

Frequently Asked Questions During Open Enrollment 2017

GENERAL INFORMATION

My address is incorrect on the Enrollment Forms, how can I change it?

The address that auto populates on the online enrollment form comes directly from our H.R. database. The address you see is the latest address that you have provided to Human Resources. If it is incorrect, you will need to fill out an electronic "Personnel Records Change Form" which is located in Document Center section of SharePoint under the "Online Forms" section. You will need to submit the electronic "Personnel Record Change Form" first before turning in your enrollment forms.

What if I submit the electronic Flexible Spending Account (FSA) Form and then decide I want to change the amounts on the form? Can I submit another form electronically?

You will only be able to submit the electronic FSA form once. If you change your mind before October 31, 2016, please contact Human Resources so we can give you a hard copy to make changes. For control measures, the system will not allow an employee to make multiple submissions.

Why can't I turn in the Medical/Dental Enrollment Form electronically since I am viewing it online?

Due to the requirements of our benefit administrator, SDRMA, Otay must submit hard copies of the Medical/Dental enrollment form for any changes that an employee makes. The advantage to viewing your enrollment form online is that your personal information will automatically populate and thus eliminate your need to enter information we already have on file for you. All you need to do is make any changes to your current plans elections, print and sign the Medical and Dental Enrollment Form and return it to Human Resources by October 31, 2016.

MEDICAL

Will medical plan premiums be changing in 2017?

There will be modest premium increases to the Gold and EPO medical plans and a decrease to the HMO plan.

Can I change medical plans?

Yes, you may change your medical plan to Gold, EPO or HMO. You and your covered dependent(s) are required to be on the same plan. Please note, Medicare-Eligible participants may only select the Gold Plan. The HMO plan is also not available to Medicare-Eligible or out-of-state participants; however, the HMO Plan does have a BlueCross BlueShield Association's Away from Home Care Program that is for students, long-term travelers, and families living apart. The Away from Home Care is available in most, but not all states. Participants are encouraged to call (800) 622-9402 to find out which states are part of the Away from Home Care program before selecting the HMO Plan. (Benefits from the Away from Home Care Plan may differ from the Access+ HMO 15 Plan.)

Frequently Asked Questions During Open Enrollment 2017

How can I verify that my existing providers are in the Blue Shield network?

All three SDRMA medical plans (Gold PPO, EPO, and HMO) have access to the Blue Shield network. To determine if your physicians are still in the network go to www.blueshieldca.com/csac and follow the prompts on how to “Find a Provider Now” or call (800) 642-6155.

Will I be receiving a new Blue Shield Medical ID Card?

You will be receiving a new Blue Shield ID Card ONLY if you are changing to a new plan. The new medical ID Cards will arrive to your home prior to January 1st.

If I join the Access + HMO 15 Plan, when do I select a new Primary Care Physician?

If you join the HMO Plan, you will need to select a Primary Care Physician when you turn in your enrollment form by going on the www.blueshieldca.com/csac website or by calling (800) 642-6155. Once you have confirmed that the doctor is in the Access + HMO 15 network, you will need to get your Primary Care Physician’s “Provider Number” (either through the 800 # or from the website) and indicate that number on the Enrollment Form. On the Enrollment Form, you will also need to indicate whether or not you are a prior patient of that Provider. If you are unsure which provider to select or you do not provide a Provider Number, Blue Shield will automatically assign a physician to you and it could take up to 30 days to change your provider.

Can I waive medical coverage for myself and my dependents?

Yes, subject to Plan provisions and District approval, you can request to waive coverage for yourself and/or your dependents, if you or your dependents have other coverage. If you elect to waive coverage for yourself, the District will reimburse you \$46.15 per-pay-period (\$1,200 annually), which will be treated as taxable income. Additionally, you must not use the waiver compensation to purchase an individual plan in the market place or a state exchange plan. There is no reimbursement for waiving coverage for your dependents. You must provide proof of other coverage.

DENTAL

Will dental premiums be changing in 2017?

No, there will not be any adjustments to the dental premiums.

How can I find a dentist that is in the network?

Log on to www.deltadentalins.com and click on “Find a Dentist” or call (800) 765-6003. With Delta Dental, you may choose to go to an in-network or out-of-network dentist. If you are online, select either the Delta Dental PPO plan or Delta Dental Premier plan for the most cost-savings. They both cover the same benefits allowances however, you will save more by going to a Delta PPO dentist. The next best option if you cannot find a PPO dentist is to select a dentist from their Premier Network. If you visit a Premier Dentist, you still will see a cost-savings because the dentist in that network will not bill you above their contracted fees, unlike the out-of-network dentists. As a third option, you can always choose to visit an out-of-network dentist. More detailed information on how to find a dentist are located in SharePoint.

Frequently Asked Questions During Open Enrollment 2017

How will I be billed for using an out-of-network dentist?

The plan gives you the choice of using a PPO or Non-PPO provider. Employees are encouraged to use PPO providers to take advantage of the additional benefits and discounts. The PPO network dentists accept reduced fees for covered services they provide you, so you'll usually pay the least when you visit a PPO network dentist. If you don't choose to visit a PPO dentist, you also have access to the Delta Dental Premier network. You'll usually pay more than if you visit a PPO dentist, but you'll still have cost protections that you don't get when you visit a non-Delta Dental dentist. Most non-Delta Dental dentists ask that you pay the entire cost up front and wait for reimbursement from Delta Dental. However, Delta Dental will only reimburse you for the usual and customary cost of the treatment/procedure which may sometimes be less than what the non-Delta Dental dentist charged you, since they are not contracted with Delta Dental and are not required to accept reduced fees for services.

Can I waive Dental coverage?

No. Employees cannot waive dental coverage for themselves. Employees are required to enroll on the dental plan however, you may waive dental coverage for your dependents. You will NOT need to submit proof of other dental coverage for dependents.

FLEXIBLE SPENDING ACCOUNT (FSA)

If I am currently on the FSA plan this year, do I need to re-enroll for 2017?

Yes, anyone who wishes to participate in the Flexible Spending Accounts (either Health Care or Dependent Care) must **RE-ENROLL** each year and submit a new enrollment form (even if you will be contributing the same amount each year).

How will I be reimbursed for my FSA claims?

All participants will be reimbursed via direct deposit to their bank accounts.

Can I view my FSA claims online?

Yes, if you wish to view your claims online, you will need to register and create an account if you have not done so. You can log on to www.takecarewageworks.com to click on the icon to create a new account or go directly to www.myflexonline.com.

Will the FSA Benefits Card be an option again this year?

Yes. The card works at eligible providers where most major credit cards are accepted and can be used whenever you incur a qualified Health Care or Dependent Care expense. Using your card for Dependent Care requires a few additional steps; please contact Wage Works for details. Always be prepared with an alternate form of payment as there are several IRS restrictions on where the Benefits Card can be used.

I currently have an FSA Benefits Card, Will I be able to continue to use the same Benefits Card in the new plan year?

Your current FSA Benefits Card will be reloaded each year with your new plan year election amounts and your card will be valid until the expiration date shown on the front of the card. If your card is expiring, Wageworks will be mailing you a new card before the beginning of the plan year with your new election amounts. You may order additional or replacement cards at no

Frequently Asked Questions During Open Enrollment 2017

charge by calling Wage Works at (800) 950-0105 after January 1st. There is no limit on how many additional cards you may order.

What is the carryover option?

In 2014 the U.S. Department of Treasury modified the “Use it or Lose it” provision which required any unused balance in a Healthcare FSA to be forfeited at the end of the plan year. With the carryover provision that has been implemented, you will be able to carryover up to \$500 of unused Healthcare FSA amounts into the next plan year. There is no carryover provision for Dependent Care accounts, however, there is a grace period for Dependent Care expenses to be incurred and eligible for reimbursement. Employees who have elected to join the Dependent Care FSA will have until March 15th of the following year to incur expenses.

What is the deadline to submit my reimbursement claims?

All Flexible Spending Account plan participants (for both Healthcare and Dependent Care) have until March 15th of the following plan year to submit claim forms for reimbursement. For example, for plan year 2016, you will have until March 15, 2017 to submit your claim forms.