Active and Early Retiree *Benefits* Guide

2024

Sacramento City
UNIFIED SCHOOL DISTRICT

Employee Benefits Guide 2024

General Information

Core Benefits

Other Benefits

Miscellaneous

Click this icon in your benefits guide to watch a video explaining the associated topic. See page 31 for a glossary of terms.

If you (and/or your dependents) have Medicare or you will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage.

Please see page 23 for more details.

The information in this brochure is a general outline of the benefits offered under Sacramento City Unified School District's benefits program. Specific details and plan limitations are provided in the Summary Plan Descriptions (SPD), which is based on the official Plan Documents that may include policies, contracts and plan procedures. The SPD and Plan Documents contain all the specific provisions of the plans. In the event that the information in this brochure differs from the Plan Documents, the Plan Documents will prevail.

General

Sacramento City Unified School District understands the importance of offering a comprehensive benefit program that meets the needs of our diverse workforce. We are pleased to continue to provide a suite of quality benefit plans to all benefit eligible employees for the 2024 plan year.

2024 Core Health Plan Offerings

- Medical Plan
- Dental Plan
- Vision Plan
- Employee Assistance Program (EAP)
- Group Life and AD&D

In addition to the core health plans, you can purchase any of the following Voluntary Products

- Optional Life Insurance

Eligibility

Eligibility for benefits is determined by employee classification, number of hours scheduled to work and a waiting period before benefits are effective.

Eligibility for Benefits			
Employee Classification	**Full-Time**		**Part-Time**
Hours Requirement			
• Certificated	30 hours		15 hours
• Classified	40 hours		20 hours
• Management	40 hours		20 hours
Waiting Period *(benefits effective date)*	Per Bargaining Unit		
Benefits Offered	• Medical • Dental	• Vision • Employee Assistance Program	• Group Life & AD&D • Voluntary Life
When Benefits Terminate	Per Bargaining Unit		

Medical HMO Plan Comparisons - Classified Employees

Plan Benefits	HMO		
	Kaiser Permanente	Western Health Advantage	Sutter Health Plus
Plan Year Deductible *(Individual/Family)*	$0/$0	$0/$0	$0/$0
Annual Out-of-Pocket Maximum* *(Individual/Family)*	$1,500/$3,000	$1,500/$2,500	$1,000/$2,000
Lifetime Maximum	Unlimited	Unlimited	Unlimited
Inpatient Services			
• Hospital Room & Board, Ancillary Hospital Charges	$0 copay	$0 copay	$0 copay
Outpatient Services			
• Surgery	$10 copay	$100 copay	$0 copay
Physician Services			
• Office Visit *(Primary Care)*	$10 copay	$15 copay	$10 copay
• Office Visit *(Specialist)*	$10 copay	$15 copay	$10 copay
Emergency Care			
• Urgent Care	$10 copay	$20 copay	$10 copay
• Emergency Room Services *(waived if admitted)*	$75 copay	$100 copay	$50 copay per visit
• Ambulance - Air/Ground	$0 copay	$0 copay	$50 copay per trip
Preventive Care/Wellness Services			
• Physical Exams and Periodic Check-Ups	$0 copay	$0 copay	$0 copay
• Well Baby and Well Child Care	$0 copay	$0 copay	$0 copay
• Well Woman Exams	$0 copay	$0 copay	$0 copay
• Immunizations	$0 copay	$0 copay	$0 copay
Other Provider Services			
• Diagnostic X-rays & Lab *(Non-preventive)*	$0 copay	$0 copay	**X-Ray:** $0 copay **Lab:** $10 copay
• Physical, Speech, Occupational Therapy	$10 copay	$15 copay	$0 copay
• Chiropractic Care	$10 copay, 30 visits/year	$15 copay, 20 visits/year	$10 copay, 30 visits/year
• Acupuncture	$10 copay (prior authorization required)	$15 copay, 20 visits/year	Not covered
Pregnancy and Maternity Care			
• Pre-Natal Care	$0 copay	$0 copay	$0 copay
• Inpatient Hospital Services	$0 copay	$0 copay	$0 copay

* The total amount of a member's financial responsibility for certain covered services received during the plan year. Copayments, coinsurance amounts or payments made toward a plan deductible apply to the maximum. For detailed information and which services apply to the out-of-pocket maximum, refer to the plan Evidence of Coverage booklet

CLICK HERE to watch a video on Health Maintenance Organizations (HMO)

The information described on this page is only intended to be a summary of benefits. It does not describe or include all benefit provisions, limitations, exclusions, or qualifications for coverage. Please review plan documents for full details. If there are any conflicts with information provided on this page, the plan documents will prevail.

Medical HMO Plan Comparisons - Classified Employees (continued)

Plan Benefits	HMO		
	Kaiser Permanente	Western Health Advantage	Sutter Health Plus
General Medical Services			
• MRI, CT Scan, PET Scan, Nuclear Cardiac Scan	$0 copay	$0 copay	$50 copay
• Skilled Nursing Facility *(up to 100 days/benefit period)*	$0 copay	$0 copay	$0 copay
• Home Health Care *(up to 100 visits/year)*	$0 copay	$0 copay	$0 copay
• Hospice Care	$0 copay	$0 copay	$0 copay
• Durable Medical Equipment	$0 copay	20% coinsurance	$0 copay*
Mental or Nervous Disorders and Substance Abuse			
• Inpatient Care *(pre-authorization required)*	$0 copay	$0 copay	$0 copay
• Outpatient Visits – Individual	$10 copay	$15 copay	$10 copay
• Outpatient Visits – Group	$5 copay	$15 copay	$5 copay
Prescription Drugs			
• Retail	**100-DAY SUPPLY**	**30-DAY SUPPLY**	**30-DAY SUPPLY**
– Generic**	$10 copay	$10 copay	$5 copay
– Formulary Brand	$10 copay	$20 copay	$20 copay
– Non-Formulary Brand	$10 copay (prior authorization required)	$30 copay	$40 copay
• Mail Order	**100-DAY SUPPLY**	**90-DAY SUPPLY**	**100-DAY SUPPLY**
– Generic**	$10 copay	$25 copay	$10 copay
– Formulary Brand	$10 copay	$50 copay	$40 copay
– Non-Formulary Brand	$10 copay (prior authorization required)	$75 copay	$80 copay

* Prior Authorization Required.

** **Preferred Generic Program:** If a brand drug is requested when a generic version exists, member pays the generic copay plus the cost difference between the maximum allowed charge for generic and brand, unless physician has specified "dispense as written" (DAW) or when medically necessary; ***OR***
If a brand drug is dispensed and a generic is available, member is responsible for brand copay plus cost difference between generic and brand.

The information described on this page is only intended to be a summary of benefits. It does not describe or include all benefit provisions, limitations, exclusions, or qualifications for coverage. Please review plan documents for full details. If there are any conflicts with information provided on this page, the plan documents will prevail.

Medical HDHP Plan Comparisons - Classified Employees

Plan Benefits	High Deductible Health Plan – Health Savings Account		
	Kaiser Permanente	Western Health Advantage	Sutter Health Plus
Plan Year Deductible *(Individual/Family)*	$3,000/$3,000/$6,000	$1,800/$3,000/$3,600	$1,600/$3,200/$3,200
Annual Out-of-Pocket Maximum* *(Individual/Family)*	$3,000/$3,000/$6,000	$3,600/$7,200	$3,200/$6,400
Lifetime Maximum	No charge after deductible	No charge after deductible	No charge after deductible
Inpatient Services			
• Hospital Room & Board, Ancillary Hospital Charges	No charge after deductible	No charge after deductible	No charge after deductible
Outpatient Services			
• Surgery	No charge after deductible	No charge after deductible	No charge after deductible
Physician Services			
• Office Visit *(Primary Care)*	No charge after deductible	No charge after deductible	No charge after deductible
• Office Visit *(Specialist)*	No charge after deductible	No charge after deductible	No charge after deductible
Emergency Care			
• Urgent Care	No charge after deductible	No charge after deductible	No charge after deductible
• Emergency Room Services *(waived if admitted)*	No charge after deductible	No charge after deductible	No charge after deductible
• Ambulance - Air/Ground	No charge after deductible	No charge after deductible	No charge after deductible
Preventive Care/Wellness Services			
• Physical Exams and Periodic Check-Ups	No charge, deductible waived	No charge, deductible waived	No charge, deductible waived
• Well Baby and Well Child Care	No charge, deductible waived	No charge, deductible waived	No charge, deductible waived
• Well Woman Exams	No charge, deductible waived	No charge, deductible waived	No charge, deductible waived
• Immunizations	No charge, deductible waived	No charge, deductible waived	No charge, deductible waived
Other Provider Services			
• Diagnostic X-rays & Lab *(Non-preventive)*	No charge after deductible	No charge after deductible	No charge after deductible
• Physical, Speech, Occupational Therapy	No charge after deductible	No charge after deductible	No charge after deductible
• Chiropractic Care	Not covered	$15 copay	Not Covered
• Acupuncture	No charge, deductible waived (prior authorization required)	$15 copay	Not Covered
Pregnancy and Maternity Care			
• Pre-Natal Care	No charge, deductible waived	No charge, deductible waived	No charge, deductible waived
• Inpatient Hospital Services	No charge after deductible	No charge after deductible	$50 copay after deductible

* The total amount of a member's financial responsibility for certain covered services received during the plan year. Copayments, coinsurance amounts or payments made toward a plan deductible apply to the maximum. For detailed information and which services apply to the out-of-pocket maximum, refer to the plan Evidence of Coverage booklet

CLICK HERE to watch a video on High Deductible Health Plans (HDHP)

The information described on this page is only intended to be a summary of benefits. It does not describe or include all benefit provisions, limitations, exclusions, or qualifications for coverage. Please review plan documents for full details. If there are any conflicts with information provided on this page, the plan documents will prevail.

Medical HDHP Plan Comparisons - Classified Employees (continued)

Plan Benefits	High Deductible Health Plan – Health Savings Account		
	Kaiser Permanente	Western Health Advantage	Sutter Health Plus
General Medical Services			
• MRI, CT Scan, PET Scan, Nuclear Cardiac Scan	No charge after deductible	No charge after deductible	No charge after deductible
• Skilled Nursing Facility *(up to 100 days/benefit period)*	No charge after deductible	No charge after deductible	No charge after deductible
• Home Health Care *(up to 100 visits/year)*	No charge after deductible	No charge after deductible	No charge after deductible
• Hospice Care	No charge after deductible	No charge after deductible	No charge after deductible
• Durable Medical Equipment	No charge after deductible	No charge after deductible	No charge after deductible
Mental or Nervous Disorders and Substance Abuse			
• Inpatient Care *(pre-authorization required)*	No charge after deductible	No charge after deductible	No charge after deductible
• Outpatient Visits	No charge after deductible	No charge after deductible	No charge after deductible
Prescription Drugs			
• Plan Year Deductible	$0	$0	$0
• Retail	**100-DAY SUPPLY**	**30-DAY SUPPLY**	**30-DAY SUPPLY**
– Generic**	No charge after deductible	No charge after deductible	No charge after deductible
– Formulary Brand	No charge after deductible	No charge after deductible	No charge after deductible
– Non-Formulary Brand	No charge after deductible (prior authorization required)	No charge after deductible	No charge after deductible
• Mail Order	**100-DAY SUPPLY**	**90-DAY SUPPLY**	**100-DAY SUPPLY**
– Generic**	No charge after deductible	No charge after deductible	No charge after deductible
– Formulary Brand	No charge after deductible	No charge after deductible	No charge after deductible
– Non-Formulary Brand	No charge after deductible (prior authorization required)	No charge after deductible	No charge after deductible

** **Preferred Generic Program:** If a brand drug is requested when a generic version exists, member pays the generic copay plus the cost difference between the maximum allowed charge for generic and brand, unless physician has specified "dispense as written" (DAW) or when medically necessary; ***OR***
If a brand drug is dispensed and a generic is available, member is responsible for brand copay plus cost difference between generic and brand.

The information described on this page is only intended to be a summary of benefits. It does not describe or include all benefit provisions, limitations, exclusions, or qualifications for coverage. Please review plan documents for full details. If there are any conflicts with information provided on this page, the plan documents will prevail.

Medical HMO Plan Comparisons - Certificated Employees

Plan Benefits	Kaiser Permanente	HealthNet
	Member Responsibility	
Plan Year Deductible *(Individual/Family)*	$0/$0	$0/$0
Annual Out-of-Pocket Maximum* *(Individual/Family)*	$1,500/$3,000	$1,000/$2,500
Inpatient Services		
• Hospital Room & Board, Ancillary Hospital Charges	$0 copay	$0 copay
Outpatient Services		
• Surgery	$10/procedure	$0 copay
Physician Services		
• Office Visit *(Primary Care)*	$10 copay	$15 copay
• Office Visit *(Specialist)*	$10 copay	$15 copay
Emergency Care		
• Urgent Care	$10 copay	$20 copay
• Emergency Room Services *(waived if admitted)*	$75 copay	$75 copay
• Ambulance – Air/Ground	$0 copay	$0 copay
Preventive Care/Wellness Services		
• Physical Exams and Periodic Check-Ups	$0 copay	$0 copay
• Well Baby and Well Child Care	$0 copay	$0 copay
• Well Woman Exams	$0 copay	$0 copay
• Immunizations	$0 copay	$0 copay
Other Provider Services		
• Physical, Speech, Occupational Therapy	$10 copay	$5 copay (prior authorization required)
• Chiropractic Care *(limited to 30 visits/year)*	$10 copay	$10 copay
• Acupuncture	$10 copay (prior authorization required)	Not covered
Pregnancy and Maternity Care		
• Pre-Natal Care	$0 copay	$0 copay
• Inpatient Hospital Services	$0 copay	$0 copay

* The total amount of a member's financial responsibility for certain covered services received during the plan year. Copayments, coinsurance amounts or payments made toward a plan deductible apply to the maximum. For detailed information and which services apply to the out-of-pocket maximum, refer to the plan Evidence of Coverage booklet

The information described on this page is only intended to be a summary of benefits. It does not describe or include all benefit provisions, limitations, exclusions, or qualifications for coverage. Please review plan documents for full details. If there are any conflicts with information provided on this page, the plan documents will prevail.

Medical HMO Plan Comparisons - Certificated Employees (continued)

Plan Benefits	Kaiser Permanente	HealthNet
	Member Responsibility	
General Medical Services		
• X-Ray and Lab *(Non-preventive)*	$0 copay	$0 copay
• MRI, CT Scan, PET Scan, Nuclear Cardiac Scan	$0 copay	$0 copay
• Skilled Nursing Facility *(limited to 100 days/benefit period)*	$0 copay	$0 copay (prior authorization required)
• Home Health Care *(up to 100 visits/plan year)*	$0 copay	$0 copay (prior authorization required)
• Hospice Care	$0 copay	$0 copay (prior authorization required)
• Durable Medical Equipment	$0 copay	$0 copay (prior authorization required)
Mental or Nervous Disorders and Substance Abuse		
• Inpatient Care *(pre-authorization required)*	$0 copay	$0 copay
• Outpatient Visits – Individual	$10 copay	$0 copay
• Outpatient Visits – Group	$5 copay	$0 copay
Prescription Drugs		
• Plan Year Deductible	$0	$0
• Retail	**100-DAY SUPPLY**	**30-DAY SUPPLY**
– Generic**	$10 copay	$10 copay
– Formulary Brand	$10 copay	$20 copay
– Non-Formulary Brand	Not covered	$35 copay
• Mail Order	**100-DAY SUPPLY**	**90-DAY SUPPLY**
– Generic**	$10 copay	$20 copay
– Formulary Brand	$10 copay	$40 copay
– Non-Formulary Brand	Not covered	$70 copay

** **Preferred Generic Program:** If a brand drug is requested when a generic version exists, member pays the generic copay plus the cost difference between the maximum allowed charge for generic and brand, unless physician has specified "dispense as written" (DAW) or when medically necessary; ***OR***
If a brand drug is dispensed and a generic is available, member is responsible for brand copay plus cost difference between generic and brand.

The information described on this page is only intended to be a summary of benefits. It does not describe or include all benefit provisions, limitations, exclusions, or qualifications for coverage. Please review plan documents for full details. If there are any conflicts with information provided on this page, the plan documents will prevail.

Dental Plan Comparisons

Plan Benefits	Classified and Management	Certificated Employees			Certificated Retirees
	Delta Dental	Delta Dental	Premier Access PPO*		Premier Access DHMO
			In-Network	Out-of-Network	
	Member Responsibility				
Annual Deductible *(waived for Diagnostic and Preventive Services)*					
• Individual/Family	$0/$0	$0/$0	$0/$0	$0/$0	$0/$0
Annual Maximum Benefit	$1,500 Premier Provider $1,700 PPO Provider	$1,500 Premier Provider $1,700 PPO Provider	Plan pays up to $3,000	Plan pays up to $3,000	Unlimited
Diagnostic and Preventive Services					
• Oral Exams, Routine Cleanings, X-Rays, Fluoride Treatment	30 - 0%	30 - 0%	100%	100% of allowed charge**	$0 copay
Basic Services					
• Fillings *(amalgam)*	30 - 0%	30 - 0%	100%	100% of allowed charge**	$0 copay
• Fillings *(porcelain/ceramic)*	30 - 0%	30 - 0%	100%	100% of allowed charge**	$0 copay
• Endodontics *(root canals)*	30 - 0%	30 - 0%	100%	100% of allowed charge**	Various copays
• Oral Surgery	30 - 0%	30 - 0%	100%	100% of allowed charge**	Various copays
• Periodontics *(gum treatment)*	30 - 0%	30 - 0%	100%	100% of allowed charge**	Various copays
Major Services					
• Crowns, Inlays, Onlays, Cast Restorations	30 - 0%	30 - 0%	70%	60% of allowed charge**	Various copays
• Prosthodontics *(Dentures, Bridges)*	50%	50%	70%	60% of allowed charge**	Various copays
Orthodontics					
• Child *(to age 19)*	50%	50%	50%	50%	N/A
• Adult	50%	50%	50%	50%	N/A
• Lifetime Maximum	$500	$1,100	$2,500	$2,500	N/A

* Premier Access does not guarantee all services can be rendered by a contracted PCN or PPO provider. You may be subject to a deductible or coinsurance for an out of network Specialist.

** Limited to covered fee schedule

The information described on this page is only intended to be a summary of benefits. It does not describe or include all benefit provisions, limitations, exclusions, or qualifications for coverage. Please review plan documents for full details. If there are any conflicts with information provided on this page, the plan documents will prevail.

Dental

Why Choose Premier Access?

- A-Rated by AM Best
- Over 4000 Provider Access Points
- Over 20 years in the Managed Care Business

The Patient Charge Schedule is a summary of the covered services. Please check the Evidence of Coverage for full details. These services are covered only when covered dental services are performed by your Network Dentist, unless otherwise authorized by Premier Access Dental as described in your plan documents. The benefits shown are performed as deemed appropriate by the attending Primary Care Dentist (PCD) subject to the limitations and exclusions of the program. Enrollees should discuss all treatment options with their PCD prior to services being rendered.

Our Member Services Department is available Monday thru Friday 8 a.m. to 6 p.m. to answer questions and provide any help you may need at 866-650-3660

The following dental Benefits are excluded:

1. **Treatment which:** a) is not included in the list of Covered Services; b) is not Dentally Necessary; or c) is Experimental or Investigational Service.
2. Appliances, inlays, cast restorations, crowns, or other laboratory prepared restorations used primarily for the purpose of splinting.
3. Services, supplies and appliances related to the change of vertical dimension, restoration or maintenance of occlusion, splinting and stabilizing teeth for periodontic reasons, bite registration, bite analysis, attrition, erosion or abrasion, and treatment for temporomandibular joint dysfunction (TMJ), unless a TMJ benefit rider was included in the policy.
4. Replacement of a lost or stolen appliance including but not limited to, full or partial dentures, space maintainers and crowns and bridges.
5. Educational procedures, including but not limited to oral hygiene, plaque control or dietary instructions, unless specifically listed as a covered procedure on Schedule A.
6. Missed dental appointments. A fee of $25 may be charged by your Primary Care Dentist for failure to cancel an appointment without 24 hours prior notification.
7. Personal supplies or equipment, including but not limited to waterpiks, toothbrushes, or floss holders.
8. Treatment for a jaw fracture.
9. **Services or supplies provided by a dentist, dental hygienist, denturist or doctor who is:** a) a close relative or a person who ordinarily resides with You or an Eligible Dependent; b) an employee of the employer; c) the employer.
10. Hospital or facility charges for room, supplies or emergency room expenses, or routine chest x-rays and medical exams prior to oral surgery.
11. Services and supplies obtained while outside the United States, except for Emergency Care.
12. Services or supplies resulting from or in the course of your or your Eligible Dependent's regular occupation for pay or profit for which you or your Eligible Dependent are entitled to benefits under any Workers' Compensation Law, Employer's Liability Law or similar law. You must promptly claim and notify Us of all such benefits.
13. **Any Charges which are:**
    a. Payable or reimbursable by or through a plan or program of any governmental agency, except if the charge is related to a non-military service disability and treatment is provided by a governmental agency of the United States. However, We will always reimburse any state or local medical assistance (Medicaid) agency for Covered Services and supplies.
    b. Not imposed against the person or for which the person is not liable.
    c. Reimbursable by Medicare Part A and Part B. If an Eligible Person at any time was entitled to enroll in the Medicare program (including Part B) but did not do so, his or her Benefits under this policy will be reduced by an amount that would have been reimbursed by Medicare, where permitted by law. However, for Eligible Persons insured under employers who notify Us that they employ 20 or more employees during the previous business year, this exclusion will not apply to an actively at work employee and/or his or her spouse who is age 65 or older if the employee elects coverage under this policy instead of coverage under Medicare.

Dental (continued)

14. Services and supplies provided primarily for cosmetic purposes, except as specified in Schedule A.
15. Services and supplies which may not reasonably be expected to successfully correct the Member's dental condition for a period of at least three years, as determined by Us.
16. Orthodontic services, supplies, appliances and orthodontic-related services, unless an orthodontic rider was included in the policy.
17. Extraction of asymptomatic, pathology-free third molars (wisdom teeth).
18. Therapeutic drug injection.
19. Correction of congenital conditions or replacement of congenitally missing permanent teeth not covered, regardless of the length of time the deciduous tooth is retained.
20. General anesthesia or intravenous/conscious sedation, except as specified in Schedule A.
21. Excision of cysts and neoplasms, except as specified in Schedule A.
22. Osseous or muco-gingival surgery, except as specified in Schedule A.
23. Restorative procedures, root canals and appliances which are provided because of attrition, abrasion, erosion, wear, or for cosmetic purposes, except as specified in Schedule A.
24. Services and supplies provided as one dental procedure, and considered one procedure based on standard dental procedure codes, but separated into multiple procedure codes for billing purposes. The covered charge for the services is based on the single dental procedure code that accurately represents the treatment performed.
25. Replacement of stayplates.
26. Dispensing of drugs not normally supplied in a dental office.
27. Malignancies.
28. Additional treatment costs incurred because a dental procedure is unable to be performed in the dentist's office due to the general health and physical limitations of the Member.
29. The member will be responsible for the actual metal fees for any procedure involving the use of noble, high noble, or titanium metal.
30. Implant-supported dental appliances, implant placement, maintenance, removal and all other services associated with dental implants.
31. Dental services that are received in an Emergency Care setting for conditions which are not emergencies if the subscriber reasonably should have known that an Emergency Care situation did not exist.
32. Dental expenses incurred in connection with any dental procedures started after termination of coverage or prior to the date the Member became eligible for such services.

Limitations

Limitations of Other Coverage:

1. This dental coverage is not designed to duplicate any Benefits to which Members are entitled under government programs, including CHAMPUS, Medi-Cal or Workers' Compensation. By executing an enrollment application, a Member agrees to complete and submit to the Plan such consents, releases, assignments, and other documents reasonably requested by the Plan or order to obtain or assure CHAMPUS or Medi-Cal reimbursement or reimbursement under the Workers' Compensation Law.
2. Benefits provided by a pediatric dentist are limited to children under six years of age following an attempt by the assigned Primary Care Dentist to treat the child and upon Prior Authorization by Access Dental Plan, less applicable copayments.

Dental (continued)

DHMO650 Benefits

Premier Access Dental provides you and your family with quality dental benefits at an affordable cost. The program is designed to encourage regular dentist visits to maintain oral health. When enrolling, you select a contracted dentist to provide services for you and your family. The size of a provider network is meaningless without the assurance of quality care. Our dental providers consist of dental facilities that have been carefully screened for quality.

Plan Benefit Highlights

- Posterior Composites Oral Cancer Screening Additional Cleanings
- Cosmetic Procedures such as Labial Veneers & External Bleaching
- Defined Fees for Metal Upgrades Unlimited Benefits*
- General Anesthesia and IV Sedation Covered

Description	ADA Code	DHMO 903 Copay
Preventive Services		
• Periodic Oral Exam	D0120	$0
• Comprehensive Exam	D0150	$0
• Full Mouth Series (FMX)	D0210	$0
• Panoramic	D0330	$0
• Periapical X-rays	D0220	$0
• Bitewings - four films	D0274	$0
• Adult Cleanings	D1110	$0
• Child Cleanings	D1120	$0
• Adult/Child *(to age 19)* Fluoride Treatment	D1203/1204	$0
• Sealants 1st and 2nd Molars	D1351	$0
• Space Maintainers	D1515	$0
Basic Services		
• Restorations - Amalgam Fillings	D2140	$0
• Extractions - Erupted tooth	D7140	$0
• Surgical Removal - Erupted tooth	D7210	$0
• Root Canal Therapy - Anterior	D3310	$10.00
• Root Canal Therapy - Bicuspid	D3320	$10.00
• Root Canal Therapy - Molar	D3330	$15.00
• Scaling & Root Planing, per quadrant	D4341	$0
Major Services		
• Crowns	D2750	$5.00
• Bridges - per unit	D6210	$5.00
• Complete Denture - per arch	D5110	$195.00
• Partial Denture - per arch	D5211	$5.00

* Refer to your Evidence of Coverage for details

The information described on this page is only intended to be a summary of benefits. It does not describe or include all benefit provisions, limitations, exclusions, or qualifications for coverage. Please review plan documents for full details. If there are any conflicts with information provided on this page, the plan documents will prevail.

Vision Plan Comparisons

Plan Benefits	Vision Service Plan							
	Classified Employees		Certificated Employee Only		Certificated Family Plan		Management, Confidential, Supervisors	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Frequency								
• Eye Exam	Once every 12 months		Once every 12 months		Once every 12 months		Once every 12 months	
• Lenses/Contacts	Once every 12 months		Once every 12 months		Once every 24 months		Once every 12 months	
• Frames	Once every 24 months		Once every 12 months		Once every 24 months		Once every 24 months	
Copay	**MEMBER RESPONSIBILITY**	**PLAN PAYS**	**MEMBER RESPONSIBILITY**	**PLAN PAYS**	**MEMBER RESPONSIBILITY**	**PLAN PAYS**	**MEMBER RESPONSIBILITY**	**PLAN PAYS**
• Exam	$10	Up to $40	$0	Up to $40	$15	Up to $40	$20	Up to $40
• Fitting for Contacts	$50	Up to $50	$50	Up to $50	$105	Up to $105	$50	Up to $50
Prescription Lenses	**PLAN PAYS**		**PLAN PAYS**		**PLAN PAYS**		**PLAN PAYS**	
• Single	100%	Up to $40	100%	Up to $40	100%	Up to $40	100%	Up to $40
• Lined Bifocal	100%	Up to $60	100%	Up to $60	100%	Up to $60	100%	Up to $60
• Lined Trifocal	100%	Up to $80	100%	Up to $80	100%	Up to $80	100%	Up to $80
• Lenticular	100%	Up to $125	100%	Up to $125	100%	Up to $125	100%	Up to $125
Frames	**PLAN PAYS**		**PLAN PAYS**		**PLAN PAYS**		**PLAN PAYS**	
	Up to $105	Up to $45	Up to $105	Up to $45	Up to $105	Up to $45	Up to $105	Up to $45
Contacts *(in lieu of lenses and frames)*	**PLAN PAYS**		**PLAN PAYS**		**PLAN PAYS**		**PLAN PAYS**	
• Medically Necessary	100%	Up to $210	100%	Up to $210	100%	Up to $210	100%	Up to $210
• Elective	Up to $105	Up to $105	Up to $105	Up to $105	Up to $105	Up to $105	Up to $105	Up to $105

The information described on this page is only intended to be a summary of benefits. It does not describe or include all benefit provisions, limitations, exclusions, or qualifications for coverage. Please review plan documents for full details. If there are any conflicts with information provided on this page, the plan documents will prevail.

Basic Life & AD&D

Plan Benefits	Sun Life Assurance Company		
Eligible Class	**Class 1 – Management, Confidential, Supervisors**	**Class 2 – Classified, Food Service Supervisors**	**Class 3 – Certificated Employees**
Coverage Amount[1]	$125,000	$10,000	$10,000
Maximum Benefit	$125,000	$10,000	$10,000
Accelerated Benefit Option	Included		
Conversion	Yes/No		
Portability	Excluded		

1 If the value of any pre-tax life insurance coverage is greater than $50,000, the amount over $50,000 is added to your taxable compensation as "imputed income."

Dependent Life – Classes 1, 2, and 3

- **Spouse:** $1,500
- **Child (age 6 months to age 26):** $1,500
- **Child (Birth to 6 months):** $100

Supplemental/Optional/Voluntary Life

Classified and Management Employees

Plan Benefits	Sun Life Assurance Company
Coverage Amount	
• Employee	$15,000
Maximum Benefit	
• Employee	$15,000
Waiver of Premium[2]	Included, terminates at age 70
Age Reduction	
• At age 65	Reduction to 65 % of the initial benefit amount
• At age 70	Reduction to 50 % of the initial benefit amount
Accelerated Benefit Option	Yes
Conversion	Yes
Portability	Yes

1. Guarantee Issue is the amount of insurance you are guaranteed without having to complete Evidence of Insurability (EOI). Any amounts above the Guaranteed Issue amount is subject to underwriting where you will be required to complete an EOI form.
2. If you become Totally Disabled while insured, the Waiver of Premium Provision may continue your Life Insurance without any further payment of premiums by you.

The information described on this page is only intended to be a summary of benefits. It does not describe or include all benefit provisions, limitations, exclusions, or qualifications for coverage. Please review plan documents for full details. If there are any conflicts with information provided on this page, the plan documents will prevail.

Employee Assistance Program

SIA has a new Employee Assistance Program partner as of July 1, 2023. Optum will provide counseling, management consulting, trainings, financial, legal and ID theft support, Critical Incident Responses Services (CIRS), training and development for managers, WorkLife services, and much more.

- Toll-free 866-248-4096
- 24 hours a day, seven days a week
- TTY support is available by dialing 711 + 1-866-248-4096

The SIA EAP offers a multitude of resources to help you and your eligible family members handle the challenges of life.

Emotional Health

When you need a helping hand, a skilled professional can provide focus, direction, and support. Optum can help you identify and resolve issues involving:

- Marriage and relationships
- Family conflict
- Stress, anxiety, and emotional distress
- Grief and depression
- Alcohol or drug dependency
- Life changes
- Coping with loss following a natural disaster

Eligible members are entitled to face-to-face counseling, telephonic consultations, and web-video consultations.

Work & Life Services

Optum can assist with information and resources for the following challenges:

- Childcare
- Eldercare
- Daily living services
- Financial services
- Legal services
- Identity theft recovery services
- Home and property repairs following a natural disaster

Management Consultation

Optum's management consultants provide professional guidance and support for managing difficult workplace situations, troubled employees, and job performance issues. Their consultants have a unique background in professional counseling, human resources, and business, allowing them to offer insight, assessment, training, and action plans that are right for your managers and employees. Other management resources include Job Performance Referrals and On-Site Critical Incident response services.

Personal Wellness

- Self care app
- Wellness assessments
- Mindfulness tools

Online Assistance

https://www.liveandworkwell.com/

Optum

You can access assistance with work, life, and health challenges at one convenient, private website. Some of the features include multi-media self-help programs, articles, and links for a variety of emotional, health, child, teen, and family issues.

Provider Search also offers a list of Optum's mental health providers. A one-time registration is required. Your dependents may use it too. These services can be accessed 24 hours a day, 7 days a week on the internet.

Optum will hold your privacy in the highest regard. They will not share any personally identifying information to your employer, or to anyone outside Optum. You can use the site with confidence and comfort when searching for the personal information you need.

Flexible Spending Accounts

A great way to save money over the course of a year is to participate in the Flexible Spending Accounts (FSA). These accounts allow you to redirect a portion of your salary on a pre-tax basis into reimbursement accounts. Money from these accounts can be used to pay eligible out-of-pocket expenses such as health care deductibles, copays, Rx, and dependent care expenses.

Pre-tax means the dollars you use for eligible expenses are not subject to Social Security tax, federal income tax and, in most cases, state and local taxes. Money you would have paid in taxes can be used to pay qualified expenses.

There are two accounts: Health Care Spending Account and Dependent Care Spending Account. You may use either account, or both. When you enroll, you decide how much money to contribute to your personal accounts for the coming year. These contributions will be gradually deducted from your paycheck in equal amounts through the year and deposited into your account.

Health Care Spending Account

This account will reimburse you with pre-tax dollars for health care expenses not reimbursed under your family's health care plans. The maximum amount you may contribute to a Health Care Spending Account for the plan year is $3,050.

Please note: You must save your itemized receipts for all debit card purchases in case you are asked to provide them to Basic Pacific, the third party administrator, for substantiation, per IRS guidelines.

Dependent Day Care Spending Account

This account will reimburse you with pre-tax dollars for day care expenses for your child(ren) and other qualifying dependents. The maximum amount you may contribute to a Dependent Day Care Spending Account for the plan year $5,000, or $2,500 if you are married and file separate tax returns. Eligible dependents include:

- Children **under the age of 13** who qualify as dependents on your federal tax return; ***and***
- Children or other dependents of any age who are physically or mentally unable to care for themselves and who qualify as dependents on your federal tax return. You may use the federal childcare tax credit and the Dependent Day Care Spending Account. However, your federal credit will be offset by any amount deferred into the dependent day care plan.

How Your FSA Accounts Work

Each year during the Open Enrollment period, you decide how much you want to contribute to your health care and dependent care spending account(s) for the next calendar year.

At the start of the plan year, money is deducted from your paycheck in equal increments before taxes. These funds are contributed to your health care and/or dependent care spending account(s), thus saving you tax dollars.

As a participant of the FSA plan, you will be provided an FSA debit card. This card is linked to your FSA account. When purchasing qualified health care services or products, simply use your FSA debit card and the transaction is complete. You must save your itemized receipts for all debit card purchases in case you are asked to provide them to Basic Pacific for substantiation as per IRS guidelines.

When you have an eligible expense and need to submit a claim form for reimbursement, the form can be found and/or submitted at www.cbadministrators.com. You can also contact Basic Pacific or Human Resources for assistance.

Non-debit card claims can be mailed to:

Custom Benefit Administrators
PO Box 2170
Rocklin, CA 95677
916-303-7083 or online at www.cbadministrators.com

Upon review and approval of the eligible expenses submitted to FSA, you will be reimbursed for the expense(s).

HRA, FSA, HSA numbers are reflected for the 2023 calendar year. 2024 amounts are not typically determined until after the release of the Benefit Guide. Employees making elections for the 2024 year should keep this in mind.

Flexible Spending Accounts (continued)

Be Cautious!

Only qualifying health care and dependent care expenses incurred during the plan year, or grace period, will be eligible for reimbursement. The plan year begins on January 1st, of each calendar year and ends on December 31st.

Use it or lose it. Money in the accounts must be claimed within 90 calendar days after the end of the plan year or it will be forfeited.

Annual Grace Period

If at the end of your plan year you have a balance in your health care or dependent care account, you will have the opportunity to utilize those funds for qualified expenses during the grace period that ends on March 15th. After March 15, any funds that are left in your rollover account will be subject to the "use it or lose it" rule and will be forfeited.

Once you enroll, you can only change your elected payroll deduction if there is a change in family status, such as marriage, divorce, death, birth, adoption, or change in employment status.

If you are no longer working for Sacramento City USD, you can continue to submit reimbursement requests for expenses incurred up to your date of separation.

Please note, all requests for reimbursement must be received by Carrier within 90 calendar days of your last day of employment.

CLICK HERE to watch a video on Flexible Spending Accounts (FSA)

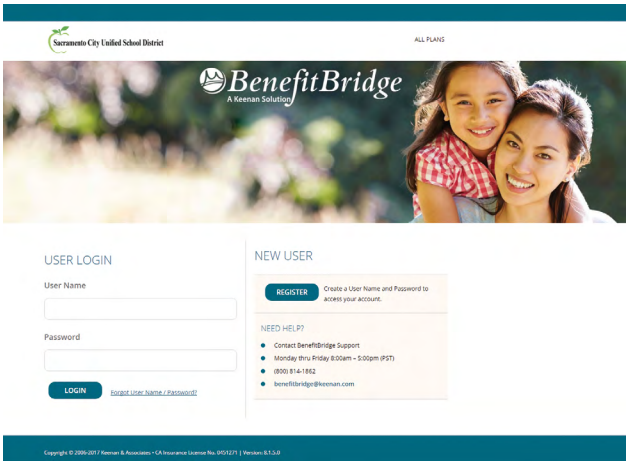
HRA, FSA, HSA numbers are reflected for the 2023 calendar year. 2024 amounts are not typically determined until after the release of the Benefit Guide. Employees making elections for the 2024 year should keep this in mind.

Employee Benefits Website: BenefitBridge

Check your BenefitBridge Web site. BenefitBridge can be accessed 24/7 from work or home PCs and offers immediate answers to benefit questions. You can view and compare your benefit choices, link to carrier websites, download forms and analyze your benefit needs. This web-based forum contains helpful information and a multitude of decision support tools. A link to Personal Choices will be available on your online enrollment Web site.

The following is a summary of the information and resources available on the Web site:

- **Benefits:** This section lists benefit plans offered to Sacramento City USD employees as well as a detailed description of each plan. This section can be used to compare and contrast different plans. It also contains your Summary Plan Descriptions and Evidence of Insurability forms.
- **Resources:** Contains news on a variety of health topics, as well as news articles and important benefits documents.
- **Understanding Benefits:** Presents the employee with situational questions, such as "Who am I?" The employee is able to choose an answer, such as "young single employee", and receive information specific to that employee-type.
- **State and Federal Programs:** Provides information and links to a variety of governmental programs including COBRA, FMLA, and HIPAA. Contact Human Resources for more specific information.
- **Life Events:** Provides employees with information for specific life events such as Having a Baby or Getting Married. This section also covers a variety of topics such as Family and Relationships, Health Education, Finances and Insurance, and Purchases. The Life Events page also contains a Health and Wellness section, which provides links to health and wellness websites such as WebMD and wellness.com.
- **Calculators:** This section provides a variety of calculators including budget, credit lines, home financing, and retirement.



To Access BenefitBridge

Log in information

www.benefitbridge.com/saccityusd

BenefitBridge Support

800-814-1862

Monday - Friday 8:00 AM - 5:00 PM

Important Notices

No Surprises Act Notice

Our medical plans are subject to the No Surprises Act, which limits the amount covered persons may have to pay for some out-of-network surprise medical bills. More information about surprise billing requirements included under the No Surprises Act and similar state laws can be found on the medical insurance company's website or the Plan Sponsor's website. Additional information may be found in your Explanation of Benefits for any affected claims.

Newborns' and Mothers' Health Protection Act (NMHPA)

Benefits for pregnancy hospital stay (for delivery) for a mother and her newborn may not be restricted to less than 48 hours following a vaginal delivery or 96 hours following a cesarean section. Also, any utilization review requirements for inpatient hospital admissions will not apply to this minimum length of stay. Early discharge is permitted only if the attending health care provider, in consultation with the mother, decides an earlier discharge is appropriate.

Women's Health and Cancer Rights Act (WHCRA) Annual Notice

Your plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services, including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema. For more information, you should review the Summary Plan Description or call your Plan Administrator at 916.643.9432 for more information.

Patient Protections

The medical plan 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. Until you make this designation, the plan will designate one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact your health plan.

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

You do not need prior authorization from the plan or any other person (including a primary care provider) to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. 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 health plan.

Networks/Claims/Appeals

The major medical plans described in this booklet have provider networks with Kaiser Permanente, HealthNet, Sutter Health Plus and Western Health Advantage. The listing of provider networks will be available to you automatically and free of charge. A list of network providers can be accessed immediately by using the Internet address found in the Summary of Benefits and Coverage that relates to the Plan. You have a right to appeal denials of claims and a right to a response within a reasonable amount of time. Claims that are not submitted within a reasonable time may be denied. Please review your Summary Plan Description or contact the Plan Administrator for more details.

COBRA Continuation Coverage

This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under covered medical, dental, and vision plans (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 get 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 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 federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

Important Notices (continued)

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 does not accept late enrollees.

WHAT IS COBRA CONTINUATION COVERAGE?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "Qualifying Event." Specific Qualifying Events are listed later in this notice. After a Qualifying Event, COBRA continuation coverage must be offered to each person who is a "Qualified Beneficiary." You, your spouse, and your dependent children could become Qualified Beneficiaries if coverage under the Plan is lost because of the Qualifying Event. Under the Plan, Qualified Beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a Qualified Beneficiary if you lose 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 are the spouse of an employee, you will 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 their 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 employment ends for any reason other than their gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or,
- The child stops being eligible for coverage under the Plan as a "dependent child."

WHEN IS COBRA CONTINUATION COVERAGE AVAILABLE?

The Plan will offer COBRA continuation coverage to Qualified Beneficiaries only after the Plan Administrator has been notified of a Qualifying Event:

- The end of employment or reduction of hours of employment;
- Death of the employee; or,
- The employee becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other Qualifying Events (e.g., divorce or legal separation of the employee and spouse, or a dependent child's losing eligibility for coverage as a dependent child, etc.), you must notify the Plan Administrator within 60 days after the Qualifying Event occurs. You must provide this notice to your employer.

Life insurance, accidental death and dismemberment benefits, and weekly income or long-term disability benefits (if part of the employer's plan), are not eligible for continuation under COBRA.

NOTICE AND ELECTION PROCEDURES

Each type of notice or election to be provided by a covered employee or a Qualified Beneficiary under this COBRA Continuation Coverage Section must be in writing, must be signed and dated, and must be mailed or hand-delivered to the Plan Administrator, properly addressed, or as otherwise permitted by the COBRA administrator, no later than the date specified in the election form, and properly submitted to the Plan Administrator.

Each notice must include all of the following items: the covered employee's full name, address, phone number, and Social Security Number; the full name, address, phone number, and Social Security Number of each affected dependent, as well as each dependent's relationship to the covered employee; a description of the Qualifying Event or disability determination that has occurred; the date the Qualifying Event or disability determination occurred; a copy of the Social Security Administration's written disability determination, if applicable; and the name of this Plan. The Plan Administrator may establish specific forms that must be used to provide a notice or election.

Important Notices (continued)

ELECTION AND ELECTION PERIOD

COBRA continuation coverage may be elected during the period beginning on the date Plan coverage would otherwise terminate due to a Qualifying Event and ending on the later of the following: (1) 60 days after coverage ends due to a Qualifying Event, or (2) 60 days after the notice of the COBRA continuation coverage rights is provided to the Qualified Beneficiary.

If, during the election period, a Qualified Beneficiary waives COBRA continuation coverage rights, the waiver can be revoked at any time before the end of the election period. Revocation of the waiver will be an election of COBRA continuation coverage. However, if a waiver is revoked, coverage need not be provided retroactively (that is, from the date of the loss of coverage until the waiver is revoked). Waivers and revocations of waivers are considered to be made on the date they are sent to the employer or Plan Administrator.

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 on behalf of their dependent children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. 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.

DISABILITY EXTENSION OF THE 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. This disability would have to have started 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. (See Notice and Election Procedures.)

SECOND QUALIFYING EVENT EXTENSION OF 18-MONTH PERIOD OF COBRA CONTINUATION COVERAGE

If your family experiences another Qualifying Event during the 18 months of COBRA continuation of coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation of 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 receiving COBRA continuation of coverage if the employee or former employee dies; becomes entitled to Medicare (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 the dependent child to lose coverage under the Plan had the first Qualifying Event not occurred. (See Notice and Election Procedures.)

OTHER OPTIONS BESIDES COBRA CONTINUATION COVERAGE

Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, Children's Health Insurance Program (CHIP), 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.

ENROLLMENT IN MEDICARE INSTEAD OF COBRA

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period[1] to sign up for Medicare Part A or B, beginning on the earlier of:

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

[1] https://www.medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b/part-a-part-b-sign-up-periods

Important Notices (continued)

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit https://www.medicare.gov/medicare-and-you.

IF YOU HAVE QUESTIONS

For more information about the Marketplace, visit www.healthcare.gov.

The U.S. Department of Health and Human Services (HHS), through the Centers for Medicare & Medicaid Services (CMS), has jurisdiction with respect to the COBRA continuation coverage requirements of the Public Health Service Act (PHSA) that apply to state and local government employers, including counties, municipalities, public school districts, and the group health plans that they sponsor (Public Sector COBRA). COBRA can be a daunting and complex area of federal law. If you have any questions or issues regarding Public Sector COBRA, you may contact the Plan Administrator or email HHS at phig@cms.hhs.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.

EFFECTIVE DATE OF COVERAGE

COBRA continuation coverage, if elected within the period allowed for such election, is effective retroactively to the date coverage would otherwise have terminated due to the Qualifying Event, and the Qualified Beneficiary will be charged for coverage in this retroactive period.

COST OF CONTINUATION COVERAGE

The cost of COBRA continuation coverage will not exceed 102% of the Plan's full cost of coverage during the same period for similarly situated non-COBRA beneficiaries to whom a Qualifying Event has not occurred. The "full cost" includes any part of the cost which is paid by the employer for non-COBRA beneficiaries.

The initial payment must be made within 45 days after the date of the COBRA election by the Qualified Beneficiary. Payment must cover the period of coverage from the date of the COBRA election retroactive to the date of loss of coverage due to the Qualifying Event (or the date a COBRA waiver was revoked, if applicable). The first and subsequent payments must be submitted and made payable to the Plan Administrator or COBRA Administrator. Payments for successive periods of coverage are due on the first of each month thereafter, with a 30-day grace period allowed for payment. Where an employee organization or any other entity that provides Plan benefits on behalf of the Plan Administrator permits a billing grace period greater than the 30 days stated above, such period shall apply in lieu of the 30 days. Payment is to be made on the date it is sent to the Plan or Plan Administrator.

The Plan will allow the payment for COBRA continuation coverage to be made in monthly installments, but the Plan can also allow for payment at other intervals. The Plan is not obligated to send monthly premium notices.

The Plan will notify the Qualified Beneficiary, in writing, of any termination of COBRA coverage based on the criteria stated in this Section that occurs prior to the end of the Qualified Beneficiary's applicable maximum coverage period. Notice will be given within 30 days of the Plan's decision to terminate.

Such notice shall include the reason that continuation coverage has terminated earlier than the end of the maximum coverage period for such Qualifying Event and the date of termination of continuation coverage.

See the Summary Plan Description or contact the Plan Administrator for more information.

Important Notices (continued)

Uniformed Services Employment and Reemployment Rights Act (USERRA)

If you leave your job to perform military service, you have the right to elect to continue your existing employer-based health plan coverage for you and your dependents (including your spouse) for up to 24 months while in the military. Even if you do not elect to continue coverage during your military service, you have the right to be reinstated in your employer's health plan when you are reemployed, generally without any waiting periods or exclusions for pre-existing conditions except for service-connected injuries or illnesses.

Flexible Spending Accounts (FSAs) – Termination and Claims Submission Deadlines

Note: If you lose eligibility for any reason during the Plan Year, your contributions to your Health and/or Dependent Care FSAs will end as of the date your eligibility terminates. You may submit claims for reimbursement from your FSAs for expenses incurred during the Plan Year prior to your eligibility termination. You must submit claims for reimbursement from your Health and/or Dependent Care FSAs no later than 30 days after the date your eligibility terminates. Any balance remaining in your FSAs will be forfeited after claims submitted prior to this date have been processed.

Special Enrollment Rights Notice

CHANGES TO YOUR HEALTH PLAN ELECTIONS

Once you make your benefits elections, they cannot be changed until the next Open Enrollment. Open Enrollment is held once a year.

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if there is a loss of other coverage. However, you must request enrollment no later than 30 days after that other coverage ends.

If you declined coverage while Medicaid or the Children's Health Insurance Program (CHIP) is in effect, you may be able to enroll yourself and/or your dependents in this plan if you or your dependents lose eligibility for that other coverage. However, you must request enrollment no later than 60 days after Medicaid or CHIP coverage ends.

If you or your dependents become eligible for Medicaid or CHIP premium assistance, you may be able to enroll yourself and/or your dependents into this plan. However, you must request enrollment no later than 60 days after the determination to remain eligible for such assistance.

If you have a change in family status such as a new dependent resulting from marriage, birth, adoption or placement for adoption, divorce (including legal separation and annulment), death, or Qualified Medical Child Support Order, you may be able to enroll yourself and/or your dependents. However, you must request enrollment no later than 30 days after the marriage, birth, adoption, or placement for adoption or divorce (including legal separation and annulment).

For information about Special Enrollment Rights, please contact:

Benefits Department
Sacramento City Unified School District
benefits@scusd.edu
916.643.9432

Medicare Part D – Important Notice About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Sacramento City Unified School District 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. 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 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:

- **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 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.**

Important Notices (continued)

- **Sacramento City Unified School District has determined that the prescription drug coverage offered by Kaiser Permanente, HealthNet, Sutter Health Plus and Western Health Advantage is, on average for all plan participants, expected to pay out 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 15th to December 7th.

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 drug plan.

WHAT HAPPENS TO YOUR CURRENT COVERAGE IF YOU DECIDE TO JOIN A MEDICARE DRUG PLAN?

If you decide to join a Medicare drug plan, your current Sacramento City Unified School District coverage will not be affected. If you keep this coverage and elect Medicare, the Sacramento City Unified School District coverage will coordinate with Part D coverage.

If you do decide to join a Medicare drug plan and drop your current Sacramento City Unified School District coverage, be aware that you and your dependents will be able to get this coverage back.

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 Sacramento City Unified School District and don't join a Medicare 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 (i.e., 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 the person listed below for further information. **Note:** You will get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Sacramento City Unified School District 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 will 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 your copy of the Medicare & You handbook for their telephone number) for personalized help.
- Call 800-MEDICARE (800-633-4227). TTY users should call 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 Social Security on the web at www.socialsecurity.gov, or call them at 800-772-1213 (TTY 800-325-0778).

Important Notices (continued)

REMEMBER

Keep this Creditable Coverage notice. If you decide to join one of the Medicare 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).

Date:	January 1, 2024
Name of Entity / Sender:	Sacramento City Unified School District
Contact:	Benefits Department
Address:	5735 47th Avenue Sacramento, CA 95824
Phone:	916.643.9432

Availability of Health Insurance Portability and Accountability Act (HIPAA) Notice of Privacy Practices

Sacramento City Unified School District Group Health Plan (Plan) maintains a Notice of Privacy Practices that provides information to individuals whose protected health information (PHI) will be used or maintained by the Plan. If you would like a copy of the Plan's Notice of Privacy Practices, please contact the Benefits Department, 916.643.9432.

Important Notices (continued)

Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: GENERAL INFORMATION

This notice provides you with information about Sacramento City Unified School District in the event you wish to apply for coverage on the Health Insurance Marketplace. All the information you need from Human Resources is listed in this notice. If you wish to have someone assist you in the application process or have questions about subsidies that you may be eligible to receive, (for California residents only) you can contact KeenanDirect at 855-653-3626 or at www.KeenanDirect.com, or (for everyone) contact the Health Insurance Marketplace directly at www.Healthcare.gov.

WHAT IS THE HEALTH INSURANCE MARKETPLACE?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget by offering "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a tax credit that lowers your monthly premium right away.

Open Enrollment for health insurance coverage through Covered California will begin on November 1, 2023, and end on January 31, 2024. For more information on Open Enrollment and other opportunities to enroll, visit www.coveredca.com or KeenanDirect at 855-653-3626 or www.KeenanDirect.com.

Open Enrollment for most other states begins on November 1 and closes on January 15 of each year. For more information on Open Enrollment and other opportunities to enroll, visit www.healthcare.gov.

CAN I SAVE MONEY ON MY HEALTH INSURANCE PREMIUMS IN THE MARKETPLACE?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer you coverage, offers medical coverage that is not "Affordable," or does not provide "Minimum Value." If the lowest cost plan from your employer that would cover you (and not any other members of your family) is more than 8.39% (for 2024) of your household income for the year, then that coverage for you is not Affordable. Affordability for dependent family members is determined separately and is based on the total cost of family coverage. Moreover, if the medical coverage offered covers less than 60% of the benefits costs, then the plan does not provide Minimum Value.

DOES EMPLOYER HEALTH COVERAGE AFFECT ELIGIBILITY FOR PREMIUM SAVINGS THROUGH THE MARKETPLACE?

Yes. If you have an offer of medical coverage from your employer that is both Affordable and provides Minimum Value, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's medical plan. If you receive premium savings for Marketplace coverage, the IRS may seek reimbursement of those funds.

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered medical coverage. Also, this employer contribution, as well as your employee contribution to employer-offered coverage, is often excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

STATES WITH INDIVIDUAL MANDATE

Taxpayers in CA, DC, MA, NJ, RI, and VT (this list is neither complete nor exhaustive) are reminded that your state imposes an individual mandate penalty (tax) should you, your spouse, and children choose to not have (and keep) medical/rx coverage for each tax year. Please consult your tax advisor for how a non-election for health coverage may affect your tax situation.

Important Notices (continued)

PART B: INFORMATION ABOUT HEALTH COVERAGE OFFERED BY YOUR EMPLOYER

In the event you wish to apply for coverage on the Exchange, all the information you need from Human Resources is listed below. If you are located in California and wish to have someone assist you in the application process or have questions about subsidies that you may be eligible to receive, you can contact KeenanDirect at 855-653-3626 or at www.KeenanDirect.com. The information is numbered to correspond to the Marketplace application.

3. Employer name Sacramento City Unified School District	**4. Employer Identification Number (EIN)** 94-6002491	
5. Employer address 5735 47th Avenue	**6. Employer phone number** 916.643.9432	
7. City Sacramento	**8. State** CA	**9. ZIP code** 95824
10. Who can we contact about employee health coverage at this job? Benefits Department		
11. Phone number (if different from above)	**12. Email address** benefits@scusd.edu	

As your employer, we offer coverage that meets the minimum value standard to the employees as described in this Guide. The coverage offered to you meets the minimum value standard and the cost of this coverage to you is intended to be affordable based on employee wages.

Important Notices (continued)

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

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.

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 either of these programs, contact your State Medicaid or CHIP office or dial 877-KIDS-NOW or 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.askebsa.dol.gov or call 866-444-EBSA (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 July 31, 2023. Contact your State for more information on eligibility.

ALABAMA – Medicaid
Website: http://myalhipp.com/
Phone: 855-692-5447

ALASKA – Medicaid
The AK Health Insurance Premium Payment Program
Website: http://myakhipp.com/
Phone: 866-251-4861
Email: CustomerService@MyAKHIPP.com
Medicaid Eligibility:
https://health.alaska.gov/dpa/Pages/default.aspx

ARKANSAS – Medicaid
Website: http://myarhipp.com/
Phone: 855-MyARHIPP (855-692-7447)

CALIFORNIA – Medicaid
Health Insurance Premium Payment (HIPP) Program Website:
http://dhcs.ca.gov/hipp
Phone: 916-445-8322
Fax: 916-440-5676
Email: hipp@dhcs.ca.gov

COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHIP+)
Health First Colorado Website:
https://www.healthfirstcolorado.com/
Health First Colorado Member Contact Center:
800-221-3943 | TTY: Colorado relay 711
CHP+: https://hcpf.colorado.gov/child-health-plan-plus
CHP+ Customer Service:
800-359-1991 | TTY: Colorado relay 711
Health Insurance Buy-In Program (HIBI):
https://www.mycohibi.com/
HIBI Customer Service: 855-692-6442

FLORIDA – Medicaid
Website:
http://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html
Phone: 877-357-3268

GEORGIA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp/
Phone: 678-564-1162, press 1
GA CHIPRA Website:
https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra
Phone: 678-564-1162, press 2

INDIANA – Medicaid
Healthy Indiana Plan for low-income adults 19-64
Website: http://www.in.gov/fssa/hip/
Phone: 877-438-4479
All other Medicaid
Website: https://www.in.gov/medicaid/
Phone: 800-457-4584IOWA – Medicaid and CHIP (Hawki)
Medicaid Website: https://dhs.iowa.gov/ime/members
Medicaid Phone: 800-338-8366
Hawki Website: http://dhs.iowa.gov/Hawki
Hawki Phone: 800-257-8563
HIPP Website:
https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp
HIPP Phone: 888-346-9562

Important Notices (continued)

KANSAS – Medicaid
Website: https://www.kancare.ks.gov/
Phone: 800-792-4884
HIPPA Phone: 800-967-4660

KENTUCKY – Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website:
https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx
Phone: 855-459-6328
Email: KIHIPP.PROGRAM@ky.gov
KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx
Phone: 877-524-4718
Medicaid Website: https://chfs.ky.gov/agencies/dms

LOUISIANA – Medicaid
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp
Phone: 888-342-6207 (Medicaid hotline) or
855-618-5488 (LaHIPP)

MAINE – Medicaid
Enrollment Website:
https://www.mymaineconnection.gov/benefits/s/?language=en_US
Phone: 800-442-6003 | TTY: Maine relay 711
Private Health Insurance Premium Webpage:
https://www.maine.gov/dhhs/ofi/applications-forms
Phone: 800-977-6740 | TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP
Website: https://www.mass.gov/masshealth/pa
Phone: 800-862-4840 | TTY: Massachusetts relay 711
Email: masspremassistance@accenture.com

MINNESOTA – Medicaid
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp
Phone: 800-657-3739

MISSOURI – Medicaid
Website:
https://www.dss.mo.gov/mhd/participants/pages/hipp.htm
Phone: 573-751-2005

MONTANA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: 800-694-3084
Email: HHSHIPPProgram@mt.gov

NEBRASKA – Medicaid
Website: http://www.ACCESSNebraska.ne.gov
Phone: 855-632-7633
Lincoln: 402-473-7000
Omaha: 402-595-1178

NEVADA – Medicaid
Medicaid Website: http://dhcfp.nv.gov/
Medicaid Phone: 800-992-0900

NEW HAMPSHIRE – Medicaid
Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program
Phone: 603-271-5218
HIPP Program Toll-Free Phone: 800-852-3345, ext. 5218

NEW JERSEY – Medicaid and CHIP
Medicaid Website:
http://www.state.nj.us/humanservices/dmahs/clients/medicaid/
Medicaid Phone: 609-631-2392
CHIP Website: http://www.njfamilycare.org/index.html
CHIP Phone: 800-701-0710

NEW YORK – Medicaid
Website: https://www.health.ny.gov/health_care/medicaid/
Phone: 800-541-2831

NORTH CAROLINA – Medicaid
Website: https://medicaid.ncdhhs.gov/
Phone: 919-855-4100

NORTH DAKOTA – Medicaid
Website: https://www.hhs.nd.gov/healthcare
Phone: 844-854-4825

OKLAHOMA – Medicaid and CHIP
Website: http://www.insureoklahoma.org
Phone: 888-365-3742

OREGON – Medicaid
Websites: http://healthcare.oregon.gov/Pages/index.aspx
Phone: 800-699-9075

PENNSYLVANIA – Medicaid and CHIP
Website:
https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx
Phone: 800-692-7462
CHIP Website: https://www.dhs.pa.gov/CHIP/Pages/CHIP.aspx
CHIP Phone: 800-986-KIDS (5437)

RHODE ISLAND – Medicaid and CHIP
Website: http://www.eohhs.ri.gov/
Phone: 855-697-4347 or 401-462-0311 (Direct RIte Share Line)

SOUTH CAROLINA – Medicaid
Website: https://www.scdhhs.gov
Phone: 888-549-0820

SOUTH DAKOTA – Medicaid
Website: http://dss.sd.gov
Phone: 888-828-0059

Important Notices (continued)

TEXAS – Medicaid
Website: https://www.hhs.texas.gov/services/financial/health-insurance-premium-payment-hipp-program
Phone: 800-440-0493

UTAH – Medicaid and CHIP
Medicaid Website: https://medicaid.utah.gov/
CHIP Website: http://health.utah.gov/chip
Phone: 877-543-7669

VERMONT – Medicaid
Website: https://dvha.vermont.gov/members/medicaid/hipp-program
Phone: 800-250-8427

VIRGINIA – Medicaid and CHIP
Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select
https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs
Medicaid Phone: 800-432-5924
CHIP Phone: 800-432-5924

WASHINGTON – Medicaid
Website: https://www.hca.wa.gov/
Phone: 800-562-3022

WEST VIRGINIA – Medicaid and CHIP
Website: https://dhhr.wv.gov/bms/
http://mywvhipp.com/
Medicaid Phone: 304-558-1700
CHIP Toll-Free Phone: 855-MyWVHIPP (855-699-8447)

WISCONSIN – Medicaid and CHIP
Website:
https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm
Phone: 800-362-3002

WYOMING – Medicaid
Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/
Phone: 800-251-1269

To see if any other states have added a premium assistance program since July 31, 2023, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
866-444-EBSA (3272)

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

Glossary

Affordable Care Act and Patient Protection (ACA)

Also called Health Care Reform, the ACA requires health plans to comply with certain requirements. The ACA became law in March 2010. Since then, the ACA has required some changes to medical coverage—like covering dependent children to age 26, no lifetime limits on medical benefits, covering preventive care without cost-sharing, etc, among other requirements.

Allowed Amount

Maximum amount on which payment is based for covered health care services. This may be called "eligible expense," "payment allowance" or "negotiated rate." If your provider charges more than the allowed amount, you may have to pay the difference. (See Balance Billing.)

Balance Billing

When a provider bills you for the difference between the provider's charge and the allowed amount. For example, if the provider's charge is $100 and the allowed amount is $70, the provider may bill you for the remaining $30. A preferred provider may not balance bill you.

Brand Name Drug

The original manufacturer's version of a particular drug. Because the research and development costs that went into developing these drugs are reflected in the price, brand name drugs cost more than generic drugs.

COBRA (Consolidated Omnibus Budget Reconciliation Act)

The Consolidated Omnibus Budget Reconciliation Act allows people who lose their jobs to continue their employer-sponsored insurance coverage for up to 18 months.

Children's Health Insurance Program (CHIP)

The government program that provides free or low-cost health coverage for children up to age 19 in families whose income is too high to qualify for Medicaid but too low to afford private insurance. CHIP covers U.S. citizens and eligible immigrants. In some states, CHIP covers pregnant people. CHIP goes by different names in some states.

Claim

A request for payment that you or your health care provider submits to your health insurer to be paid or reimbursed for items or services you have received. Most often, you will not be responsible for making claim requests. Usually, billing and claims specialists employed by the health care provider (e.g. primary care office, hospital) will make the claim on your behalf.

Coinsurance

A percentage of costs you pay "out-of-pocket" for covered expenses after you meet the deductible.

Copayment (Copay)

A fee you have to pay "out-of-pocket" for certain services, such as a doctor's office visit or prescription drug.

Comprehensive Coverage

A health insurance plan that covers the full range of care that you may need. This may include preventive services (like flu shots), physical exams, prescription drugs, and doctor or hospital care.

Deductible

The amount you pay "out-of-pocket" before the health plan will start to pay its share of covered expenses.

Formulary

A list of prescription drugs covered by the health plan, often structured in tiers that subsidize low-cost generics at a higher percentage than more expensive brand-name or specialty drugs.

Generic Drug

Lower-cost alternative to a brand name drug that has the same active ingredients and works the same way.

High-Deductible Health Plan (HDHP)

High-deductible health plans (HDHPs) are health insurance plans with lower premiums and higher deductibles than traditional health plans. Only those enrolled in an HDHP are eligible to open and contribute tax-free to a health savings account (HSA).

Glossary (continued)

Health Savings Account (HSA)

A health savings account (HSA) is a portable savings account that allows you to set aside money for health care expenses on a tax-free basis. State taxes may apply. You must be enrolled in a high-deductible health plan in order to open an HSA. An HSA rolls over from year to year, pays interest, can be invested, and is owned by you—even if you leave the company.

Health Reimbursement Arrangements (HRAs)

Unlike HSAs, only an employer may fund an HRA and the funds revert back to the employer when the employee leaves the organization. HRAs are not subject to the same contribution limits as HSAs, and they may be paired with either high-deductible plans or traditional health plans.

In-Network

Doctors, clinics, hospitals and other providers with whom the health plan has an agreement to care for its members. Health plans cover a greater share of the cost for in-network health providers than for providers who are out-of-network.

Non-Preferred Provider

A provider who doesn't have a contract with your health insurer or plan to provide services to you. You'll pay more to see a non-preferred provider.

Out-of-Pocket Maximum

The most you pay each year "out-of-pocket" for covered expenses. Once you've reached the out-of-pocket maximum, the health plan pays 100% for covered expenses.

Out-Of-Network

A health plan may not cover treatment for doctors, clinics, hospitals and other providers who are out-of-network, but covered employees will pay more out-of-pocket to use out-of-network providers than for in-network providers.

Out-Of-Pocket Limit

The most an employee could pay during a coverage period (usually one year) for his or her share of the costs of covered services, including co-payments and co-insurance.

Plan Year

The year for which the benefits you choose during Annual Enrollment remain in effect. If you're a new employee, your benefits remain in effect for the remainder of the plan year in which you enroll, and you enroll for the next plan year during the next Annual Enrollment.

Preferred Provider

A provider who has a contract with your health insurer or plan to provide services to you at a discount.

Premium

The amount that must be paid for a health insurance plan by covered employees, by their employer, or shared by both. A covered employee's share of the annual premium is generally paid periodically, such as monthly, and deducted from his or her paycheck.

Preventive Care

Health care services you receive when you are not sick or injured— so that you will stay healthy. These include annual checkups, gender- and age-appropriate health screenings, well-baby care, and immunizations recommended by the American Medical Association.

Qualifying Life Event

A change in your life that can make you eligible for a Special Enrollment Period to enroll in health coverage. Examples of qualifying life events include moving to a new state, certain changes in your income, and changes in your family size.

Skilled Nursing Care

Services from licensed nurses in your own home or in a nursing home. Skilled care services are from technicians and therapists in your own home or in a nursing home.

Urgent Care

Care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room care.

CLICK HERE to watch a video on Benefits Key Terms Explained

Contact Information

Below is a listing of the telephone numbers you can call with questions about the plans available to you. You can also use the web site (if available) to access information from providers for the various plans.

Plan	Plan Number	Phone Number	Web Site
Medical			
• Kaiser Permanente	212	800-278-3296	www.kp.org
• HealthNet	69929	800-522-0088	www.healthnet.com
• Western Health Advantage – HMO	107512	888-563-2250	www.westernhealth.com
• Sutter Health Plus	042103	855-315-5800	www.sutterhealthplus.org
Dental			
• Delta Dental	6428	866-499-3001	www.deltadentalins.com
• Premier Access	16636	888-715-0760	www.premierlife.com
Vision			
• Vision Service Plan	00407301	800-877-7195	www.vsp.com
Employee Assistance Program (EAP)			
• Managed Health Network (MHN)		800-227-1060	members.mhn.com
Basic Life/AD&D and Optional Life			
• Sun Life Assurance Company	238103	800-247-6875	www.sunlife.com/us
Flexible Spending Accounts (FSA)			
• Basic Pacific		800-574-5448	www.basicpacific.com