



2023



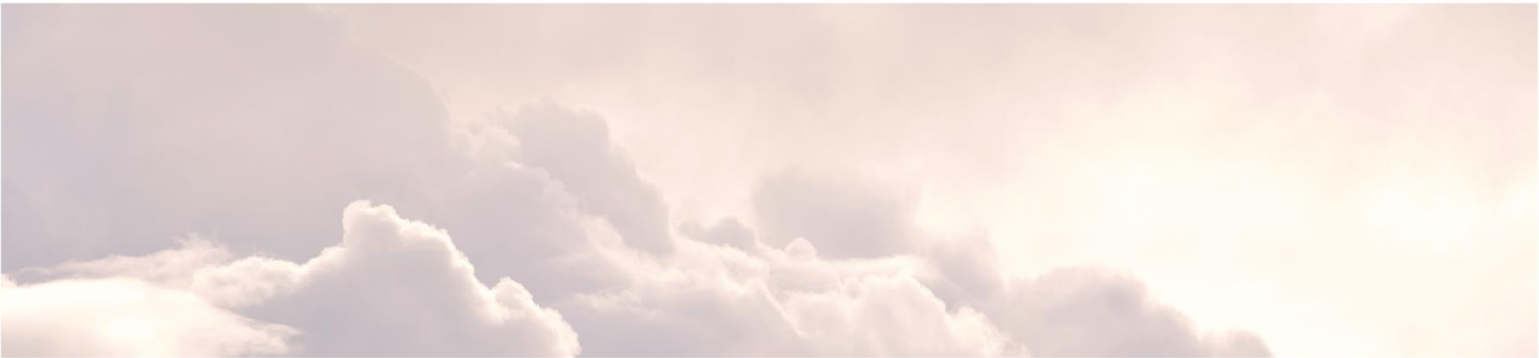
# Benefits

## Information Guide



**San Diego Unified**  
SCHOOL DISTRICT

Active Employees



# Welcome to the San Diego Unified School District 2023 Employee 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 employees and their eligible dependents.

San Diego Unified pays the full monthly premium cost for Medical, Dental and Vision coverage for benefits eligible employees and all their eligible dependents. The District also covers the premium cost in full for employee only Basic Life and AD&D insurance up to 1X your annual salary. The District is a member of the California Schools Voluntary Employees Benefits Association (VEBA). Membership provides the additional resources for you and your enrolled dependents.

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

Our goal in providing this Benefit Information Guide is to help you better understand the plans and programs that you and your family will be enrolled in for the plan year. To get the most out of your employee benefits program, we encourage you to review this booklet in its entirety

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](mailto:employeebenefits@sandi.net)

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The rates quoted for these benefits may be subject to change based on final enrollment and/or final underwriting requirements. This material is for informational purposes only and is neither an offer of coverage nor medical advice. It contains only a partial, general description of the plan or program benefits and does not constitute a contract. Consult your plan documents (Schedule of Benefits, Certificate of Coverage, Group Agreement, Group Insurance Certificate, Booklet, Booklet-certificate, Group Policy) to determine governing contractual provisions, including procedures, exclusions and limitations relating to your plan. All the terms and conditions of your plan or program are subject to applicable laws, regulations and policies. In case of a conflict between your plan document and this information, the plan documents will always govern.

# Discover Your Benefits

*Let's explore your benefit plan options, programs and resources.*



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# Eligibility & Enrollment

*Time to answer some questions...*

## Who can enroll?

Active employees in paid status, in a monthly-salaried position of half-time or more and employees on paid leave of absence receiving 50% or more of full salary are eligible to participate in the benefits program. Employees in job-share assignments are also eligible to participate; however, they may be responsible for a pro-rata share of the cost, in accordance with their collective bargaining agreement. Employees on District-approved unpaid leave may continue coverage by contributing the required premium to the District.

## Tax Implications for Domestic Partnerships and Covered Dependents

Premiums for **registered** domestic partners who do not meet the tax dependent definition of IRC section 152 for the employee, may be considered taxable income for federal taxes, but not state taxes. Premiums for domestic partners who are **not state registered domestic partners** and who do not meet the tax dependent definition of IRC section 152 for the employee, may be considered taxable income for federal taxes and state taxes.

Premiums for children:

- Your and your spouse's children who are under age 26 are not taxable
- Your registered domestic partner's children are not taxable for state taxes, but are taxable for federal taxes unless they are your tax dependents under IRS Section 152
- Your unregistered domestic partner's children are taxable for state and federal taxes unless they are your tax dependents under IRS Section 152
- Totally disabled children over age 26 are taxable for state and federal taxes unless they are your tax dependents under IRS Section 152

### Important: Dependent Verification!

The District requires employees who enroll dependents in their medical, dental and/or vision insurance plans to provide documents to verify their dependents' eligibility for coverage.

Your enrollment form must be accompanied with supporting documentation for your dependents.

## Dependent Eligibility Verification Requirements

Eligible Dependent Type	Eligible Dependent Definition	Required Documentation for Proof of Eligibility
<b>Legal Spouse</b>	Legally married spouse as defined by State law	<ul style="list-style-type: none"> <li>• If married more than one year, please provide copy of the first two pages of the most recent Federal Tax Return with signature of Employee and Spouse (blackout financial information)**</li> <li>• If married less than one year, please provide copy of marriage certificate</li> </ul>
<b>State-Registered Domestic Partner</b>	Same-sex or opposite-sex domestic partner age 18 or older	<ul style="list-style-type: none"> <li>• California Certificate of Domestic Partnership issued by the California Secretary of State</li> </ul>
<b>Unregistered Domestic Partner</b>	Same-sex domestic partner age 18 or older who meet District requirements in their Declaration of Domestic Partnership	<ul style="list-style-type: none"> <li>• San Diego Unified School District Declaration of Domestic Partnership (including joint residence and financial interdependence documentation) and Domestic Partner Health Care Enrollment Statement</li> </ul>
<b>Biological Child</b>	Direct biological child (under age 26)	<ul style="list-style-type: none"> <li>• Government-issued Birth Certificate reflecting that the child is the Employee's child, or</li> <li>• 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) **</li> </ul>
<b>Step Child</b>	Direct biological child (under age 26) from a spouse/Domestic Partner's prior marriage	<ul style="list-style-type: none"> <li>• Government-issued Birth Certificate reflecting that the child is the Spouse/Domestic Partner's child, or</li> <li>• 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) **</li> </ul>
<b>Adopted Child</b>	Adopted child under age 26	<ul style="list-style-type: none"> <li>• Government-issued Adoption Order, AND government issued Birth Certificate, or</li> <li>• Foreign adoption approved by the INS or legal adoption documents from foreign country AND home government-issued Birth Certificate</li> </ul>
<b>Guardianship Child</b>	Persons under the age of 18 for whom you have legal guardianship	<ul style="list-style-type: none"> <li>• 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.</li> </ul>
<b>Disabled Child</b>	Disabled child age 26 or older for whom you have the legal responsibility to care	<ul style="list-style-type: none"> <li>• Notice of disability determination from medical carrier prior to attaining age 26 AND child documentation (biological/step/adopted/guardianship), or</li> <li>• Notice of disability determination from the Social Security Administration prior to attaining age 26 AND child documentation (biological/step/adopted/guardianship)</li> </ul>

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

\*\* Copies of most recent Federal Tax Return must include the signed first two pages and be for the tax year prior to adding the dependents. This document provides proof of dependent eligibility only if your filing status is married (either jointly or separately).

## When Does Coverage Begin?

Your enrollment choices remain in effect for the benefits plan year, January 1st through December 31st. Benefits for new hires or newly eligible employees will commence as outlined below:

- Employees whose first day of paid service as an eligible employee is the 1st through the 15th of the month will have a benefits effective date of the first day of the month following the first day of paid service as an eligible employee.
- Employees whose first day of paid service as an eligible employee is after the 15th of the month will have a benefits effective date of the first day of the second full month following the first day of paid service as an eligible employee.
- Dependent benefits will commence on the date the employee's benefits commence or the date the dependent becomes an eligible dependent, whichever is later.

## Initial Enrollment Period?

New Hires and Newly Eligible Employees must enroll in benefits within 31 days of being hired or becoming eligible. If an employee does not enroll during their Initial Enrollment Period, they will not be able to enroll in Benefits until the next Open Enrollment period or if they have an IRS-Qualified Family Status change. See the next page for details on IRS-Qualified Family Status Change Events.

## 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
- Enrolling in or opting out of medical, dental and vision plans
- Enrolling or re-enrolling in the Health and Dependent Care Flexible Spending Accounts

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

## No Dual Coverage Allowed Under District Sponsored Medical Plans

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

Family members may not be covered by more than one eligible employee's medical plan.

For example, if a husband and wife both work for the District, both cannot cover their children under the medical plan.

Dual coverage is however allowed under the dental and vision plans.



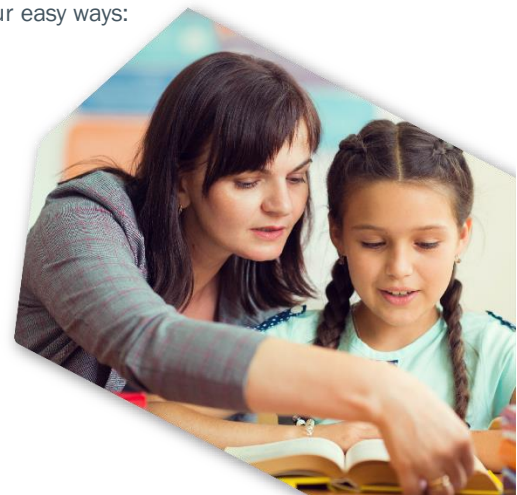
### How do I get started with my enrollment?



- You must enroll within 31 days of your hire date or the date you become benefits eligible.
- Turn in your election form for medical, dental, vision and flexible spending accounts in one of four easy ways:

**Scan and e-mail to:** [employeebenefits@sandi.net](mailto: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

- Provide proof of relationship for any dependents that you are enrolling in your benefit plans. See Dependent Eligibility required documentation on page 5.
- To enroll in optional life insurance, follow the instructions in the Voluntary Coverage section of this guide on pages 26 and 27.
- Benefit enrollment forms and informational materials are available online at [www.sandiegounified.org/departments/benefits](http://www.sandiegounified.org/departments/benefits).



## Changes Outside of Open Enrollment?

Good news! You are permitted to make changes to your benefits outside of the open enrollment period if you have Qualified Family Status change 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 IRS-Qualified Family Status Change. Change in status examples include:

- Marriage, divorce or legal separation.
- Birth or adoption of a child.
- Death of a dependent.
- You or your dependent'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 to HMO health care services.

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 an IRS-Qualified Family Status Change events, please refer to the "Legal Information Regarding Your Plans" contents on page 38.

For information regarding Health Care Reform, please contact your District's Benefits Department or visit [www.cciio.cms.gov](http://www.cciio.cms.gov). You can also visit [www.coveredca.com](http://www.coveredca.com) to review information specific to the Covered California State Health Insurance Exchange.

## Leaves of Absence

Employees on a paid leave of absence receiving 50% or more of their full salary continue to be eligible for benefits as a regular eligible employee. Employees on a District-approved, unpaid leave of absence may continue their medical, dental, vision and/or life insurance benefits by remitting the full monthly premiums to the District.

## Termination of Benefits

An eligible employee's benefits will terminate at the end of the month in which the last day in paid status in the benefits-eligible position occurs, e.g., if the last day of paid status is December 10, coverage terminates December 31. A dependent's benefits terminate on the date the employee's benefits terminate or the date the dependent ceases to qualify as an eligible dependent, whichever is earlier.

## Do I have to enroll?

Although the federal penalty for individuals who do not maintain health coverage has been reduced to \$0, some states have their own state-specific individual mandates.

To avoid paying the penalty in some states, you can obtain health insurance through our benefits program or purchase coverage elsewhere, such as from a State or Federal Health Insurance Exchange.

For information regarding Healthcare Reform and the Individual Mandate, please visit [www.cciio.cms.gov](http://www.cciio.cms.gov). You can also visit [www.coveredca.com](http://www.coveredca.com) to review information specific to the Covered California State Health Insurance Exchange.

You may elect to "waive" medical/dental/and/or vision coverage if you have access to coverage through another plan. Please complete and return a Waiver of Group Health Benefits form which is available on the Benefits Department website. It is important to note that if you waive our medical coverage, you must maintain medical/health coverage through another source. It is also important to note that if coverage is waived, the next opportunity to enroll in our group benefit plans would be during the next annual Open Enrollment period, unless a change in status event occurs.



## 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.

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

### 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. 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. Contact the Employee Benefits Department to request a benefits enrollment/change form.
2. The monthly premium cost for out-of-area dependent is the same as it is for dependents who live at home.
3. The plan your dependent is enrolled in is based on their out-of-area address.
4. 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.
5. Dependents who are enrolled in an HMO plan must choose a Primary Care Physician (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 the employee's address.**

### 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 dependent loses eligibility (subject to any continued coverage option available and elected).

**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.**



# Medical

*Which plan type is right for you?*



	HMO	HMO	PPO
	Kaiser	United Healthcare	UMR NexusACO Select Plus
<b>Required to select and use a Primary Care Physician (PCP)</b>	Yes	Yes	No
<b>Seeing a Specialist</b>	PCP referral required in most cases	PCP referral required in most cases	No referral required
<b>Deductible Required</b>	No	<ul style="list-style-type: none"> <li>Deductible is not required for Network 1, 2 or 3</li> <li>Alliance and Journey-Harmony HMO plans do include a deductible</li> </ul>	Yes, in most cases
<b>Claims Process</b>	Typically handled by providers	Typically handled by providers	PPO providers will submit claims You submit claims for other services
<b>Other Important Tips</b>	<ul style="list-style-type: none"> <li>This plan requires that you see a Kaiser doctor to receive coverage</li> <li>Out-of-Network services without proper PCP referral will not be covered</li> </ul>	<ul style="list-style-type: none"> <li>These plans require that you see a doctor from a medical group available under your particular HMO plan to receive coverage</li> <li>Out-of-Network services without proper PCP referral will not be covered</li> </ul>	<ul style="list-style-type: none"> <li>You may choose in or out of network care; however, in-network care provides you a higher level of benefit</li> <li>Out of network providers will bill the balance to the member for amounts not paid by UnitedHealthcare</li> </ul>

## The Options Are the Same in Terms of:

- Free in-network preventive care
- Emergencies are covered worldwide but employees likely will have to pay first and then be reimbursed by the carrier
- Access to Teledoc Medical 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 childcare 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.MyOptumPhysicalHealthofCA.com](http://www.MyOptumPhysicalHealthofCA.com)

## The Options Differ from Each Other in Terms of:

- 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. Please consult with your Employee Benefits Department for more specific information as it relates to your specific plan. For a detailed view of your medical plan summaries, visit [www.sandiegounified.org/departments/benefits](http://www.sandiegounified.org/departments/benefits)

## Your Medical Plan Options

San Diego Unified School District offers seven choices of medical plans, including one Kaiser HMO option, five Health Maintenance Organizations (HMO) options administered by UnitedHealthcare, and a Preferred Provider Organization (PPO) option administered by UnitedHealthcare's subsidiary, UMR. Employee and Dependents must be enrolled in the same medical plan.

## 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/chooseyourdoctor](http://kp.org/chooseyourdoctor), 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 16. 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:

- 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](http://kp.org/getcare)
- Target Clinic (provided by Kaiser) Visit: [kp.org/scal/targetclinic](http://kp.org/scal/targetclinic)
- Email your physician for simple, direct communications securely through [kp.org](http://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) HMO Plans

These HMO's operate as follows:

- You and your family members ALL must enroll in the same HMO plans for the entire year
- 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 by contacting UHC.
- You cannot change your HMO plan 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 UnitedHealthcare Journey Harmony HMO plan includes 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.

UHC Performance Network 1	UHC Performance Network 2	UHC Performance Network 3	UHC Signature Value Alliance HMO \$1800	UHC Journey- Harmony HMO
Sharp Rees-Stealy MG	Mercy Physicians MG	Scripps Clinic	Scripps Clinic	Sharp Rees-Stealy MG
Sharp Community MG <i>(Includes Graybill and Arch Health Partners)</i>	Greater Tri-Cities MG	Scripps Coastal Medical Center	Mercy Physicians MG	Sharp Community MG <i>(Includes Graybill and Arch Health Partners)</i>
	Scripps Physicians MG	Rady Children's Health Network	Scripps Coastal Medical Center	UCSD MG
Optum Care (formally Primary Care Associated MG)	Rady Children's Health Network		Optum Care (formally Primary Care Associated MG)	
Rady Children's Health Network			Scripps Physicians MG	
			UCSD MG	
			Rady Children's Health Network	

## Health Reimbursement Accounts (HRA)

Below is important information regarding the Health Reimbursement Accounts (HRA) issued with the Signature Value Alliance HMO \$1800 HRA and Journey-Harmony HMO plans:

### UHC Signature Value Alliance HMO

- You will be mailed 2 debit cards from Optum Financial to access an \$1,800 HRA
- HRA fund can be used to help you pay for out-of-pocket expenses for the HMO's deductibles, copays and coinsurance for yourself and covered family members. HRA funds can be used for covered benefits under the medical plan only.
- Up to \$500 of unused HRA funds will roll over to the next plan year if you continue to be enrolled in the Signature Value Alliance HMO \$1800 HRA plan.
- Any remaining funds in the HRA account will be forfeited if you are no longer enrolled in the Signature Value Alliance HMO or leave the District.

### UHC Journey-Harmony HMO

- You will be issued a debit card to access your member-owned Gallagher HealthInvest HRA (Health Reimbursement Account).
- The amount funded to the HRA is based on the number of individuals covered on the medical plan (\$1,000 if enrolling as employee only, \$1,600 for employees covering one dependent and \$2,200 for employees covering two or more dependents). Amounts funded will be prorated for employees joining after January 1.
- You may use the HRA 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 leave the District.
- You have the ability to invest the HRA in a menu of funds offered by Gallagher.
- To obtain more information and to file claims, you may download the HealthInvest app (HRAgo) or go to the following website: [HealthInvestHRA.com](http://HealthInvestHRA.com).
- A Summary Plan Description (SPD) can be found on the District Benefits webpage for the HealthInvest HRA.

## 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 freestanding lab, x-ray or outpatient 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. This includes spine, orthopedic, coronary artery bypass graft (CABG) and bariatric surgery. Visit [carrum.me/CSVEBA](http://carrum.me/CSVEBA) for more information.
- myHealthcare **Cost Estimator** tool helps employees estimate their cost before you see the doctor; visit [www.myuhc.com](http://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.

## 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 [whyuhc.com/csveba](http://whyuhc.com/csveba)
2. Select “Search for a Provider” that appears near the top of the page.
3. Scroll down and choose from the plan options.
4. Select “Continue”
5. Select “Change Location” and enter zip code, then select “Update Location”
6. Now you can search by People, Places, Service and Treatments, or Care by Condition

### UMR NexusACO PPO Plan Providers

1. Go to [www.umar.com](http://www.umar.com) Select “Find a Provider”.
2. In the search box, type “NexusACO” to bring up the UnitedHealthcare Nexus ACO Network. Or scroll down to the “U” menu and choose the UnitedHealthcare NexusACO Network
3. “View Providers” to be taken to the search menu
4. You can search by Name, Specialty, Facility Name or Zip code
5. Choose a Tier 1 PCP for the highest level of coverage

# Prescription Drug (Rx) Benefits

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

Employees 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.

## UnitedHealthcare Members

Employees enrolled in a 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.

- The UnitedHealthcare plan(s) include a 3-tier prescription benefit through Express Scripts
- 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.
- 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](http://www.express-scripts.com). After registering, click on Prescriptions, followed by Price a Medication.

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 and Vons and many independent pharmacies.

Express Scripts has also introduced a subset network of the Advantage Network called **Smart90**. Smart90 pharmacies are for maintenance medications where you can receive up to a 90-day supply of your medication at a reduced price. The Smart90 network includes Costco, Rite Aid, Sharp-Rees Stealy retail pharmacies and Express Scripts Mail Order. Costco membership is not required in order to fill a prescription at a Costco pharmacy. Copays will be waived for preferred generic hypertension, preferred generic oral hypoglycemic medications and preferred generic cholesterol 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](http://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, Rite-Aid or Sharp-Rees Stealy retail 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 in cost 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 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, Costco and Sharp-Rees Stealy retail 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.



## Plan Highlights

	Kaiser	UHC HMO Network 1	UHC HMO Network 2	UHC HMO Network 3
	In-Network Only	In-Network Only	In-Network Only	In-Network Only
Calendar Year Medical Plan Deductibles	None	None	None	None
Calendar Year Maximum Medical Out-of-pocket				
Per Individual / Per Family	\$1,500 / \$3,000	\$1,500 / \$3,000	\$3,000 / 6,000	\$3,000 / 6,000
Professional Services				
Physician Office Visits – Primary Care Physician	\$10 copay	\$10 copay	\$20 copay	\$20 copay
Physician Office Visits – Specialty Care Physician	\$10 copay	\$10 copay	\$20 copay	\$30 copay
Preventive Care Exam	No charge	No charge	No charge	No charge
Outpatient Basic Diagnostic X-ray and Lab	No charge	No charge	No charge	No charge
Complex Diagnostics (MRI/CT/PET Scan)	No charge	No charge	No charge	\$200 copay
Outpatient Physical / Rehabilitation Therapy	\$10 copay	\$10 copay <sup>(4)</sup>	\$20 copay <sup>(4)</sup>	\$20 copay <sup>(4)</sup>
Chiropractic Care (Must be Medically Necessary)	\$10 copay	\$10 copay	\$20 copay	\$20 copay
Hospital Services				
Inpatient	No charge	No charge	No charge	\$500 copay / admit
Outpatient Surgery	\$10 copay	No charge	No charge	\$250 copay
Emergency Room (Copay Waived if Admitted)	\$50 copay	\$100 copay	\$100 copay	\$150 copay
Urgent Care (Your Medical Group)	\$10 copay	\$10 copay	\$20 copay	\$20 copay
Urgent Care (Other Medical Group)	N/A	\$10 copay	\$20 copay	\$20 copay
Maternity Care				
Physician Services (Including Regular Prenatal Care)	No charge	No charge	No charge	No charge
Hospital Services	No charge	No charge	No charge	\$500 copay / admit
Infertility Diagnostic Testing	\$10 copay	Not covered	Not covered	Not covered
Infertility Treatment – Refer to EOC for exclusions	\$10 copay	Not covered	Not covered	Not covered
Mental Health & Substance Abuse				
Mental Health (outpatient / inpatient)	\$10 / No charge	\$10 / No charge	\$20 / No charge	\$20 / \$500 per admit
Substance Abuse (outpatient / inpatient)	\$10 / No charge	No Charge	No Charge	No Charge
Prescription Drugs		See Notes 2 & 3, Below	See Notes 2 & 3, Below	See Notes 2 & 3, Below
Calendar Year Brand Name Rx Deductibles	None	None	None	None
Calendar Year Rx Max Out-of-Pocket/Individual	Included with Medical	\$3,000	\$3,000	\$1,600
Calendar Year Rx Max Out-of-Pocket/Family		\$6,000	\$6,000	\$3,200
Retail Prescription Drugs <b>Up to a→</b>	100-day supply	30-day supply	30-day supply	30-day supply
Tier 1 – Generic	\$10 copay	\$5 copay	\$10 copay	\$10 copay
Tier 2 – Formulary Brand Name	\$10 copay	\$25 copay	\$30 copay	\$30 copay
Tier 3 – Non-Formulary Brand Name	\$10 copay	50% (4 & 5)	50% (4 & 5)	50% (4 & 5)
Mail Order Prescription Drugs <b>Up to a→</b>	100-day supply	90-day supply	90-day supply	90-day supply
Tier 1 – Generic	\$10 copay	\$10 copay	\$20 copay	\$20 copay
Tier 2 – Formulary Brand Name	\$10 copay	\$50 copay	\$60 copay	\$60 copay
Tier 3 – Non-Formulary Brand Name	\$10 copay	50% (4 & 5)	50% (4 & 5)	50% (4 & 5)

(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 15 for special requirements for "Specialty Medicine"

The above information is a summary only and not a guarantee of what services are provided at no charge.



## Plan Highlights

### UHC Alliance HMO \$1800 HRA

### UHC Journey-Harmony HMO w/ HRA

	In-Network Only	In-Network Only
Health Reimbursement Account	\$1,800 Up to \$500 can rollover to new plan year	\$1,000 Employee Only \$1,600 Employee & 1 Dependent \$2,200 Employee & 2+ Dependents
Calendar Year Medical Plan Deductibles	\$2,000 per Individual / \$2,000 per Family	\$2,000 per Individual / \$4,000 per Family
Calendar Year Maximum Medical Out-of-pocket	\$3,000 per Individual / \$6,000 per Family	\$3,500 per Individual / \$7,000 per Family
<b>Professional Services</b>		
Physician Office Visits – Primary Care Physician	\$35 copay <sup>(1)</sup>	\$25 copay <sup>(1)</sup>
Physician Office Visits – Specialty Care Physician	\$50 copay <sup>(1)</sup>	\$40 copay <sup>(1)</sup>
Preventive Care Exam	No charge	No charge <sup>(1)</sup>
Outpatient Basic Diagnostic X-ray and Lab	No charge	No charge <sup>(1)</sup>
Complex Diagnostics (MRI/CT/PET Scan)	20% coinsurance	\$100 copay <sup>(1)</sup>
Outpatient Physical / Rehabilitation Therapy <sup>(2)</sup>	\$35 copay <sup>(1)</sup>	\$25 copay <sup>(1)</sup>
Chiropractic Care (Must be Medically Necessary)	\$30 copay <sup>(1)</sup>	\$30 copay <sup>(1)</sup>
<b>Hospital Services</b>		
Inpatient	20% coinsurance	20% coinsurance
Outpatient Surgery	20% coinsurance	20% coinsurance
Emergency Room (Copay Waived if Admitted)	\$ 300 copay (after Deductible met)	20% coinsurance
Urgent Care (Your Medical Group)	\$35 copay <sup>(1)</sup>	\$25 copay <sup>(1)</sup>
Urgent Care (Other Medical Group)	\$35 copay <sup>(1)</sup>	\$25 copay <sup>(1)</sup>
<b>Maternity Care</b>		
Physician Services (Including Regular Prenatal Care)	Pre-natal: \$35 copay <sup>(1)</sup> Other: 20% coinsurance	Pre-natal: \$25 copay <sup>(1)</sup> Other: 20% coinsurance
Hospital Services	20% coinsurance	20% coinsurance
Infertility Diagnostic Testing	Not covered	Not covered
Infertility Treatment - Artificial Insemination Only	Not covered	Not covered
<b>Mental Health &amp; Substance Abuse</b>		
Mental Health (outpatient/inpatient)	\$40 copay <sup>(1)</sup> / 20% coinsurance	\$25 copay <sup>(1)</sup> / Other: 20% coinsurance
Substance Abuse (outpatient/inpatient)	No Charge	No Charge
<b>Prescription Drugs</b>	<b>See Notes: 3 &amp; 4, Below</b>	<b>See Notes: 3 &amp; 4, Below</b>
Calendar Year Brand Name Rx Deductibles	None	None
Calendar Year Rx Max Out-of-Pocket/Individual	\$1,600	\$1,600
Calendar Year Rx Max Out-of-Pocket/Family	\$3,200	\$3,200
<b>Retail Prescription Drugs Up to a→</b>	<b>30-day supply</b>	<b>30-day supply</b>
Tier 1 – Generic	\$10 copay <sup>(1)</sup>	\$10 copay <sup>(1) (4)</sup>
Tier 2 – Formulary Brand Name	\$30 copay <sup>(1)</sup>	\$30 copay <sup>(1) (4)</sup>
Tier 3 – Non-Formulary Brand Name	50% <sup>(1) (5 &amp; 6)</sup>	50% coinsurance <sup>(1) (5 &amp; 6)</sup>
<b>Mail Order Prescription Drugs Up to a→</b>	<b>90-day supply</b>	<b>90-day supply</b>
Tier 1 – Generic	\$20 copay <sup>(1)</sup>	\$20 copay <sup>(4)</sup>
Tier 2 – Formulary Brand Name	\$60 copay <sup>(1)</sup>	\$60 copay <sup>(4)</sup>
Tier 3 – Non-Formulary Brand Name	50% <sup>(1) (5 &amp; 6)</sup>	50% coinsurance <sup>(1) (5 &amp; 6)</sup>

<sup>(1)</sup> Deductible Waived

<sup>(2)</sup> The specialty care physician copay applies if therapy is provided by a physician other than the patient's primary care physician.

<sup>(3)</sup> Copays are \$5 higher for medicine obtained from Non-EAN pharmacies.

<sup>(4)</sup> Plan participants pay 100% of the cost for certain drugs that are available over-the-counter, i.e., Proton Pump inhibitors, Antihistamines & Intranasal Steroids

<sup>(5)</sup> Subject to minimum \$40, maximum \$175 for retail; and minimum \$80, maximum \$350 for mail order

<sup>(6)</sup> See page 15 for special requirements for "Specialty Medicine"

The above information is a summary only and not a guarantee of what services are provided at no charge.

## Plan Highlights

## UMR NexusACO Select Plus PPO

	Tier 1 In-Network	Other In-Network	Out-of-Network
<b>Calendar Year Deductible – Applies to all expenses for which the plan member pays 20% or 50% coinsurance, except for Rx</b>			
Individual/Family Maximum	\$2,000 / \$4,000		
<b>Maximum Calendar Year Out-of-pocket <sup>(1)</sup> Excluding Additional Maximum for Prescription Medication</b>			
Individual/Family Maximum	\$5,000/\$10,000		\$5,000/\$10,000 <sup>(1)</sup>
<b>Professional Services (* For all benefit levels followed by a *, the benefits are payable after the deductible is met.)</b>			
Primary Care Physician (PCP)	\$30 copay	20% coinsurance*	50% coinsurance*
Specialist	\$50 copay	20% coinsurance*	50% coinsurance*
Preventive Care Exam	No charge		Not covered
Diagnostic X-ray and Lab (Standard Procedures)	M.D. Office or Free-Standing Facility: No Charge; At a hospital: 20% coinsurance*		50% coinsurance*
Complex Radiology e.g., MRI / CT/PET Scan	Free-Standing Facility: 20% coinsurance*; Hospital: \$100 copay / occurrence then 20% coinsurance*		50% coinsurance*
Outpatient Physical / Rehabilitation Therapy (PCP or Specialist)	\$30 copay		50% coinsurance*
Chiropractic Care & Acupuncture (Must be Medically Necessary)	\$30 copay		50% coinsurance*
<b>Hospital Services (* For all benefit levels followed by a *, the benefits are payable after the deductible is met.)</b>			
Inpatient	20% coinsurance*		50% coinsurance*
Outpatient Surgery	M.D. office or Free-Standing Facility: 20% coinsurance*; Hospital: \$100 copay / occurrence then 20% coinsurance*		50% coinsurance* (Pre-authorization is required)
Emergency Room (Copay Waived if Admitted)	\$100 copay		\$100 copay
Urgent Care	\$50 copay		50% coinsurance*
<b>Maternity Care (* For all benefit levels followed by a *, the benefits are payable after the deductible is met.)</b>			
Physician Services	Prenatal: No Charge; Delivery: 20% coinsurance* Postnatal: \$30 copay		50% coinsurance*
Hospital Services	20% coinsurance*		50% coinsurance* (Pre-authorization is required)
Infertility	Not covered		Not covered
<b>Mental Health &amp; Substance Abuse (* For all benefit levels followed by a *, the benefits are payable after the deductible is met.)</b>			
Inpatient	20% coinsurance*		50% coinsurance*
Outpatient	\$30 copay		50% coinsurance*
<b>Prescription Drugs Calendar Year Maximum Out-of-Pocket</b>			
Per Individual	\$1,600		N/A
Maximum Per Family	\$3,200		N/A
<b>Retail Prescription Drugs (Up to a 30-day supply at an EAN pharmacy; \$5 higher at non-EAN pharmacies) <sup>(2)</sup></b>			
Tier 1 – Generic	\$10 copay		Not covered
Tier 2 – Formulary Brand	\$30 copay		Not covered
Tier 3 – Non-Formulary	50% <sup>(3 &amp; 4)</sup>		Not covered
<b>Mail Order Prescription Drugs (Up to a 90-day supply)</b>			
Tier 1 – Generic	\$20 copay		Not covered
Tier 2 – Formulary Brand	\$60 copay		Not covered
Tier 3 – Non-Formulary	50% <sup>(3 &amp; 4)</sup>		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 & Intranasal Steroids

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

(4) See page 15 for special requirements for "Specialty Medicine"

The above information is a summary only and not a guarantee of what services are provided at no charge.

# 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!

## 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](http://kp.org/getcare) (or call 1.833.574.2273 for assistance in making a video appointment).

## 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!

## UnitedHealthcare 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](http://www.AmWell.com) (or call 1.844.733.3627) or [www.doctorondemand.com](http://www.doctorondemand.com) (or call 1.800.997.6196).

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.

# VEBA Member Benefits

The District is a member of the California Schools Voluntary Employees Benefits Association (VEBA). Membership provides the additional resources for you and your enrolled dependents, if covered on a District medical and/or dental plan.

## 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.

### 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](mailto:advocacy@mcgregorinc.com)

## VEBA Resource Center (VRC)

The VEBA Resource Center (VRC) is a caring and safe environment that supports VEBA members as they define their path to well-being. Everyone's health care journey is unique, so the center helps members find the resources that work for them. Most health care systems are designed for efficiencies, which does not give people the space they need to explore their most pressing issues. At the VRC, chronic disease is viewed as the symptom of greater underlying challenges, as opposed to a singular challenge to solve. With a focus on improving overall health, services at the center consider one's mental health, activity level, stress and nutrition.

Employees can receive personalized and comprehensive care working directly with Care Navigators at the VRC to address their emotional, social, financial and physical health. Services include holistic care, yoga, cooking classes, health coaching and more. The VRC offers more than 300 virtual group classes every month available at no cost. Program information and class calendars are available on the VEBA Resources Center website at [vebaresourcecenter.com](http://vebaresourcecenter.com). The VEBA Resource Center has a new location in Serra Mesa at 5520 Ruffin Road.

## Teladoc Medical (formally Best Doctors)

Your expert medical services with Best Doctors will now be provided by Teladoc Medical Experts to offer the same great medical advice, but with easier access. Get the answers you need from world-renowned experts by web, phone or app at no additional cost to you. 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 any District offered medical plan.

**Services are free, confidential, and just a phone call away at 1.800.Teladoc (835.2362)**

- Ask the Expert – Get answers to medical questions or concerns from a leading expert
- Find a Doctor – Get help finding a doctor who specializes in your specific condition
- Expert Medical Opinion – Get confirmation on a diagnosis or help deciding on a treatment plan
- Critical Case Support – Receive expert medical guidance if you've been admitted into the hospital

For more information, visit [teladoc.com/medical-experts](http://teladoc.com/medical-experts)

# Dental Plan

*A smile is the nicest thing you can wear.*



## Your Dental HMO & PPO Plan

The District offers two Dental Health Maintenance Organization (HMO) plans offered by Delta Dental (DeltaCare USA) or Western Dental, as well as a Dental Preferred Provider Organization (PPO) plan offered by Delta Dental.

## 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 that network. 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 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.

## Cost Estimator Tool – Delta Dental PPO plan

Looking to budget your dental cost? Try the Cost Estimator. You must first register on the Delta Dental website or app to access the link for the 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](http://www.deltadentalins.com) or [www.westerndental.com](http://www.westerndental.com) and search the Provider Network.

Plan highlights for all dental plans are included on the next page for your review and consideration.



Plan Highlights	Delta Dental PPO		DeltaCare USA DHMO	Western Dental DHMO
	In-Network	Out-of- Network	In-Network only	In-Network only
<b>Calendar Year Deductible</b>				
Per Person	\$25 per individual		None	None
Family Maximum	\$75 per family		None	None
<b>Calendar Year Maximum</b>	\$1,500 per individual		None	None
<b>Preventive</b>				
Office Visit	No charge	Plan pays 70% <sup>(1)</sup>	No charge	No charge
X-rays	No charge	Plan pays 70% <sup>(1)</sup>	No charge	No charge
Cleanings	No charge	Plan pays 70% <sup>(1)</sup>	No charge	No charge
<b>Restorative</b>				
Amalgam Fillings	No charge	Plan pays 70% <sup>(1)</sup>	No charge	No charge
Composite Fillings	No charge	Plan pays 70% <sup>(1)</sup>	No charge	No charge
<b>Periodontics (gum treatment)</b>				
Scaling & Root Planing	No charge	Plan pays 70% <sup>(1)</sup>	No charge	No charge
Gingivectomy	No charge	Plan pays 70% <sup>(1)</sup>	No charge	No charge
<b>Endodontics</b>				
Pulpotomy	No charge	Plan pays 70% <sup>(1)</sup>	No charge	No charge
Root Canals	No charge	Plan pays 70% <sup>(1)</sup>	No charge	No charge
<b>Oral Surgery</b>				
General Anesthesia	No charge	Plan pays 70% <sup>(1)</sup>	No charge	No charge
Simple Extraction	No charge	Plan pays 70% <sup>(1)</sup>	No charge	No charge
Soft Tissue Impaction	No charge	Plan pays 70% <sup>(1)</sup>	No charge	No charge
Bony Impaction	No charge	Plan pays 70% <sup>(1)</sup>	No charge	No charge
<b>Crowns &amp; Bridges</b>				
Inlay / Onlay (2 surfaces)	No charge	Plan pays 70% <sup>(1)</sup>	No charge	No charge
Crowns	No charge	Plan pays 70% <sup>(1)</sup>	No charge	No charge
<b>Prosthetics (dentures)</b>				
Denture Adjustment	No charge	Plan pays 70% <sup>(1)</sup>	No charge	No charge
Denture (Complete / Partial)	No charge	Plan pays 70% <sup>(1)</sup>	No charge	No charge
<b>Orthodontia Services</b>				
Adults / Child(ren)	\$50 Benefit per lifetime (per person)	Not covered	\$1,000 copay	\$1,000 copay

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

The above information is a summary only and not a guarantee of what services are provided at no charge.



# Vision Plan

*Keep a clear focus on your sight.*

## Your Vision Plan

Vision coverage is offered by VSP Vision Care as a Preferred Provider Organization (PPO) plan. You are automatically enrolled for VSP vision coverage when you enroll in a dental plan option. The plan has coverage for routine eye exams, frames and lenses. Note: Coverage for medical care for your eyes, such as eye infection, injury or glaucoma, is provided through your medical plan, not the Vision Plan.

## 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 VSP Vision Care by calling 1.800.877.7195 or visiting their website, [www.vsp.com](http://www.vsp.com).

**“I need specific vision care! How much does it cost?”**

## Plan Highlights

## VSP Vision Care PPO

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

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



# Hearing Aids

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

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 1.877.372.4040. 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.truhearing.com/vsp](http://www.truhearing.com/vsp) or call TruHearing at 1.877.372.4040

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.





# Life and AD&D

*Protection for your loved ones.*



## Basic Life and AD&D

In the event of your death, Life Insurance will provide your family members or other beneficiaries with financial protection and security. Additionally, if your death is a result of an accident or if you become dismembered, your Accidental Death & Dismemberment (AD&D) coverage may apply.

## Your District-Paid Basic Life and AD&D Coverage

Paid for in full by San Diego Unified School District, the benefits outlined below are provided by The Hartford:

- Basic Life Insurance of 1x annual earnings up to \$250,000
- Basic AD&D of 1x annual earnings up to \$250,000

Coverage begins on the first day of the month following your first day of paid service in a monthly salaried position of half-time or more if hired between the 1<sup>st</sup> through 15<sup>th</sup> of the month. Employees hired on the 16<sup>th</sup> through the end of the month will have coverage effective the first of the second month following date of hire.

IRS Regulation: Employees can receive employer paid life insurance up to \$50,000 on a tax-free basis and do not have to report the payment as income. However, an amount in excess of \$50,000 will trigger taxable income for the “economic value” of the coverage provided to you.

**TIP**

### Are Your Beneficiaries Up to Date?

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

- You can make your initial beneficiary designation once coverage begins
- You can change your beneficiary designation at any time.
- To select or change your beneficiary, please visit: <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 and AD&D

In addition to district-paid coverage, a variety of optional benefits are available for purchase. If you would like to supplement your employer-paid insurance, Voluntary Life and Accidental Death & Dismemberment (AD&D) coverage for you and your dependents is available for purchase through The Hartford.

### Voluntary Supplemental Life for Employees

- Voluntary Supplemental Life may be purchased in increments of \$10,000 up to the lesser of 5 times your annual salary or \$400,000.
- Newly eligible employees under age 65 have a one-time opportunity to purchase up to \$50,000 Voluntary Life Insurance with no Evidence of Insurability if election is made within 31 days of eligibility. Amounts above this guarantee issue amount and applications after 31 days of eligibility will be subject to Evidence of Insurability.
- If you do not elect voluntary supplemental life insurance when you are first eligible, you will be required to submit a health questionnaire to The Hartford, also known as Evidence of Insurability (EOI). An EOI will also be required if you wish to become insured for an amount greater than \$50,000.

### Voluntary Supplemental Life for Dependents

If you elect the Supplemental life insurance for yourself, you may also choose to purchase Supplemental Life Insurance for your spouse/ Domestic Partner (DP) and/or child(ren).

Please consider the following if you are purchasing Supplemental Life for a dependent:

- You must purchase coverage for yourself in order to purchase coverage for your spouse/DP or child(ren)
- You may apply for Supplemental Life Insurance for your spouse/DP in increments of \$5,000, up to a maximum of the lesser of 50% of your employee Voluntary Life Insurance or \$100,000
- You may enroll a newly eligible spouse/DP for up to \$20,000 without Evidence of Insurability
- Children may be enrolled for Supplemental Life Insurance in increments of \$2,500, up to \$10,000, with no Evidence of Insurability
  - For child(ren) coverage, one rate is charged for the increment elected for all eligible children in a family, regardless of the number of children

### Voluntary Supplemental AD&D

- Voluntary Supplemental AD&D: You can purchase Supplemental AD&D coverage in the amounts of \$50,000, \$100,000, \$150,000, \$200,000, \$250,000, \$300,000, \$400,000 or \$500,000. The maximum amount purchased cannot be more than 10 times your annual salary. No medical information is required.
- If you wish to add Dependent's Supplemental AD&D Insurance, the insurance amount is based on the dependents covered at the time of the accident:
  - Spouse/DP Only: 60% of the employee benefit
  - Spouse/DP & Children: Spouse benefit: 50%, Children benefit: 15% of the employee benefit
  - Children Only: 20% of the employee benefit – up to \$75,000 per child

**Please note:** Voluntary Supplemental Life benefits for an active employee will reduce when you reach age 70 to 50% of the pre-age 70 amount, to 25% at age 75 and, at age 80 to the lesser of \$10,000 or the pre-age 80 amount.

Age reduction schedule does not apply to the district-paid Hartford Basic Life/AD&D benefits shown on page 25.

Restrictions may apply if you and/or your dependent(s) are confined in the hospital or terminally ill on the date coverage would otherwise be effective. Please refer to your Certificate of Coverage (COC) for exclusions and further details.

**Premium Waiver Provision:** If you become totally disabled (as defined by Hartford) before age 60, you may be eligible to have premiums waived for your insurance and your dependents' insurance up to the earlier of the date you are no longer totally disabled or age 70.

**Living Benefit:** If you are under age 70 and terminally ill with a life expectancy of under 12 months, you may be eligible to accelerate your death benefit so that you may receive a portion of your life insurance while you are still living with the remainder paid to your beneficiary after your death. In this circumstance, you may apply to receive an amount from \$3,000 to 80% of your life insurance.

## Enrolling

To enroll in Voluntary Life and AD&D coverage, please visit: <https://enroll.thehartfordatwork.com>. It may take up to 10 days after the date you become covered by the District's benefits plans before you are able to log in. New hires will receive an email from The Hartford with enrollment instructions. If you do not receive the email or have difficulty logging in, call The Hartford at 855.396.7655.

**Do not mail applications to The Hartford or the District's Employee Benefits Office.**

- Initial User ID: Your District employee ID number
- Initial PIN: The first letter of your first name and the first letter of your last name (both lower case) followed by your date of birth (in MMDDYYYY format)
- You can complete a simplified Evidence of Insurability online

## Tentily Premium Rates – Voluntary Life Coverage

Employee Age	Tentily Rates / \$10,000		Tentily Rates / \$5,000	
	Employee (Non-Smoker)	Employee (Smoker)	Spouse / DP (Non-Smoker)	Spouse / DP (Smoker)
Under 40	\$0.59	\$1.13	\$0.28	\$0.54
40 – 49	\$1.17	\$1.94	\$0.56	\$0.93
50 – 59	\$2.90	\$5.42	\$1.38	\$2.58
60 – 64	\$5.90	\$9.27	\$2.81	\$4.42
65 – 69	\$10.46	\$16.00	\$4.98	\$7.62
70 – 74	\$19.39	\$26.47	\$9.23	\$12.61
75 – 79	\$25.96	\$44.10	\$12.36	\$21.00
80+	\$25.96	\$61.21	\$12.36	\$29.15
<b>Children's Insurance</b>	\$2,500	\$5,000	\$7,500	\$10,000
Tentily Rate	\$0.53	\$1.06	\$1.59	\$2.12

## Tentily Premium Rates – Voluntary AD&D Coverage

	Tentily Rates / \$50,000
Employee Only	\$0.85
Employee & Dependents	\$1.45

# Additional Services Offered by The Hartford

Life Insurance from The Hartford can help you protect the financial future of your loved ones. Your District provided coverage includes valuable services that can help you and your family.

## Funeral Concierge Services

The Hartford's Funeral Concierge offers a suite of online tools and live support to help guide you through key decisions. It allows for pre-planning, documentation of wishes, and even offers cost comparisons of funeral related expenses.

After a loss, this service includes family advocacy and professional negotiations of funeral prices with local providers – often resulting in significance savings,

For more information, please call 1.866.854.5429 or visit [www.everestfuneral.com/hartford](http://www.everestfuneral.com/hartford). Use code: HFEVLC

## Beneficiary Assist Counseling Services

Getting through a loss is hard. Getting support shouldn't be which is why Hartford offers you Beneficiary Assist counseling that can help you and your beneficiaries (names in your policy) copes with emotional, financial and legal issues that arise after a loss.

Includes unlimited phone contact with a counselor, attorney or financial planner and five face-to-face sessions for up to a year from the date a claim is filed.

For more information, please call 1.800.411.7239

## EstateGuidance Will Services

Whether your assets are few or many, it's important to have a will. Through The Hartford, you have access to EstateGuidance, which allows you to create a simple will online from the convenience of your home, backed by online, support from licensed attorneys.

For more information, please visit [www.estateguidance.com](http://www.estateguidance.com). Use code: WILLHLF

## Travel Assistance with ID Theft Protections

Even the best-planned trips can be full of surprises. Travel Assistance with ID Theft Protection includes pre-trip information to help you feel more secure while traveling. It can also help you access professionals across the globe for medical assistance when traveling 100+ miles away from home for 90 days or less.

ID Theft services are available to you and your family at home or when traveling.

**In case of a serious medical emergency while traveling**, please obtain emergency medical services first (contact your local "911") and then contact Travel Assistance to alert them.

- Call toll-free: 1.800.243.6108
- From other locations, call collect: 202.828.5885
- Email: [assist@imglobal.com](mailto:assist@imglobal.com)

### What to have ready:

- Your employer's name
- Your phone number
- Nature of the problem
- Your policy number
- Your Travel Assist ID number: GLD-09012



# Employee Assistance Program (EAP)

*Your free and confidential go-to resource.*

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 through Optum Health to employees covered by a District-sponsored medical plan and their families.

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. The EAP provides up to five (5) face-to-face confidential and personal counseling sessions per incident, per 12 months, at no cost through participating providers.

- For authorization or referrals call Optum EAP at 1.888.625.4809 or visit the EAP's website at [www.LiveAndWorkWell.com](http://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:**

- 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







# Spending Accounts

## Flexible Spending Accounts (FSA)

A flexible spending account is an IRS-regulated plan, which lets you use pre-tax dollars to cover eligible health care and/or dependent care expenses. These are different types of FSAs that help to reduce your taxable income when paying for eligible expenses for yourself, your spouse, and any eligible dependents, as outlined below:

FSA Type	Detail
 Healthcare FSA	<ul style="list-style-type: none"><li>• Can reimburse for eligible healthcare expenses not covered by your medical, dental, and vision insurance.</li><li>• Maximum contribution for 2023 is \$2,850.</li></ul>
 Dependent Care FSA	<ul style="list-style-type: none"><li>• Can be used to pay for a child's (up to the age of 13) childcare expenses and/or care for a disabled family member in the household, who is unable to care for themselves.</li><li>• Maximum contribution 2023 is \$5,000 (\$2,500 maximum if married filing separately).</li></ul>

## What are the Benefits?

- Your taxable income is reduced and your spendable income increases!
- Save money while keeping you and your family healthy.

*If you have questions about tax savings, you may want to consult a tax advisor.*

## A Few Rules You Need to Know!

- **Contributions are deducted from your paycheck on a tenths basis** and taken from paychecks issued from September to June during the year before federal, state and social security taxes are taken out.
- Although the plan year runs from January 1, 2023 through December 31, 2023 the plan allows an annual run-out period through March 31, 2024, allowing you to seek reimbursement for any expenses incurred during the prior plan year (from January 1, 2023 through December 31, 2023).
- If you participate in the Health Care FSA (HC-FSA) immediately preceding your termination, you may have options for FSA continuation after termination. Please call / contact the District Benefits Department as soon as you know you will be separating from the District.

## Remember to Plan Carefully!

- It's important to estimate your annual expenses carefully, because the Internal Revenue Service requires that you forfeit any unclaimed funds in your account after the closing date for the plan year. By estimating the eligible expenses, you and your family might incur during the plan year, you will have a better sense of how much your annual contribution towards the FSA should be.
- You cannot change your Health Care FSA or Dependent Care FSA contributions during the year unless you experience an applicable Qualified Life Event.
- You should use all the funds in your account(s) each calendar year. 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 or Dependent 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.
- Contributions and expenses cannot be transferred between your Health Care FSA and your Dependent Care FSA.

*\*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.*

## Enrolling in an FSA

To participate in the FSA program, enrollment must be completed each year during the Open Enrollment period for active employees up to the maximum amounts allowed. Employees must re-elect each year during Open Enrollment; an annual contribution amount must be determined at the time of enrollment. **Elections do not remain in force for more than one plan year.**

If you enroll in the Health Care FSA, you may elect to receive an FSA Debit Card that can be used to pay for eligible health care expenses at approved health care merchants such as doctors' offices and pharmacies. Instead of paying first and then filing a claim for reimbursement, the expenses are automatically deducted from your Flexible Spending Account.

If you enroll in the Dependent Care FSA and you incur eligible dependent care expenses, you will need to submit a claim form and receipts for the expenses to American Fidelity, the plan administrator, who will then reimburse you through an automatic deposit to your bank or by check. Keep itemized receipts in a safe place. The IRS or American Fidelity may request a copy to substantiate a claim. If you are required to submit a receipt or some form of claim documentation and failure to comply, reimbursement may be denied.

Once enrolled, you can establish online access to view your FSA balance(s), check on a reimbursement status, upload receipts and more.

American Fidelity offers two ways to access your personal account; online or through their mobile app:

- **Online:** From your desktop or laptop create an account at <https://americanfidelity.com>. Register using your email address and Social Security Number.
- **Mobile App:** Download their mobile app, AFmobile, in the Apple App store or Google Play Store. To register, you will need your email address – this should be the same email address provided at time of enrollment – and your Social Security Number.

**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 for claims incurred between January 1 and December 31 of the current plan year. If you do not receive automatic reimbursement by using your debit card, you can submit a manual reimbursement request by:

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

# 457(b) and 403(b) Retirement Options

*Make retirement a reality, not a wish.*

Whether you're just a few years away from retirement or you're in the early planning stages for your future, San Diego Unified School District offers two powerful options to help you accumulate money for your retirement. They are a Deferred Compensation IRC 457(b) plan and a Tax Sheltered Annuity IRC Section 403(b) plan. Eligible employees may contribute to either or both plans. Maximum contribution amounts show below are for 2022. Contribution limits for 2023 have not been announced by the IRS as of the date of publication of this guide.

For complete information, contact a Variable Annuity Life Insurance Company (VALIC) financial advisor at 1.619.718.7000 or go to [MyRetirementManager.com](http://MyRetirementManager.com)

## Deferred Compensation Plan 457(b) Option

A Deferred Compensation IRC Section 457(b) Plan allows you to plan for your future by contributing a pre-tax portion of each paycheck today. An employee is eligible to participate in the plan on the first day of the month following your date of hire. Once you become eligible, you may elect to have a portion of your paycheck withheld and invested in your 457(b) account, subject to federal law and plan guidelines.

**In 2022, you can contribute up to \$20,500 plus possible "catch-up" contributions (additional forms required):**

- Up to an additional \$20,500 if you are within the last three taxable years ending in the year before your Normal Retirement Age under the Plan and have under-contributed in prior years, OR
- An additional \$6,500 if you are an eligible District employee age 50 or older.

## Tax Sheltered Annuity 403(b) Option

A Tax Sheltered Annuity IRC Section 403(b) Plan allows you to plan for your future by contributing a pre-tax portion of each paycheck today. An employee is eligible to participate in the plan on the first day of the month following your date of hire. Once you become eligible, you may elect to have a portion of your paycheck withheld and invested in your 403(b) account, subject to federal law and plan guidelines.

**In 2022, you can contribute up to \$20,500 plus a possible "catch-up" contribution:**

- Up to an additional \$3,000 if you have at least 15 years of service with the District and have under-contributed in prior years, AND
- An additional \$6,500 if you are age 50 or older. (If you are eligible for both the 15-year service-based and the age 50-based catch-ups, you must exhaust the 15 year catch-up first.)

## Enrollment & Account Access

- To enroll in the 457(b) plan, please visit [MyRetirementManager.com](http://MyRetirementManager.com) to enroll online or contact the VALIC Office at 1.619.718.7000 to receive your enrollment forms. To enroll in the 403(b) plan select a TSA provider from the District's Approved Provider List and establish an account with the provider before accessing [MyRetirementManager.com](http://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](http://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](mailto:deferred.comp@sandi.net).

**Contribution Changes:** You may change the amount of your contribution on a monthly basis. You also may stop your contribution entirely at any time. Requests to change or stop your contributions must be made through the provider website at [MyRetirementManager.com](http://MyRetirementManager.com). Any change in contributions needs to be made prior to the 15<sup>th</sup> of the month, that the change is to take effect.

**Loans & Hardship Withdrawals:** Plans may allow for both Loans and Hardship withdrawals to be taken from your accounts while still employed with the District. Please call your VALIC Financial Advisor at 1.619.718.7000 for 457(b) withdrawal information and requirements. For 403(b) withdrawal information, please contact your provider directly.



## Withdrawals

Except for unforeseen emergencies or financial hardship, withdrawals generally cannot be made before:

Deferred Compensation 457(b): Employee must have terminated employment or if you reach age 70½, you must take your first required minimum distribution by April 1<sup>st</sup> of the year after you reach age 72.

Tax Sheltered Annuity 403(b): Employee must have terminated employment or attained age 59 ½; however, employees may withdraw money before this age and pay a 10% early withdrawal penalty.

## Financial Hardship and Emergencies

Tax Sheltered Annuity: Employees may have the opportunity to withdraw money only for financial hardship, for example:

- Significant unreimbursed medical expenses,
- Payments to purchase a principal residence,
- Higher education expenses, and
- Payments to prevent eviction or foreclosure of a mortgage.

Deferred Compensation: The rules are more restrictive. Withdrawals may only be made for unforeseeable emergencies. Examples are:

- A sudden and unexpected serious accident or illness for you or a dependent,
- Loss to your property due to fire, earthquake or flood,
- Other similar, extraordinary events beyond your control.
- Note that sending a child to college and purchasing a home are examples of events that are not considered emergencies.

**Termination of Employment:** Upon termination of employment from the District, regardless of reason, you will be entitled to request a full distribution of your vested account balance. This may be done as a rollover to another plan or 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 a qualified plan.

## What is the maximum amount I can contribute to both plans in 2022?

Deferred Compensation 457(b)		Tax Sheltered Annuity 403(b)	
Basic Contribution	\$20,500	Basic Contribution	\$20,500
Eligible employees within the last 3 taxable years ending in the year before normal retirement age under their plan	<u>+\$20,500</u>	Eligible Employees with 15+ years of service	+\$3,000
		Employees age 50 or older	<u>+\$6,500</u>
<b>TOTAL</b>	<b>\$41,000</b>	<b>TOTAL</b>	<b>\$30,000</b>
<b>OR</b>			
Basic Contribution	\$20,500		
Employee age 50 or older	<u>+\$6,500</u>		
<b>TOTAL</b>	<b>\$27,000</b>		

# Directory & Resources

Below, please find important contact information and resources for San Diego Unified School District.

## Information Regarding

## Contact Information

<b>Enrollment &amp; Eligibility</b>		
<ul style="list-style-type: none"> <li>SDUSD Benefits Department</li> </ul>	619.725.8130	Email: <a href="mailto:employeebenefits@sandi.net">employeebenefits@sandi.net</a> <a href="http://www.sandiegounified.org/departments/benefits">www.sandiegounified.org/departments/benefits</a>
<b>California Schools VEBA</b>		
<ul style="list-style-type: none"> <li>VEBA</li> <li>VEBA Advocacy Program</li> <li>VEBA Resource Center (VRC)</li> </ul>	619.278.0021 888.276.0250 619.398.4220	<a href="http://www.vebaonline.com">www.vebaonline.com</a> Email: <a href="mailto:advocacy@mcgregorinc.com">advocacy@mcgregorinc.com</a> <a href="http://www.vebaresourcecenter.com">www.vebaresourcecenter.com</a>
<b>Medical Coverage &amp; Programs</b>		
Kaiser		
<ul style="list-style-type: none"> <li>HMO</li> </ul>	800.464.4000	<a href="http://my.kp.org/veba">my.kp.org/veba</a>
UnitedHealthcare		
<ul style="list-style-type: none"> <li>HMO</li> <li>UMR NexusACO Select Plus PPO</li> <li>Express Scripts RX – UHC Members</li> <li>Carrum Health</li> </ul>	888.586.6365 800.826.9781 800.918.8011 888.855.7806	<a href="http://www.whyuhc.com/csveba">www.whyuhc.com/csveba</a> <a href="http://www.umr.com">www.umr.com</a> <a href="http://www.express-scripts.com">www.express-scripts.com</a> <a href="http://carrum.me/CSVEBA">carrum.me/CSVEBA</a>
TelaDoc Medical (formerly Best Doctors)	800.835.2362	<a href="http://www.teladoc.com/medical-experts">www.teladoc.com/medical-experts</a>
Optum Health Chiropractic – All Members	800.428.6337	<a href="http://www.MyOptumPhysicalHealthofCA.com">www.MyOptumPhysicalHealthofCA.com</a>
Optum Financial Services – Alliance HRA	800.243.5543	<a href="http://www.optumbank.com">www.optumbank.com</a>
HealthInvest HRA – UHC Journey-Harmony HRA	844.342.5505	<a href="http://www.HealthInvestHRA.com">www.HealthInvestHRA.com</a>
<b>Dental Coverage</b>		
Delta Dental		
<ul style="list-style-type: none"> <li>PPO</li> </ul>	866.499.3001	<a href="http://www.deltadentalins.com">www.deltadentalins.com</a>
DeltaCare		
<ul style="list-style-type: none"> <li>HMO</li> </ul>	800.422.4234	<a href="http://www.deltadentalins.com">www.deltadentalins.com</a>
Western Dental		
<ul style="list-style-type: none"> <li>HMO</li> </ul>	800.992.3366	<a href="http://www.westerndental.com">www.westerndental.com</a>
<b>Vision Coverage</b>		
VSP Vision Care		
<ul style="list-style-type: none"> <li>Vision PPO</li> </ul>	800.877.7195	<a href="http://www.vsp.com">www.vsp.com</a>
<b>Life Insurance Plans</b>		
The Hartford		
<ul style="list-style-type: none"> <li>Basic Life &amp; Supplemental Life</li> </ul>	855.396.7655	<a href="http://www.enroll.thehartfordatwork.com/enroll/login.aspx">www.enroll.thehartfordatwork.com/enroll/login.aspx</a>
<b>Flexible Spending Accounts</b>		
American Fidelity	800.662.1113	<a href="http://www.americanfidelity.com">www.americanfidelity.com</a> Email: <a href="mailto:flex@americanfidelity.com">flex@americanfidelity.com</a>
<b>Deferred Compensation 457(b) Plans</b>		
VALIC Office	619.718.7000	<a href="http://myretirementmanager.com">myretirementmanager.com</a>
<b>Tax Sheltered Annuity 403(b) Plans</b>		
VALIC Office	619.718.7000	<a href="http://myretirementmanager.com">myretirementmanager.com</a>
<b>Employee Assistance Plan</b>		
OptumHealth	888.625.4809	<a href="http://www.liveandworkwell.com">www.liveandworkwell.com</a> 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.ccio.cms.gov](http://www.ccio.cms.gov). You can also visit [www.coveredca.com](http://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.

# Medicare Part D notice

## Important Notice from San Diego Unified School District 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 with San Diego 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:

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. San Diego Unified School District has determined that the prescription drug coverage offered by the San Diego Unified District offered medical plans 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 15<sup>th</sup> to December 7<sup>th</sup>. 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?

If you decide to join a Medicare drug plan while enrolled in San Diego Unified School District coverage as an active employee, please note that if your San Diego Unified School District coverage is subject to the Medicare Secondary Payer rules, the San Diego Unified School District Active Medical plans will be the primary payer for your prescription drug benefits and Medicare will pay secondary. As a result, the value of your Medicare prescription drug benefits will be significantly reduced if your San Diego Unified School District coverage is subject to the Medicare Secondary Payer rules, which applies to all employers with 20 or more employees. Medicare will usually pay primary for your prescription drug benefits if you participate in San Diego Unified School District coverage as an individual who loses eligibility under the plan (e.g., termination, reduction in hours).

You may also choose to drop your San Diego Unified School District coverage. If you do decide to join a Medicare drug plan and drop your current San Diego Unified School District coverage, be aware that you and your dependents may not 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 San Diego 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 (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 California Schools VEBA at 619.278.0021. NOTE: You'll 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 San Diego 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'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](http://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](http://www.socialsecurity.gov), or call SSA at 1-800-772-1213 (TTY 1-800-325-0778).

**Remember:** Keep this Creditable 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).

Date:	01/01/2023
Name of Entity/Sender:	San Diego Unified School District
Contact-Position/Office:	Employee Benefits Department
Address:	4100 Normal Street, Room 1150A San Diego, CA 92103
Phone Number:	619.725.8130

# Legal Information Regarding Your Plans

## REQUIRED NOTICES

### Women's Health & Cancer Rights Act

The Women's Health and Cancer Rights Act (WHCRA) requires group health plans to make certain benefits available to participants who have undergone or who are going to have a mastectomy. In particular, a plan must offer mastectomy patients benefits for:

All stages of reconstruction of the breast on which the mastectomy was performed;  
Surgery and reconstruction of the other breast to produce a symmetrical appearance;  
Prostheses; and

Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan.

Your plans comply with these requirements.

### Health Insurance Portability & Accountability Act Non-discrimination Requirements

Health Insurance Portability & Accountability Act (HIPAA) prohibits 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 that other coverage (or if the employer stopped contributing towards your or your dependents' other coverage). However, you must request enrollment within 30 days (60 days if the lost coverage was Medicaid or Healthy Families) after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

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 Human Resources Representative.

"HIPAA Special Enrollment Opportunities" include:

COBRA (or state continuation coverage) exhaustion

Loss of other coverage <sup>(1)</sup>

Acquisition of a new spouse or dependent through marriage <sup>(1)</sup>, adoption <sup>(1)</sup>, placement for adoption <sup>(1)</sup> or birth <sup>(1)</sup>

Loss of state Children's Health Insurance Program coverage (e.g., Healthy Families) (60-day notice) <sup>(1)</sup>

Employee or dependents become eligible for state Premium Assistance Subsidy Program (60-day notice)

## 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 Human Resources office

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 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 Human Resources office.

### 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.

### 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 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 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.

<sup>(1)</sup> Indicates that this event is also a qualified "Change in Status"

<sup>(2)</sup> Indicates this event is also a HIPAA Special Enrollment Right

<sup>(3)</sup> Indicates that this event is also a COBRA Qualifying Event

## CONTINUATION COVERAGE RIGHTS UNDER COBRA (CONTINUED)

### 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 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's employment ends for any reason other than his or her 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."

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 all 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: SDUSD Benefits Department.

### 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 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.

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 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.

### 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 18 additional 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, 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](http://www.healthcare.gov).

#### Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?

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<sup>(1)</sup> 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.

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

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts 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](http://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](http://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 Brucker 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 Human Resources Representative.

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](http://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 assister in your area who you can talk to about the different options, visit [www.healthcare.gov](http://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 child birth;
- 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, child 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.

(1) <https://www.medicare.gov/sign-up-changes-plans/how-to-get-into-a-special-enrollment-period>

## Military Family Leave Entitlements

Eligible employees whose spouse, son, daughter or parent is on covered active duty or call to covered active duty status may 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 <sup>(1)</sup>; 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. <sup>(2)</sup>

## 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 <sup>(2)</sup>, and if at least 50 employees are employed by the employer within 75 miles.

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

<sup>(2)</sup> 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 continuing 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 continuing 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 employee 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 employees' 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.

FMLA section 109 (29 U.S.C. § 2619) requires FMLA covered employers to post the text of this notice. Regulations 29 C.F.R. § 825.300(a) may require additional disclosures.

For additional information: (866) 4US-WAGE ((866) 487-9243) TTY: (877) 889-5627 [www.wagehour.dol.gov](http://www.wagehour.dol.gov)

## 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; and
- 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.

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 Human Resources 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 Human Resources 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:

Period of Uniformed Service	Report to Work Requirement
Less than 31 days	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
31-180 days	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
181 days or more	Submit an application for reemployment within 90 days after completion of your service
Any period if for purposes of an examination for fitness to perform uniformed service	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, as soon as is possible
Any period if you were hospitalized for or are convalescing from an injury or illness incurred or aggravated as a result of your service	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 report to work within the above time periods

### Definitions

For you to be entitled to continued coverage under USERRA, your absence from work must be due to "service in the uniformed services."

- "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)

# 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, 2023

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 your choices about 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 fundraising 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 assist in your treatment. For example, the Plan may provide a treating physician with the name of another treating provider to obtain records or information needed for your treatment.

**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 employees. We may also use and disclose your information to run our organization and contact you when necessary. If PHI is used or disclosed for underwriting purposes, the Plan is prohibited from using or disclosing any of your PHI that is genetic information for such purposes. The Plan is also not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long term care plans.

**Payment for Health Services and Administration of the Plan:** The Plan can use and disclose your health information when paying 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 disclose your health information to your health plan sponsor for plan administration. For example, where your company contracts with an insurer to provide a health plan, and the Plan provides your company with certain statistics to explain the premiums charged.

**Business Associates:** There are some services provided in our organization through contracts with business associates. Business associates with access to your 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 health oversight 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 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 records 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 not 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 you tell us you would be in danger if we do not.
- 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 day 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 not to use, share, disclose or request 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).
- Accommodate 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/noticepp.html](http://www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html)

### 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  
Attention: Plan Privacy Officer  
1843 Hotel Circle South  
San Diego, CA 92108  
619.278.0021



# 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](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 either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or [www.insurekidsnow.gov](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.askebsa.dol.gov](http://www.askebsa.dol.gov) or call **1-866-444-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 January 31, 2022. Contact your State for more information on eligibility –**

<p><b>ALABAMA – Medicaid</b></p> <p>Website: <a href="http://myalhipp.com/">http://myalhipp.com/</a> Phone: 1-855-692-5447</p>	<p><b>CALIFORNIA – Medicaid</b></p> <p>Website: Health Insurance Premium Payment (HIPP) Program <a href="http://dhcs.ca.gov/hipp">http://dhcs.ca.gov/hipp</a> Phone: 916-445-8322 Fax: 916-440-5676 Email: <a href="mailto:hipp@dhcs.ca.gov">hipp@dhcs.ca.gov</a></p>
<p><b>ALASKA – Medicaid</b></p> <p>The AK Health Insurance Premium Payment Program Website: <a href="http://myakhipp.com/">http://myakhipp.com/</a> Phone: 1-866-251-4861 Email: <a href="mailto:CustomerService@MyAKHIPP.com">CustomerService@MyAKHIPP.com</a> Medicaid Eligibility: <a href="http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx">http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx</a></p>	<p><b>COLORADO – Health First Colorado (Colorado's Medicaid Program) &amp; Child Health Plan Plus (CHP+)</b></p> <p>Health First Colorado Website: <a href="https://www.healthfirstcolorado.com/">https://www.healthfirstcolorado.com/</a> Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: <a href="https://www.colorado.gov/pacific/hcpf/child-health-plan-plus">https://www.colorado.gov/pacific/hcpf/child-health-plan-plus</a> CHP+ Customer Service: 1-800-359-1991/ State Relay 711 Health Insurance Buy-In Program (HIBI): <a href="https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program">https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program</a> HIBI Customer Service: 1-855-692-6442</p>
<p><b>ARKANSAS – Medicaid</b></p> <p>Website: <a href="http://myarhipp.com/">http://myarhipp.com/</a> Phone: 1-855-MyARHIPP (855-692-7447)</p>	<p><b>FLORIDA – Medicaid</b></p> <p>Website: <a href="https://www.flmedicaidprecovery.com/flmedicaidprecovery.com/hipp/index.html">https://www.flmedicaidprecovery.com/flmedicaidprecovery.com/hipp/index.html</a> Phone: 1-877-357-3268</p>
<p><b>GEORGIA – Medicaid</b></p> <p>A HIPP Website: <a href="https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp">https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp</a> Phone: 678-564-1162, Press 1 GA CHIPRA Website: <a href="https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra">https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra</a> Phone: (678) 564-1162, Press 2</p>	<p><b>MASSACHUSETTS – Medicaid and CHIP</b></p> <p>Website: <a href="https://www.mass.gov/info-details/masshealth-premium-assistance-pa">https://www.mass.gov/info-details/masshealth-premium-assistance-pa</a> Phone: 1-800-862-4840</p>
<p><b>INDIANA – Medicaid</b></p> <p>Healthy Indiana Plan for low-income adults 19-64 Website: <a href="http://www.in.gov/fssa/hip/">http://www.in.gov/fssa/hip/</a> Phone: 1-877-438-4479 All other Medicaid Website: <a href="https://www.in.gov/medicaid/">https://www.in.gov/medicaid/</a> Phone 1-800-457-4584</p>	<p><b>MINNESOTA – Medicaid</b></p> <p>Website: <a href="https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp">https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp</a> Phone: 1-800-657-3739</p>
<p><b>IOWA – Medicaid and CHIP (Hawki)</b></p> <p>Medicaid Website: <a href="https://dhs.iowa.gov/ime/members">https://dhs.iowa.gov/ime/members</a> Medicaid Phone: 1-800-338-8366 Hawki Website: <a href="http://dhs.iowa.gov/Hawki">http://dhs.iowa.gov/Hawki</a> Hawki Phone: 1-800-257-8563 HIPP Website: <a href="https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp">https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp</a> HIPP Phone: 1-888-346-9562</p>	<p><b>MISSOURI – Medicaid</b></p> <p>Website: <a href="http://www.dss.mo.gov/mhd/participants/pages/hipp.htm">http://www.dss.mo.gov/mhd/participants/pages/hipp.htm</a> Phone: 573-751-2005</p>
<p><b>KANSAS – Medicaid</b></p> <p>Website: <a href="https://www.kancare.ks.gov/">https://www.kancare.ks.gov/</a> Phone: 1-800-792-4884</p>	<p><b>MONTANA – Medicaid</b></p> <p>Website: <a href="http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP">http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP</a> Phone: 1-800-694-3084</p>
<p><b>KENTUCKY – Medicaid</b></p> <p>Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: <a href="https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx">https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx</a> Phone: 1-855-459-6328 Email: <a href="mailto:KIHIPPPROGRAM@ky.gov">KIHIPPPROGRAM@ky.gov</a></p> <p>KCHIP Website: <a href="https://kidshealth.ky.gov/Pages/index.aspx">https://kidshealth.ky.gov/Pages/index.aspx</a> Phone: 1-877-524-4718</p> <p>Kentucky Medicaid Website: <a href="https://chfs.ky.gov">https://chfs.ky.gov</a></p>	<p><b>NEBRASKA – Medicaid</b></p> <p>Website: <a href="http://www.ACCESSNebraska.ne.gov">http://www.ACCESSNebraska.ne.gov</a> Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178</p>
<p><b>LOUISIANA – Medicaid</b></p> <p>Website: <a href="http://www.medicicaid.la.gov">www.medicicaid.la.gov</a> or <a href="http://www.ldh.la.gov/lahipp">www.ldh.la.gov/lahipp</a> Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)</p>	<p><b>NEVADA – Medicaid</b></p> <p>Medicaid Website: <a href="http://dhcfo.nv.gov">http://dhcfo.nv.gov</a> Medicaid Phone: 1-800-992-0900</p>
<p><b>MAINE – Medicaid</b></p> <p>Enrollment Website: <a href="https://www.maine.gov/dhhs/ofi/applications-forms">https://www.maine.gov/dhhs/ofi/applications-forms</a> Phone: 1-800-442-6003 TTY: Maine relay 711</p> <p>Private Health Insurance Premium Webpage: <a href="https://www.maine.gov/dhhs/ofi/applications-forms">https://www.maine.gov/dhhs/ofi/applications-forms</a> Phone: 1-800-977-6740 TTY: Maine relay 711</p>	<p><b>NEW HAMPSHIRE – Medicaid</b></p> <p>Website: <a href="https://www.dhhs.nh.gov/oi/hipp.htm">https://www.dhhs.nh.gov/oi/hipp.htm</a> Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 5218</p>

<b>NEW JERSEY – Medicaid and CHIP</b>	<b>SOUTH DAKOTA – Medicaid</b>
Medicaid Website: <a href="http://www.state.nj.us/humanservices/dmahs/clients/medicaid/">http://www.state.nj.us/humanservices/dmahs/clients/medicaid/</a> Medicaid Phone: 609-631-2392 CHIP Website: <a href="http://www.nifamilycare.org/index.html">http://www.nifamilycare.org/index.html</a> CHIP Phone: 1-800-701-0710	Website: <a href="http://dss.sd.gov">http://dss.sd.gov</a> Phone: 1-888-828-0059
<b>NEW YORK – Medicaid</b>	<b>TEXAS – Medicaid</b>
Website: <a href="https://www.health.ny.gov/health_care/medicaid/">https://www.health.ny.gov/health_care/medicaid/</a> Phone: 1-800-541-2831	Website: <a href="http://gethipptexas.com/">http://gethipptexas.com/</a> Phone: 1-800-440-0493
<b>NORTH CAROLINA – Medicaid</b>	<b>UTAH – Medicaid and CHIP</b>
Website: <a href="https://medicaid.ncdhhs.gov/">https://medicaid.ncdhhs.gov/</a> Phone: 919-855-4100	Medicaid Website: <a href="https://medicaid.utah.gov/">https://medicaid.utah.gov/</a> CHIP Website: <a href="http://health.utah.gov/chip">http://health.utah.gov/chip</a> Phone: 1-877-543-7669
<b>NORTH DAKOTA – Medicaid</b>	<b>VERMONT – Medicaid</b>
Website: <a href="http://www.nd.gov/dhs/services/medicalserv/medicaid/">http://www.nd.gov/dhs/services/medicalserv/medicaid/</a> Phone: 1-844-854-4825	Website: <a href="http://www.greenmountaincare.org/">http://www.greenmountaincare.org/</a> Phone: 1-800-250-8427
<b>OKLAHOMA – Medicaid and CHIP</b>	<b>VIRGINIA – Medicaid and CHIP</b>
Website: <a href="http://www.insureoklahoma.org">http://www.insureoklahoma.org</a> Phone: 1-888-365-3742	Website: <a href="https://www.coverva.org/en/famis-select">https://www.coverva.org/en/famis-select</a> <a href="https://www.coverva.org/en/hipp">https://www.coverva.org/en/hipp</a> Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-800-432-5924
<b>OREGON – Medicaid</b>	<b>WASHINGTON – Medicaid</b>
Website: <a href="http://healthcare.oregon.gov/Pages/index.aspx">http://healthcare.oregon.gov/Pages/index.aspx</a> <a href="http://www.oregonhealthcare.gov/index.es.html">http://www.oregonhealthcare.gov/index.es.html</a> Phone: 1-800-699-9075	Website: <a href="https://www.hca.wa.gov/">https://www.hca.wa.gov/</a> Phone: 1-800-562-3022
<b>PENNSYLVANIA – Medicaid</b>	<b>WEST VIRGINIA – Medicaid and CHIP</b>
Website: <a href="https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx">https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx</a> Phone: 1-800-692-7462	Website: <a href="http://mywvhipp.com/">http://mywvhipp.com/</a> Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447) Website: <a href="https://dhr.wv.gov/bms/">https://dhr.wv.gov/bms/</a> <a href="http://mywvhipp.com/">http://mywvhipp.com/</a> Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
<b>RHODE ISLAND – Medicaid and CHIP</b>	<b>WISCONSIN – Medicaid and CHIP</b>
Website: <a href="http://www.eohhs.ri.gov/">http://www.eohhs.ri.gov/</a> Phone: 1-855-697-4347, or 401-462-0311 (Direct Rlte Share Line)	Website: <a href="https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm">https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm</a> Phone: 1-800-362-3002
<b>SOUTH CAROLINA – Medicaid</b>	<b>WYOMING – Medicaid</b>
Website: <a href="https://www.scdhhs.gov">https://www.scdhhs.gov</a> Phone: 1-888-549-0820	Website: <a href="https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/">https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/</a> Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since January 31, 2022, or for more information on special enrollment rights, contact either:

U.S. Department of Labor  
Employee Benefits Security Administration  
[www.dol.gov/agencies/ebsa](http://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](http://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](mailto:ebsa.opr@dol.gov) and reference the OMB Control Number 1210-0137.

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