2018

Employee Benefits Overview

WATER & POWER

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IBEW Only

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Medicare Part D Notice: If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a federal law gives you more choices about your prescription drug coverage. Please see the Annual Notices for more details.

KNOW YOUR BENEFITS.

At the Turlock Irrigation District (TID), we believe that you, our employees, are our most important asset. Helping you and your family achieve and maintain good health—physical, emotional and financial—is the reason TID offers you this benefits program. We are providing you with this overview to help you understand the benefits that are available to you and how to best use them. Please review it carefully and make sure to ask about any important issues that are not addressed here. A list of plan contacts is provided at the back of this summary.

While we've made every effort to make sure that this guide is comprehensive, it cannot provide a complete description of all benefit provisions. For more detailed information, please refer to your plan benefit booklets or summary plan descriptions (SPDs). In the event that information in this brochure differs from the SPD & Plan Documents, the SPD & Plan Documents will prevail.

The benefits in this summary are effective:

January 1, 2018 - December 31, 2018

Who Can You Cover?

WHO IS ELIGIBLE?

An **active, Regular Full-Time Employee** of TID who is classified as a full-time employee, Actively at Work (as defined in the SPD), and currently reported on the payroll.

Members of the Board of Directors of TID. Elected, or appointed, individuals actively serving on the TID Board of Directors who elects coverage.

You can enroll the following family members on our medical, dental and vision plans:

- Your Lawfully Married Spouse, or Qualified Domestic Partner.
- Your children **up to age 26**, including natural born children, stepchildren, children who are adopted by the Employee or placed with the Employee for adoption, or a child for whom Plan coverage is required because of a Qualified Medical Child Support Order.
- Your child **after age 26,** ONLY if they are incapacitated due to a disability and primarily dependent on you for support.

All employees adding or removing dependents must submit documentation to verify their dependent's eligibility for the plan, or Qualifying Life Event.

Please refer to the Summary Plan Description for complete details on how benefits eligibility is determined.

WHO IS NOT ELIGIBLE?

Family members who are not eligible for coverage include (but are not limited to):

- Parents, grandparents, and siblings.
- Any individual who is covered as an employee of TID cannot also be covered as a dependent.
- Employees that are not active, Regular Full-Time Employees of TID, seasonal employees**,** temporary employees, contract employees, or employees residing outside the United States.

Who Can You Cover, continued

WHEN CAN I ENROLL?

New employees of TID shall enroll in benefits within 31 days of their hire date. Elections may be made prior to new hire orientation. After orientation you may still make changes to your elections as long as they are made within 31 days of your hire date. If an employee fails to select a health plan during their New Enrollment Period, or fails to provide the information required to enroll in a health plan, the employee shall be enrolled by default in the PPO plan for Employee Only coverage.

Employees hired between the first and fifteenth day of a month shall be eligible for health insurance benefits on the first day of the first full calendar month following their first day of active service. Employees hired between the sixteenth and the last day of a month shall become eligible for health insurance benefits on the first day of the second full calendar month following their first day of active service.

Example:	**Hire Date**	**Benefits Begin**
	January 1-15	February 1
	January 16-31	March 1

Open Enrollment for current full-time employees is held in October. Open Enrollment is the one time each year that employees can make changes to their benefit elections without a qualifying life event. Changes made during Open Enrollment will have an effective date of January 1 of the following plan year.

Make sure to notify Human Resources right away if you do have a Qualifying Life Event and need to make a change (add or drop) to your coverage. These changes include (but are not limited to):

- Birth, or adoption, of a child
- Marriage
- Divorce
- Loss of other healthcare coverage
- Eligibility for new healthcare coverage

All Qualifying Life Event changes must be made within 31 days from the date of the event.

Where To Go For Care

Helping you and your family members stay healthy and making sure you use your benefits program to its best advantage is our goal in offering this program. Here are a few things to keep in mind.

GOING TO THE DOCTOR?

To get the most out of your doctor visit, being organized and having a plan helps. Bring the following with you:

- Your plan ID card
- A list of your current medications
- A list of what you want to talk about with your doctor

If you need a medication, you could save money by asking your doctor if there are generics or generic alternatives for your specific medication.

WHEN TO USE THE ER

The emergency room shouldn't be your first choice unless there's a true emergency—a serious or life threatening condition that requires immediate attention or treatment that is only available at a hospital.

WHEN TO USE URGENT CARE

Urgent care is for serious symptoms, pain, or conditions that require immediate medical attention but are not severe or life-threatening and do not require use of a hospital or ER. Urgent care conditions include, but are not limited to: earache, sore throat, rashes, sprains, flu, and fever up to 104°.

GET A VIDEO HOUSE CALL

Anthem members can video chat with a doctor from the comfort of their own homes, without an appointment. LiveHealth Online provides 24/7 access to U.S. board-certified physicians for the fraction of the cost of an office visit. Physicians can treat a host of common illnesses quickly and effectively through a real-time video visit. They can even send prescription orders to your local pharmacy. For more information, visit www.livehealthonline.com.

WHEN YOU NEED CARE NOW

What do you do when you need care right away, but it's not an emergency?

- Call Anthem's 24/7 NurseLine at 800-977-0027
- Find an urgent care center by visiting anthem.com/ca
- Use Anthem LiveHealth Online

WHAT YOU PAY FOR A VISIT TO AN IN-NETWORK FACILITY

Care Facility	PPO Cost	HDHP Cost[1]
Emergency Room	$150	20%
Walk-In Doctor's office	$25	20%
Urgent Care Center	$25	20%
LiveHealth Online	$25 [2]	$49

[1] HDHP coinsurance applied after annual deductible is met
[2] Not subject to deductible

Medical – Anthem Blue Cross

Medical coverage provides you with benefits that help keep you healthy like preventive care screenings and access to urgent care. It also provides important financial protection if you have a serious medical condition. TID provides you with comprehensive coverage through Anthem Blue Cross.

	Traditional PPO - Actives	
	In-Network	Out-Of-Network (Coinsurance % of UCR, PLUS anything over UCR)
Annual Deductible Individual Family	 $170 $650	 $170 (combined with in-network) $650 (combined with in-network)
Annual Out-of-Pocket Max Individual Family	 $1,615 $3,460	 $3,000 (combined with in-network) $6,000 (combined with in-network)
Lifetime Max	Unlimited	Unlimited
Office Visit Primary Provider Specialist	 $25 copay then plan pays 100% after deductible $25 copay then plan pays 100% after deductible	 $25 copay then plan pays 60% UCR after deductible $25 copay then plan pays 60% UCR after deductible
Telemedicine **LiveHealth Online**	$25 copay (deductible waived)	Not Covered
Preventive Services	Plan pays 100%	Plan pays 60% after deductible
Chiropractic Care	Plan pays up to $20 per visit (up to 3 visits per week and $800 per year)	Plan pays up to $20 per visit (up to 3 visits per week and $800 per year)
Lab and X-ray	20% up to $500/day; after $500 plan pays 100% after deductible	40% up to $500/day; after $500 plan pays 100% after deductible
Inpatient Hospitalization	$100 copay then plan pays 100% after deductible	$500 copay then plan pays 60% UCR after deductible
Outpatient Surgery	Hospital: $100 copay then plan pays 100% after deductible; Ambulatory Surgical Center: $50 copay then plan pays 100% after deductible	$500 copay then plan pays 60% UCR after deductible
Urgent Care	$25 copay then plan pays 100% after deductible	$25 copay then plan pays 60% UCR after deductible
Emergency Room	Emergency (No Admission): $150 copay then plan pays 100% after deductible; Emergency (With Admission): $100 copay then plan pays 100% after deductible; Non-Emergency (No Admission): $200 copay then plan pays 100% after deductible	Emergency (No Admission): $150 copay then plan pays 100% after deductible; Emergency (With Admission): $100 copay then plan pays 100% after deductible; Non-Emergency (No Admission): $500 copay then plan pays 60% after deductible

Medical – Anthem Blue Cross, continued

	High Deductible Health Plan (HDHP)	
	In-Network	**Out-Of-Network** (Coinsurance % of UCR, PLUS anything over UCR)
Annual Deductible Individual Family	 $2,000 $4,000	 $4,000 (combined with in-network) $8,000 (combined with in-network)
Annual Out-of-Pocket Max Individual Family	 $4,000 $8,000	 $8,000 (combined with in-network) $16,000 (combined with in-network)
Lifetime Max	Unlimited	Unlimited
Office Visit Primary Provider Specialist	 Plan pays 80% after deductible Plan pays 80% after deductible	 Plan pays 60% after deductible Plan pays 60% after deductible
Telemedicine **LiveHealth Online**	 Plan pays 80% after deductible	 Not Covered
Preventive Services	Plan pays 100%	Plan pays 60% after deductible
Chiropractic Care	Plan pays 80% after deductible	Plan pays 60% after deductible
Lab and X-ray	Plan pays 80% after deductible	Plan pays 60% after deductible
Inpatient Hospitalization	Plan pays 80% after deductible	Plan pays 60% after deductible
Outpatient Surgery	Plan pays 80% after deductible	Plan pays 60% after deductible
Urgent Care	Plan pays 80% after deductible	Plan pays 60% after deductible
Emergency Room	Plan pays 80% after deductible	Plan pays 80% after deductible; Non-Emergency (No Admission): Plan pays 60% after deductible

Prescription Drugs – Express Scripts

Prescription drug coverage provides a benefit that is important to your overall health, whether you need a prescription for a short-term health issue like bronchitis or an ongoing condition like high blood pressure.

If you enroll in medical coverage, you will automatically receive coverage for prescription drugs.

	Traditional PPO - Actives		High Deductible Health Plan (HDHP)	
	In-Network	Out-Of-Network	In-Network	Out-Of-Network
Prescription Drug Deductible	$0	$0	Combined with HDHP Medical Deductible	
Annual Out-of-Pocket Limit Individual Family	$4,985 $9,740		Combined with HDHP Medical Annual Out-of-Pocket Limits	
Pharmacy				
Generic	$10 copay then plan pays 100% (Mandatory Generic when available)	$10 (non-ESI pharmacy needs to pay in full and submit for reimbursement) copay then plan pays 100%	Plan pays 80% after deductible	Plan pays 80% after deductible
Preferred Brand	$30 copay then plan pays 100%	$30 copay then plan pays 100%	Plan pays 80% after deductible	Plan pays 80% after deductible
Non-preferred Brand	$60 copay then plan pays 100%	$60 copay then plan pays 100%	Plan pays 80% after deductible	Plan pays 80% after deductible
Supply Limit	30 days	30 days	30 days	30 days
Mail Order				
Generic	$20 copay then plan pays 100%	Not covered	Plan pays 80% after deductible	Plan pays 80% after deductible
Preferred Brand	$60 copay then plan pays 100%	Not covered	Plan pays 80% after deductible	Plan pays 80% after deductible
Non-preferred Brand	$120 copay then plan pays 100%	Not covered	Plan pays 80% after deductible	Plan pays 80% after deductible
Specialty Drug	20% up to $150 maximum	20% up to $150 maximum	N/A	N/A
Supply Limit	90 days	90 days	90 days	90 days

Mandatory Mail Order Starting January 1, 2018 For Traditional PPO Members

After three (3) 30-day supply fills of any medication, succeeding refills must be obtained through Express Scripts' mail order service. Otherwise, you will pay the full cost of the prescription if you choose to continue having your prescriptions filled at retail pharmacies.

Carrum Health

Carrum Health is a special surgery benefit that provides exclusive access to "Regional Centers of Excellence" with no additional cost to members. These hospitals and doctors provide for an improved patient experience and top-quality, more affordable care. Carrum's Care Concierge will help each patient by providing personalized support and guidance.

WHICH PROCEDURES ARE COVERED?

Eligible procedures include:

- Hip Replacement
- Knee Replacement
- Cervical Spinal Fusion
- Lumbar Spinal Fusion
- Coronary Bypass Surgery

HOW DO I QUALIFY FOR THESE SERVICES?

The following criteria must be met to qualify for the Carrum Health program:

- You have primary medical coverage through the District's health plan.
- You meet requirements of the hospital physician(s) considering your case. Additional diagnostic or medical services may be required.
- Your local physician agrees to assume care for you upon return home.
- You have an adult caregiver physically able to assist you during your care and travel, if travel is needed.

WHICH FACILITIES ARE CONSIDERED REGIONAL CENTERS OF EXCELLENCE?

Northern California: Stanford Health Care

Southern California: Scripps

WHO MANAGES MY TRAVEL?

Your personal Care Concierge will make all travel arrangements for you and one adult companion.

WHICH SERVICES AND EXPENSES ARE COVERED?

Coverage includes the following:

- All eligible medical expenses associated with your evaluation or procedure at the hospital.
- Travel expenses for you and one companion including transportation, lodging, and a daily allowance.
- Medically necessary services or equipment related to this program provided after discharge from the hospital before returning home (excluding outpatient medication).

WHICH TRAVEL EXPENSES ARE COVERED?

The following expenses are covered for you and one companion:

- Transportation – air, train, bus, rental car or mileage allowance (if driving your own car).
- Lodging – one hotel room to be shared by you and one adult companion.
- Meals – a daily allowance consistent with the company's travel policy.
- Parking and baggage fees – as appropriate.

HOW DO I PARTICIPATE IN THE PROGRAM?

If your doctor has recommended surgery, you can contact Carrum Health by visiting www.my.carrumhealth.com or calling 1-888-855-7806. A Care Concierge will be assigned to you and he/she will help verify your eligibility, assist you in selecting a hospital and doctor and begin coordinating the clinical visits and travel logistics, if necessary. Your Care Concierge will continue supporting you throughout the entire episode of care.

Vision - VSP

Routine vision exams are important, not only for correcting vision but because they can detect other serious health conditions.

We offer you a vision plan through Vision Service Plan.

	Base Plan	Buy-Up Plan
	With a VSP doctor	With a VSP doctor
Exam Copay	$0	$0
Materials Copay	$0	$0
Frames	$130 Retail Allowance	$180 Retail Allowance
Lenses		
Single Lenses	Covered in Full	Covered in Full
Bifocal Lenses	Covered in Full	Covered in Full
Trifocal Lenses	Covered in Full	Covered in Full
Contact Lenses		
Elective	$130 Retail Allowance	$180 Retail Allowance
Medically Necessary	Covered in Full	Covered in Full
Frequency		
Exam	12 months	12 months
Lenses	12 months	12 months
Contact Lenses[2]	12 months[1]	12 months[3]
Frames	12 months	12 months
Lens Options Tints/Photochromic Lenses	Not Covered	Covered

Out-Of-Network Allowances

Exam	Up to $45.00
Frame	Up to $70.00
Single vision lenses	Up to $30.00
Lined bifocal lenses	Up to $50.00
Lined trifocal lenses	Up to $65.00
Contacts, Medically Necessary	Up to $210.00

[1] Contact lenses are in lieu of lenses and frame.
[2] Fitting and evaluation-standard or premium fit not to exceed $60 copay, 15% discount for fitting and evaluation will apply.
[3] Contact lens rider allows for contacts every 12 months (50 copay), even if frames and lenses are also purchased every 12 months.

Dental – Delta Dental

Regular visits to your dentist can protect more than your smile; they can help protect your health. Recent studies have linked gum disease to damage elsewhere in the body and dentists are able to screen for oral symptoms of many other diseases including cancer, diabetes, and heart disease.

TID provides you with a comprehensive coverage through Delta Dental of California.

	Dental Base Plan	Dental Base Plus $1K Plan
Calendar Year Deductibles	$25 per person $50 per family	$25 per person $50 per family
Calendar Year Plan Maximums	PPO Dentists: $2,100 Non-PPO Dentists: $2,000	PPO Dentists: $3,100 Non-PPO Dentists: $3,000

Waiting Period	Basic Benefits	Major Benefits	Prosthodontics
	None	None	12 Months

Benefits and Covered Services	Delta Dental[1] PPO Dentists	Non-PPO[2] Dentists	Delta Dental[1] PPO Dentists	Non-PPO[2] Dentists
Diagnostic and Preventive (D&P) Exams, cleanings and x-rays	100%	100%	100%	100%
Basic Services Fillings, simple tooth extractions, sealants and night guards	80%	80%	80%	80%
Endodontics (root canals) Covered under basic services	80%	80%	80%	80%
Periodontics (gum treatment) Covered under basic services	80%	80%	80%	80%
Oral Surgery Covered under basic services	80%	80%	80%	80%
Major Services Crowns, inlays, onlays and cast restorations	50%	50%	60%	60%
Prosthodontics Bridges, dentures and implants	50%	50%	60%	60%

[1]Limitations or waiting periods may apply for some benefits, some services may be excluded from your plan. Reimbursement is based on Delta Dental maximum contract allowances and not necessarily each dentist's submitted fees.
[2]Reimbursement is based on PPO contracted fees for PPO dentists, Premier contracted fees for Premier dentists and program allowance for non-Delta Dental dentists.

Dental – Delta Dental, continued

Dental Base with Orthodontic Benefit Plan

Calendar Year Deductibles	$25 per person $50 per family			
Calendar Year Plan Maximums	PPO Dentists: $2,100 Non-PPO Dentists: $2,000			
Waiting Period	Basic Benefits None	Major Benefits None	Prosthodontics 12 months	Orthodontics None

Benefits and Covered Services	Delta Dental[1] PPO Dentists	Non-PPO[2] Dentists
Diagnostic and Preventive (D&P) Exams, cleanings and x-rays	100%	100%
Basic Services Fillings, simple tooth extractions, sealants and night guards	80%	80%
Endodontics (root canals) Covered under basic services	80%	80%
Periodontics (gum treatment) Covered under basic services	80%	80%
Oral Surgery Covered under basic services	80%	80%
Major Services Crowns, inlays, onlays and cast restorations	50%	50%
Prosthodontics Bridges, dentures and implants	50%	50%
Orthodontic Benefits Adults and Dependent Children	50%	50%
Orthodontic Maximum	$3,000 Lifetime	$3,000 Lifetime

[1]Limitations or waiting periods may apply for some benefits, some services may be excluded from your plan. Reimbursement is based on Delta Dental maximum contract allowances and not necessarily each dentist's submitted fees.
[2]Reimbursement is based on PPO contracted fees for PPO dentists, Premier contracted fees for Premier dentists and program allowance for non-Delta Dental dentists.

Life Insurance - Voya

If you have loved ones who depend on your income for support, having life and accidental death insurance can help protect your family's financial security.

LIFE AND AD&D

Basic Life Insurance pays your beneficiary a lump sum if you die. AD&D provides another layer of benefits to either you or your beneficiary if you suffer from loss of a limb, speech, sight, or hearing, or if you die in an accident. The cost of coverage is paid in full by the District.

Basic Life Amount	2 x covered annual earnings up to a maximum of $200,000
Basic AD&D Amount	2 x covered annual earnings up to a maximum of $200,000

VOLUNTARY LIFE

Voluntary Life Insurance allows you to purchase additional life insurance to protect your family's financial security.

Employee Voluntary Life Amount	Increments of $10,000 up to $500,000 Guarantee Issue Amount is $150,000
Spouse Voluntary Life Amount	Increments of $10,000 up to $100,000. Cannot exceed 100% of the Employee's Voluntary Life Amount. Guarantee Issue Amount is $30,000
Child(ren) Voluntary Life Amount	Increments of $2,500 up to $10,000 Guarantee Issue Amount is $10,000

VOLUNTARY AD&D

Voluntary AD&D Insurance allows you to purchase additional accidental death and dismemberment insurance to protect your family's financial security in case you suffer from loss of a limb, speech, sight or hearing or if you die in an accident.

Employee Voluntary AD&D Amount	Increments of $10,000 up to $500,000

Beneficiary Reminder: Make sure that you have named a beneficiary for your life insurance benefit. It's important to know that many states require that a spouse be named as the beneficiary, unless they sign a waiver.

Contact HR to get a Beneficiary Designation Form

Evidence of Insurability: Depending on the amount of coverage you select, you may need to submit an Evidence of Insurability form, which involves providing the insurance company with additional information about your health.

Taxes: Due to IRS regulations, a life insurance benefit of $50,000 or more is considered a taxable benefit. You will see the value of the benefit included in your taxable income on your paycheck and W-2.

Disability Insurance - Voya

If you become disabled and cannot work, your financial security may be at risk. Protecting your income stream can provide you and your family with peace of mind.

SHORT-TERM DISABILITY INSURANCE

Short-Term Disability coverage pays you a benefit if you temporarily can't work because of an injury, illness, or maternity leave. Benefits may be reduced by income from other income sources such as paid time off. Your doctor and the insurance company will work together to determine how long benefits are payable, based on your condition.

Weekly Benefit Amount	Plan pays 66.67% of covered weekly earnings
Maximum Weekly Benefit	$1,846
Benefits Begin After:	
Accident	59 days of disability
Sickness	59 days of disability
Maximum Payment Period*	18th week of disability

*Maximum payment period is based on the first day you are disabled, not when benefits begin.

LONG-TERM DISABILITY INSURANCE

Long-Term Disability coverage pays you a certain percentage of your income if you can't work because an injury or illness prevents you from performing any of your job functions over a long time. It's important to know that benefits are reduced by income from other benefits you might receive while disabled, like workers' compensation and Social Security.

If you qualify, long-term disability benefits begin after short-term disability benefits end.

Monthly Benefit Amount	Plan pays 66.67% of covered monthly earnings
Maximum Monthly Benefit	$8,000
Benefits Begin After:	
Accident	180 days of disability
Sickness	180 days of disability
Maximum Payment Period*	Social Security normal retirement age

*The age at which the disability begins may affect the duration of the benefits.

Accident & Critical Illness Plans - Voya

VOLUNTARY ACCIDENT INSURANCE

Accident insurance pays a specified amount for specific injuries resulting from a covered accident. Money can be used in any way you like, for example: deductibles, child care, prescription or utilities – any purpose that can help you meet personal, financial, or household needs.

If you are an employee who works **at least 20 hours per week**, you qualify for this insurance. There are no medical questions that need to be answered or medical tests you need to take to get coverage.

This is an optional benefit that you can purchase. Premium payments will be made through automatic deduction from your paycheck. This coverage is portable which means if you leave TID, you can maintain your coverage. If you choose to keep it, you will be billed directly by Voya.

Optional Riders:

Spouse Accident Rider	You may elect coverage for your spouse/domestic partner through age 69.
Children's Accident Rider	You may elect coverage for your child or children, up to age 26.

You must have coverage for yourself in order to select these riders.

Here are some of the covered services that must be related to a covered accident:

Surgery (open abdominal, thoracic)	$1,000
Hospital Admission	$900
Hospital Confinement per day up to 365	$225
Medical Equipment	$100
Burns, 2nd degree – at least 35% of the body	$750
Emergency Dental Work While Hospital Confined	Crown: $150 Extraction: $50
Shoulder Dislocation	$300 or $600
Fractured Ribs	$250 or $500

VOLUNTARY CRITICAL ILLNESS INSURANCE

Critical illness insurance pays a one-time, lump sum benefit amount upon the diagnosis of a covered disease or illness. You can use this money for any purpose you like, such as: to pay for expenses not covered by your Anthem plan, lost wages, child care, or any regular household expenses.

If you are an employee you works for **at least 30 hours a week**, you qualify for this insurance. There are no medical questions that need to be answered nor medical tests that need to be taken to get coverage.

Here are some of the covered illnesses:

- Heart Attack
- Stroke
- End Stage Renal (Kidney) Failure
- Major Organ Failure

Supporting documentation will be required in order for the benefits to be paid.

Optional Riders:

Wellness Benefit Rider	Covered employee will receive a single standard annual benefit of $100 for each covered employee & spouse who completes a health screening test.
Spouse Accident Rider	You may elect coverage for your spouse/domestic partner through age 69.
Children's Accident Rider	You may elect coverage for your child or children, up to age 26.

Employee Assistance Program

The MHN Employee Assistance Program (EAP) is designed to assist with short-term counseling needs, as well as tools to manage the challenges of everyday life. EAP offers quick and easy access to confidential, professional assistance and resources to assist employees in addressing difficulties related to emotional concerns, relationships, substance abuse, legal and financial concerns.

You and those family members living in your household are covered for up to **five (5)** face-to-face clinical counseling sessions per issue, per benefit year. If it is determined that more than ten sessions are needed for your specific situation, the EAP will help coordinate your needs under your medical plan.

Clinical Counseling

- Marriage, Family & Relationship Issues
- Stress & Anxiety
- Depression
- Grief & Loss
- Alcohol & Drug Dependency
- Domestic Violence

You are also entitled to thirty (30) minute phone consultation on a one-time per issue basis on work and life services such as:

- Childcare and Eldercare Assistance
- Financial Issues
- Federal Tax Assistance
- Pre-retirement planning
- Organizing Life's Affairs
- Concierge Services
- Legal Services
- Identity Theft

All services are confidential and in accordance with professional ethics and federal and state laws.

Online Member Services

Access EAP information and tools online. With a click of a mouse you can:

- Search for an MHN counselor and get a referral
- Manage stress with interactive tools
- Take a health risk assessment
- Ask an expert an emotional health question

IF YOU NEED HELP, CALL TOLL-FREE
24 HOURS A DAY, 7 DAYS A WEEK:

(800) 242-6220

or visit members.mhn.com
and register with the access code: TID

Flexible Spending Accounts - BCC

Starting January 1, 2018, TID's Flexible Spending Accounts will administered by **Benefit Coordinators Corporation (BCC).**

Flexible Spending Accounts (FSA) are a great way to save money over the course of the year. These accounts allow you to redirect a portion of your salary on a pre-tax basis into reimbursement accounts. Pre-tax means the dollars you use for eligible expenses are not subject to federal income tax and, in most cases, state and local taxes.

When you enroll, you decide how much money to contribute to your personal accounts for the coming year. These contributions are gradually deducted from your paychecks throughout the course of the year and deposited into the appropriate account. The tax-free money that you set aside is then used to pay for qualified expenses.

The FSA plan year is based on calendar year from January 1 to December 31.

For reimbursement, eligible expenses must have been incurred during the plan year. It is important to remember that **funds left in the account at the end of the plan year may be utilized under the grace period.** The grace period begins the first day of the next plan year and ends 2 months and 15 days later. Any funds that are not applied to pay expenses by the 91st day following the end of the plan year will be forfeited. This is referred to as the **Use It or Lose It Rule**. Participants have 90 days after the end of every plan year to submit claims for expenses incurred. Participants should submit claims for eligible expenses to BCC no later than March 31st of the following year for timely reimbursement. ***Please note that if you enroll in the High Deductible Health Plan, you cannot enroll in FSA. You still may enroll in the Dependent Care Spending Account.***

Healthcare Reimbursement

This account allows you to use pre-tax dollars for healthcare expenses that are not reimbursed under your family's healthcare plans. The maximum amount you may contribute to a Healthcare Spending Account for the Plan Year is $2,600.

Dependent Care Spending Account

This account allows you to use pre-tax dollars for **daycare expenses** for your child(ren) or other qualifying dependents.

The maximum amounts you may contribute to a Dependent Care Spending Account per IRS are:

- $5,000 per year, if you are married and filing a joint return, or if you are a single parent
- $2,500 per year, if you are married and filing separately

Pre-funding is not available for this account. Reimbursement of eligible expenses is provided as funds are accrued.

Eligible Dependents for the Dependent Care Spending Account Include:

- Children under the age of 13 who qualify as dependents on your federal tax return; and
- Children or other dependents of any age who are physically or mentally unable to care for themselves and who qualify as dependents on your federal tax return.

Both the Health Care Spending Account and the Dependent Care Spending Account are annual benefit plans that you must enroll in each year you wish to participate.

Flexible Spending Accounts – BCC

DEBIT CARD

Aside from using your BCC debit card, there are two ways you can manually submit claims for reimbursement:

MY SMARTCARE MOBILE APP:

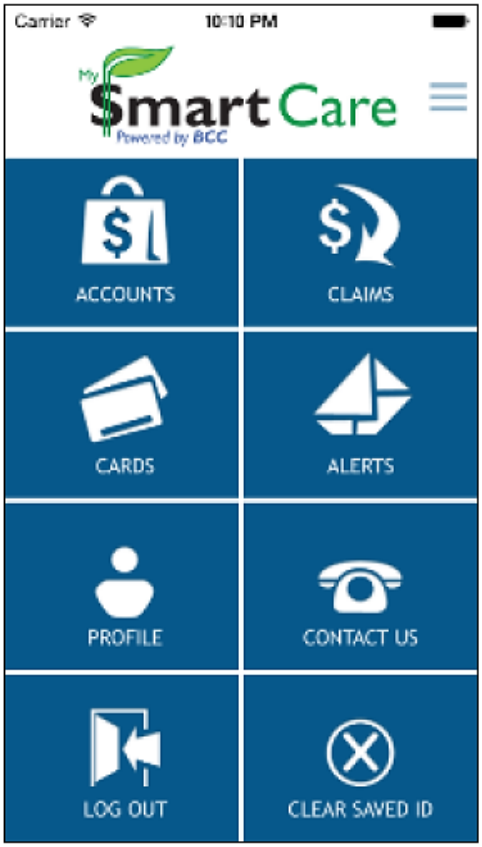
The My SmartCare mobile app and online portal allow you to freely and securely access your BCC Reimbursement Accounts 24/7. Participants use the same user name and password to log into both the app and the online portal. Here's how it all works:

Download

1. Open the app store from your iOS or Android powered device.
2. Search "BCCSmartCare".
3. Install the free app to your device.

Launch

1. Open the app on your device.
2. Sign in using your existing My SmartCare login and password OR click "Register" if you are a new user.
3. You have the option to save your User ID to your mobile device by choosing 'ON' next to "Save this Online ID". This will allow you to bypass the secure sign in process each time you log in after you verify your identity during the initial login.



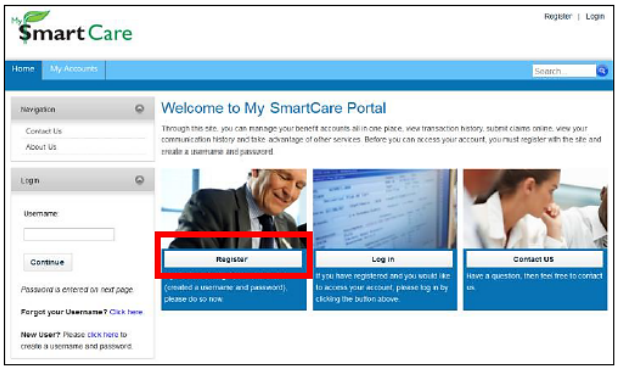
New Users

- When registering as a new user, MySmartCare will walk you through a series of registration questions followed by a secure authentication process to validate you as a user.
- Each time you log in with a new device, you will complete the secure authentication process.
- Be sure to use your Social Security Number as your Employee ID and your FSA debit card number as your Registration ID when registering.
- By registering your e-mail address, you will receive important push notifications regarding your account balance, grace period or year-end reminders, notice of debit card mailed, etc.

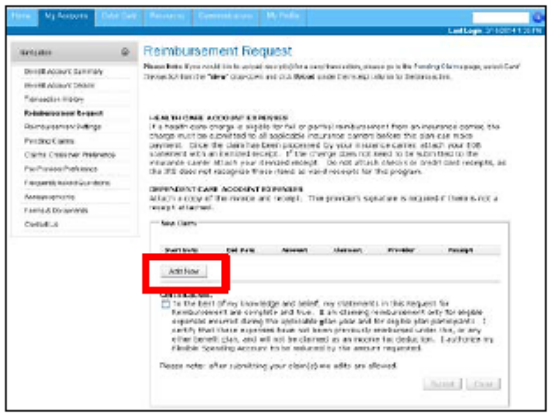
Flexible Spending Accounts – BCC

MY SMARTCARE ONLINE PORTAL

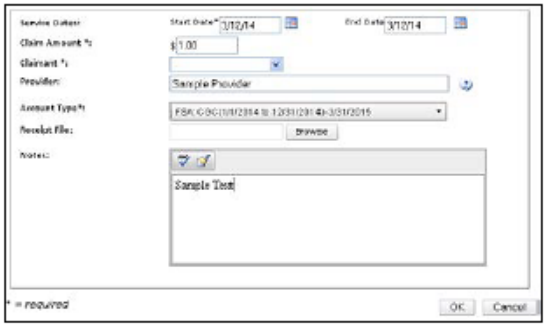
- Log on to https://www.mywealthcareonline.com/bccsmartcare/
- Sign in using your existing MySmartCare log in and password OR click "Register" if you are a new user.
- You have the option to save your User ID to your mobile device by choosing 'ON' next to "Save this Online ID". This will allow you to bypass the secure sign in process each time you log in after you verify your identity during the initial login.



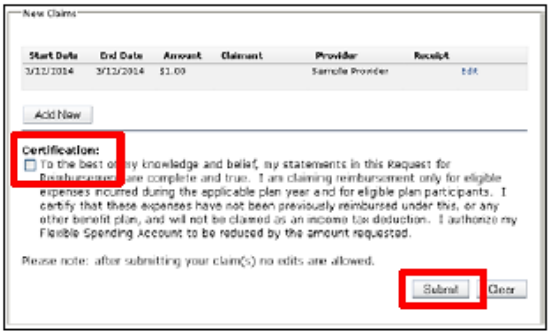
- Once logged in to My SmartCare Portal, click on 'Reimbursement Request' in the left Navigation menu.
- In the 'New Claims' box, click 'Add New' and a new screen will appear.



- Fill out all required fields (marked with *).
- Upload a receipt file by clicking 'Browse' and choosing the pdf or the image of your claim substantiation. *You can upload one receipt file per claim.*
- Click 'OK' when form is complete.



- When finished adding new claims, read the Certification message and click the acknowledgement box that you agree with the statement.
- Click the 'Submit' button to submit all claims.



A 'Thank You' screen will appear once the claim has been successfully submitted to BCC.

Flexible Spending Accounts – BCC

IMPORTANT DATES TO REMEMBER

With the transition of our FSA administration (medical & dependent care) to SmartCare (BCC) effective January 1, 2018, **please be advised that BCC will still be administering Run-Out* claims and a grace period* from plan year 2017.**

- Grace Period—A period of up to 74 days (until March 15th, 2018) during which time participants may incur expenses during the prior plan year and be reimbursed with the prior plan year with the prior plan year pre-tax dollars.
- Run Out—A period of up to 3 months (until March 30th, 2018) during which time participants may submit claims for expenses incurred during the prior plan year and be reimbursed with the prior plan year pre-tax dollars.

To ensure a smooth transition to BCC, you need to be aware of important deadlines in terms of claim submissions and expenses incurred to EBS.

DEADLINE	HOW IT AFFECTS YOU	WHAT YOU NEED TO DO
December 31, 2017	Last day to use your EBS debit card	Plan accordingly! Starting January 1, 2018, claims incurred using remaining funds from 2017 will need to be submitted to BCC via My SmartCare mobile app or portal.
January 1, 2018	BCC's Mastercard/Visa debit card will be available for use	Start using your BCC debit card for your eligible medical & dependent care expenses. You may disregard your old EBS debit card.
March 15, 2018	Last day to submit 2017 plan year claims or receipts to BCC (Grace Period)	Submit any remaining claims or receipts to BCC.

Health Savings Account

What is a Health Savings Account (HSA)?

A Health Savings Account (HSA) is a special "tax-advantaged" account owned by an individual used to pay for current and future "Qualified Medical Expenses." It must be used in conjunction with a High Deductible Health Plan, such as the High Deductible PPO plan offered by the District through Delta Health Systems.

How does an HSA work?

- Money goes into the account pre-tax and comes out "tax-free" for qualified medical expenses. This can be made from pre-tax deductions from your paycheck. You may also make post-tax contributions directly into the account and take the deduction when you file your taxes.
- Unused money in the account continues to roll over year after year and can earn interest—unlike the "use it or lose it" rule that the Flexible Spending Accounts must abide by.
- Upon turning age 65, the individual can use any unused funds in the account for any purpose, penalty free, but subject to ordinary income tax.
- HSAs encourage individuals to take a more proactive approach to their own healthcare, by learning to make informed choices about their health care.

What is a High Deductible Health Plan (HDHP)?

An HDHP is insurance wherein, except for preventive care, you must reach your deductible before benefits start paying out. Once you meet the deductible, however, you may see very little out of pocket, depending on your plan.

What happens to my Health Savings Account if I leave or change plans?

You will not lose your account. If you change jobs to another company and enroll in another HDHP, you may roll over your money from one account to another. If you are unable to enroll in another HDHP, you may not make any contributions but you can spend it down or leave it to earn interest.

Who is eligible for an HSA?

Any individual who meets the following qualifications:

- Is covered by a High Deductible Health Plan
- Is not covered by other health insurance (dental, vision, EAP, or Long Term Care are allowed)
- Is not participating in the Medical Spending portion of a Flexible Spending Account
- Is not enrolled in Medicare
- Cannot be claimed as a dependent on someone else's tax return
- Children cannot establish their own HSAs
- Spouses can establish their own HSAs, if eligible, but contribution limits are applicable

How much can I contribute to my account?

This plan is regulated by the IRS. The maximum amount that may be contributed (and deducted) to the account from all sources in 2017 is $3,400 for individual coverage and $6,750 for family coverage. In 2018, the maximums will be $3,450 for individual and $6,900 for family. Contributions in excess of the contribution limits must be withdrawn by the individual or will be subject to ordinary income tax.

TotalWorks: Your Online Benefits Website

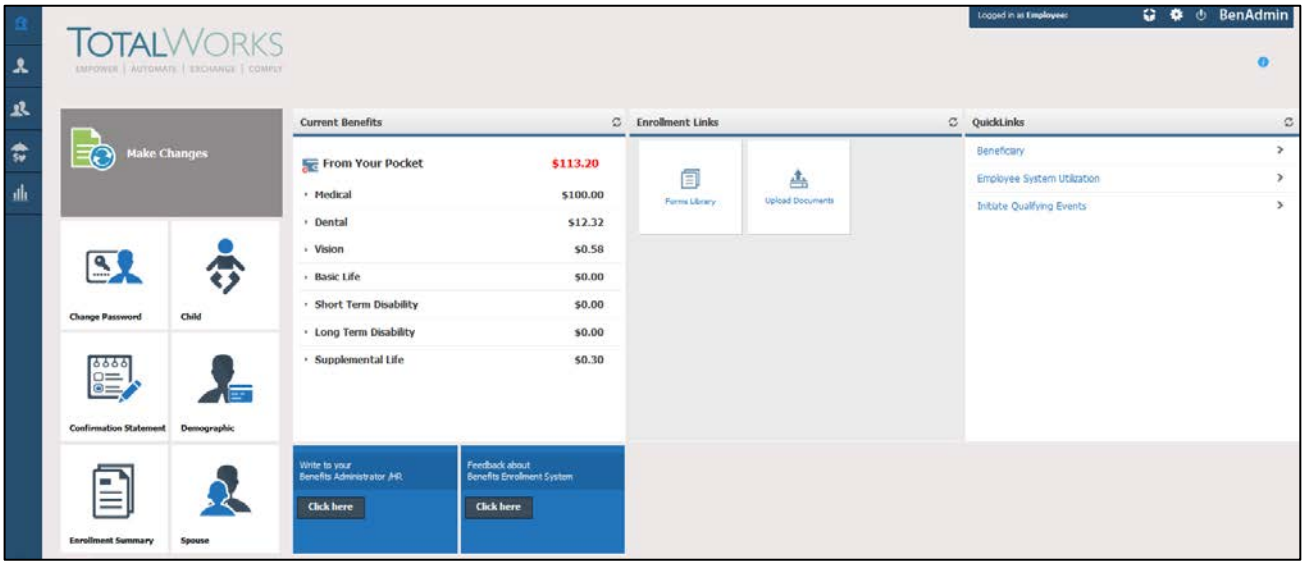
ENROLLING IN YOUR BENEFITS

NOTE: THIS PAGE IS ONLY VISIBLE TO NEW HIRES AND DURING OPEN ENROLLMENT

You will receive an e-mail from BenXcel or a communication from the TID Benefits Team prior to your first sign on that will provide you with information on your user name and initial password into BenXcel. Use this information to log into BenXcel:

1. To log into BenXcel, go to: https://benxcel.net
2. Your username will be the first letter of your first name, your entire last name, and last 4 digits of your Social Security Number
3. Enter "TID" as your Company Name
4. Click the Sign In button to enter the system.
5. If you are logging in for the first time, you will be asked to change your password.

The enrollment "Tunnel" is a series of screens where you can choose which benefit plans and coverage tiers you want. On each screen, select the plan you want by clicking on the radio button next to it. Bi-weekly premiums (amounts taken out of your paycheck) will be shown on each plan selected. Then, check boxes to include any eligible dependents. If you don't wish to enroll in a benefit, click the Waive enrollment box. When finished, click "Save & Continue" to move to the next screen.



You can find details of the plans by clicking the "Forms Library" tab at the top right of the enrollment screens. There are quite a few screens to go through. Please allow ample time to complete.

IMPORTANT: Selections you make will NOT be saved until you click Finish on your confirmation statement.

TotalWorks, continued

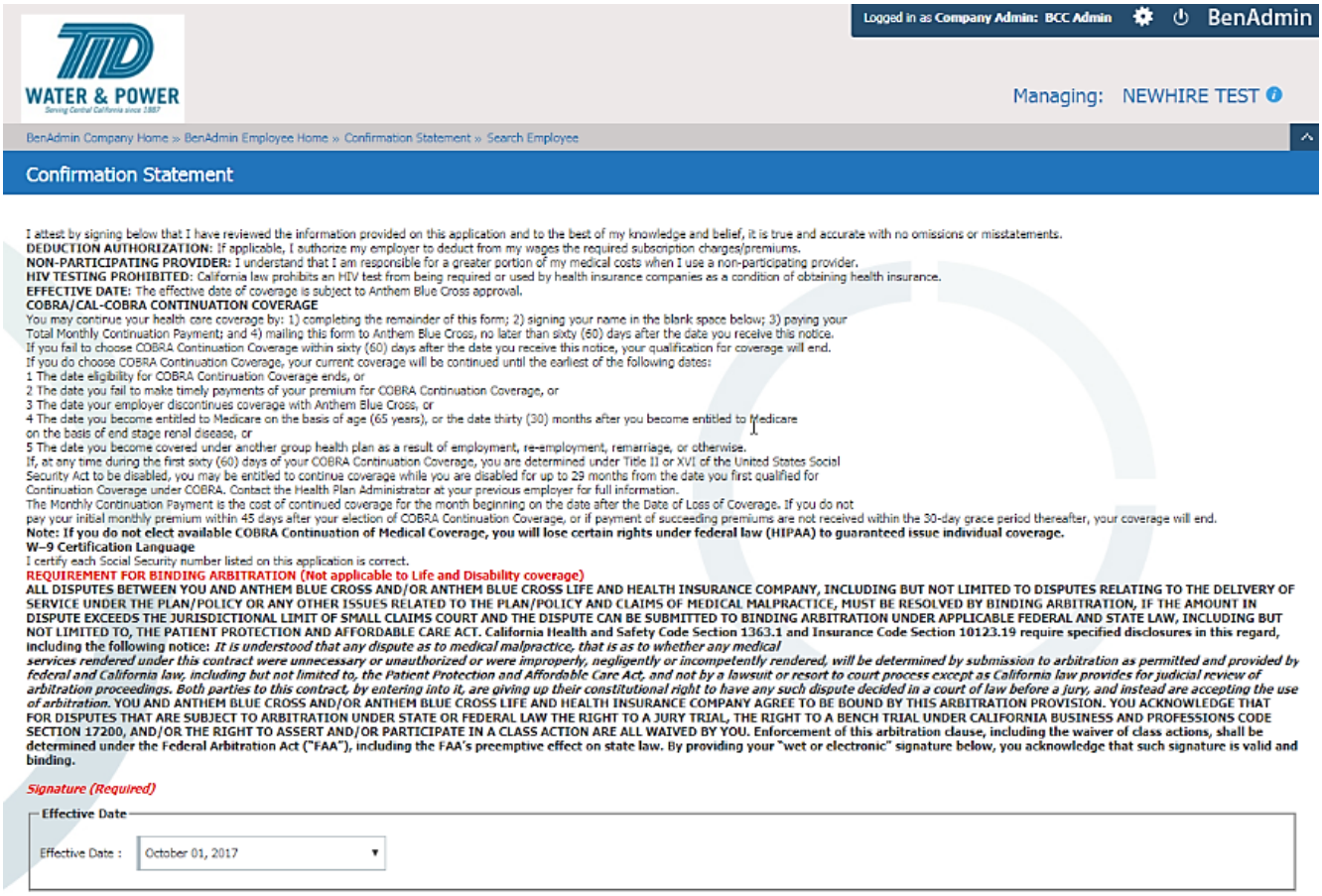
ENROLLING IN YOUR BENEFITS— CONFIRMATION STATEMENT

On the Confirmation Statement page, review your demographic information and your plan elections.

At the bottom of the page click "Finish" to complete your election and enrollment process.

Please Note: You will only be able to enroll in benefit plans during "Open Enrollment" or as a "New Hire" unless you have a "Qualifying Life Event" (like childbirth or marriage). The system will indicate that you are not eligible for any benefits outside of these events.

NOTE: YOU MUST CLICK "FINISH" TO COMPLETE YOUR REGISTRATION AND/OR ENROLLMENT.



TROUBLESHOOTING AND HELP

Some of the more common problems you may run into are web-browser-related. Internet Explorer (IE), Firefox, Safari, and Chrome all display websites in slightly different ways. We recommend Internet Explorer 7 or higher for the best user experience. If you are having problems with buttons, dropdown menus, or other functions, try it in Google Chrome. Another helpful tip: use the blue "back" buttons on each page to go back to the previous screen instead of clicking "back" in your browser.

If you are still having problems, or have any other questions or concerns, please contact the BCC Customer Service Call Center at **(800) 685-6100.** Representatives are available Monday -Thursday: 5:00am - 5:00pm PT & Friday: 5:00am - 3:00pm PT.

Meet Ben-IQ

Ben-IQ is a free app that includes much of the information that's included in this overview, but in a place that's always at your fingertips — your smartphone. Ben-IQ is available for Android and iPhone.

GETTING STARTED WITH BEN-IQ

1. Download and launch the app.
2. Enter your assigned username: **Turlock Irrigation District**
3. Read and agree to the Terms and Conditions.

TAKE ADVANTAGE OF:

BENEFIT INFO

Access to health plan highlights

FIND CONTACTS

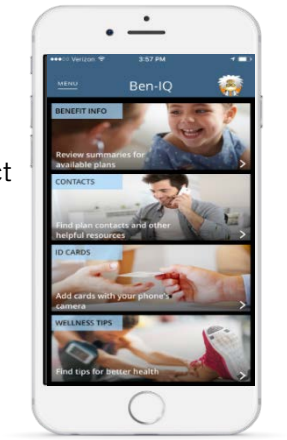
Find nurse line and other important contact numbers

ACCESS ID CARDS

Store and organize plan ID cards

WELLNESS TIPS

Wellness program information and tips



COST OF CARE

Find out how much care should cost

MESSAGES

Receive important messages from your HR/benefits team

VIDEOS

Learn more about plan benefits with access to online videos

FAQ

Access answers to frequently asked benefits questions

Take a tour of Ben-IQ and review plan summaries and important contacts numbers. Store and organize ID cards using your phone's camera, and much more! Be sure to share Ben-IQ with your covered family members too.

Key Contacts At A Glance

DELTA HEALTH SYSTEMS

(Third Party Administrator of our Medical Plan)

· Use this website to look up Medical Benefits and Claims. · The claims processed (copies of your Explanation of Benefits (EOB's) · You must register yourself before viewing EOBs. · All dependents will need a separate log-in.	www.deltahealthsystems.com (800) 422-6099

ANTHEM BLUE CROSS

(Insurance Provider Network)

· To find a doctor or a medical facility click · "Find A Doctor" (under Useful Tools) · What are you looking for? · About the Provider: Name or Specialty · Where are you looking? · What insurance plan would you like to use? · *It is asking for the Anthem Blue Cross ID# on your Medical Card* · Select 'I have an insurance card'; use the first 3 letters of your member ID: **DLU**	www.anthem.com/ca

LIVEHEALTH ONLINE

Quick and easy access to a board-certified doctor in minutes just by using your smartphone, tablet or computer with a webcam.	www.livehealthonline.com

EXPRESS SCRIPTS

(Pharmacy Benefit Manager)

· View prescription history. · See how much prescriptions will cost. · Various other online tools available. You must register before viewing information online.	www.expressscripts.com Customer Help Desk (877)554-3091 Pharmacy Help Desk (800)922-1557

Key Contacts At A Glance

DELTA DENTAL

(Administrator of our Dental Plan)

· Search for a dentist in the PPO Network · Use this website to look up Dental Benefits and Claims · The claims processed (copies of your EOB's) · You must register yourself before viewing EOB's	www.deltadentalins.com (800) 765-6003

SMARTCARE

BCC (Benefit Coordinators Corporation)

(Flexible Spending Account)

· View your annual election, contributions and expenses incurred · Log in to get forms to submit claims for medical expenses and dependent care (day care) expenses	https://www.mywealthcareonline.com/bccsmartcare/ (800) 685-6100

VOYA LIFE AND DISABILITY

(Administrator of Group Life Insurance and Disability Plans)

· Filing a disability claim · Use this website below to submit a Medical History Statement during the annual open enrollment for election of Optional Life.	Contact HR for questions regarding Life, Disability, and Compass Plans

VISION SERVICE PLAN (VSP)

· Inquire about benefits, eligibility or claims · Locate a VSP Network provider	vsp.com Member Services: 800.877.7195

TID BENEFITS TEAM

Andrew Guzman: (209) 883-8256

Grace Garrison: (209) 883-8326

BenefitsTeam@tid.org

Frequently Asked Questions

Q. Do we now have Anthem Blue Cross insurance?

A. No, we don't have Anthem Blue Cross "insurance".

We still use Delta Health Systems to administer our Medical Plan and we utilize the Anthem Blue Cross Network of Providers and Utilization Management.

Q. How long can my children stay on the benefit plans?

A. Your eligible dependent child(ren) may remain on the benefit plans until last day of the month in which they turn 26. Your child may remain on the benefit plans after the age 26 only if they are incapacitated due to a disability and primarily dependent on you for support.

It is the responsibility of both the employee and/or the Adult Child to notify Human Resources if there has been an eligibility change to avoid any fraudulent charges or adverse benefit determinations.

Coverage is **not** available for your:

- adult child's spouse
- adult child's children (i.e., employee's grandchildren)

Q. At what point is it appropriate to ask for a second opinion and for what type of procedures?

A. There is no clear guideline of requiring a second opinion. Second opinions are covered at the same benefit allowable amounts. Call the network provider telephone # and request an appointment. Under our health plan there is no pre-authorization required for a consultation.

Q. When a member goes to a specialist, why does the specialist ask who is referring the patient?

A. Depending on the provider's office, this may be a requirement for other insurances, not TID's policy. TID's PPO Network does not mandate a primary care physician referral.

Q. How do you get a replacement health I.D. card for yourself or a dependent?

A. Log in to your account at Delta Health Systems www.deltahealthsystems.com and on the member profile, submit a request for a new health I.D. card(s).

Q. What is the Annual Medical Deductible for the PPO plan and when is it applied?

A. For the PPO Plan, the Annual Medical Deductible is $170 per person and $650 for your family. It is applied when the claim is paid, not when the service is incurred.

Q. What is the Annual Medical Deductible for the HDHP plan and when is it applied?

A. The individual deductible is $2,000 (in-network) and $4,000 (out-of-network). The Family deductible is $4,000 (in-network) and $8,000 (out-of-network). There is no per person deductible under the Family coverage.

Q. I was told at the pharmacy that the prescription is not covered by our pharmacy benefits, what do I do?

A. Ask your pharmacist the explanation of why and/or contact Express Scripts Customer Service at (877) 554-3091 for a more complete explanation.

Q. Is there benefit coverage for a nutritionist?

A. Nutritional Counseling may be covered when supervised by a physician for a pre-diabetic or diabetic condition. No nutritional program is allowed whose primary purpose is weight reduction, regardless of the diagnosis of diabetes.

Frequently Asked Questions, continued

Q. What does not count towards the annual out of pocket maximum for the PPO Plan?

A. The Out-of-Pocket Maximum does not apply to, or include, charges in excess of the Usual, Customary and Reasonable charges, or expenses which become the Covered Person's responsibility for failure to comply with the requirements of the Utilization Management program.

Q. EBS has mailed me a "Request for Substantiation Documentation," what do I do?

A. Substantiation of FSA reimbursements is a requirement for all Plan Participants. **Substantiation is not optional**. To substantiate your transactions you will need to send EBS an Explanation of Benefits, or an itemized receipt. You can upload your receipts by logging in to EBS' FSA user administration website (http://ebsbenefits.Lh1ondemand.com) or by faxing your information to the number provided in your letter.

Key Terms

MEDICAL/GENERAL TERMS

Allowable Charge - The most that an in-network provider can charge you for an office visit or service.

Balance Billing - Non-network providers are allowed to charge you more than the plan's allowable charge. This is called Balance Billing.

Coinsurance - The cost share between you and the insurance company. Coinsurance is always a percentage totaling 100%. For example, if the plan pays 70%, you are responsible for paying the remaining 30% of the cost.

Copay - The fee you pay to a provider at the time of service.

Deductible - The amount you have to pay out-of-pocket for expenses before the insurance company will cover any benefit costs for the year (except for preventive care and other services where the deductible is waived).

Explanation of Benefits (EOB) - The statement you receive from the insurance carrier that explains how much the provider billed, how much the plan paid (if any) and how much you owe (if any). In general, you should not pay a bill from your provider until you have received and reviewed your EOB (except for copays).

Family Deductible - The maximum dollar amount any one family will pay out in individual deductibles in a year. IMPORTANT: If you enroll for family coverage on the HDHP plan, one or more family members will need to meet the deductible.

Individual Deductible - The dollar amount a member must pay each year before the plan will pay benefits for covered services. Important: If you enroll for family coverage on the HDHP plan, the individual deductible does not apply.

In-Network - Services received from providers (doctors, hospitals, etc.) who are a part of your health plan's network. In-network services generally cost you less than out-of-network services.

Out-of-Network - Services received from providers (doctors, hospitals, etc.) who are not a part of your health plan's network. Out-of-network services generally cost you more than in-network services.

Out-of-Pocket - Healthcare costs you pay using your own money, whether from your bank account, credit card, Health Savings Account (HSA) or Flexible Spending Account (FSA).

Out-of-Pocket Maximum – The most you would pay out-of-pocket for covered services in a year. Once you reach your out-of-pocket maximum, the plan covers 100% of eligible expenses.

Preventive Care – A routine exam, usually yearly, that may include a physical exam, immunizations and tests for certain health conditions.

PRESCRIPTION DRUG TERMS

Brand Name Drug - A drug sold under its trademarked name. A generic version of the drug may be available.

Generic Drug – A drug that has the same active ingredients as a brand name drug, but is sold under a different name. Generics only become available after the patent expires on a brand name drug. For example, Tylenol is a brand name pain reliever commonly sold under its generic name, Acetaminophen.

Dispense as Written (DAW) - A prescription that does not allow for substitution of an equivalent generic or similar brand drug.

Maintenance Medications - Medications taken on a regular basis for an ongoing condition such as high cholesterol, high blood pressure, asthma, etc. Oral contraceptives are also considered a maintenance medication.

Non-Preferred Brand Drug - A brand name drug for which alternatives are available from either the plan's preferred brand drug or generic drug list. There is generally a higher copayment for a non-preferred brand drug.

Preferred Brand Drug - A brand name drug that the plan has selected for its preferred drug list. Preferred drugs are generally chosen based on a combination of clinical effectiveness and cost.

Prior Authorization - Program that monitors certain prescription drugs and their costs to get you the medication you require while monitoring your safety and reducing costs. This program makes sure you are getting a prescription that is suitable for the intended use and covered by your pharmacy benefit.

Quantity Management - Program in your pharmacy benefit that's designed to make the use of prescription drugs safer and more affordable. It provides the medication you need for your good health and the health of your family, while making sure you receive them in the amount — or quantity — considered safe.

Specialty Pharmacy - Provides special drugs for complex conditions such as multiple sclerosis, cancer and HIV/AIDS.

DENTAL TERMS

Basic Services - Generally include coverage for fillings and oral surgery.

Diagnostic and Preventive Services - Generally include routine cleanings, oral exams, x-rays, sealants and fluoride treatments. Most plans limit preventive exams and cleanings to two times a year.

Endodontics - Commonly known as root canal therapy.

Implants - An artificial tooth root that is surgically placed into your jaw to hold a replacement tooth or bridge. Many dental plans do not cover implants.

Major Services - Generally include restorative dental work such as crowns, bridges, dentures, inlays and onlays.

Orthodontia - Some dental plans offer Orthodontia services for children (and sometimes adults too) to treat alignment of the teeth. Orthodontia services are typically limited to a lifetime maximum.

Periodontics - Diagnosis and treatment of gum disease.

Pre-Treatment Estimate - An estimate of how much the plan will pay for treatment. A pre-treatment estimate is not a guarantee of payment.

9.1.2017