Hello!

Welcome to the San Diego Unified School District 2020 Retiree Benefits Program!

We know your benefits are important to you and your entire family, and we are proud to offer a generous and comprehensive benefits package to eligible retirees and their eligible dependents. This is why we developed a benefits program that will meet the broad needs of our retirees and their families. The programs referenced in this booklet are meant to keep you healthy and productive, while also giving you options to plan for and protect yourself in the future.

The ever-changing world of health care has become increasingly complex. Our goal in providing this Benefit Information Guide for retiree health is to help you better understand the plans and programs that you and your family will be enrolled in for the plan year, while easily navigating the health care landscape. To get the most out of your retiree health benefits program, we encourage you to review this booklet in its entirety.

Enclosed you will find:

- Who is eligible to participate
- How to enroll and how to make changes during the year, if applicable
- Each benefit and a summary of what is covered under the plan
- The Insurance Companies who administer our benefits and how to contact them if you need assistance

Offering competitive and cost effective benefits to San Diego Unified School District’s retirees is important. It is a way for us to say “thank you” for contributing to the underlying success of the district.

If you have any questions about the retiree health benefits described herein or would like more information, please refer to your plan documents and insurance booklets or contact the District’s Employee Benefits Department.

Sincerely

San Diego Unified School District

We’re here to help!

If you have any questions at all, please contact the District’s Employee Benefits Department.

Phone: 619-725-8130
Email: employeebenefits@sandi.net
Getting Started

Benefits Bird’s Eye View 4
Before You Retire Checklist 5
Eligibility & Enrollment 6

Your Health

Medical 12
Prescription Drug Coverage 16
Dental Plan 27
Vision Plan 29

Life & AD&D

Basic Life and AD&D 31
Voluntary Supplemental Life and AD&D 32

Work/Life

Flexible Spending Accounts (FSA) 33
Employee Assistance Program (EAP) 34
Retirement Program 35

Required Notices

Directory & Resources 36
Plan Guidelines and Evidence of Coverage 37
Medicare Part D Notice 38
Legal Information Regarding Your Plans 40
Premium Assistance Under Medicaid and the Children’s Health Insurance Program (CHIP) 44
## Benefits Bird’s Eye View

At San Diego Unified School District, we offer a range of options to fit your lifestyle.

<table>
<thead>
<tr>
<th>Benefits</th>
<th>Plan Options</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Medical for those (under age 65) and not in Medicare</strong></td>
<td>• Kaiser HMO</td>
</tr>
<tr>
<td></td>
<td>• UHC Performance HMO Network 1</td>
</tr>
<tr>
<td></td>
<td>• UHC Performance HMO Network 2</td>
</tr>
<tr>
<td></td>
<td>• UHC Signature Value Alliance HMO $1800 HRA</td>
</tr>
<tr>
<td></td>
<td>• UMR NexusACO Select Plus PPO</td>
</tr>
<tr>
<td></td>
<td>• UHC Journey Harmony HMO with HealthInvest HRA <em>New option for 2020</em></td>
</tr>
<tr>
<td><strong>Medical (for those with Medicare Parts A &amp; B)</strong></td>
<td>• Kaiser Senior Advantage HMO</td>
</tr>
<tr>
<td></td>
<td>• UHC Medicare Advantage HMO</td>
</tr>
<tr>
<td></td>
<td>• UHC Medicare Advantage PPO</td>
</tr>
<tr>
<td><strong>Dental</strong></td>
<td>• Delta Dental PPO (DPO)</td>
</tr>
<tr>
<td></td>
<td>• DeltaCare USA DHMO</td>
</tr>
<tr>
<td></td>
<td>• Western Dental DHMO</td>
</tr>
<tr>
<td><strong>Vision</strong></td>
<td>• Vision Service Plan PPO</td>
</tr>
<tr>
<td><strong>Life &amp; AD&amp;D</strong></td>
<td>• The Hartford Basic Life and AD&amp;D</td>
</tr>
<tr>
<td></td>
<td>• The Hartford Supplemental Life and AD&amp;D</td>
</tr>
<tr>
<td><strong>Additional Benefits</strong></td>
<td>• Flexible Spending Accounts</td>
</tr>
<tr>
<td></td>
<td>• Employee Assistance Program</td>
</tr>
<tr>
<td></td>
<td>• 457(b) and 403(b) Retirement Savings Plans</td>
</tr>
</tbody>
</table>
Before You Retire: Retiree Checklist

Planning to Retire? Here is a checklist to get you started!

✔ Visit CalSTRS/CalPERS web sites for information specific to planning your retirement.
✔ Use the calculators available on those web sites to estimate your monthly benefit.
✔ Attend a benefits planning session with CalSTRS/CalPERS or make an appointment with a benefits counselor.
✔ CalSTRS members: Six months before retiring, submit your Service Retirement Application and other required forms online through myCalSTRS account.
✔ CalPERS members: Six months before retiring, fill out and mail the Retirement Allowance Estimate Request. Three months before retiring, submit your completed retirement application and required documents to CalPERS online through myCalPERS account.
✔ If you are 65 or older: Three months prior to retirement, enroll in Medicare Parts A and B with the Social Security Administration. This is extremely important prior to enrolling in the District retiree health plan.
✔ Submit your Resignation/Retirement/Separation Notice to your immediate supervisor with your retirement effective date. This notice is available on the Human Resource Services web page.
✔ One month prior to retirement, Contact the District Employee Benefits Department to discuss retiree medical options in retirement. You’ll need to discuss medical plan options, dental plan options, vision plan continuation for up to 18 months with COBRA (see page 40 for a description of COBRA) and life insurance options. Ask about your eligibility for a subsidy toward your retiree medical health premium.
✔ 403(b)/457(b) Savings Accounts: If you have a 403(b) or 457(b) account, contact Fiscal Control to discuss your options.

Important

This is not meant to be an all exhaustive list of what employees should be doing to plan for retirement. It is highly recommended you review requirements by visiting the pension system web sites and talking to a benefits counselor. Questions about post-retirement options with the District? Talk to Human Resources prior to retirement.

Employee Benefits
Website: www.sandi.net/benefits
Phone: 619-725-8130
Email: employeebenefits@sandi.net

CalPERS
Website: www.calpers.ca.gov
Phone: 888-CalPERS (888-225-7377)

Human Resources
Website: www.sandi.net/human-resources
Phone: 619-725-8089

CalSTRS
Website: www.calstrs.com
Phone: 800-228-5453 or 916-414-1099

Fiscal Control: 403(b) & 457(b)
Website: www.sandi.net/fiscal-control
Phone: 619-725-7669

Social Security Administration
Website: www.ssa.gov
Phone: 800-772-1213
Eligibility

Who Can Enroll?
A retiree from the San Diego Unified School District may continue medical and dental benefits provided the retiree:

- Was enrolled in District-sponsored medical and dental benefits plans immediately preceding retirement, and
- Receives a monthly service retirement benefit from the California Public Employees’ Retirement System (CalPERS) or the California State Teachers’ Retirement System (CalSTRS), and
- Payment of premium is received within 31 days of the date coverage would normally terminate, and
- Has been continuously enrolled in a District-sponsored medical and dental plan since retirement.

Eligible retirees may also choose to enroll eligible family members, including:

- For medical and dental:
  - A legal spouse who is not on active duty as a member of the Armed Forces, and
  - A Domestic Partner (DP) who is not on active duty as a member of the Armed Forces and who is not legally married to another individual.

Note: Retirees and spouses/DPs who were enrolled in a District-sponsored vision plan on the retiree’s retirement date may be eligible to continue vision benefits, for up to 18 months as a result of the federal COBRA law, by paying the full monthly premiums (plus 2%) to the District. Enrollment must be made through the District within 60 days of a retiree’s retirement from the District.

- For medical only:
  - An eligible retiree’s child (including any stepchild, legally adopted child, or the biological child of the retiree’s spouse or domestic partner, or child for whom the retiree is named legal guardian by court order) who has not reached their 26th birthday, is not covered for benefits as an employee of the District, and is not on active duty as a member of the armed forces.
  - An eligible retiree’s child (including any stepchild, legally adopted child, or the biological child of the retiree’s spouse or domestic partner, or child for whom the retiree is named legal guardian by court order) who is at least 26 years of age, is primarily dependent upon the retiree for support and maintenance and is incapable of self-sustaining employment because of a mental or physical disability and has been approved by the medical benefits plan i.e., Kaiser or UnitedHealthcare, as being totally disabled.
  - A retiree’s child, as described above, may be eligible to continue dental and vision benefits as a result of the federal COBRA law, for up to 18 months, by paying the full monthly premiums (plus 2%) to the District. Enrollment must be made through the District within 60 days of a retiree’s retirement from the District.

Important: Dependent Verification!
The District requires retirees who enroll dependents in their medical or dental insurance plans to provide documents to verify their dependents’ eligibility for coverage.

Your enrollment form must be accompanied with supporting documentation for your dependents. Please refer to the Dependent Eligibility Verification sheet found on page 9 of this guide for more information.

When Does Coverage Begin?
Your enrollment choices remain in effect for the benefits plan year, January 1st through December 31st. Benefits for newly eligible retirees will commence as outlined below:

- Retiree’s benefits become effective the day following the day benefits cease as an active employee.
- Eligible family members’ benefits will commence on the date the retiree’s benefits commence or the date the family member becomes an eligible family member, whichever is later.
Enrollment

**Initial Enrollment Period**

New Retirees must enroll in benefits within 31 days of becoming an eligible retiree.

For instructions on how to enroll, call or visit the Employee Benefits Department.

**Open Enrollment**

Each autumn, the District provides an Open Enrollment opportunity to review and make changes to your benefits, including:

- Transferring to a different medical or dental plan
- Adding or dis-enrolling eligible family members

Changes made during Open Enrollment are effective January 1 of the following year.

**No Duplicate Coverage for Medical Coverage**

You can enroll in a District-sponsored medical plan as a retiree or as a dependent of an eligible retiree or active employee, but not as both a retiree and a dependent at the same time.

Family members may not be covered under more than one medical plan. For example, if one parent works for the district and the other parent has retired, their children cannot be covered by both parents.

Duplicate coverage is allowed under the dental plan.

---

**Be Prepared**

You must enroll within 31 days of your retirement date.

**Take Action**

Turn in your election form for medical and dental benefits in one of four easy ways:

- **Scan and e-mail to:** employeebenefits@sandi.net
- **Fax to:** 619.725.8132
- **Mail or walk-in to:**
  - Employee Benefits – SDUSD
  - 4100 Normal St., Room 1150A
  - San Diego, CA 92103

Benefit enrollment forms and informational materials are available online at www.sandi.net/benefits.

If additional information is needed, please contact the Employee Benefits Department located in Room 1150A of the Eugene Brucker Education Center. We can be reached by telephone at 619.725.8130. Walk-in office hours are Monday through Friday, from 8:00 a.m. to 5:00 p.m.

---

**Return Your Enrollment Forms!**

To participate in the Medical Plan or Dental Plan, you must enroll within 31 days of your retirement date.

Return your enrollment forms along with supporting documentation to the Employee Benefits Department immediately to ensure timely enrollment.

As you enroll, you will also need to provide personal information, such as Social Security numbers and dates of birth, for any eligible dependents you would like to cover under your Medical or Dental Plan.
What If My Needs Change During the Year?

You are permitted to make changes to your benefits outside of the open enrollment period if you have a qualified change in status as defined by the IRS. Generally, you may add or remove dependents from your benefits, as well as add, drop, or change coverage if you submit your request for change within 31 days of the Qualified Life Event. Change in status examples include:

- Marriage, divorce or legal separation.
- Birth or adoption of a child.
- Death of a dependent.
- You or your spouse’s / domestic partner’s loss or gain of coverage through our organization or another employer.
- You enroll, or intend to enroll, in a Qualified Health Plan (QHP) through the State Marketplace or Federal Exchange, and it is effective no later than the day immediately following the revocation of your employer sponsored coverage.
- Change in residence affecting eligibility or access.

If your change during the year is a result of the loss of eligibility or enrollment in Medicaid, Medicare or state health insurance programs, you must submit the request for change within 60 days.

For a complete explanation of Qualified Life Events, please refer to the “Legal Information Regarding Your Plans” contents.

Please note!

If you do not enroll a Dependent within 31 days of the date the Dependent becomes eligible, you must wait until the District’s next Open Enrollment to enroll the dependent, unless you have a subsequent Qualified Life Event during the plan year.

IF YOU ARE ON A NON-MEDICARE PLAN AND A DEPENDENT MOVES OUTSIDE OF YOUR HMO’S SERVICE AREA, PLEASE NOTIFY THE DISTRICT BENEFITS OFFICE REGARDING AVAILABLE OPTIONS FOR COVERAGE SINCE THE HMO WILL ONLY COVER EXPENSES RELATED TO A QUALIFYING EMERGENCY.

For information regarding Health Care Reform, please contact your District’s Benefits Department or visit www.cciio.cms.gov. You can also visit www.coveredca.com to review information specific to the Covered California State Health Insurance Exchange.
## Dependent Eligibility Verification Requirements

<table>
<thead>
<tr>
<th>Eligible Dependent Type</th>
<th>Eligible Dependent Definition</th>
<th>Required Documentation for Proof of Eligibility</th>
</tr>
</thead>
<tbody>
<tr>
<td>Legal Spouse</td>
<td>Legally married spouse as defined by State law</td>
<td>• Marriage Certificate if married less than one year; otherwise, a copy of the first two pages of the most recent Federal Tax Return with signature of Employee and Spouse (blackout financial information)**</td>
</tr>
<tr>
<td>State-Registered Domestic Partner</td>
<td>Same-sex or opposite-sex domestic partner age 18 or older</td>
<td>• California Certificate of Domestic Partnership issued by the California Secretary of State</td>
</tr>
<tr>
<td>Unregistered Domestic Partner</td>
<td>Same-sex domestic partner age 18 or older who meet District requirements in their Declaration of Domestic Partnership</td>
<td>• San Diego Unified School District Declaration of Domestic Partnership (including joint residence and financial interdependence documentation) and Domestic Partner Health Care Enrollment Statement</td>
</tr>
<tr>
<td>Biological Child</td>
<td>Direct biological child under age 26</td>
<td>• Government-issued Birth Certificate reflecting that the child is the Employee’s child, or • A copy of the first two pages of the most recent Federal Tax Return tax return with signature of Employee listing child as dependent (blackout financial information) **</td>
</tr>
<tr>
<td>Step Child</td>
<td>Direct biological child (under age 26) from a spouse/Domestic Partner’s prior marriage</td>
<td>• Government-issued Birth Certificate reflecting that the child is the Spouse/Domestic Partner’s child, or • A copy of the first two pages of the most recent Federal Tax Return tax return with signature of Employee listing child as dependent (blackout financial information) **</td>
</tr>
<tr>
<td>Adopted Child</td>
<td>Adopted child under age 26</td>
<td>• Government-issued Adoption Order, AND government issued Birth Certificate, or • Foreign adoption approved by the INS or legal adoption documents from foreign country AND home government-issued Birth Certificate</td>
</tr>
<tr>
<td>Guardianship Child</td>
<td>Persons under the age of 18 for whom you have legal guardianship</td>
<td>• Court Order of Legal Guardianship, AND a copy of the first two pages of the most recent Federal Tax Return tax return with signature of Employee listing child as dependent (blackout financial information).** Excludes temporary guardianship orders</td>
</tr>
<tr>
<td>Disabled Child</td>
<td>Disabled child over the age of 26 for whom you have the legal responsibility to care</td>
<td>• Notice of disability determination from medical carrier prior to attaining age 26 AND child documentation (biological/step/adopted/guardianship), or • Notice of disability determination from the Social Security Administration prior to attaining age 26 AND child documentation (biological/step/adopted/guardianship)</td>
</tr>
</tbody>
</table>

Dependents who do not meet the definitions as listed above are not eligible dependents

** Copies of most recent Federal Tax Return must include all pages, including the signature page, and return must be for the tax year prior to adding the dependents.
If A Dependent Loses Eligibility

You are responsible for dis-enrolling any dependent who loses eligibility (e.g., divorce, termination of a domestic partnership, death) **within 31 days** of the dependent’s eligibility status change.

In many cases, dependents losing coverage will be entitled to continue coverage under COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985). They also may want to explore their options through the health insurance Marketplace established under the Affordable Care Act. They can find information for California at [www.coveredca.com](http://www.coveredca.com) or by calling 800.300.1506.

Regardless of the timing of notice to the District, coverage for an ineligible dependent will end on the last day of the month in which the member loses eligibility (subject to any continued coverage option available and elected).

Contributions/Premium Payments for Benefits

Health premiums are paid by retirees and billed/debited by the District on a monthly basis. Premiums change each January 1. Premiums are due the first of the month for each month of benefits. If you are eligible to receive a subsidy from your union, your monthly invoice or the amount debited will reflect the appropriate reduction in your monthly premium due for medical benefits.

The first payment is due the date benefits terminate as an active employee. If a retiree does not make payments when due, the benefits will cease at the end of the month for which the retiree made the last payment. If benefits are allowed to terminate, they cannot be reinstated. To make the payment process easier, the District offers an electronic payment program. To participate in this program, the retiree must complete and return a Debit Authorization for Benefit Premiums Form to the District.

Termination of Benefits

A retiree’s benefits cease the earliest of:

- For retirees on a non-Medicare plan, the first day of a month for which the retiree submits a cancellation notice or does not make required premium payments to the District by the last day of the month, or
- The future date a retiree submits a cancellation notice to the District that the retiree wishes to terminate the benefits (Retroactive terminations are prohibited, and the retiree is responsible for all premiums prior to the date of termination, or
- The last day of the month in which the retiree dies.
- Medicare Advantage group medical plans follow Medicare-imposed guidelines and have specific requirements for termination. Medicare Advantage group medical plans may not be retroactively terminated. The retiree must give the plan thirty (30) day written advance notice of the termination. The retiree is responsible for all premiums prior to the date of termination.

**IMPORTANT:** If medical and/or dental benefits are terminated, the benefits may not be reinstated in the future.

Benefits of a dependent terminate on the date the retiree’s benefits terminate or the date the dependent ceases to qualify as an eligible dependent, whichever is earlier.

Surviving Dependents Benefits

In the event the retiree dies, please contact the Employee Benefits Department within thirty (30) days of the death regarding information on eligibility for surviving dependent benefits.
Benefits Information on the Go

**Kaiser Permanente – On the Go!**

The KP mobile app gives you a suite of tools to use on the go! Use this application with your Kaiser Permanente user ID and password to:

- See your health history at your fingertips.
- Refill prescriptions for yourself or another member.
- Check the status of your prescription order.
- Schedule, view, and cancel appointments.
- Access your message center to email your doctor or another KP department.
- Find KP locations and facilities near you.

Search for Kaiser’s mobile app in the App Store or Google Play to get started!

**UnitedHealthcare’s Health4Me App!**

UnitedHealthcare’s Health4Me mobile application will help you manage your health care easier and faster! Use the app to:

- Search for Quick Care, either urgent care or emergency room services.
- View and share your member ID card.
- Access your account balance and check the status of benefit amounts, such as your deductible and out-of-pocket maximum.
- View the latest claims for your plan.

Search for the Health4Me mobile app in the App Store or Google Play to get started!
Medical Coverage for those not in Medicare (under age 65)

What are my Options?

Use the chart below to help compare medical plan options and determine which would be the best for you and your family. The plan options available to retirees under age 65 are the same plans currently offered to active employees.

<table>
<thead>
<tr>
<th>HMO Kaiser</th>
<th>HMO UnitedHealthcare</th>
<th>PPO UnitedHealthcare</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Required to select and use a Primary Care Physician (PCP)</strong></td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td><strong>Seeing a Specialist</strong></td>
<td>PCP referral required in most cases</td>
<td>PCP referral required in most cases</td>
</tr>
<tr>
<td><strong>Deductible Required</strong></td>
<td>No</td>
<td>• Deductible is not required for Network 1 or 2.</td>
</tr>
<tr>
<td><strong>Claims Process</strong></td>
<td>Typically handled by providers</td>
<td>Typically handled by providers</td>
</tr>
<tr>
<td><strong>Other Important Tips</strong></td>
<td>• This plan requires that you see a Kaiser doctor to receive coverage</td>
<td>• These plans require that you see a doctor from a medical group available under your particular HMO plan to receive coverage</td>
</tr>
<tr>
<td></td>
<td>• Out-of-Network services without proper PCP referral will not be covered</td>
<td>• Out-of-Network services without proper PCP referral will not be covered</td>
</tr>
<tr>
<td></td>
<td>• Emergencies are covered worldwide but employees likely will have to pay first and then be reimbursed by the carrier</td>
<td>• Emergencies are covered worldwide but employees likely will have to pay first and then be reimbursed by the carrier</td>
</tr>
</tbody>
</table>

The Options Are the Same in Terms of:

- Free in-network preventive care
- Access to Best Doctors which offers expert opinions to all enrolled members on topics such as Critical Care Support, Ask the Expert, In-Depth Medical Review and Find a Doctor where you can learn more about best-in-class providers
- Access to OptumHealth Employee Assistance Program (EAP) and WorkLife Services. The EAP provides short-term, problem-focused counseling in addition to access to referral services for a range of issues from parenting and child care to money management.
- Chiropractic care through OptumHealth for both Kaiser and UHC members. A referral from your primary physician is not required. However, Optum will determine if services are medically necessary. To find a provider near you, contact OptumHealth at 1.800.428.6337 or search online at [www.myoptumhealthphysicalhealthofca.com](http://www.myoptumhealthphysicalhealthofca.com).
The Options Differ from Each Other in Terms of:

- The premiums differ between plans
- The deductibles, copayments, and out-of-pocket maximums
- The prescription drug administration and plan designs
- The networks of doctors and facilities you may use.

Please note the above examples are used for general illustrative purposes only.

For eligible individuals who are entitled to Medicare, the District offers Medicare Advantage HMO plans through Kaiser and UnitedHealthcare (UHC) and a Medicare Advantage PPO through UHC. Please refer to page 23 for information on these options.

You should carefully evaluate your family circumstances before selecting medical plan coverage.

Your Medical Plan Options for those not enrolled in Medicare Parts A & B

San Diego Unified School District offers six choices of medical plans, including one Kaiser HMO option, four Health Maintenance Organizations (HMO) options administered by UnitedHealthcare, and a Preferred Provider Organization (PPO) option administered by UnitedHealthcare’s subsidiary, UMR.

Using the Kaiser HMO Plan

As a member of the Kaiser Permanente Health Maintenance Organization (HMO) plan, you will receive your medical care from an integrated network of physicians and specialists at a Kaiser medical office, Kaiser medical center or affiliated hospital near you. Additional information regarding the Kaiser Permanente HMO is outlined below:

- You may choose a primary care doctor for yourself or your family members by reviewing a physician’s profile at kp.org/choosetheynourdoctor, or receive assistance in selecting a physician and scheduling your first appointment by calling 888.956.1616 (for Southern CA)
- Initial referrals for most specialty care services will be coordinated by your Kaiser primary care physician. However, many departments such as OB/GYN, Optometry, Psychiatry and Addiction Medicine allow for self-referral
- There are no deductibles with the Kaiser Permanente HMO and no claim forms to submit unless you receive emergency services outside of a plan facility
- Preventive care is covered at 100%

An abbreviated schedule of covered services under the Kaiser Permanente HMO plan is listed on page 19. For a complete listing of covered services for each plan, please refer to your Kaiser Evidence of Coverage (EOC).

Kaiser offers many ways to get care in San Diego:

- Telephone appointments and after-hours care with primary care physicians and specialists: Call 1.800.290.5000 to make a telephone appointment
- 24/7 Nurse Advice Line to see what type of care you need: Call 1.800.290.5000 M-F 7am to 7pm, and 1.888.576.6225 after 7pm and on weekends
- Kaiser Telehealth – Schedule a Phone or Video Appointments on your mobile device or computer for primary care, pediatrics, OB/GYN, allergy or psychiatry; your regular office copay will apply. Download Kaiser’s app at your device’s app store. Type in KP or Kaiser Permanente. Visit: kp.org/getcare
- Target Clinic (provided by Kaiser) Visit: kp.org/scal/targetclinic
- Email your physician for simple, direct communications securely through kp.org
- Travel Line when you are away from home and need medical care: call 1.951.268.3900 for assistance
Using the UnitedHealthcare (UHC) Performance HMO Plans, Signature Value Alliance HMO $1800 HRA Plan and the new Journey-Harmony HMO Plan

Members of a UHC HMO plan are required to select a Primary Care Physician (PCP) who will direct the majority of their health care needs. Their PCP’s medical group must be in the Performance HMO Network 1, Performance HMO Network 2, Journey Harmony HMO Network, or the Signature Value Alliance HMO Network you elect for your family. These HMO’s operate as follows:

- You and your family members ALL must enroll in the same HMO Network for the entire year (choose Performance HMO Network 1 or Network 2, or Journey-Harmony HMO or the Signature Value Alliance HMO)
- You and your family members can select different PCPs and/or medical groups within the network you choose. You can also change PCPs or medical groups within the network you choose during the year
- Your HMO network choice is effective for the entire year; you cannot change your HMO network unless you have an IRS-Qualified Family Status Change (e.g. change in address affecting eligibility or access)
- With the exception of an OB/GYN specialist who is affiliated with your selected medical group, you must receive a referral from your PCP before receiving services from a specialist who must be affiliated with your Medical Group
- Services may require a fixed-dollar or percentage payment up-front, referred to as a copay or coinsurance
- There are no annual deductibles, except for the Signature Value Alliance and Journey-Harmony HMOs
- You do not have to submit claim forms to UHC unless you receive emergency care from a non-plan provider
- Any services rendered out-of-network without the proper referral from your PCP will not be covered
- The Signature Value Alliance HMO $1800 HRA plan and the Journey-Harmony HMO each have a Health Reimbursement Account (HRA) associated with the plan. Please see a brief description of each on the next page.
- The New UnitedHealthcare Journey Harmony HMO plan is designed to provide a smart and affordable solution to traditional plans. It focuses on simple care today while wealth building for tomorrow through a proprietary, member-owned HealthInvest HRA (funded by CA Schools VEBA) which gives you a flexible savings option for future health care costs. The money in the HRA (Health Reimbursement Account) is yours to keep and can be used for current qualified medical expenses plus qualified medical expenses after leaving the plan or the District.
- These HMO plans provide you with the option of selecting from one of the four UnitedHealthcare HMO Networks illustrated below. Please remember that while all enrolled family members must select a PCP within the same HMO Network, each enrolled family member does not need to pick the same PCP or the same medical group (MG) within that network. Unless you have an IRS-Qualified Family Status Change, you will not be able to change your HMO Network until next Open Enrollment.

<table>
<thead>
<tr>
<th>UHC Performance Network 1</th>
<th>UHC Performance Network 2</th>
<th>Signature Value Alliance HMO $1800</th>
<th>Journey-Harmony HMO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sharp Rees-Steeally MG</td>
<td>Mercy Physicians MG</td>
<td>Scripps Clinic</td>
<td>Sharp Rees-Steeally MG</td>
</tr>
<tr>
<td>Sharp Community MG</td>
<td>Greater Tri-Cities MG</td>
<td>Mercy Physicians MG</td>
<td>Sharp Community MG</td>
</tr>
<tr>
<td>(Includes Graybill and</td>
<td></td>
<td></td>
<td>(Includes Graybill</td>
</tr>
<tr>
<td>Arch Health Partners)</td>
<td></td>
<td></td>
<td>and Arch Health</td>
</tr>
<tr>
<td>Primary Care Associated MG</td>
<td></td>
<td>Scripps Coastal MG</td>
<td>UCSD MG</td>
</tr>
<tr>
<td>(Includes Cassidy)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rady Children’s Health Network</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Your Health getting started
Health Reimbursement Accounts (HRA) with the Signature Value Alliance HMO and the Journey-Harmony HMO

With the **Signature Value Alliance HMO $1800 HRA plan**, you will be issued 2 debit cards from Optum Financial to access an $1,800 Health Reimbursement Account each plan year to help you pay for out-of-pocket expenses for the HMO’s deductibles, copays and coinsurance for yourself and covered family members. Up to $500 of an unused HRA balance will be rolled over to the next plan year if you continue to be enrolled in the Signature Value Alliance HMO $1800 HRA plan. Account balances will be forfeited if you do not continue with the Signature Value Alliance HMO in the next plan year or upon termination of employment. For the 2020 plan year only, the HRA benefit will remain at $1,800 rather than the plan’s normal $1,200 amount.

With the **Journey-Harmony HMO plan**, you will be automatically enrolled in a member-owned Gallagher HealthInvest HRA (Health Reimbursement Account). For employees joining the plan on January 1, an amount will be deposited into your HRA on February 15. The amount will be $800 if enrolling as employee only, $1,600 for employees covering one dependent and $2,200 for employees covering two or more dependents. Funding is prorated for new employees joining after January 1. You may use these funds to pay for any IRS-qualified out-of-pocket expenses as specified in IRS Code Section 213(d) for out-of-pocket expenses incurred by you or your IRS-qualified dependents as specified in IRS Code Section 152. Examples include copays, deductibles and coinsurance required in your medical, dental and vision plans; orthodontia and hearing aids. The HRA is “portable,” which means the account balance continues to be yours even if you change to another health plan and when you terminate or retire from the District. Because the money is yours to keep even after leaving the plan or the District, you can build up savings for long-term protection. As a result, you also may use the funds to pay for Medicare Parts B and D premiums.

With this HRA, you have the ability to invest your HRA money in a menu of funds offered by Gallagher.

To obtain more information and to file claims, you may download the app: HRAgo or go to the following website: HealthInvestHRA.com.

Using the UMR NexusACO Select Plus PPO Plan

With a Preferred Provider Organization (PPO) plan, you have greater flexibility and choice to use both in-network and out-of-network physicians. However, you are encouraged to receive services from in-network doctors, specialists or facilities. By doing so, you obtain a higher level of benefit than if services were rendered from an out-of-network provider. Additional important information regarding the use of the PPO plan includes:

- The Nexus ACO has in-network providers divided into “Tier 1” and “Other” providers. Your out-of-pocket expenses will be lowest when using a Tier 1 provider, higher for Other In-Network providers and highest for Out-Of-Network providers. Members can also save money when using an In-Network free-standing lab, x-ray or out-patient care center. Members should look for the “Free-Standing Facility” indicator to find locations near them.
- Members are encouraged to choose a Primary Care Physician (PCP) for each covered family member similar to an HMO, but they can still seek services at any doctor or facility without a referral from their PCP.
- Certain services, such as doctor’s visits, may require a fixed-dollar payment up-front, referred to as a copay.
- Before the insurance company will pay certain medical expenses, such as hospital expenses, you may be required to pay a specific amount, referred to as the calendar year deductible, before benefits are paid.
- Once the deductible has been fulfilled, UMR will pay a large percentage of the cost of your care, known as coinsurance. You are then responsible for the remaining cost up to the calendar year out-of-pocket maximum.
- Veba and UHC have arranged for a special program that eliminates the deductible, coinsurance and copays for certain hospital-based surgeries through Carrum Health when the surgery is performed at a Carrum Health contracted hospital. The surgeries are for spine, orthopedic and coronary artery bypass graft (CABG). The contracted hospitals are Scripps Green in La Jolla, Hoag Orthopedic Institute in Irvine, Providence St. Johns in Santa Monica and Stanford in Palo Alto. If a member does not call Carrum Health at 1.888.855.7806 to obtain pre-certification before one of these surgeries, they will be subject to a $1,000 pre-certification penalty that will not apply to their out-of-pocket maximum. If the member does call Carrum before the surgery but chooses to use another provider, there will be no penalty, and normal benefits will be paid.
- MyHealthcare Cost Estimator tool helps employees estimate their cost before you see the doctor; visit www.myuhc.com or Health4Me App.
- Claim forms are submitted to UMR on your behalf by the service provider when services are received from within the network.
UHC Telemedicine / Online Program

If you are enrolled in any UHC plan, you can obtain medical assistance from the comfort of your home. To learn more and register for their services, go online to www.AmWell.com (or call 1.844.733.3627) or www.doctorondemand.com.

This program provides convenient and affordable care for symptoms such as the flu, allergies, sore throat, pink eye and more. You will have 24/7/365 access to a physician via secure webcam, chat, phone, or mobile application. The cost to you for this service is the same as your plan’s PCP office visit copay.

How to Find a UnitedHealthcare Network Provider

Before you go to the doctor or receive health care services, make sure your doctor, facility or specialist is participating in your plan’s network. This may ensure you receive the highest level of benefit and could reduce your health care costs. Check out the instructions below to find out how to perform a “Provider Search” for your plan or call UnitedHealthcare at 1.888.586.6365 to speak with a representative.

UnitedHealthcare HMO Providers

1. Go to www.csveba.welcometouhc.com - Under “Wondering if your doctor is in our network”; select “Find a network doctor or hospital”.
   - Select the appropriate plan: CS VEBA Performance HMO Network 1 or 2, Signature Value Alliance HMO, or Journey-Harmony HMO plan
2. On the next screen click “continue” and then enter your zip code
3. Then click “People” for information on participating Medical Groups and Physicians.

UnitedHealthcare NexusACO (Accountable Care Organization) PPO Plan Providers

1. Go to www.umr.com - Select “Find a Provider”.
2. Click on the letter “U” then select “UnitedHealthcare NexusACO Network”
3. You can search by Name, Specialty, Facility Name, Clinic or Medical Group and other categories
4. The Premium Designation PPO Network in San Diego is changing to the Nexus ACO (Accountable Care Organization). UMR’s partnership with large local medical groups such as Sharp Rees-Stealy and Sharp Community Medical Group will increase the overall number of Tier 1 network providers. UMR, a UnitedHealthcare company, will take over as the new plan administrator. Employees will receive new ID cards and have a new customer service contact phone number but the plan design will not change. Claim forms will now go to UMR.

Prescription Drug Coverage

Many FDA-approved prescription medications are covered through the benefits program. Your prescription drug benefits depend on which medical option you select. Refer to the plan summaries for cost information. Kaiser and UnitedHealthcare have a drug formulary, or preferred list of prescription drugs, including both generic and brand name medications. Important information regarding your prescription drug coverage is outlined below:

Kaiser HMO Members

Retirees enrolled in Kaiser have prescription drug coverage through Kaiser.

- There is a $10 copay for all covered prescriptions, for up to a 100-day supply.
- All medicine must be obtained from a Kaiser pharmacy or through Kaiser’s mail order program.
untedHealthcare Members

Retirees enrolled in a non-Medicare UHC plan have prescription drug coverage through Express Scripts. You will receive a separate ID card from Express Scripts for you to use at your pharmacy. You must use an Express Scripts participating pharmacy or their online mail order service.

- Tiered prescription drug plans require varying levels of payment depending on the drug’s tier, and your copayment or coinsurance will be higher with a higher tier number.
- The UnitedHealthcare plan(s) include a 3-tier prescription benefit through Express Scripts.
- Tier 1 prescriptions offer the greatest value compared to other drugs that treat the same conditions and are often the lowest cost. These are typically formulary generic medications.
- Tier 2 drugs are generally formulary brand name with a moderate copayment. Some drugs may also be Tier 2 because they are “preferred” among other drugs that treat the same conditions.
- Tier 3 drugs are a higher copayment compared to the lower tiers, as they are higher cost, non-formulary drugs. Some drugs on this list may have a generic counterpart in Tier 1 or Tier 2.

To see a current listing of formulary medicines log onto www.express-scripts.com. After registering, click on Benefits information.

Express Scripts has an Express Advantage Network (EAN) of pharmacies that offer greater discounts on prescription medication. The prescription medication copays shown in the schedule on the following pages are for EAN pharmacies. These include Costco, Walmart, K-Mart, Ralphs, Rite-Aid, Vons and many independent pharmacies.

Express Scripts has also introduced a subset network of the Advantage Network called Smart90. The Smart90 network includes Costco, Rite Aid, and Express Scripts Mail Order. Costco membership is not required in order to fill a prescription at a Costco pharmacy. Effective 1/1/20 - Copays will be waived for preferred generic hypertension and preferred generic oral hypoglycemic medications when filled at a Smart90 retail or mail-order pharmacy.

The EAN network and Smart90 network does not include CVS, Walgreens, Target, Safeway and Winn-Dixie and some independent pharmacies.

For medicine dispensed from non-EAN pharmacies, the copays are $5.00 higher than those shown in the schedule on the following pages. Visit www.express-scripts.com for a complete list of EAN and Smart90 pharmacies.

For members on longer-term medications (over 3 months), the use of Express Scripts’ Mail Order pharmacy is encouraged. If a member chooses to obtain such medicine at a local retail pharmacy beyond the third refill of the prescription (other than at a Costco or Rite-Aid pharmacy), the copays will be doubled for a 30-day supply.

If a member receives brand-name medication when a generic equivalent is available, the member will pay the generic medication copay plus the entire price difference between the brand-name medication and the generic equivalent, even if the physician prescribes “Dispense as Written.”

Many drugs in the following three classes are available both over-the-counter (OTC) and through a physician’s prescription. As a result, medicine in these three classes is no longer covered under the Express Scripts pharmacy benefits program. Therefore, you will pay the entire cost of these medicines even if they are prescribed by a physician and obtained from a pharmacy. The classes are:

- Antihistamines (Examples: Citirizine, Loratadine, and Fexofenadine)
- Intranasal Steroids
- Proton Pump Inhibitors (Examples: Nexium, Prilosec and Protonix)

Express Scripts has implemented a new program for Specialty Medicine called SaveonSP effective October 1, 2019. This program is designed to save members money by reducing or eliminating out-of-pocket costs on certain specialty medicines. More than 150 specialty medications will be available at no cost when members enroll in the program and have these specialty medicines dispensed by the Express Scripts mail order provider, Accredo. Members on these medicines will receive a letter to sign up for SaveOnSP. Members who do not enroll in the program will be subject to increased copays for specialty medicine. These copays can range from $700 to more than $7,000 per month.
Why Pay More for Prescriptions?

There are a few ways you might save money through the Prescription Drug plan:

- **Use Generic Drugs:** Talk to your doctor or pharmacist about trying generic drugs, which contain the same active ingredients as the brand-name equivalent at a fraction of the cost.

- **Use Express Scripts’ Express Advantage Network (EAN) pharmacies.**

- **Preventative Medicine:** Some are available with no copays, including low/moderate dose of cholesterol-reducing drugs for members ages 40-75 without a history of cardiovascular disease where there is a presence of a health risk factor such as hypertension or smoking.

- **Use Mail Order:** If you take long-term medications for chronic conditions such as high blood pressure, diabetes, and/or depression, you could save time and money by utilizing your mail order service for your medications. Up to a 90-day supply of your medication will be shipped directly to your home. Ask your doctor to write you a 90-day prescription to use Mail Order. Please contact Express Scripts for more information about their mail order service for UnitedHealthcare members.

  UHC members can get the same mail order discounts at Rite Aid and Costco pharmacies.

  Note: This offer does not apply to specialty medications that MUST BE filled through Express Scripts’ Specialty Pharmacy, Accredo.

- **Price Compare:** Some pharmacies, such as those at warehouse clubs or discount stores, may offer less expensive prescriptions than others. By calling ahead, you may determine which pharmacy provides the most competitive price.

- **Explore Over-the-Counter Options:** For common ailments, over-the-counter drugs may provide a less expensive option that serves the same purpose as prescription medications.
## HMO Plan Highlights for those not Enrolled in Medicare (under age 65)

<table>
<thead>
<tr>
<th>Plan Highlights</th>
<th>Kaiser</th>
<th>UHC HMO Network 1</th>
<th>UHC HMO Network 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Calendar Year Medical Plan Deductibles</td>
<td>None</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Calendar Year Maximum Medical Out-of-pocket Per Individual / Per Family</td>
<td>$1,500 / $3,000</td>
<td>$1,500 / $3,000</td>
<td>$3,000 / 6,000</td>
</tr>
<tr>
<td><strong>Professional Services</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physician Office Visits – Primary Care Physician</td>
<td>$10 copay</td>
<td>$10 copay</td>
<td>$10 copay</td>
</tr>
<tr>
<td>Physician Office Visits – Specialty Care Physician</td>
<td>$10 copay</td>
<td>$10 copay</td>
<td>$10 copay</td>
</tr>
<tr>
<td>Preventive Care Exam</td>
<td>No charge</td>
<td>No charge</td>
<td>No charge</td>
</tr>
<tr>
<td>Outpatient Basic Diagnostic X-ray and Lab</td>
<td>No charge</td>
<td>No charge</td>
<td>No charge</td>
</tr>
<tr>
<td>Complex Diagnostics (MRI / CT/PET Scan)</td>
<td>No charge</td>
<td>No charge</td>
<td>No charge</td>
</tr>
<tr>
<td>Outpatient Physical / Rehabilitation Therapy</td>
<td>$10 copay</td>
<td>$10 copay(1)</td>
<td>$10 copay(1)</td>
</tr>
<tr>
<td>Chiropractic Care (Must be Medically Necessary)</td>
<td>$10 copay</td>
<td>$10 copay</td>
<td>$20 copay</td>
</tr>
<tr>
<td><strong>Hospital Services</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient</td>
<td>No charge</td>
<td>No charge</td>
<td>No charge</td>
</tr>
<tr>
<td>Outpatient Surgery</td>
<td>$10 copay</td>
<td>No charge</td>
<td>$10 copay</td>
</tr>
<tr>
<td>Emergency Room (Copay Waived if Admitted)</td>
<td>$50 copay</td>
<td>$100 copay</td>
<td>$100 copay</td>
</tr>
<tr>
<td>Urgent Care (Your Medical Group)</td>
<td>$10 copay</td>
<td>$10 copay</td>
<td>$20 copay</td>
</tr>
<tr>
<td>Urgent Care (Other Medical Group)</td>
<td>$10 copay</td>
<td>$50 copay</td>
<td>$50 copay</td>
</tr>
<tr>
<td><strong>Maternity Care</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physician Services (Including Regular Prenatal Care)</td>
<td>No charge</td>
<td>No charge</td>
<td>No charge</td>
</tr>
<tr>
<td>Hospital Services</td>
<td>No charge</td>
<td>No charge</td>
<td>No charge</td>
</tr>
<tr>
<td>Infertility Diagnostic Testing</td>
<td>$10 copay</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
<tr>
<td>Infertility Treatment – Artificial Insemination Only</td>
<td>$10 copay</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
<tr>
<td><strong>Mental Health &amp; Substance Abuse</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mental Health (outpatient / inpatient)</td>
<td>$10/No charge</td>
<td>$10/No charge</td>
<td>$20/No charge</td>
</tr>
<tr>
<td>Substance Abuse (outpatient / inpatient)</td>
<td>$10/No charge</td>
<td>No Charge</td>
<td>No Charge</td>
</tr>
<tr>
<td><strong>Prescription Drugs</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Calendar Year Brand Name Rx Deductibles</td>
<td>None</td>
<td>None</td>
<td>See Notes 2 &amp; 3, Below</td>
</tr>
<tr>
<td>Calendar Year Rx Max Out-of-Pocket/Individual</td>
<td>Included with Medical</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Calendar Year Rx Max Out-of-Pocket/Family</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Retail Prescription Drugs Up to a→</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tier 1 – Generic</td>
<td>$10 copay</td>
<td>$5 copay</td>
<td>$10 copay</td>
</tr>
<tr>
<td>Tier 2 – Formulary Brand Name</td>
<td>$10 copay</td>
<td>$25 copay</td>
<td>$30 copay</td>
</tr>
<tr>
<td>Tier 3 – Non-Formulary Brand Name</td>
<td>$10 copay</td>
<td>50% (4 &amp; 5)</td>
<td>50% (4 &amp; 5)</td>
</tr>
<tr>
<td><strong>Mail Order Prescription Drugs Up to a→</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tier 1 – Generic</td>
<td>$10 copay</td>
<td>$10 copay</td>
<td>$20 copay</td>
</tr>
<tr>
<td>Tier 2 – Formulary Brand Name</td>
<td>$10 copay</td>
<td>$50 copay</td>
<td>$60 copay</td>
</tr>
<tr>
<td>Tier 3 – Non-Formulary Brand Name</td>
<td>$10 copay</td>
<td>50% (4 &amp; 5)</td>
<td>50% (4 &amp; 5)</td>
</tr>
</tbody>
</table>

(1) The specialty care physician copay applies if therapy is provided by a physician other than the patient’s primary care physician.

(2) Copays are $5 higher for medicine obtained from Non-EAN pharmacies.

(3) Plan participants pay 100% of the cost for certain drugs that are available over-the-counter, i.e., Proton Pump inhibitors, Antihistamines & Intranasal Steroids

(4) Subject to minimum $40, maximum $175 for retail; and minimum $80, maximum $350 for mail order

(5) See page 17 for special requirements for “Specialty Medicine”

The above information is a summary only. Please refer to your Evidence of Coverage (EOC) for complete details of Plan benefits, limitations and exclusions.
## Plan Highlights

### Health Reimbursement Account
- **Plan**: UHC Alliance HMO
- **HRA**: $1800
- **In-network Only**: $1,800
- **Note**: Up to $500 can rollover to new plan year

### Calendar Year Medical Plan Deductibles
- **Per Individual**: $2,000
- **Per Family**: $2,000
- **Total**: $4,000

### Calendar Year Maximum Medical Out-of-pocket
- **Per Individual**: $3,000
- **Per Family**: $6,000
- **Total**: $9,000

### Professional Services
- **Physician Office Visits – Primary Care Physician**: $35 copay
- **Physician Office Visits – Specialty Care Physician**: $50 copay
- **Preventive Care Exam**: No charge
- **Outpatient Basic Diagnostic X-ray and Lab**: No charge
- **Complex Diagnostics (MRI / CT/PET Scan)**: 20% coinsurance
- **Outpatient Physical / Rehabilitation Therapy (2)**: $35 copay
- **Chiropractic Care (Must be Medically Necessary)**: $30 copay

### Hospital Services
- **Inpatient**: 20% coinsurance
- **Outpatient Surgery**: 20% coinsurance
- **Emergency Room (Copay Waived if Admitted)**: $300 copay (after Deductible met)
- **Urgent Care (Your Medical Group)**: $35 copay
- **Urgent Care (Other Medical Group)**: $25 copay

### Maternity Care
- **Physician Services (Including Regular Prenatal Care)**: Pre-natal: $35 copay, Other: 20% coinsurance
- **Hospital Services**: 20% coinsurance
- **Infertility Diagnostic Testing**: Not covered
- **Infertility Treatment - Artificial Insemination Only**: Not covered

### Mental Health & Substance Abuse
- **Mental Health (outpatient/inpatient)**: $40 copay / 20% coinsurance
- **Substance Abuse (outpatient/inpatient)**: No Charge

### Prescription Drugs
- **Calendar Year Brand Name Rx Deductibles**: None
- **Calendar Year Rx Max Out-of-Pocket/Individual**: $1,600
- **Calendar Year Rx Max Out-of-Pocket/Family**: $3,200

#### Retail Prescription Drugs Up to a

<table>
<thead>
<tr>
<th>Tier</th>
<th>30-day supply</th>
<th>90-day supply</th>
<th>30-day supply</th>
<th>90-day supply</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tier 1 – Generic</td>
<td>$10 copay</td>
<td>$20 copay</td>
<td>$10 copay</td>
<td>$20 copay</td>
</tr>
<tr>
<td>Tier 2 – Formulary Brand Name</td>
<td>$30 copay</td>
<td>$60 copay</td>
<td>$30 copay</td>
<td>$60 copay</td>
</tr>
<tr>
<td>Tier 3 – Non-Formulary Brand Name</td>
<td>50% coinsurance</td>
<td>50% coinsurance</td>
<td>50% coinsurance</td>
<td>50% coinsurance</td>
</tr>
</tbody>
</table>

#### Mail Order Prescription Drugs Up to a

<table>
<thead>
<tr>
<th>Tier</th>
<th>30-day supply</th>
<th>90-day supply</th>
<th>30-day supply</th>
<th>90-day supply</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tier 1 – Generic</td>
<td>$20 copay</td>
<td>$40 copay</td>
<td>$20 copay</td>
<td>$40 copay</td>
</tr>
<tr>
<td>Tier 2 – Formulary Brand Name</td>
<td>$60 copay</td>
<td>$120 copay</td>
<td>$60 copay</td>
<td>$120 copay</td>
</tr>
<tr>
<td>Tier 3 – Non-Formulary Brand Name</td>
<td>50% coinsurance</td>
<td>50% coinsurance</td>
<td>50% coinsurance</td>
<td>50% coinsurance</td>
</tr>
</tbody>
</table>

### Notes:
1. **Deductible Waived**: Pre-natal: $35 copay, Other: 20% coinsurance
2. **The specialty care physician copay applies if therapy is provided by a physician other than the patient’s primary care physician.**
3. **Copays are $5 higher for medicine obtained from Non-EAN pharmacies.**
4. **Plan participants pay 100% of the cost for certain drugs that are available over-the-counter, i.e., Proton Pump inhibitors, Antihistamines & Intranasal Steroids.**
5. **Subject to minimum $40, maximum $175 for retail; and minimum $80, maximum $350 for mail order.**
6. **See page 17 for special requirements for “Specialty Medicine.”**

The above information is a summary only. Please refer to your Evidence of Coverage (EOC) for complete details of Plan benefits, limitations, and exclusions.
### Plan Highlights

#### UMR NexusACO Select Plus PPO

<table>
<thead>
<tr>
<th></th>
<th>Tier 1</th>
<th>Other</th>
<th>Out-of-network</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Calendar Year Deductible</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual/Family Maximum</td>
<td>$2,000</td>
<td>$4,000</td>
<td></td>
</tr>
<tr>
<td><strong>Maximum Calendar Year Out-of-pocket</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual/Family Maximum</td>
<td>$5,000/$10,000</td>
<td>$5,000/$10,000</td>
<td></td>
</tr>
<tr>
<td>*<em>Professional Services (For all benefit levels followed by a <em>, the benefits are payable after the deductible is met.)</em></em></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary Care Physician (PCP)</td>
<td>$30 copay</td>
<td>20% coinsurance*</td>
<td>50% coinsurance*</td>
</tr>
<tr>
<td>Specialist</td>
<td>$50 copay</td>
<td>20% coinsurance*</td>
<td>50% coinsurance*</td>
</tr>
<tr>
<td>Preventive Care Exam</td>
<td>No charge</td>
<td></td>
<td>Not covered</td>
</tr>
<tr>
<td>Diagnostic X-ray and Lab (Standard Procedures)</td>
<td>M.D. Office or Free-Standing Facility: No Charge; At a hospital: 20% coinsurance*</td>
<td></td>
<td>50% coinsurance*</td>
</tr>
<tr>
<td>Complex Radiology e.g., MRI / CT/PET Scan</td>
<td>Free-Standing Facility: 20% coinsurance*; Hospital: $100 copay / occurrence then 20% coinsurance*</td>
<td></td>
<td>50% coinsurance*</td>
</tr>
<tr>
<td>Outpatient Physical / Rehabilitation Therapy (PCP or Specialist)</td>
<td>$30 copay</td>
<td></td>
<td>50% coinsurance*</td>
</tr>
<tr>
<td>Chiropractic Care &amp; Acupuncture (Must be Medically Necessary)</td>
<td>$30 copay</td>
<td></td>
<td>50% coinsurance*</td>
</tr>
<tr>
<td>*<em>Hospital Services (For all benefit levels followed by a <em>, the benefits are payable after the deductible is met.)</em></em></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient</td>
<td>20% coinsurance*</td>
<td></td>
<td>50% coinsurance*</td>
</tr>
<tr>
<td>Outpatient Surgery</td>
<td>M.D. office or Free-Standing Facility; 20% coinsurance*; Hospital: $100 copay / occurrence then 20% coinsurance*</td>
<td></td>
<td>50% coinsurance* (Pre-authorization is required)</td>
</tr>
<tr>
<td>Emergency Room (Copay Waived if Admitted)</td>
<td>$100 copay</td>
<td></td>
<td>$100 copay</td>
</tr>
<tr>
<td>Urgent Care</td>
<td>$50 copay</td>
<td></td>
<td>50% coinsurance*</td>
</tr>
<tr>
<td>*<em>Maternity Care (For all benefit levels followed by a <em>, the benefits are payable after the deductible is met.)</em></em></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physician Services</td>
<td>Prenatal: No Charge; Delivery: 20% coinsurance* Postnatal: $30 copay</td>
<td></td>
<td>50% coinsurance*</td>
</tr>
<tr>
<td>Hospital Services</td>
<td>20% coinsurance*</td>
<td></td>
<td>50% coinsurance* (Pre-authorization is required)</td>
</tr>
<tr>
<td>Infertility</td>
<td>Not covered</td>
<td></td>
<td>Not covered</td>
</tr>
<tr>
<td>*<em>Mental Health &amp; Substance Abuse (For all benefit levels followed by a <em>, the benefits are payable after the deductible is met.)</em></em></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient</td>
<td>20% coinsurance*</td>
<td></td>
<td>50% coinsurance*</td>
</tr>
<tr>
<td>Outpatient</td>
<td>$30 copay</td>
<td></td>
<td>50% coinsurance*</td>
</tr>
<tr>
<td><strong>Prescription Drugs Calendar Year Maximum Out-of-Pocket</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Per Individual</td>
<td>$1,600</td>
<td></td>
<td>N/A</td>
</tr>
<tr>
<td>Maximum Per Family</td>
<td>$3,200</td>
<td></td>
<td>N/A</td>
</tr>
</tbody>
</table>

#### Retail Prescription Drugs (Up to a 30-day supply at an EAN pharmacy; $5 higher at non-EAN pharmacies) *(2)*

| Tier 1 – Generic | $10 copay | Not covered |
| Tier 2 – Formulary Brand | $30 copay | Not covered |
| Tier 3 – Non-Formulary | 50% *(3 & 4)* | Not covered |

#### Mail Order Prescription Drugs (Up to a 90-day supply)

| Tier 1 – Generic | $20 copay | Not covered |
| Tier 2 – Formulary Brand | $60 copay | Not covered |
| Tier 3 – Non-Formulary | 50% *(3 & 4)* | Not covered |

1. Out-of-pocket maximum is based on the maximum allowable charge the carrier allows. This does not include any balance billing that may occur when using an out-of-network provider.

2. Plan participants pay 100% of the cost for certain drugs that are available over-the-counter, i.e., Proton Pump inhibitors, Antihistamines & Intrasanal Steroids

3. Subject to minimum $40, maximum $175 for retail; and minimum $80, maximum $350 for mail order

4. See page 17 for special requirements for “Specialty Medicine”

The above information is a summary only. Please refer to your Evidence of Coverage (EOC) for complete details of Plan benefits, limitations and exclusions.
Medical Coverage for those in Medicare Parts A & B

General Information about Medicare

Medicare is a health insurance program for:
- People age 65 and over
- People under 65 with certain disabilities
- People of any age with End-Stage Renal Disease (ESRD)-permanent kidney failure requiring dialysis or a kidney transplant

Whether you are turning 65 or are older than 65 (still working but about to retire), you have an opportunity to enroll in Medicare. Individuals enrolling for coverage to be effective when they turn 65 can enroll three months before the month they turn 65, the month of their birthday or three months after their birth month. Individuals who work beyond age 65 and are covered by district medical benefits should begin the process of enrolling three months before the month they plan on retiring from the district.

Eligibility requirements include:
- You or your spouse have worked for at least 10 years (40 quarters) in Medicare-covered employment, and
- You’re a U.S. citizen or permanent resident for at least five years
- Even if you’re not collecting Social Security yet, you’re eligible to join at age 65 or later

When Medicare coverage begins for those enrolling for coverage to begin at age 65: If your birthday is not the first day of a month, Medicare coverage begins the first of the month in which you turn 65 if you enroll that month or during the 3 months before turning 65. If your birthday is on the first day of the month, your Medicare coverage starts the first day of the prior month.

If you continue your medical coverage through San Diego Unified School District ("SDUSD") by enrolling in a Medicare Advantage Plan, it is still necessary to enroll in Medicare Parts A and B; however, it is not necessary to enroll in an independent Medicare Part D plan (prescription drug coverage). The Medicare Advantage medical plans offered by the district include prescription drug coverage. Please note that if you enroll in another Medicare Advantage plan or a stand-alone Medicare Part D prescription drug plan after your enrollment in a district plan, you will be disenrolled from your Medicare Advantage Plan provided through the district.

* Please consult the Social Security Administration to verify eligibility in Medicare Parts A and B at 1.800.772.1213 or www.socialsecurity.gov. You cannot enroll in Medicare through the SDUSD Employee Benefits Department.

IMPORTANT DISTRICT ENROLLMENT INFORMATION:

The SDUSD Medicare plan enrollment form must be completed and submitted with a copy of your Medicare ID Card/Medicare Entitlement Letter to the Employee Benefits Department, no later than the 10th of the month prior to your birth month to ensure timely enrollment in your Medicare plan. Delayed enrollment may result in a substantial increase to your monthly premium and loss of your Retiree Medical Benefits Fund ("subsidy"), if applicable. Refer to the VEBA/SDUSD Retiree Benefits Comparison sheet for an overview of available plans, and for Medicare Advantage plan rates and detailed plan information visit www.sandi.net/retiree-benefits. If your rate is not included, please contact the Employee Benefits Department at 619.725.8130 or employeebenefits@sandi.net, Monday – Friday from 8:00 a.m.– 5:00 p.m.

To ensure timely enrollment:
- Contact the Social Security Administration 3 months prior to your 65th birthday month to enroll in Medicare Parts A & B.
- Review the plan year VEBA/SDUSD Retiree Benefits Comparison and medical premium rate sheets.
- Complete a SDUSD Medicare plan enrollment form (forms are not automatically mailed; please contact the district to obtain the applicable form). For your convenience, you may also find the enrollment forms on www.sandi.net/retiree-benefits. If you cover a dependent(s), you must select a Medicare Advantage plan with the same carrier as the dependent plan. The next opportunity for plan change will be during the next Open Enrollment.
- Attach the required copy of your Medicare A & B ID Card/Entitlement Letter to your enrollment form.

Incomplete applications will not be accepted. This may result in the delay of enrollment, a substantial increase to your monthly premium and loss of your Retiree Medical Benefits Fund ("subsidy"), if applicable.
Medical Coverage for those in Medicare Parts A & B

IMPORTANT INFORMATION REGARDING CERTIFICATE OF CREDITABLE COVERAGE

Each November, members will receive an annual “Certificate of Creditable Coverage” from our third party administrator, California Schools Voluntary Employee Benefits Association (VEBA), as required by Federal Law. If you are on Medicare or have a dependent on Medicare, you must KEEP this certification in your permanent records. Should you ever leave the VEBA program to purchase an individual plan, you will be required to provide Medicare with copies of each certificate of creditable coverage that you have received from VEBA.

YOUR MEDICAL PLAN OPTIONS FOR THOSE ENROLLED IN MEDICARE PARTS A & B

Retirees entitled to Medicare have three available Medicare Advantage plan options through VEBA/SDUSD:

1. Kaiser Senior Advantage HMO plan for those living in the California, Hawaii and Colorado Kaiser HMO service areas and who are enrolled in Medicare Parts A and B

2. UnitedHealthcare (UHC) Medicare Advantage HMO plan for those living in the Southern California UHC HMO service area and who are enrolled in Medicare Parts A and B

3. UnitedHealthcare (UHC) Group Medicare Advantage PPO plan for retirees enrolled in Medicare Parts A and B and who wish to have the freedom to obtain medical care outside of the local service area. This plan is available nationwide. You can see any provider (network or out-of-network) at the same cost share as long as they accept the plan and have not opted out of or been excluded from Medicare. However, you must use pharmacies in UHC’s network for covered prescription medication.

For all three options, Medicare beneficiaries must assign all of their Medicare benefits to the health plan you select, i.e., Kaiser or UnitedHealthcare.

For couples where either the retiree or spouse has Medicare Parts A and B, but the other partner does not, the one without Medicare may enroll in one of the plans described on the previous pages for those not enrolled in Medicare.
### Medicare Advantage Plan Highlights for those Enrolled in Medicare Parts A & B (Age 65+)

<table>
<thead>
<tr>
<th>Plan Highlights</th>
<th>Kaiser Senior Advantage HMO</th>
<th>UHC Medicare Advantage HMO</th>
<th>UHC Medicare Advantage PPO</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Calendar Year Medical Plan Deductibles</strong></td>
<td>None</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td><strong>Calendar Year Maximum Medical Out-of-pocket Per Covered Family Member</strong></td>
<td>$1,500</td>
<td>$6,700</td>
<td>$6,700</td>
</tr>
<tr>
<td><strong>Professional Services</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physician Office Visits – Primary Care Physician</td>
<td>$10 copay</td>
<td>$5 copay</td>
<td>$5 copay</td>
</tr>
<tr>
<td>Physician Office Visits – Specialty Care Physician</td>
<td>$10 copay</td>
<td>$5 copay</td>
<td>$5 copay</td>
</tr>
<tr>
<td>Preventive Care Exam</td>
<td>No charge</td>
<td>No charge</td>
<td>No charge</td>
</tr>
<tr>
<td>Outpatient Basic Diagnostic X-ray and Lab</td>
<td>No charge</td>
<td>No charge</td>
<td>No charge</td>
</tr>
<tr>
<td>Outpatient Physical / Rehabilitation Therapy</td>
<td>$10 copay</td>
<td>$5 copay</td>
<td>$5 copay – Up to 36 Sessions /36 weeks per lifetime</td>
</tr>
<tr>
<td>Chiropractic Care (Must be Medically Necessary)</td>
<td>$10 copay</td>
<td>$5 copay – Up to 12 visits/year</td>
<td>$5 copay - Up to 12 visits/year</td>
</tr>
<tr>
<td>Annual Hearing Exam</td>
<td>$10 copay</td>
<td>No charge (1x / Year)</td>
<td>No charge</td>
</tr>
<tr>
<td>Hearing Aids</td>
<td>Not covered</td>
<td>Plan pays up to $500 allowance (Every 3 years)</td>
<td>Plan pays up to $1,000 allowance (Every 3 years)</td>
</tr>
<tr>
<td>Annual Eye Exam</td>
<td>$10 copay</td>
<td>$5 copay</td>
<td>$5 copay</td>
</tr>
<tr>
<td>Eyewear – Every 24 months</td>
<td>Plan pays up to $150 eyewear allowance every 2 years</td>
<td>Plan pays up to $130 eyewear allowance or $175 contacts lenses allowance every 2 years</td>
<td>Plan pays up to $130 eyewear allowance or $175 contacts lenses allowance every 2 years</td>
</tr>
<tr>
<td>Durable Medical Equipment</td>
<td>No charge</td>
<td>No charge</td>
<td>No charge</td>
</tr>
<tr>
<td><strong>Hospital Services</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient</td>
<td>No charge</td>
<td>No charge</td>
<td>No charge</td>
</tr>
<tr>
<td>Outpatient Surgery</td>
<td>$10 copay</td>
<td>No charge</td>
<td>No charge</td>
</tr>
<tr>
<td>Emergency Room (Copay Waived if Admitted)</td>
<td>$50 copay</td>
<td>$5 copay</td>
<td>$50 copay</td>
</tr>
<tr>
<td>Urgent Care</td>
<td>$10 copay</td>
<td>$5 copay</td>
<td>$5 copay</td>
</tr>
<tr>
<td>Ambulance</td>
<td>No charge</td>
<td>No charge</td>
<td>No charge</td>
</tr>
<tr>
<td>Skilled Nursing Facility (up to 100 days per benefit period)</td>
<td>No charge</td>
<td>No charge</td>
<td>No charge</td>
</tr>
<tr>
<td>Home Health Care</td>
<td>No charge</td>
<td>No charge</td>
<td>No charge</td>
</tr>
<tr>
<td>Hospice (Other than Rx and Respite Care)</td>
<td>No charge</td>
<td>No charge</td>
<td>No charge</td>
</tr>
<tr>
<td><strong>Mental Health &amp; Substance Abuse</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mental Health (outpatient / inpatient)</td>
<td>$10 copay / No charge</td>
<td>$5 copay / No charge</td>
<td>$5 copay / $0 – Up to 190 days/lifetime</td>
</tr>
<tr>
<td><strong>Prescription Drugs</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Retail Prescription Drugs</td>
<td>Up to a→</td>
<td>Up to a→</td>
<td>Up to a→</td>
</tr>
<tr>
<td>Tier 1 – Generic</td>
<td>100-day supply</td>
<td>30-day supply</td>
<td>30-day supply</td>
</tr>
<tr>
<td>Tier 2 – Formulary /Preferred Brand Name</td>
<td>$10 copay</td>
<td>$7 copay</td>
<td>$5 copay</td>
</tr>
<tr>
<td>Tier 3 – Non-Formulary Brand Name</td>
<td>$10 copay</td>
<td>$14 copay</td>
<td>$20 copay</td>
</tr>
<tr>
<td>Mail Order Prescription Drugs</td>
<td>Up to a→</td>
<td>Up to a→</td>
<td>Up to a→</td>
</tr>
<tr>
<td>Tier 1 – Generic</td>
<td>100-day supply</td>
<td>90-day supply</td>
<td>90-day supply</td>
</tr>
<tr>
<td>Tier 2 – Formulary /Preferred Brand Name</td>
<td>$10 copay</td>
<td>$14 copay</td>
<td>$40 copay</td>
</tr>
<tr>
<td>Tier 3 – Non-Formulary Brand Name</td>
<td>$10 copay</td>
<td>$28 copay</td>
<td>$80 copay</td>
</tr>
</tbody>
</table>
The above information is merely a brief description of the major benefits offered through the District. It is not intended to alter or expand benefits, rights or liabilities as set forth in the official plan document contracts. Please refer to the Summary of Benefits or Evidences of Coverage for each plan for complete details of Plan benefits, limitations and exclusions.

VEBA Advocacy Benefits

VEBA Advocacy

Navigating the healthcare system can be a confusing and complicated experience. The VEBA Advocacy Department is here to help. VEBA members can reach out to an Advocate when they are experiencing an issue with their insurance carrier or their health care providers. Here is a list of who to contact when you are experiencing any of the following challenges:

Contact VEBA Advocacy when you...
- Are experiencing trouble with a doctor or insurance carrier
- Need help getting a referral or second opinion
- Have quality of care or other escalated issues

Call 1.888.276.0250 or email advocacy@mcgregorinc.com

Contact the Insurance Carrier when you...
- Need to order a medical ID card
- Need to change your Primary Care Physician
- Need help finding an in-network provider
- Have questions about a medical bill
- Have questions about co-pay, co-insurance, or deductible
- Have questions about your coverage

Contact the District when you...
- Need to update demographic information
- Need to change your plan
- Need to add or delete a dependent
- Have questions regarding premium costs

Best Doctors

Best Doctors® is a medical case-review program started by Harvard physicians. It provides free consultations with medical experts so you can make sure you have the right diagnosis and treatment when you have a serious, complex medical condition. This program is for members covered under both the Kaiser and UnitedHealthcare plans.

Services are free, confidential, and just a phone call away at 1.866.904.0910.
- Medical Review: Get in-depth advice from expert physicians about your complex medical condition.
- Ask the Expert: Get advice about your medical condition.
- Oncology Insight with Watson is a new offering from Best Doctors that partners leading oncologists with the most advanced in cognitive technology.

For more information, visit the Best Doctors website at members.bestdoctors.com.

VEBA Resource Center (VRC)

The VRC offers comprehensive well-being care by addressing emotional, social, financial and physical health. Services include holistic care, yoga, cooking classes, health coaching and more.

For more information, email VRC@mcgregorinc.com
# Out-of-Area Dependents Plans

The chart below describes what plans are available to your out-of-area dependents, based on the plan you enroll in and their out-of-area address. Please note that the option to move a dependent to an out-of-area plan is only available if the primary subscriber is enrolled in an under age 65 medical plan.

<table>
<thead>
<tr>
<th>Your Health Plan</th>
<th>Dependents living in California but OUTSIDE of San Diego County Area</th>
<th>Dependents living OUTSIDE of California</th>
</tr>
</thead>
<tbody>
<tr>
<td>UnitedHealthcare (UHC)</td>
<td>Based on dependent’s out-of-area address, dependent will be enrolled in either a UHC HMO or PPO plan.</td>
<td>Based on dependent’s out-of-state address, dependent will be enrolled in a PPO plan.</td>
</tr>
<tr>
<td>HMO Plan</td>
<td></td>
<td></td>
</tr>
<tr>
<td>UnitedHealthcare (UHC)</td>
<td>Your dependent will be enrolled in a UHC California PPO plan.</td>
<td>Based on dependent’s address, his or her out-of-state PPO plan may not be the same as yours, meaning network, copayment and deductible amounts, may be different than yours.</td>
</tr>
<tr>
<td>PPO Plan</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kaiser</td>
<td>Dependents of Kaiser members who live outside of a Kaiser service area or outside of California are eligible for Urgent or Emergency care only.</td>
<td>Dependents of Kaiser members who live outside of a Kaiser service area or outside of California are eligible for Urgent or Emergency care only.</td>
</tr>
</tbody>
</table>

## How does it work?

VEBA will assist in matching your out-of-area dependent’s health plan as closely as possible to the health plan you enroll in. Sometimes, your out-of-area dependent(s) may need to be placed/enrolled in another plan. This will ensure your dependent(s) have access to a provider network wherever they live.

## Here’s what you need to know:

1. The monthly premium cost for out-of-area dependent is the same as it is for dependents who live at home.
2. The plan your dependent is enrolled in is based on their out-of-area address.
3. Even if you enroll in an HMO plan, based on your dependent’s address, they may be enrolled in a different plan, either an HMO or PPO plan with different copays and benefits amounts. Again, it depends on your dependent’s address.
4. You must provide your dependent’s out-of-area address to the district’s benefits office. This will ensure the dependent is placed in an out-of-area plan that has a local provider network.
5. Dependents will remain on their out-of-area plan unless they change their permanent address. This means they cannot switch back to your HMO or PPO plan if they return home for a short period, such as winter, spring, or summer break.
6. Dependents who are enrolled in an HMO plan must choose a PCP within 30 miles of their out-of-area address.

*Please remember, if you are in an HMO plan, we will try to keep your dependent in an HMO plan. However, based on your dependent’s address, we may have to enroll them in the out-of-area PPO plan.*

**New ID cards will be issued by the carrier and sent to your home address.**
Dental Plan

Dental benefits are another important element of your overall health. With proper care, your teeth can and should last a lifetime. The District offers three choices of dental plans to eligible retirees. The retiree pays the full cost of coverage on a monthly basis.

Your Dental HMO & PPO Plan

This year, you and your eligible dependents will have the opportunity to enroll in either of two Dental Health Maintenance Organization (HMO) plans offered by Delta Dental (DeltaCare USA) or Western Dental, or a Dental Preferred Provider Organization (PPO) plan offered by Delta Dental. We encourage you to review the coverage details and select the option that best suits your needs.

Using the Plans

If you decide to enroll in either of the Dental HMO plans, you and your enrolled eligible dependents must first select a primary care dentist who participates in either the DeltaCare USA DHMO or Western Dental DHMO networks. To receive benefits in the Dental HMO plan, your dental care must either be provided by or referred to a specialist by your primary care dentist. If you receive services from any other dentist, you will be responsible for paying the entire dental bill yourself.

The Delta Dental PPO, available worldwide, provides you and your eligible dependents with the flexibility to choose any licensed dentist or specialist. Your share of the cost of services depends on whether you use a dentist in Delta Dental’s PPO network or an out-of-network dentist. If you choose a PPO dentist, you’ll receive the highest level of benefit from the plan versus an out-of-network dentist who has not agreed to provide services at the negotiated rate. Additionally, no claim forms are required when using in-network PPO dentists. If you go to a dentist not affiliated with Delta Dental, you may have to pay the dentist’s total fee and then submit your claim form to Delta Dental for reimbursement.

Kaiser and UHC Medicare Advantage medical plans automatically include a basic dental benefit which cannot be waived. Please contact the carrier directly i.e. Kaiser or UnitedHealthcare for additional information regarding these dental plans.

Cost Estimator – Delta Dental PPO plan

Looking to budget your dental cost? Try the Cost Estimator. This feature of Delta Dental’s Online Services gives you a personalized estimate of how much you’ll pay for your next dentist visit. You will get a customized cost based on your actual benefits, taking into account any maximums and remaining deductible. Make an informed decision about going in-or out-of-network: Available on desktop and mobile; get an estimate on your computer, tablet or phone.

Choose your Primary Care Dentist

It’s important to carefully select a dental provider, and based on the plan you enroll in, the best choice for you may vary. To determine whether your dentist is in or out of your insurance network, go to www.deltadentalins.com or www.westerndental.com and search the Provider Network.

Plan highlights for both the Dental HMO and Dental PPO are included on the next page for your review and consideration.
### Plan Highlights

<table>
<thead>
<tr>
<th></th>
<th>Delta Dental PPO</th>
<th>Deltacare USA DHMO</th>
<th>Western Dental DHMO</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Calendar Year Deductible</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Per Person</td>
<td>$25 per individual</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Family Maximum</td>
<td>$75 per family</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Calendar Year Maximum</td>
<td>$1,500 per individual</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td><strong>Preventive</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Office Visit</td>
<td>No charge</td>
<td>No charge</td>
<td>No charge</td>
</tr>
<tr>
<td>X-rays</td>
<td>No charge</td>
<td>No charge</td>
<td>No charge</td>
</tr>
<tr>
<td>Cleanings</td>
<td>No charge</td>
<td>No charge</td>
<td>No charge</td>
</tr>
<tr>
<td><strong>Restorative</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Amalgam Fillings</td>
<td>No charge</td>
<td>No charge</td>
<td>No charge</td>
</tr>
<tr>
<td>Composite Fillings</td>
<td>No charge</td>
<td>No charge</td>
<td>No charge</td>
</tr>
<tr>
<td><strong>Periodontics (gum treatment)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Scaling &amp; Root Planing</td>
<td>No charge</td>
<td>No charge</td>
<td>No charge</td>
</tr>
<tr>
<td>Gingivectomy</td>
<td>No charge</td>
<td>No charge</td>
<td>No charge</td>
</tr>
<tr>
<td><strong>Endodontics</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pulpotomy</td>
<td>No charge</td>
<td>No charge</td>
<td>No charge</td>
</tr>
<tr>
<td>Root Canals</td>
<td>No charge</td>
<td>No charge</td>
<td>No charge</td>
</tr>
<tr>
<td><strong>Oral Surgery</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>General Anesthesia</td>
<td>No charge</td>
<td>No charge</td>
<td>No charge</td>
</tr>
<tr>
<td>Simple Extraction</td>
<td>No charge</td>
<td>No charge</td>
<td>No charge</td>
</tr>
<tr>
<td>Soft Tissue Impaction</td>
<td>No charge</td>
<td>No charge</td>
<td>No charge</td>
</tr>
<tr>
<td>Bony Impaction</td>
<td>No charge</td>
<td>No charge</td>
<td>No charge</td>
</tr>
<tr>
<td><strong>Crowns &amp; Bridges</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inlay / Onlay (2 surfaces)</td>
<td>No charge</td>
<td>No charge</td>
<td>No charge</td>
</tr>
<tr>
<td>Crowns</td>
<td>No charge</td>
<td>No charge</td>
<td>No charge</td>
</tr>
<tr>
<td><strong>Prosthetics (dentures)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Denture Adjustment</td>
<td>No charge</td>
<td>No charge</td>
<td>No charge</td>
</tr>
<tr>
<td>Denture (Complete / Partial)</td>
<td>No charge</td>
<td>No charge</td>
<td>No charge</td>
</tr>
<tr>
<td>Orthodontia Services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adults / Child(ren)</td>
<td>$50 Benefit per lifetime (per person)</td>
<td>Not covered</td>
<td>$1,000 copay</td>
</tr>
</tbody>
</table>

(1) 70% of the PPO contracted fee schedule for both Delta Premier Dentists and Non-Delta Dental dentists

The above information is a summary only. Please refer to your Evidence of Coverage for complete details of Plan benefits, limitations and exclusions.
Vision Plan

This separate vision benefit is available only for retirees who elected to continue vision coverage for a maximum of 18 months through COBRA within 60 days after retirement. Coverage for medical care for your eyes, such as eye infection, injury or glaucoma is provided through your medical plan. Please review the summary of benefits for your medical plan to see if it also includes any vision exam or hardware benefit.

Your Vision Plan

Vision coverage is offered by Vision Service Plan as a Preferred Provider Organization (PPO) plan. The plan has coverage for routine eye exams, frames and lenses.

Using the Plan

As with a traditional PPO, you may take advantage of the highest level of benefit by receiving services from in-network vision providers and doctors. You would be responsible for a copayment at the time of your service. There is no ID card; just make an appointment with a VSP-Signature doctor and tell them you are a VSP member. However, if you receive services from an out-of-network doctor, you pay all expenses at the time of service and submit a claim for reimbursement up to the VSP-allowed amount.

Any questions pertaining to your vision coverage can be directed to Vision Service Plan by calling 1.800.877.7195 or visiting their website, www.vsp.com.

Plan Highlights

<table>
<thead>
<tr>
<th>Vision Service Plan Vision PPO</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Exam – Every 12 months</strong></td>
<td>$25 copay for eye exam &amp; glasses</td>
<td>Reimbursement up to $40</td>
</tr>
<tr>
<td><strong>Lenses – Every 24 months</strong></td>
<td>No charge</td>
<td>Reimbursement up to $40</td>
</tr>
<tr>
<td>Single</td>
<td>No charge</td>
<td>Reimbursement up to $60</td>
</tr>
<tr>
<td>Lined Bifocal</td>
<td>No charge</td>
<td>Reimbursement up to $80</td>
</tr>
<tr>
<td>Lined Trifocal</td>
<td>$105 Allowance</td>
<td>Reimbursement up to $45</td>
</tr>
<tr>
<td><strong>Frames – Every 24 months</strong></td>
<td>Allowance inclusive of both Contacts &amp; Contact Lens Exam</td>
<td>Reimbursement up to $210</td>
</tr>
<tr>
<td><strong>Contacts – Every 24 months, in lieu of lenses &amp; frames</strong></td>
<td>No Charge</td>
<td>Reimbursement up to $105</td>
</tr>
<tr>
<td><strong>Medically Necessary</strong></td>
<td>$105 Allowance</td>
<td>N/A</td>
</tr>
<tr>
<td><strong>Cosmetic Lenses fitting and evaluation (15% Savings on Exam)</strong></td>
<td>30% Discount</td>
<td>N/A</td>
</tr>
<tr>
<td><strong>Additional Benefits</strong></td>
<td>Discount varies between 5% - 15%</td>
<td>N/A</td>
</tr>
<tr>
<td>Additional Pairs of Glasses</td>
<td></td>
<td></td>
</tr>
<tr>
<td>LASIK</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The above information is a summary only. Please refer to your Evidence of Coverage (EOC) to learn the plan benefits details, limitations and exclusions.

Five Tips for Superior Vision

Don’t take your eyes for granted! The following pointers can help you keep your vision strong:

- Eat lots of leafy greens and dark berries.
- Get regular eye exams.
- Give your eyes a rest from staring into the computer screen.
- Wear sunglasses to protect your eyes from bright light.
Hearing Aids

Please review the summary of benefits for your medical plan to determine if there is any hearing aid benefit under that plan, prior to seeking services for hearing aids.

VSP Members Exclusive Member Extra Benefit – TruHearing Hearing Aid Discount Program

For retirees, the hearing aid benefit for VSP members is available only for retirees who elect vision coverage through COBRA within 60 days of retirement. Continuation of vision coverage under COBRA is for a maximum of 18 months from the date coverage ended as an active employee.

The cost of a pair of quality hearing aids usually costs more than $5,000. TruHearing is making hearing aids affordable by providing exclusive savings to all VSP Vision Care members. VSP members can save up to $2,400 on a pair of digital hearing aids. Dependents and even extended family members are eligible for exclusive savings too.

In addition to great pricing, TruHearing provides VSP members with:

- Three visits for an exam, fitting, adjustments and cleanings with a TruHearing-participating licensed hearing aid professional. The provider may charge up to $75 for the exam.
- 45-day money back guarantee
- Three year manufacturer’s warranty for repairs and for one-time loss and damage
- 48 free batteries per hearing aid
- Deep discounts on replacement batteries shipped directly to your home

How do you get started?

1. Call TruHearing at 1.877.396.7194. You and family members MUST mention VSP when you call.
2. TruHearing will answer your questions and schedule a hearing exam with a local, participating provider.
3. The provider will make a recommendation, order the hearing aids through TruHearing, and fit them for you.

Learn more about this VSP Exclusive Member Extra at www.vsp.truhearing.com or call TruHearing at 1.877.396.7194.

The relationship between VSP and TruHearing is that of independent contractors. VSP makes no endorsement, representations or warranties regarding any products or services offered by TruHearing, a third-party vendor. The vendor is solely responsible for the products or services offered by them. If you have any questions regarding the services offered here, you should contact the vendor directly.
Basic Life and AD&D

Protect your loved ones

In the event of your death, Life Insurance will provide your family members or other beneficiaries with financial protection and security.

District-Paid Basic Life and AD&D Coverage

Your district-paid Basic Life and AD&D benefit ceases on your retirement date. However, Hartford offers two options to continue the amount of your Basic Life insurance with an individual policy without your having to provide evidence of good health. Application for either option must be made within 31 days of your retirement. The options are:

1. Convert to a Permanent, level-premium policy, or
2. If you have not reached your Social Security Normal Retirement Age, “port” your insurance to a different Term, increasing-premium insurance policy.

These post-retirement options do not include AD&D insurance. To obtain more information about these options, contact Hartford after your official retirement date, but not later than 31 days after your retirement date by calling The Hartford at 1-855-396-7655. The premium rates are based on your age at retirement and your gender.

Premium Waiver Provision: If you are totally disabled (as defined by Hartford) on the day you cease working as a benefit-eligible employee and are under age 70, you may be eligible to continue your Basic Life insurance with no premium payments up to the earlier of your age 70 or the date you are no longer totally disabled. If you think you may be eligible, please contact the Employee Benefits Department to request a premium waiver claim form.

Required! Are Your Beneficiaries Up to Date?

Beneficiaries are individuals or entities that you select to receive benefits from your policy.

- You can change your beneficiary designation at any time.
- You may designate a sole beneficiary or multiple beneficiaries to receive payment in the percent allocated.
- To select or change your beneficiary, you must go to: https://enroll.thehartfordatwork.com

You will need to have the following information for each beneficiary you would like to designate:
- Name
- Birth Date
- Social Security Number
Voluntary Life Insurance

For retirees who elected Voluntary Supplemental Life insurance coverage (excludes AD&D coverage) as an active employee for yourself and/or spouse/RDP, you may:

1. Continue that existing coverage by contacting Hartford directly at 1-855-396-7655 after your retirement date but within 60 days of retirement. Billing for monthly premium payments will continue to be handled by the District, or

2. Elect to change to an individual policy with The Harford within 31 days of your retirement and without having to provide evidence of insurability. The options are:
   a. Convert to a Permanent, level-premium policy, or
   b. If you have not reached your Social Security Normal Retirement Age, “port” your insurance to a different Term, increasing-premium policy.

To obtain more information about individual policies, please first contact the Employee Benefits Department for a Notice of Conversion and/or Portability Rights form within 31 days of your retirement date

Please note: If you elect to continue the existing program through the District, benefits reduce in accordance with the following schedule:

<table>
<thead>
<tr>
<th>AT AGE</th>
<th>BENEFITS REDUCE TO THE FOLLOWING PERCENT OF YOUR UNDER AGE 65 BENEFIT</th>
</tr>
</thead>
<tbody>
<tr>
<td>65</td>
<td>65%</td>
</tr>
<tr>
<td>70</td>
<td>50%</td>
</tr>
<tr>
<td>75</td>
<td>25%</td>
</tr>
<tr>
<td>80</td>
<td>The lesser of $10,000 or your age 75 amount</td>
</tr>
</tbody>
</table>

Premium Waiver Provision: If you are totally disabled (as defined by Hartford) on the day you cease working as a benefit-eligible employee and are under age 60, you may be eligible to continue your life insurance with no premium payments up to the earlier of your age 70 or the date you are no longer totally disabled. If you think you may be eligible, please contact the Employee Benefits Department to request a premium waiver claim form.

Please refer to your Certificate of Insurance for complete descriptions of the benefits, limitations, exclusions and further details about your life insurance.

Tenthly Premium Rates – Voluntary Life Coverage
THROUGH the District

<table>
<thead>
<tr>
<th>Retiree Age</th>
<th>Tenthly Rates / $10,000</th>
<th>Tenthly Rates / $5,000</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Retiree (Non-Smoker)</td>
<td>Retiree (Smoker)</td>
</tr>
<tr>
<td>Under 40</td>
<td>$0.56</td>
<td>$1.08</td>
</tr>
<tr>
<td>40 – 49</td>
<td>$1.12</td>
<td>$1.85</td>
</tr>
<tr>
<td>50 – 59</td>
<td>$2.76</td>
<td>$5.16</td>
</tr>
<tr>
<td>60 – 64</td>
<td>$5.62</td>
<td>$8.83</td>
</tr>
<tr>
<td>65 – 69</td>
<td>$9.96</td>
<td>$15.24</td>
</tr>
<tr>
<td>70 – 74</td>
<td>$18.47</td>
<td>$25.21</td>
</tr>
<tr>
<td>75 – 79</td>
<td>$24.72</td>
<td>$42.00</td>
</tr>
<tr>
<td>80+</td>
<td>$24.72</td>
<td>$58.30</td>
</tr>
</tbody>
</table>
Flexible Spending Accounts (FSA)

If you contributed to a Health Care FSA as an active employee, you may submit claims for expenses that were incurred during the portion of the plan year up to the end of the month after termination except when termination of employment occurs between June 1 and August 31 of the plan year. In that case, you may continue to submit claims for expenses incurred up to August 31 of the plan year.

The plan year is defined as January 1 to December 31. A Health Care FSA is eligible for COBRA continuation through the end of the plan year only if there is a positive balance in the Health Care FSA account at the time of retirement. Continuation of a Health Care FSA under COBRA is not a pre-tax benefit and is subject to a 2% administrative fee. In lieu of COBRA, active employees may continue their coverage after retirement through the end of the current plan year by having the remainder of their annual election deducted from their last paycheck on a pre-tax basis.

If you contributed to a Dependent Care FSA as an active employee, you may submit claims for employment related dependent care expense reimbursements incurred through the remainder of the plan year in which you retired from the district. Claims must be submitted for reimbursement within 90 days after the end of the plan year.

<table>
<thead>
<tr>
<th>FSA Type</th>
<th>Detail</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Care FSA</td>
<td>• Can reimburse for eligible health care expenses not covered or only partially covered by your medical, dental and vision insurance.</td>
</tr>
<tr>
<td></td>
<td>• Only those who elected a Health Care FSA as an active employee have options to file claims for reimbursement and/or have COBRA continuation rights after retirement.</td>
</tr>
<tr>
<td></td>
<td>• The Health Care FSA covers expenses for yourself, your legal spouse, your children up to age 26 or anyone else you claim as a dependent on your federal income tax return.</td>
</tr>
<tr>
<td></td>
<td>• Maximum contribution for 2020 is $2,700</td>
</tr>
</tbody>
</table>

Remember to Plan Carefully!

- You cannot change your Health Care FSA contributions during the year unless you experience an applicable Qualified Life Event. In lieu of COBRA, active employees can elect to have the remainder of their annual Health Care FSA election deducted pre-tax from their final paycheck.
- You should use all the funds in your account(s) prior to retirement. Any amount remaining in your account(s) at the end of the calendar year cannot be refunded or carried over to the next year. If you don’t use the money in your Health Care FSA, you’ll lose it, based on IRS regulations.
- You must save all receipts* as proof of the eligibility of the expense is required by the Internal Revenue Code (IRC); even if you use your American Fidelity Benefits Debit Card as payment.

*The internal Revenue Code (IRC) requires proof of the eligible expenses using itemized receipts or other documentation showing the date of service, person for whom service was provided and description of the expense. Depending on the type of expense, documentation may come in the form of third party itemized statements or Explanation of Benefits.

INDIVIDUALS ENROLLED IN THE UNITEDHEALTHCARE SIGNATURE VALUE ALLIANCE HMO $1800 OR THE JOURNEY-HARMONY HMO PLAN MAY NOT RECEIVE REIMBURSEMENT FROM BOTH THEIR HEALTH REIMBURSEMENT ACCOUNT AND THEIR HEALTH CARE FSA FOR THE SAME OUT-OF-POCKET HEALTH CARE EXPENSES.

Receiving Reimbursements

You will have until March 31 of the following plan year to submit a reimbursement request. If you do not receive automatic reimbursement by using your debit card, you can submit a manual reimbursement request by:

- Online: [https://americanfidelity.com](https://americanfidelity.com)
- Phone: 1.800.662.1113
- Mail: P.O. Box 25510, Oklahoma City, OK 73125-0510
- Mobile App: AFmobile

You may receive your manual reimbursement by check in the mail or by means of direct deposit into your personal Checking or Savings Account.
Employee Assistance Program (EAP)
(EXCLUDES RETIREES ON MEDICARE PLANS)

There may be times in your life when you need personal help and don’t know where to turn. Whatever the problem, you don’t need to handle it alone. VEBA has arranged to provide confidential EAP services to retirees under age 65 retirees and their dependents who are covered by a District-sponsored medical plan.

When you call the EAP, you will be connected with a licensed EAP counselor who will help you determine the most appropriate type of assistance to resolve your issue. For authorization or referrals call Optum EAP at 1.888.625.4809 or visit the EAP’s website at www.LiveAndWorkWell.com. Use Access Code: VEBA

The EAP program can help with life issues through a wide range of services, including face-to-face counseling sessions or a referral to community resources. Here are some examples:

**Counseling Services** (The first 5 face-to-face counseling sessions are free; then small copayments are required):
- Depression, anxiety and stress
- Workplace conflicts
- Grief and loss
- Relationship problems
- Alcohol and substance abuse/addiction

**Dependent Care Referrals:**
- Referrals to child care or elder care providers
- Referrals to home health care providers

**Legal and Financial Issues** (One free 30-minute legal consultation is provided; subsequent assistance is available with a 25% discount.)
- Wills, trusts and estate planning
- Divorce or custody
- Small claims and personal injury
- Real estate transactions
- Financial planning and debt management
- Planning for retirement
Retirement Savings Plans – IRC 457(B) / 403(B)

After your retirement, you may not make contributions to your Deferred Compensation IRC 457(b) plan or your Tax Sheltered Annuity IRC Section 403(b) plan. In general, your withdrawal options are listed below; however, it is strongly recommended that you discuss your options with a financial advisor at Variable Annuity Life Insurance Company (VALIC) by calling at 619.718.7000 or by going to MyRetirementManager.com.

To check your 457(b) plan and/or the 403(b) plan account balance, view your contributions, change your investments and more, visit MyRetirementManager.com. For login or password assistance please contact the Fiscal Control Department at 1-619-725-7669 or send an email to deferred.comp@sandi.net.

Additional 457(b) and 403(b) Information

**Distributions after Retirement:** Upon retirement from the District, you are entitled to request a full distribution of your vested account balance. This may be done as a rollover to another 457(b) or 403(b) plan, a 401(k) plan, or to an IRA. You also may request a lump-sum cash payment to yourself. Please be aware of possible taxes and penalties, which may apply to any payment other than a rollover. To avoid tax penalties, IRS determined required minimum withdrawals must commence in the calendar year in which a retiree attains age 72.
Below, please find important contact information and resources for San Diego Unified School District.

### Information Regarding

<table>
<thead>
<tr>
<th>Enrollment &amp; Eligibility</th>
<th>Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>• SDUSD Benefits Department</td>
<td>619.725.8130 <a href="mailto:employeebenefits@sandi.net">employeebenefits@sandi.net</a></td>
</tr>
<tr>
<td>California Schools VEBA</td>
<td></td>
</tr>
<tr>
<td>• VEBA</td>
<td>619.278.0021 <a href="http://www.vebaonline.com">www.vebaonline.com</a></td>
</tr>
<tr>
<td>• VEBA Advocacy Program</td>
<td>888.276.0250 Email: <a href="mailto:advocacy@mcgregorinc.com">advocacy@mcgregorinc.com</a></td>
</tr>
</tbody>
</table>

### Medical Coverage & Programs

| Kaiser | 800.464.4000 my.kp.org/veba |
| UnitedHealthcare | 800.443.0815 my.kp.org/veba |
| • HMO | 888.586.6365 www.csveba.welcometouhc.com |
| • Senior Advantage HMO | 800.457.8506 www.UHCRetiree.com |
| • Medicare Advantage HMO | 800.826.9781 www.umr.com |
| • UMR NexusACO Select Plus PPO | 877.211.6550 www.UHCRetiree.com |
| • Medicare Advantage PPO | 800.918.8011 www.express-scripts.com |
| • Express Scripts RX – Under Age 65 Plans | 888.279.1828 www.optumrx.com |
| • Optum Rx for UHC Medicare Plans | 888.855.7806 |
| • Carrum Health – Under Age 65 Plans | 844.342.5505 email: customercare@healthinvesthra.com |
| Best Doctors | 866.904.0910 members.bestdoctors.com |
| Optum Financial Services – Alliance HRA | 800.243.5543 www.optumbank.com |
| VEGA Resource Center (VRC) | 619.398.4220 VRC@mcgregorinc.com |

### Dental Coverage

| Delta Dental | 866.499.3001 www.deltadentalins.com |
| DeltaCare | 800.422.4234 www.deltadentalins.com |
| Western Dental | 800.992.3366 www.westerndental.com |

### Vision Coverage

| Vision Service Plan | 800.877.7195 www.vsp.com |

### Life Insurance Plans


### Flexible Spending Accounts

| American Fidelity | 800.662.1113 www.americanfidelity.com Email: flex@americanfidelity.com |

### Deferred Compensation 457(b) Plans / Tax Sheltered Annuity 403(b) Plans

| VALIC Office | 619.718.7000 myretirementmanager.com |

### Employee Assistance Plan

| OptumHealth (Under Age 65 Plans) | 888.625.4809 www.liveandworkwell.com access code: Veba |
Plan Guidelines and Evidence of Coverage

The benefit summaries listed on the previous pages are brief summaries only. They do not fully describe the benefits coverage for your health and welfare plans. For details on the benefits coverage, please refer to the plan’s Evidence of Coverage. The Evidence of Coverage or Summary Plan Description is the binding document between the elected health plan and the member.

A health plan physician must determine that the services and supplies are medically necessary to prevent, diagnose, or treat the members’ medical condition. These services and supplies must be provided, prescribed, authorized, or directed by the health plan’s network physician unless the member enrolls in the PPO plan where the member can use a non-network physician.

The HMO member must receive the services and supplies at a health plan facility or skilled nursing facility inside the service area except where specifically noted to the contrary in the Evidence of Coverage.

For details on the benefit and claims review and adjudication procedures for each plan, please refer to the plan’s Evidence of Coverage. If there are any discrepancies between benefits included in this summary and the Evidence of Coverage or Summary Plan Description, the Evidence of Coverage or Summary Plan Description will prevail.

Informing You of Health Care Reform - The Affordable Care Act (ACA)

You can obtain health insurance through our benefits program or purchase coverage elsewhere, such as a State Health Insurance Exchange.

For more information regarding Health Care Reform, please contact the District’s Employee Benefits Department or visit www.cciio.cms.gov. You can also visit www.coveredca.com to review information specific to the Covered California State Health Insurance Exchange.

As part of ACA, “full-time” employees, as defined by ACA will receive an IRS Form 1095-C from the District. This form provides information about whether the District offered such employees medical benefits plans that met ACA “Affordability” and “Minimum Value” requirements in the prior calendar year. The form also identifies the months that eligible employees were enrolled in a medical benefits plan in the prior calendar year. Covered dependents will not be reflected on this Form.

In addition, employees, retirees and COBRA beneficiaries who were covered under a District-sponsored medical plan in the prior calendar year will receive an IRS Form 1095-B from their medical benefits provider, i.e., Kaiser or UnitedHealthcare. The form also will identify the months in the prior calendar year that eligible employees, retirees COBRA beneficiaries and their family members were enrolled in a medical benefits plan.

The above identified individuals should receive the forms by January 31 of the subsequent calendar year and can be used by individuals for the completion of their federal tax filings and to prove enrollment in medical benefits in the event an individual is audited by the IRS.

The District reserves the right, through the collective negotiations process with the employee organizations/associations to modify, amend or eliminate plans and carriers at any time in the future.
Important Notice about Your Prescription Drug Coverage and Medicare

Model Individual CREDITABLE Coverage Disclosure

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage and about your options under Medicare’s prescription drug coverage. This information can help you decide whether or not you want to join a Medicare prescription drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is available at the end of this notice.

There are two important things you need to know about your current coverage and Medicare’s prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. Your employer has determined that the prescription drug coverage offered is expected to pay, on average, as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join a Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15 to December 7. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare prescription drug plan.

What Happens to Your Current Coverage if You Decide to Join a Medicare Prescription Drug Plan?

Individuals who are eligible for Medicare should compare their current coverage, including which drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in their area.

If you are eligible for Medicare and do decide to enroll in a Medicare prescription drug plan and drop your employer’s group health plan prescription drug coverage, be aware that you and your dependents may not be able to get this coverage back.

Please contact your District’s Benefits Department for more information about what happens to your coverage if you enroll in a Medicare prescription drug plan.

Your medical benefits brochure contains a description of your current prescription drug benefits.

When Will You Pay a Higher Premium (Penalty) to Join a Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with your employer and don’t join a Medicare prescription drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later. If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information about This Notice or Your Current Prescription Drug Coverage...

Contact your District’s Benefits Department for further information. NOTE: You will receive this notice annually, before the next period you can join a Medicare prescription drug plan, and if this coverage through your employer changes. You also may request a copy of this notice at any time.

For More Information about Your Options Under Medicare Prescription Drug Coverage...

More detailed information about Medicare plans that offer prescription drug coverage is in the “Medicare & You” handbook. You’ll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans. For more information about Medicare prescription drug coverage:

Visit www.medicare.gov

Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the “Medicare & You” handbook for their telephone number) for personalized help

Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit the Social Security Administration (SSA) online at www.socialsecurity.gov, or call SSA at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Credible Coverage notice. If you decide to join one of the Medicare prescription drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).
Medicare Part D Notice

Important Notice about Your Prescription Drug Coverage and Medicare

Model Individual NON-CREDITABLE Coverage Disclosure

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage and about your options under Medicare’s prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. For information about where you can get help to make decisions about your prescription drug coverage, contact your District’s Benefits Department.

There are three important things you need to know about your current coverage and Medicare’s prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. Your employer has determined that the prescription drug coverage offered is NOT expected to pay, on average, as much as standard Medicare prescription drug coverage pays and is therefore considered Non-creditable Coverage. This is important because, most likely, you will get more help with your drug costs if you join a Medicare drug plan, than if you only have prescription drug coverage from your employer. This is also important because it may mean that you may pay a higher premium (a penalty) if you do not join a Medicare drug plan when you first become eligible.

3. You can keep your current coverage from your employer. However, because your coverage is non-creditable, you have decisions to make about Medicare prescription drug coverage that may affect how much you pay for that coverage, depending on if and when you join a drug plan. When you make your decision, you should compare your current coverage, including what drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area. Read this notice carefully – it explains your options.

When can you join a Medicare drug plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15 to December 7.

If Your Plan is an Employer/Union Sponsored Group Plan: However, if you decide to drop your current coverage with San Diego Unified District, since it is employer/union sponsored group coverage, you will be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan; however, you also may pay a higher premium (a penalty) because you did not have creditable coverage under employer/union sponsored group plan.

If Previous Coverage Provided was Creditable Coverage: Since you are losing creditable prescription drug coverage, you are also eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

When will you pay a higher premium (penalty) to join a Medicare drug plan?

Since the coverage provided by your employer, is not creditable, depending on how long you go without creditable prescription drug coverage you may pay a penalty to join a Medicare drug plan. Starting with the end of the last month that you were first eligible to join a Medicare drug plan but didn’t join, if you go 63 continuous days or longer without prescription drug coverage that is creditable, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

What happens to your current coverage if you decide to join a Medicare prescription drug plan?

If you decide to join a Medicare drug plan, your current coverage will be affected.

For individuals who elect Part D coverage, coverage under the employer plan will end for the individual and all covered dependents.

See pages 9–11 of the CMS Disclosure of Creditable Coverage to Medicare Part D Eligible Individuals Guidance (available at http://www.cms.hhs.gov/CreditableCoverage/), which outlines the prescription drug plan provisions/options that Medicare eligible individuals may have available to them when they become eligible for Medicare Part D.

If you do decide to join a Medicare drug plan and drop your current coverage, be aware that you and your dependents may not be able to get this coverage back.

For More Information about this Notice or Your Current Prescription Drug Coverage...

Contact your District’s Benefits Department for further information NOTE: You’ll receive this notice annually, before the next period you can join a Medicare drug plan, and if this coverage through your employer changes. You also may request a copy of this notice at any time.

For More Information about Your Options under Medicare Prescription Drug Coverage...

More detailed information about Medicare plans that offer prescription drug coverage is in the “Medicare & You” handbook. You’ll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans. For more information about Medicare prescription drug coverage:

• Visit www.medicare.gov
• Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the “Medicare & You” handbook for their telephone number) for personalized help
• Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit the Social Security Administration (SSA) online at www.socialsecurity.gov or call SSA at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this notice. If you enroll in one of the plans approved by Medicare which offer prescription drug coverage, you may be required to provide a copy of this notice when you join to show that you are not required to pay a higher premium amount.
REQUIRED NOTICES

Women’s Health & Cancer Rights Act

The Women’s Health and Cancer Rights Act (WHCRA) requires group health plans and health insurance issuers from discriminating against individuals in eligibility and continued eligibility for benefits and in individual premium or contribution rates based on health factors.

These health factors include: health status, medical condition (including both physical and mental illnesses), claims experience, receipt of health care, medical history, genetic information, evidence of insurability (including conditions arising out of acts of domestic violence and participation in activities such as motorcycling, snowmobiling, all-terrain vehicle riding, horseback riding, skiing, and other similar activities), and disability.

Special Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, HIPAA Special Enrollment Rights require your plan to allow you and/or your dependents to enroll in your employer’s plans (except dental and vision plans elected separately from your medical plans) if you or your dependents lose eligibility for other coverage (or if the employer stopped contributing towards your or your dependents’ other coverage). However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Other midyear election changes may be permitted under your plan (refer to “Change in Status” section). To request special enrollment or obtain more information, contact your District’s Benefits Department.

HIPAA Special Enrollment Opportunities include:

- COBRA (or state continuation coverage) exhaustion
- Loss of other coverage (1)
- Acquisition of a new spouse or dependent through marriage (1), adoption (1), or placement for adoption (1) or birth (1)
- Loss of state Children’s Health Insurance Program coverage (e.g., Healthy Families) (60-day notice) (1)
- Employee or dependents become eligible for state Premium Assistance Subsidy Program (60-day notice)

“Change in Status” Permitted Midyear Election Changes

- Due to the Internal Revenue Service (IRS) regulations, in order to be eligible to take your premium contribution using pre-tax dollars, your election must be irrevocable for the entire plan year. As a result, your enrollment in the medical, dental, and vision plans or declaration of coverage when you are first eligible, will remain in place until the next Open Enrollment period, unless you have an approved “change in status” as defined by the IRS.
- Examples of permitted “change in status” events include:
  - Change in legal marital status (e.g., marriage, divorce or legal separation)
  - Change in number of dependents (e.g., birth, adoption or death)
  - Change in eligibility of a child
  - Change in your / your spouse’s / your registered domestic partner’s employment status (e.g., reduction in hours affecting eligibility or change in employment)
  - A substantial change in your / your spouse’s / your registered domestic partner’s benefits coverage
  - A relocation that impacts network access
  - Enrollment in state-based insurance Exchange
  - Medicare Part A or B enrollment
  - Qualified Medical Child Support Order or other judicial decree
  - A dependent’s eligibility ceases resulting in a loss of coverage (2)
  - Loss of other coverage (3)
  - Change in employment status where you have a reduction in hours to an average below 30 hours per week, but continue to be eligible for benefits, and you intend to enroll in another plan that provides Minimum Essential Coverage that is effective no later than the first day of the second month following the date of revocation of your employer sponsored coverage
  - You enroll, or intend to enroll, in a Qualified Health Plan (QHP) through the State Marketplace (i.e., Exchange) and it is effective no later than the day immediately following the revocation of your employer sponsored coverage

You must notify your District’s Benefits Department within 30 days of the above change in status, with the exception of the following which requires notice within 60 days:

- Loss of eligibility or enrollment in Medicaid or state health insurance programs (e.g., Healthy Families)

IMPORTANT INFORMATION ON HOW HEALTH CARE REFORM AFFECTS YOUR PLAN

Primary Care Provider Designations

For plans and issuers that require or allow for the designation of primary care providers by participants or beneficiaries:

- Your HMO generally requires the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact your District’s Benefits Department.

For plans and issuers that require or allow for the designation of a primary care provider for a child:

- For children, you may designate a pediatrician as the primary care provider.

For plans and issuers that provide coverage for obstetric or gynecological care and require the designation by a participant or beneficiary of a primary care provider:

- You do not need prior authorization from your insurance provider or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from your designated primary care provider.

The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact your District’s Benefits Department.

Grandfathered Plans

If your group health plan is grandfathered, then the following will apply. As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator.

Prohibition on Excess Waiting Periods

Group health plans may not apply a waiting period that exceeds 90 days. A waiting period is defined as the period that must pass before coverage for an eligible employee or his or her dependent becomes effective under the Plan. State law may require shorter waiting periods for insured group health plans. California law requires fully-insured plans to comply with the more restrictive waiting period limitation of no more than 60-days.

Preexisting Condition Exclusion

Effective for Plan Years on or after January 1, 2014, Group health plans are prohibited from denying coverage or excluding specific benefits from coverage due to an individual’s preexisting condition, regardless of the individual’s age. A PCE includes any health condition or illness that is present before the coverage effective date, regardless of whether medical advice or treatment was actually received or recommended.

CONTINUATION COVERAGE RIGHTS UNDER COBRA

You’re getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to it. When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan’s Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30–day special enrollment period for another group health plan for which you are eligible (such as a spouse’s plan), even if that plan generally doesn’t accept late enrollees.

(1) Indicates that this event is also a qualified “Change in Status”
(2) Indicates this event is also a HIPAA Special Enrollment Right
(3) Indicates that this event is also a COBRAQualifying Event
CONTINUATION COVERAGE RIGHTS UNDER COBRA (CONTINUED)

What is COBRA continuation coverage?

COBRA continuation coverage is the same coverage that the plan gives to other participants or beneficiaries who aren’t getting continuation coverage. Each “qualified beneficiary” (described below) who elects COBRA continuation coverage will have the same rights under the plan as other participants or beneficiaries covered under the plan.

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called “qualifying event.” Specific qualifying events are listed later. After the qualifying event, COBRA continuation coverage must be offered to each person who is a “qualified beneficiary.” Your, your spouse, and your dependent children could become qualified beneficiaries if covered under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation must pay for COBRA continuation coverage.

If you’re an employee, you’ll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you’re the spouse of an employee, you’ll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse’s hours of employment are reduced;
- Your spouse’s employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employee’s hours of employment are reduced;
- The parent-employee becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a “dependent child.”

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to [enter name of employer sponsoring the Plan], and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary. The retired employee’s spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

When is COBRA continuation coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee;
- Commencement of a proceeding in bankruptcy with respect to the employer; or
- The employee’s becoming entitled to Medicare benefits (under Part A, Part B, or both).

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child’s losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to: Employee Benefits Department, San Diego Unified School District, 4100 Normal Street, Room 1150A; San Diego, CA 92103.

How is COBRA continuation coverage provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to termination or reduction of hours of employment. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability must have been in existence at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.

How is COBRA continuation coverage provided? (Continued)

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to an additional 18 months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse’s plan) through what is called a “special enrollment period.” Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact persons identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor’s Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA’s website.) For more information about the Marketplace, visit www.healthcare.gov.

Keep your Plan informed of address changes

To protect your family’s rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan contact information

VEBA – San Diego Unified School District
Eugene Bruicker Education Center
San Diego Unified School District
Employee Benefits Department
4100 Normal Street, Room 1150A
San Diego, CA 92103

For More Information

This notice doesn’t fully describe continuation coverage or other rights under the plan. More information about continuation coverage and your rights under the plan is available in your summary plan description or from the Plan Administrator.

If you have questions about the information in this notice, your rights to coverage, or if you want a copy of your summary plan description, contact your District’s Benefits Department.

For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, visit the U.S. Department of Labor’s Employee Benefits Security Administration (EBSA) website at www.dol.gov/ebsa or call their toll-free number at 1-866-444-3272. For more information about health insurance options available through the Health Insurance Marketplace, and to locate an assistor in your area who you can talk to about the different options, visit www.healthcare.gov.

EMPLOYEE RIGHTS & RESPONSIBILITIES UNDER THE FAMILY MEDICAL LEAVE ACT

Basic Leave Entitlement

Family Medical Leave Act (FMLA) requires covered employers to provide up to 12 weeks of unpaid, job protected leave to eligible employees for the following reasons:

- For incapacity due to pregnancy, prenatal medical care or childbirth;
- To care for the employee’s child after birth, or placement for adoption or foster care;
- To care for the employee’s spouse, son or daughter, or parent, who has a serious health condition; or
- For a serious health condition that makes the employee unable to perform the employee’s job.

Military Family Leave Entitlements

Eligible employees whose spouse, son, daughter or parent is on covered active duty or call to covered active duty status must use their 12 week leave entitlement to address certain qualifying exigencies. Qualifying exigencies may include attending certain military events, arranging for alternative childcare, addressing certain financial and legal arrangements, attending certain counseling sessions, and attending post-deployment reintegration briefings.

FMLA also includes a special leave entitlement that permits eligible employees to take up to 26 weeks of leave to care for a covered service member during a single 12-month period. A covered service member is: (1) a current member of the Armed Forces, including a member of the National Guard or Reserves, who is undergoing medical treatment, recuperation or therapy, is otherwise in outpatient status, or is otherwise on the temporary disability retired list, for a serious injury or illness (1); or (2) a veteran who was discharged or released under conditions other than dishonorable at any time during the five year period prior to the first date the eligible employee takes FMLA leave to care for the covered veteran, and who is undergoing medical treatment, recuperation, or therapy for a serious injury or illness. (1)

Benefits & Protections

During FMLA leave, the employer must maintain the employee’s health coverage under any “group health plan” on the same terms as if the employee had continued to work. Upon return from FMLA leave, most employees must be restored to their original or equivalent positions with equivalent pay, benefits, and other employment terms.

Use of FMLA leave cannot result in the loss of any employment benefit that accrued prior to the start of an employee’s leave.

Eligibility Requirements

Employees are eligible if they have worked for a covered employer for at least 12 months, have 1,250 hours of service in the previous 12 months (4), and if at least 50 employees in an area employed by the employer within 75 miles.

(1) The FMLA definitions of "serious injury or illness" for current servicemembers and veterans are distinct from the FMLA definition of "serious health condition"

(2) Special hours of service eligibility requirements apply to airline flight crew employees.
Definition of Serious Health Condition
A serious health condition is an illness, injury, impairment, or physical or mental condition that involves either an overnight stay in a medical care facility, or ongoing treatment by a health care provider for a condition that either prevents the employee from performing the functions of the employee's job, or prevents the qualified family member from participating in school or other daily activities.

Subject to certain conditions, the ongoing treatment requirement may be met by a period of incapacity of more than 3 consecutive calendar days combined with at least two visits to a health care provider or one visit and a regimen of continuing treatment, or incapacity due to pregnancy, or incapacity due to a chronic condition. Other conditions may meet the definition of continuing treatment.

Use of Leave
An employee does not need to use this leave entitlement in one block. Leave can be taken intermittently or on a reduced leave schedule when medically necessary. Employees must make reasonable efforts to schedule leave for planned medical treatment so as not to unduly disrupt the employer's operations. Leave due to qualifying exigencies may also be taken on an intermittent basis.

Substitution of Paid Leave for Unpaid Leave
Employees may choose or employers may require use of accrued paid leave while taking FMLA leave. In order to use paid leave for FMLA leave, employees must comply with the employer's normal paid leave policies.

Employee Responsibilities
Employees must provide 30 days advance notice of the need to take FMLA leave when the need is foreseeable. When 30 days' notice is not possible, the employer must provide notice as soon as practicable and generally must comply with an employer's normal call-in procedures.

Employees must provide sufficient information for the employer to determine if the leave may qualify for FMLA protection and the anticipated timing and duration of the leave. Sufficient information may include that the employee is unable to perform job functions; the family member is unable to perform daily activities, the need for hospitalization or continuing treatment by a health care provider; or circumstances supporting the need for military family leave. Employees also must inform the employer if the requested leave is for a reason for which FMLA leave was previously taken or certified. Employees also may be required to provide a certification and periodic recertification supporting the need for leave.

Employer Responsibilities
Covered employers must inform employees requesting leave whether they are eligible under FMLA. If they are, the notice must specify any additional information required as well as the employee's rights and responsibilities. If they are not eligible, the employer must provide a reason for the ineligibility.

Covered employers must inform employees if leave will be designated as FMLA-protected and the amount of leave counted against the employee's leave entitlement. If the employer determines that the leave is not FMLA protected, the employer must notify the employee.

Unlawful Acts by Employers
FMLA makes it unlawful for any employer to:

• Interfere with, restrain, or deny the exercise of any right provided under FMLA;
• Discharge or discriminate against any person for opposing any practice made unlawful by FMLA or for involvement in any proceeding under or relating to FMLA.

Enforcement
An employee may file a complaint with the U.S. Department of Labor or may bring a private lawsuit against an employer.

FMLA does not affect any Federal or State law prohibiting discrimination, or supersede any State or local law or collective bargaining agreement which provides greater family or medical leave rights.

Definitions
For you to be entitled to continued coverage under USERRA, your absence from work must be due to uniformed service (including military family leave) for any of the following reasons:

• "Uniformed services" means the Armed Forces, the Army National Guard, and the Air National Guard when an individual is engaged in active duty for training, inactive duty training, or full-time National Guard duty (i.e., pursuant to orders issued under federal law), the commissioned corps of the Public Health Service, and any other category of persons designated by the President in time of war or national emergency

• "Service in the uniformed services" or "service" means the performance of duty on a voluntary or involuntary basis in the uniformed services under competent authority, including active duty, active and inactive duty for training, National Guard duty under federal statute, a period for which a person is absent from employment for an examination to determine his or her fitness to perform any of these duties, and a period for which a person is absent from employment to perform certain funeral honors duty. It also includes certain service by intermittent disaster response appointees of the National Disaster Medical System (NDMS)

If you do not elect continuation coverage, your coverage (and the coverage of your covered dependents, if any) under the Plan ends effective the end of the month in which you stop working due to your leave for uniformed service.

Premium for Continuing Your Coverage
The premium that you must pay to continue your coverage depends on your period of service in the uniformed services. Contact your District's Benefits Department for more details.

Length of Time Coverage Can Be Continued
If elected, continuation coverage can last 24 months from the date on which employee's leave for uniformed service began. However, coverage will automatically terminate earlier if one of the following events takes place:

• A premium is not paid in full within the required time;
• You fail to return to work or apply for reemployment within the time required under USERRA (see below) following the completion of your service in the uniformed services; or
• You lose your rights under USERRA as a result of a dishonorable discharge or other conduct specified in USERRA.

Reporting to Work / Applying for Reemployment
Your right to continue coverage under USERRA will end if you do not notify your District's Benefits Department of your intent to return to work within the timeframe required under USERRA following the completion of your service in the uniformed services by either reporting to work (if your uniformed service was for less than 31 days) or applying for reemployment (if your uniformed service was for more than 30 days). The time for returning to work depends on the period of uniformed service, as follows:

<table>
<thead>
<tr>
<th>Period of Uniformed Service</th>
<th>Report to Work Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 31 days</td>
<td>The beginning of the first regularly scheduled work period on the day following the completion of your service, after allowing for safe travel home and an eight-hour rest period, or if that is unreasonable or impossible through no fault of your own, then as soon as is possible</td>
</tr>
<tr>
<td>31–180 days</td>
<td>Submit an application for reemployment within 14 days after completion of your service or, if that is unreasonable or impossible through no fault of your own, then as soon as is possible</td>
</tr>
<tr>
<td>181 days or more</td>
<td>Submit an application for reemployment within 90 days after completion of your service</td>
</tr>
<tr>
<td>Any period if for purposes of an examination for fitness to perform uniformed service</td>
<td>Report by the beginning of the first regularly scheduled work period on the day following the completion of your service, after allowing for safe travel home and an eight-hour rest period, or if that is unreasonable or impossible through no fault of your own, then as soon as is possible</td>
</tr>
<tr>
<td>Any period if you were hospitalized for or are convalescing from an injury or illness incurred or aggravated as a result of your service</td>
<td>Report or submit an application for reemployment as above (depending on length of service period) except that time periods begin when you have recovered from your injuries or illness rather than upon completion of your service. Maximum period for recovering is limited to two years from completion of service but may be extended if circumstances beyond your control make it impossible or unreasonable for you to return to work within the above time periods</td>
</tr>
</tbody>
</table>

UNIFORMED SERVICES EMPLOYMENT & REEMPLOYMENT RIGHTS ACT NOTICE OF 1994, NOTICE OF RIGHT TO CONTINUED COVERAGE UNDER USERRA

Right to Continue Coverage
Under the Uniformed Services Employment & Reemployment Rights Act of 1994 (USERRA), you (the employee) have the right to continue the coverage that you (and your covered dependents, if any) had under the Company Medical Plan if the following conditions are met:

• You are absent from work due to service in the uniformed services (defined below);
• You were covered under the Plan at the time your absence from work began;
• You (or an appropriate officer of the uniformed services) provided your employer with advance notice of your absence from work (you are excused from meeting this condition if compliance is precluded by military necessity or is otherwise impossible or unreasonable under the circumstances).

How to Continue Coverage
If the conditions are met, you (or your authorized representative) may elect to continue your coverage (and the coverage of your covered dependents, if any) under the Plan by completing and returning an Election Form 60 days after date that USERRA election notice is mailed, and by paying the applicable premium for your coverage as described below.

What Happens If You Do Not Elect to Continue Coverage?
If you fail to submit a timely, completed Election Form as instructed or do not make a premium payment within the required time, you will lose your continuation rights under the Plan, unless compliance with these requirements is precluded by military necessity or is otherwise impossible or unreasonable under the circumstances.
HIPAA PRIVACY NOTICE

Notice of Health Information Privacy Practices

This notice describes how medical information about you may be used and disclosed, and how you can obtain access to this information. Please review it carefully.

This notice is EFFECTIVE: January 1, 2020

This notice is required by law under the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) and is intended to provide information about the legal protections that apply to your health information. HIPAA includes numerous provisions that are designed to maintain the privacy and confidentiality of your Protected Health Information (PHI). PHI is health information that contains identifiers (such as your name, address, social security number, or other information that identifies you) and information related to your past, present or future health condition and treatments.

This notice is for participants in the Company Health & Welfare Plan (referred to as the “Plan”), including its component plans.

Required by Law

- The Plan must make sure that health information that identifies you is kept private.
- The Plan must give you this notice of our legal duties and privacy practices with respect to health information about you.
- The Plan must obtain written authorization from you for the use and disclosure of your PHI related to psychotherapy notes; when for purposes of marketing; and/or for disclosures constituting a sale of PHI.
- The Plan must follow the terms of the notice that are currently in effect.

Permitted Plan Use of Your Health Information

For certain health information, you can tell us about your choices as to what we share. If you have a clear preference for how we share your information in the situations described below, contact the Plan Privacy Officer.

You have both the right and choice to tell us to share information with your family, close friends, or others involved in payment for your care; share information in a disaster relief situation; and contact you for fund raising efforts.

If you are not able to tell us your preference, for example if you are unconscious, the Plan may go ahead and share your information if it believes it is in your best interest. The Plan may also share your information when needed to lessen a serious and imminent threat to health or safety.

The Plan will never share your information unless you give us written permission for: marketing purposes and the sale of your information.

Treatment: The Plan may use your health information to assist your health care providers (doctors, pharmacies, hospitals and others) to treat your health condition. For example, the Plan may provide information to a doctor to assist in giving you care.

Regular Operations: We may use information in health records to review our claims experience and to make determinations with respect to the benefit options that we offer to employers. We may also use and disclose your information to run our organization and contact you when necessary. For example, the Plan may use or disclose your information to send you our member newsletter or other employment updates.

Payment for Health Services and Administration of the Plan: The Plan can use and disclose your information for payment for your health services. For example, the Plan may share information about you with your dental plan to coordinate payment for your dental work. The Plan may use and disclose your information to decide whether we will provide you coverage and the price of that coverage. This does not apply to long term care plans.

Business Associates: There are some services provided in our organization through contracts with business associates. Business associates with access to your health information must adhere to a contract requiring compliance with HIPAA privacy rules and HIPAA security rules.

As Required by Law: We will disclose health information about you when required to do so by federal, state or local law (this includes the Department of Health and Human Services if it wants to see that the Plan is complying with federal privacy law).

To Respond to Organ and Tissue Donation Requests and Work with a Medical Examiner or Funeral Director: We may share health information about you with organ procurement organizations; and may share health information with a coroner, medical examiner, or funeral director when an individual dies.

Workers’ Compensation: We may release health information about you for workers’ compensation programs or claims or similar programs. These programs provide benefits for work-related injuries or illness.

Law Enforcement and other Government Requests: We may disclose your health information for law enforcement purposes or with a law enforcement official, in response to a valid subpoena or other judicial or administrative request/order, with health oversight agencies for activities authorized by law, or for special government functions such as military, national security, and presidential protective services.

Public Health and Research: We may also use and disclose your health information to assist with public health activities (for example, reporting to a federal agency) or other public health activities (for example, in a government investigation). Additionally, we may share health information about you when: preventing disease; helping with product recalls; reporting adverse reactions to medications; reporting suspected abuse, neglect, or domestic violence; preventing or reducing a serious threat to anyone’s health or safety or for purposes of health research.

Your Rights Regarding Your Health Information

Although your health record is the physical property of the entity that compiled it, the information belongs to you. You have the right to:

- Request a restriction on certain uses and disclosures of your information where concerning a service already paid for.
- Obtain a paper copy of the notice of health information practices promptly (even if you have agreed to receive the notice electronically) by requesting it from the Plan Privacy Officer.
- Ask to see or get a copy of your health and claims records and other health information we have about you. We will provide you a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
- Inspect and obtain a copy of your PHI contained in a “designated record set.” A designated record set includes medical and billing records; enrollment, payment, billing, claims adjudication and case or medical management record systems; or other information used in whole or in part by or for the covered entity to make decisions about individuals. A written request to access your PHI must be submitted to your company Privacy Officer. Requested information will be provided within 30 days if maintained on site or 60 days if maintained off site.
- Request an amendment/correction to your health information; you can ask us to correct your health and claims records if you think they are incorrect or incomplete. We may say “no” to your request, but we’ll tell you why in writing within 60 days.
- Ask us to limit what we use or share. You can ask us to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say “no” if it would affect your care.
- Obtain an accounting of disclosures of your PHI during the preceding six years, who we shared it with, and why, with the exception of disclosures made for purposes of treatment, payment or health care operations, and certain other disclosures (such as any you asked us to make); made to individuals about their own PHI; or, made through use of an authorization form. A reasonable fee may be charged for more than one request per year.
- Request confidential communications of your health information be sent in a different way (for example, home, office or phone) or to a different place than usual (for example, you could request that the envelope be marked “confidential” or that we send it to your work address rather than your home address). We will consider all reasonable requests, and must say “yes” if we believe it is in your best interest.
- Revoke in writing your authorization to use or disclose health information except to the extent that action has already been taken, in reliance on that authorization.
- Receive notification within 60 days (5 days for California residents) for any breaches of your unsecured PHI.
- Assign someone as your medical power of attorney or your legal guardian, who can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.

Plan Responsibilities

The Plan is required to maintain the privacy of PHI and to comply with the terms of this notice. The Plan reserves the right to change our health privacy practices. Should we change our privacy practices in a material way, we will make a new version of our notice available to you within 60 days of the effective date of any material change to the rights and duties listed in this notice. The Plan is required to:

- Maintain the privacy and security of your health information.
- Make reasonable efforts to accommodate your request for more than the minimum necessary amount of PHI needed to accomplish the intended purpose, unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.
- Follow the duties and privacy practices described in this notice with respect to information we collect and maintain about you and provide you a copy of the notice.
- Abide by the terms of this notice.
- Notify you if we are unable to agree to a requested restriction, amendment or other request.
- Notify you of any breaches of your protected health information that may have compromised the privacy or security of your information within 60 days (5 days for California residents).
- Accredit any reasonable request you may have to communicate health information by alternative means or at alternative locations.

The Plan will not use or disclose your health information without your consent or authorization, except as provided by law or described in this notice. The Plan may use or disclose “summary health information” to the plan sponsor for obtaining premium bids or modifying, amending or terminating the Group Health Plan, which summarizes the claims history, claims expenses or type of claims experienced by individuals for whom a plan sponsor has provided health benefits under a Group Health Plan; and from which identifying information has been deleted in accordance with HIPAA. The plan is prohibited from using or disclosing PHI that is genetic information of an individual for any purposes, including underwriting.

For more information, see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticce.pdf

Your Right to File a Complaint

If you believe your privacy rights have been violated, you can file a formal complaint with the Plan Privacy Officer; or with the U.S. Department of Health and Human Services (by mail or email). We will not retaliate against you and you will not be penalized for filing a complaint.

Changes to the Terms of This Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site, and we will mail a copy to you.

Contact Person

If you have questions or would like additional information, or if you would like to make a request to inspect, copy, or amend health information, or for an accounting of disclosures, contact the Plan Privacy Officer. All requests must be submitted in writing to the address shown below.

CA Schools VEBA

Santee: Plan Privacy Officer
1843 Hotel Circle South
San Diego, CA 92108
619.278.0021
If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit [www.healthcare.gov](http://www.healthcare.gov).

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for premium assistance, call [1-877-KIDS NOW](http://www.insurekidsnow.gov) to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren’t already enrolled. This is called a “special enrollment” opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance. If you have questions about enrolling in your employer plan, contact the Department of Labor at [www.afge.org](http://www.afge.org) or call [1-866-444-EBSA](http://www.ebsa.dol.gov) (3272).

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2019. Contact your State for more information on eligibility.

<table>
<thead>
<tr>
<th>State</th>
<th>Medicaid URL</th>
<th>CHIP URL</th>
</tr>
</thead>
<tbody>
<tr>
<td>ALABAMA</td>
<td><a href="http://myalhipe.com">http://myalhipe.com</a></td>
<td></td>
</tr>
<tr>
<td>ALASKA</td>
<td><a href="http://myahigpp.com">http://myahigpp.com</a></td>
<td></td>
</tr>
<tr>
<td>ARKANSAS</td>
<td><a href="http://myahigpp.com">http://myahigpp.com</a></td>
<td></td>
</tr>
<tr>
<td>KANSAS</td>
<td><a href="http://www.lhcsks.org">http://www.lhcsks.org</a></td>
<td></td>
</tr>
<tr>
<td>LOUISIANA</td>
<td><a href="https://dhhs.louisiana.gov/index.cfm/lhcs/eh/1/2/331">https://dhhs.louisiana.gov/index.cfm/lhcs/eh/1/2/331</a></td>
<td></td>
</tr>
<tr>
<td>MINNESOTA</td>
<td><a href="https://www.dhs.state.mn.us/sponsored/healthcare/healthcare-programs/programs-and-services/other-insurance.jsp">https://www.dhs.state.mn.us/sponsored/healthcare/healthcare-programs/programs-and-services/other-insurance.jsp</a></td>
<td></td>
</tr>
<tr>
<td>MISSOURI</td>
<td><a href="http://www.dss.mo.gov/mhl/participants/pages/hipp.htm">http://www.dss.mo.gov/mhl/participants/pages/hipp.htm</a></td>
<td></td>
</tr>
<tr>
<td>MONTANA</td>
<td><a href="http://dphhs.mt.gov/MontanaHealthCarePrograms/HIPP">http://dphhs.mt.gov/MontanaHealthCarePrograms/HIPP</a></td>
<td></td>
</tr>
<tr>
<td>NEBRASKA</td>
<td><a href="http://www.ACCESSNebraska.ne.gov">http://www.ACCESSNebraska.ne.gov</a></td>
<td></td>
</tr>
</tbody>
</table>

**Premium Assistance Under Medicaid and the Children’s Health Insurance Program (CHIP)**

**Alabama – Medicaid**

Website: http://myalhipe.com
Phone: 1-855-692-5447

**Alaska – Medicaid**

Website: http://myahigpp.com
Phone: 1-866-251-4861
Email: CustomerServices@MyAHIGPP.com
Medicaid Eligibility: http://dhs.state.ak.us/dps/phones/medicaid/default.aspx

**Arkansas – Medicaid**

Website: [http://myahigpp.com](http://myahigpp.com)
Phone: 1-855-MyAHIGPP (855-692-7447)

**Colorado – Health First Colorado (Colorado’s Medicaid Program) & Child Health Plan Plus (CHIP)**

Website: [https://www.healthfirstcolorado.com/](https://www.healthfirstcolorado.com/)
Health First Colorado Member Contact Center:
1-800-221-3943/ State Relay 711

**Connecticut – Medicaid**

Website: [http://www.ct.gov/dhhs/section/24/hip-index.html](http://www.ct.gov/dhhs/section/24/hip-index.html)

**Florida – Medicaid**

Website: [http://floridahealth Connector/consumerhelp/patient-answers.html](http://floridahealth Connector/consumerhelp/patient-answers.html)

**Georgia – Medicaid**

Website: [http://myahigpp.com](http://myahigpp.com)
Phone: 1-866-251-4861
Email: CustomerServices@MyAHIGPP.com
Medicaid Eligibility: http://dphhs.state.ga.us/dps/phones/medicaid/default.aspx

**Indiana – Medicaid**

Website: [http://www.indianahealth.com](http://www.indianahealth.com)

**Iowa – Medicaid**

Website: [https://www.dhs.iowa.gov/hipp](https://www.dhs.iowa.gov/hipp)
Phone: 1-800-257-8563

**Kansas – Medicaid**

Website: [http://www.lhckks.org](http://www.lhckks.org)
Phone: 1-876-296-3512

**Nebraska – Medicaid**

Website: [http://www.dhs.ne.gov](http://www.dhs.ne.gov)
Phone: 1-866-521-2570

**New Hampshire – Medicaid**

Website: [https://chfs.nh.gov](https://chfs.nh.gov)
Phone: 1-800-221-3943/ State Relay 711

**New Jersey – Medicaid and CHIP**

Website: [http://www.njdhs.gov](http://www.njdhs.gov)
Phone: 1-888-695-2447

**New York – Medicaid**

Website: [https://www.ny.gov](https://www.ny.gov)
Phone: 1-888-541-5100

**North Carolina – Medicaid**

Website: [http://www.ncdhhs.gov](http://www.ncdhhs.gov)
Phone: 1-888-541-5100

**North Dakota – Medicaid**

Website: [http://www.nd.gov/dhs/services/medicalassistance/chip](http://www.nd.gov/dhs/services/medicalassistance/chip)
Phone: 1-888-695-5218

**Ohio – Medicaid**

Website: [http://medicaid.ohio.gov](http://medicaid.ohio.gov)
Phone: 1-888-731-8967

**Oklahoma – Medicaid and CHIP**

Website: [http://www.insureoklahoma.org](http://www.insureoklahoma.org)

**Oregon – Medicaid**

Website: [http://www.oregonhealthcare.gov](http://www.oregonhealthcare.gov)
Phone: 1-888-695-9075

**Pennsylvania – Medicaid**

Website: [http://wwwACCESSPa.gov](http://wwwACCESSPa.gov)
Phone: (866) 332-7633
Lincoln: (402) 473-7000
Omaha: (402) 595-1178

**Washington – Medicaid**

Website: [http://www.dhr.wa.gov](http://www.dhr.wa.gov)
Phone: 1-888-363-3742

**Wisconsin – Medicaid**

Website: [http://wisconsinhealthcare.gov](http://wisconsinhealthcare.gov)
Phone: 1-888-363-3742

**Wyoming – Medicaid**

Website: [http://www.wyoming.gov/dhs/services/medical-assistance/chip](http://www.wyoming.gov/dhs/services/medical-assistance/chip)
<table>
<thead>
<tr>
<th>State</th>
<th>Program</th>
<th>Website</th>
<th>Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rhode Island</td>
<td>Medicaid and CHIP</td>
<td><a href="http://www.eohhs.ri.gov/">http://www.eohhs.ri.gov/</a></td>
<td>855-697-4347, or 401-462-0311 (Direct Rite Share Line)</td>
</tr>
<tr>
<td>South Carolina</td>
<td>Medicaid</td>
<td><a href="http://www.scdhhs.gov">http://www.scdhhs.gov</a></td>
<td>1-888-549-0820</td>
</tr>
<tr>
<td>South Dakota</td>
<td>Medicaid and CHIP</td>
<td><a href="http://dept.sd.gov">http://dept.sd.gov</a></td>
<td>1-888-828-0059</td>
</tr>
<tr>
<td>Virginia</td>
<td>Medicaid and CHIP</td>
<td><a href="http://www.coverva.org/programs_premium_assistance.cfm">http://www.coverva.org/programs_premium_assistance.cfm</a></td>
<td>1-855-699-8447</td>
</tr>
<tr>
<td>Washington</td>
<td>Medicaid</td>
<td><a href="http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program">http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program</a></td>
<td>1-800-562-3022 ext. 15473</td>
</tr>
</tbody>
</table>

To see if any other states have added a premium assistance program since July 31, 2019, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration Centers for Medicare & Medicaid Services
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

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

**Paperwork Reduction Act Statement**

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 | Expires 12/31/2019
Notes