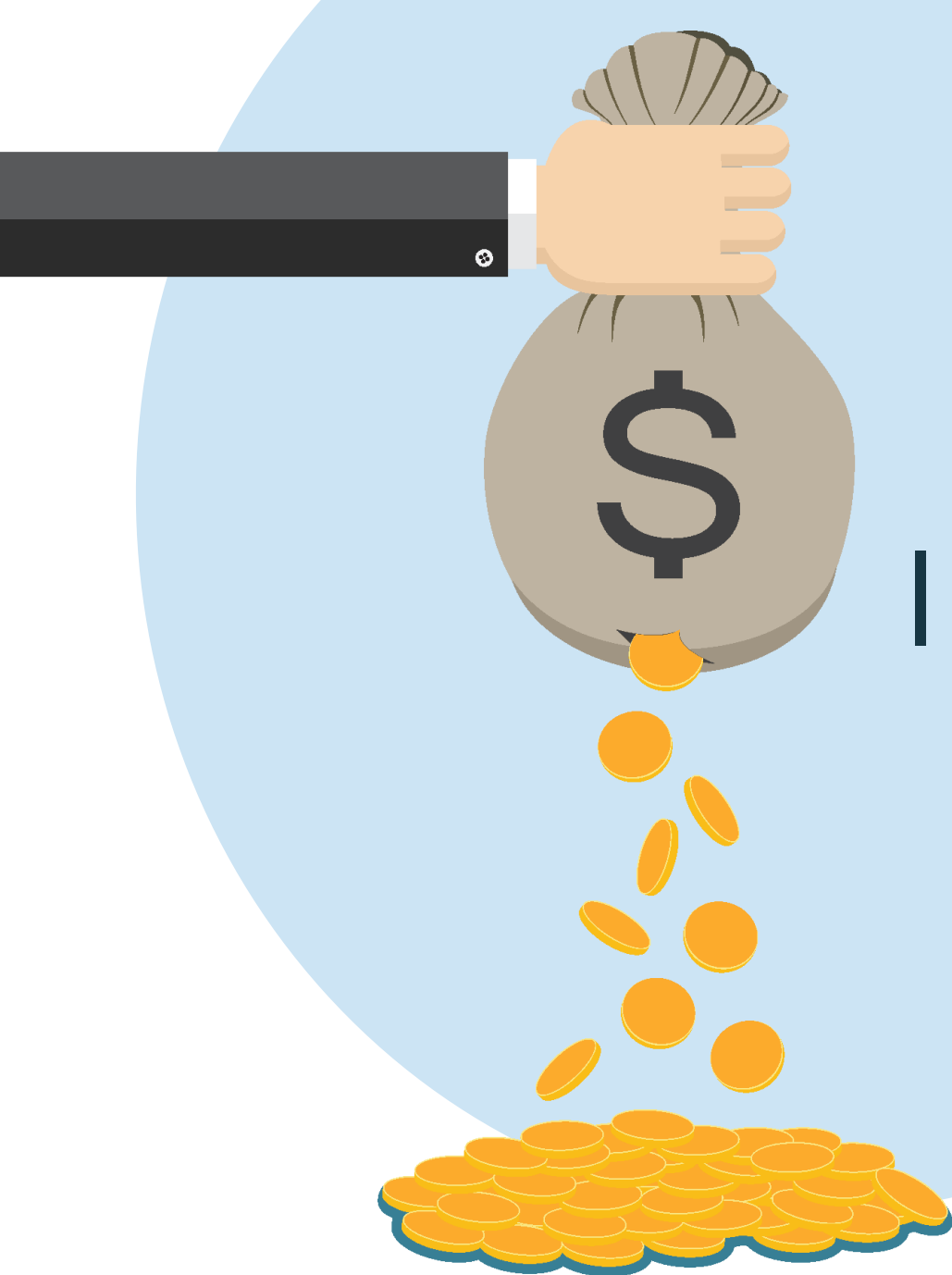


Daycare for
Children



Home Care
for Disabled
Family
Member

Dependent Care FSA
\$5,000



IRS: USE IT OR LOSE IT
Grace Period

Employee Contributions



2023 Employee Contributions

	Certificated ANNUAL PREMIUM	Classified ANNUAL PREMIUM
Medical PPO – SISC Anthem 80-M - Dental Incentive (Pkg 1) - Dental PPO (Pkg 5)	\$5,382.20 \$5,467.73	\$4,882.20 \$4,968.00
Medical PPO – SISC Anthem 80-G - Dental Incentive (Pkg 2) - Dental PPO (Pkg 6)	\$7,578.20 \$7,664.00	\$7,078.20 \$7,164.00
Medical PPO – SISC Anthem 90-C - Dental Incentive (Pkg 3) - Dental PPO (Pkg 7)	\$8,976.20 \$9,062.00	\$8,476.20 \$8,562.00
Medical PPO – SISC Anthem 100-A - Dental Incentive (Pkg 4) - Dental PPO (Pkg 8)	\$9,858.20 \$9,944.00	\$9,358.20 \$9,444.00
Medical PPO – SISC 2-Tier HSA 5000 - Single - w/children	\$1,616.00 \$4,058.00	\$1,116.00 \$3,558.00
Medical PPO – SISC Anthem HSA 1500 - Dental Incentive (Pkg 9) - Dental PPO (Pkg 10)	\$6,378.20 \$6,464.00	\$5,878.20 \$5,964.00

Open Enrollment Action Items

- Log into Helios and view your current elections
- Make enrollment changes if desired
- Open enrollment for SISC's FSA through Navia is in November. The FSA plan year begins January 1, 2024. **Reminder**, you cannot be enrolled in an FSA and open an HSA bank account concurrently.

Open Enrollment is May 15th through June 18th, 2023!

