

BASIC LIFE/ AD&D – UNUM	
Basic Life	\$40,000
Accidental Death & Dismemberment	Same as life insurance benefit
Repatriation Benefit	Not to exceed the lesser of \$5,000 or 10% of the life benefit
Seat Belt Benefit	\$25,000
Airbag Benefit	\$5,000
Age Reduction Formula	Benefit reduces by 33% at age 70, and to 50% of the original amount at age 75
Employer Contribution	100%

VOLUNTARY TERM LIFE/ AD&D – UNUM	
Employee Coverage	Up to 5 times salary in increments of \$10,000, up to \$500,000
Spouse Coverage	Up to 100% of employee amount in increments of \$10,000, up to \$500,000
Child Coverage	Up to 100% of employee amount in increments of \$2,000, up to \$10,000
In order to purchase Life coverage for your spouse and/or child you must purchase Life coverage for yourself.	

EMPLOYEE ASSISTANCE PROGRAM (EAP) – UNUM
UNUM offers a comprehensive EAP service, with an extensive network. Clinicians, consultants and trainers all work together to help employees manage emotional health, family and work-related challenges. Employee and dependents of East Side Union High School District are eligible for three visits per six month period.

FLEXIBLE SPENDING ACCOUNTS (FSA) – AMERICAN FIDELITY
The FSA allows you to set aside pre-tax dollars to pay for certain healthcare and dependent care expenses. The medical FSA covers expenses that are not covered or are only partially covered by your healthcare plans (medical, dental, vision, and prescription drug). The dependent care FSA covers childcare, elder care, and other eligible dependent care. You can set aside up to \$2,550 per plan year for the healthcare FSA, and you can rollover up to \$500 of your unused balance to the next plan year so you don't lose funds! You can set aside up to \$5,000 for the dependent care FSA.
Refer to the American Fidelity website, www.americanfidelity.com , for a complete list of eligible expenses and for details about the new rollover provision.

IMPORTANT PHONE NUMBERS & WEB ADDRESSES			
	GROUP NUMBER	PHONE NUMBER	WEBSITE
Kaiser	#855	800.464.4000	www.kaiserpermanente.org
Anthem HMO	#57U33	800.227.3771	www.bluecrossca.com
East Side Self-Funded PPO	#280453	844.344.8320	www.mypomco.com
ProAct Self-Funded PPO Rx	ESU	877.635.9545	www.proacrxt.com
Delta Dental	#6585	866.499.3001	www.deltadentalca.org
Vision Service Plan (VSP)	#12077044	800.877.7195	www.vsp.com
UNUM (Life and AD&D Insurance)	Life and AD&D #145452 Voluntary Term Life and AD&D #145453	N/A	www.unum.com
UNUM (Employee Assistance Program)	#ESUHSD	800.854.1446	www.lifebalance.net
American Fidelity (FSA)	N/A	800.654.8489	www.americanfidelity.com

2016-17 MONTHLY BENEFIT COST – CLASSIFIED 100% Paid By East Side Union High School District					
	Kaiser	Anthem HMO	East Side PPO	Delta Dental	VSP
EE Only	\$679.24	\$715.87	\$819.28	\$62.16	\$10.49
EE + 1	\$1,358.48	\$1,503.33	\$1,638.57	\$118.10	\$20.96
EE + Family	\$1,922.25	\$2,147.59	\$2,662.67	\$202.02	\$33.75

EAST SIDE UNION HIGH SCHOOL DISTRICT



GROUP BENEFIT PROGRAM

CLASSIFIED EMPLOYEES ONLY

Effective July 1, 2016

**830 NORTH CAPITOL AVENUE
SAN JOSE, CA 95133
(408) 347-5141**

*The information presented in this brochure is a summary only. Please refer to the individual contract, or plan description. If there are any discrepancies between this summary and the plan contracts, the plan contracts will prevail. If you need detailed information regarding benefits, please contact: **Marissa Juarez, Benefits Coordinator (408) 347-5141, JuarezM@esuhsd.org**.*

MEDICAL – ANTHEM & KAISER		
East Side Union High School District employees and eligible dependents have a choice between the Kaiser HMO, Anthem HMO, and ESUHSD PPO.		
HMO Plans	Anthem	Kaiser
Calendar Year Deductible	None	None
Coinsurance	100%	100%
Out-of-Pocket Maximum	\$800/individual \$2,400/family	\$1,500/individual \$3,000/family
Lifetime Plan Maximum	Unlimited	Unlimited
HOSPITALIZATION		
Room & Board	100%	100%
X-Ray & Lab	100%	100%
Emergency Room	\$35 copay; waived if admitted	\$20 copay; waived if admitted
Mental Health Services	Inpatient: 100% Outpatient: \$20 copay	Inpatient: 100% Outpatient: \$20 copay
Substance Abuse Services	Inpatient: 100% Outpatient: \$20 copay	Inpatient: 100% (detoxification only) Outpatient: \$20 copay
PHYSICIAN SERVICES		
Office Visit	\$20 copay	\$20 copay
Well Baby Care	100%	100%
Immunizations	100%	100%
Adult Routine Exams	100%	100%
Maternity Care	100%	100%
Chiropractic Care	\$20 copay (60 days/benefit period following illness/injury)	Not covered
Acupuncture	\$20 copay	Not covered
Home Health Care/ Private Nursing	\$20 copay (100 visits/calendar year)	100% (100 visits/calendar year)
Skilled Nursing Facility	100% (100 days/calendar year)	100% (100 days/benefit period)
Physical, Occupational & Speech Therapy	\$20 copay (60 days/benefit period following illness/injury)	\$20 copay
PRESCRIPTION DRUGS		
Generic	\$10 copay (30 day supply)	\$10 copay (100 day supply)
Brand	\$20 copay (30 day supply)	\$20 copay (100 day supply)
Mail Order	Generic: \$10 copay Brand: \$20 copay (90 day supply)	Generic: \$10 copay Brand: \$20 copay (100 day supply)

MEDICAL –EAST SIDE SELF-FUNDED PPO PLAN		
The East Side PPO (Preferred Provider Organization) utilizes the Anthem PPO Network.		
	In-Network	Out-of-Network
Calendar Year Deductible	\$100/individual \$300/family	\$100/individual \$300/family
Coinsurance	90%	80%
Out-of-Pocket Maximum	\$500/member	\$1,000/member
Lifetime Plan Maximum	Unlimited	Unlimited
HOSPITALIZATION		
Room & Board	90%	80%
X-Ray & Lab	90%	80%
Emergency Room	90%	90%
Mental Health Services	Inpatient: 90% Outpatient: \$20 copay	Inpatient: 80% Outpatient: \$20 copay
Substance Abuse Services	Inpatient: 90% Outpatient: \$20 copay	Inpatient: 80% Outpatient: \$20 copay
PHYSICIAN SERVICES		
Office Visit	\$20 copay	80%
Well Baby Care	100%	100%
Immunizations	100%	100%
Adult Routine Exams	100%	100%
Maternity	90%	80%
Chiropractic Care	80% (25 visits/year)	80% (25 visits/year)
Acupuncture	\$35 copay (\$350/calendar year)	
Home Health Care/ Private Nursing	80% (100 visits/calendar year)	
Skilled Nursing Facility	100% for the first 10 days, then 80% (lifetime maximum of 180 days)	
Physical, Occupational & Speech Therapy	80% after deductible	
PRESCRIPTION DRUGS – Administered by Catamaran		
Rx Out-of-Pocket Maximum	\$4,500/individual; \$9,000/family	
Generic	\$10 copay (30 day supply)	
Brand	\$20 copay (30 day supply)	
Mail Order	Generic: \$10 copay (90 day supply) Brand: \$20 copay (90 day supply)	

East Side Union High School District

Classified Employees Only

MANAGED DENTAL BENEFITS – DELTA DENTAL	
When choosing the Delta Dental plan, you receive a higher level of discounts if you select an in-network dentist.	
Maximum Annual Benefit	\$2,000/person
Calendar Year Deductible	None
Annual Plan Year Maximum Period	September 1 st through August 31 st
Preventive* – oral examinations, fluoride treatment, space maintainers, specialist consultation	70% – 100% 70% 1st year, increases 10% each consecutive year to a max of 100%. If there is a break in service the coinsurance goes back to 70%
Basic – oral surgery (extractions), fillings, root canals, periodontal (gum) treatment, sealants	70% – 100% 70% 1st year, increases 10% each consecutive year to a maximum of 100%.
Crowns, Jackets and Cast Restorations	70% – 100% 70% 1st year, increases 10% each consecutive year to a maximum of 100%.
Prosthodontic Benefits – bridges, partial dentures, full dentures	70% of contract allowance
Orthodontic Benefits – for dependent children to age 25	50%; subject to a \$1,000 lifetime maximum/person
Dental Accident Benefits	100% of Delta dentist's allowed fee separate (\$1,000 maximum per person per calendar year)
*Three cleanings per year in-network; two per year out-of-network	
Note: Delta dental percentage of coinsurance/employee is tracked on a calendar year basis	

VISION – VISION SERVICE PLAN		
	In-Network	Out-of-Network
Copay	\$15	
Exam every 12 months	100% after copay	Up to \$45 after copay
Lenses every 12 months		
Single	100% after copay	Up to \$30 after copay
Bi-Focal	100% after copay	Up to \$50 after copay
Tri-Focal	100% after copay	Up to \$65 after copay
Lenticular	100% after copay	Up to \$100 after copay
Frames once every 24 months	Up to \$120 after copay	Up to \$70 after copay
Contact Lenses in lieu of frames/ glasses every 12 months		
Visually necessary*	75% of U&C after copay	Up to \$210 after copay
Elective	Up to \$150 plus 15% discount off of cost of contact lens exam, fitting and evaluation	Up to \$105
*Visually necessary contacts require pre-approval from VSP		