EMPLOYEE 2025 BENEFITS GUIDE

WASHINGTON UNIFIED SCHOOL DISTRICT
WEST SACRAMENTO

Employee Benefits Guide 2025

General Information

Core Benefits

Other Benefits

Miscellaneous

Click this icon in your benefits guide to watch a video explaining the associated topic.

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

Please see page 51 for more details.

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

Introduction and Eligibility

Flexible Solutions For Your Benefits Needs

We consider our employee benefits program to be one of our most important investments. Because we recognize the value our employees bring to our district, we are committed to providing you with a complete benefits program as part of your total compensation.

This guide has been prepared to assist you in making informed decisions regarding your employee benefits. We urge you to read this guide carefully and keep it as a reference. If you are well informed you will be better able to make the benefit choices that best meet your needs.

Please contact the Benefits Department at 916-375-7604 Ext. 7 (Ext. 4001 if calling internally) if you have any questions regarding your employee benefits package.

Thank you.

Who's Eligible?

Employees

Please contact the Washington Unified School District Benefits Department to inquire about eligibility guidelines.

Eligible Dependents

Your eligible dependents include your legally married spouse, domestic partner, and children (including stepchildren and adopted children) up to age 26. Age limits may apply to dependents enrolled as full-time students.

Coverage may be available for a mentally or physically disabled child who is age 26 or older. Requirements for such coverage and documentation of disability depend on the insurance carrier.

For more information, contact the Benefits Department at 916-375-7604 Ext. 7 (Ext. 4001 if calling internally)

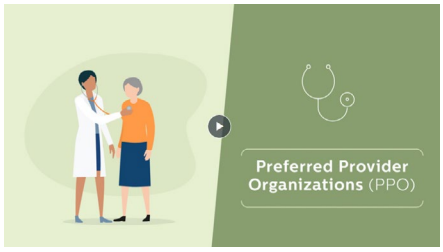
Videos that Explain Benefits Topics

Find answers to your benefits questions and learn about a variety of subjects in this video library.
Click on a topic below to learn more.

Benefits Key Terms Explained

Qualifying Life Events

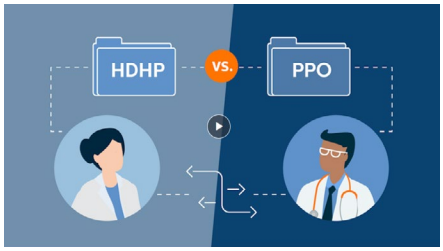
PPO vs. HMO



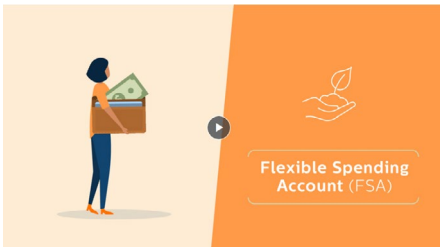
Preferred Provider Organizations (PPO)

Health Maintenance Organizations (HMO)

High Deductible Health Plan (HDHP)

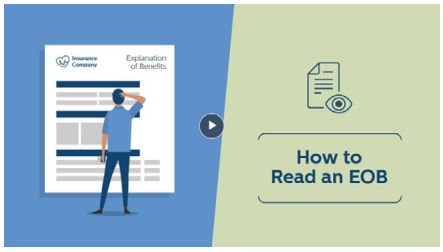


HDHP vs. PPO



Flexible Spending Account (FSA)

Health Savings Account (HSA)



How to Read an EOB

How to Optimize Your HSA

When You Can Enroll

New Hires/Newly Eligible for Benefits

When you are first hired or become eligible for benefits, you have 30 days to enroll for benefits. If you do not enroll within that time period you will not be eligible for benefits until the next Open Enrollment, unless you have a **Change in Status**.

Open Enrollment

During Open Enrollment you will have the opportunity to make changes to your benefit elections. You must enroll by the Open Enrollment deadline for your benefits to be effective January 1st. Except for a **Change in Status**, you will not be able to change your elections until the next year's Open Enrollment.

Change in Status

If you have a Change in Status, you may be able to change your benefits before the next Open Enrollment. You must notify the Benefits Department within 30 days of the change.* If you meet the deadline, changes will be effective on the event date.

***Change in Status events include:**

- Change in marital status
- Change in dependents
- Change in benefits eligibility for you, your spouse or dependent
- Change in employment for you, your spouse or dependent
- Change in work schedule for you or your spouse
- Gaining other coverage through your spouse
- Loss of other coverage for your dependent
- Change in residence causing loss of coverage
- Federal and state family medical leave, if qualified
- Medicare or Medicaid entitlement for you, your spouse or dependent
- Qualified Medical Child Support Order (QMCSO)

Contact the Benefits Department at 916-375-7604 Ext. 7 (Ext. 4001 if calling internally) for a complete explanation of qualifying family status change.

Medical

Eligible Employees and Early Retirees

WUSD employees can choose from various medical plans. The medical plans provide comprehensive coverage but are different in how they are designed. Review the benefit summaries featured to understand the differences between the plans. Medicare eligible Retirees receive vision benefits from Kaiser and Health Net.

You decide which plan best meets your needs

- **Certificated:**
  - **Kaiser Permanente HMO –** $20 office visit copay plan
  - **Kaiser Permanente DHMO –** $20 office visit copay plan; $1000 Deductible
  - **Kaiser Permanente HMO HSA –** HDHP #9835 plan
  - **United Healthcare PPO –** BPFJ PPO $400 Deductible
  - **Western Health Advantage HMO –** $20 office visit copay plan
  - **Western Health Advantage HMO –** Advantage 0/40/30% plan
  - **Western Health Advantage HMO HSA –** 1800/0 plan
  - **Sutter Health Plus HMO –** ML81 $20 office visit copay plan

When enrolling in an HMO, you must select a primary care physician who will manage your care and refer you to a specialist when it is needed. Most services are covered at a 100% after you pay a copayment.

Visit Kaiser Permanente:
www.kp.org

Visit Western Health Advantage:
www.westernhealth.com

Visit Sutter Health Plus:
www.sutterhealthplus.org

Visit United Healthcare:
www.uhc.com

Visit Superior Vision:
www.superiorvision.com

Health Saving Account

Your HSA-compatible plan is a high deductible health plan (HDHP) that enables you, as a consumer, to manage your individual or family health care expenditures. This highly-rated plan provides you and your family medical services at lower premiums. Your HSA is the financial component (the account that holds your funds) providing a tax-free way to save and pay for qualified medical expenses. The combined strength of your HSA-compatible plan and the funds in your HSA provides you peace of mind about your current and future health care needs. This plan has been updated to include member maximums within family coverage.

Superior Vision Plan

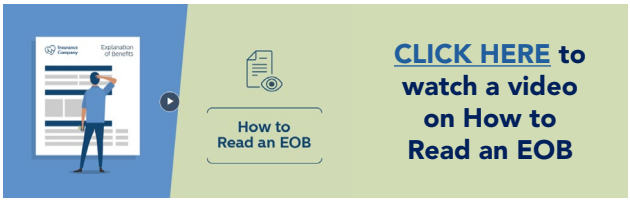
All eligible employees have two Superior Vision plans from which to choose. There is a base plan and buy-up plan option, and both offer comprehensive coverage through the Superior Vision National Network of providers. Superior Vision also offers a number of non-covered services at a discount.

Post-65 Retirees

(Must have Medicare Parts A & B and live within 30 miles of a Kaiser Facility.)

You have the choice to select one plan from the following:

- Kaiser Permanente HMO Senior Advantage (California Only)



Medical (continued)

Eligible Employees & Early Retirees

Plan Benefits	Kaiser Permanente HMO Traditional Certificated Employees & Early Retirees
Lifetime Maximum	Unlimited
Maximum Out of Pocket	$1,500 Individual/$3,000 Family
Preventive Services	
• Routine Physical	No charge
• Well Baby/Immunizations	No charge
Physician/Diagnostic Services	
• Office Visits	$20 copay
• Lab & X-ray & Diagnostic Test	No charge
• Prenatal/Postnatal Office Visits	No charge
Hospital Services	
• Semi-Private Room & Board	$250 copay
• Outpatient Surgery	$100 copay
• Emergency Room *(waived if admitted)*	$125 copay
• Urgent Care	$20 copay
Other Services	
• Ambulance	$100 copay
• Durable Medical Equipment	No charge
Prescription Drugs	
• Plan Pharmacy *(Up to a 30-day supply)*	
– Generic	$10 copay
– Brand	$30 copay
• Mail-order *(Up to a 100-day supply)*	
– Generic	$20 copay
– Brand	$60 copay

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Medical (continued)

Eligible Employees & Early Retirees

Plan Benefits	Kaiser Permanente DHMO Certificated Employees & Early Retirees
Lifetime Maximum	Unlimited
Deductible	$1,000 Individual/$2,000 Family
Maximum Out of Pocket	$3,000 Individual/$6,000 Family
Preventive Services	
• Routine Physical	No charge
• Well Baby/Immunizations	No charge
Physician/Diagnostic Services	
• Office Visits	$20 copay
• Lab & X-ray & Diagnostic Test	Preventive/No Charge - $10 copay
• Prenatal/Postnatal Office Visits	No charge
Hospital Services	
• Semi-Private Room & Board	20% coinsurance after deductible
• Outpatient Surgery	20% coinsurance after deductible
• Emergency Room *(waived if admitted)*	20% coinsurance after deductible
• Urgent Care	$20 copay
Other Services	
• Ambulance	$150 copay
• Durable Medical Equipment	80%
Prescription Drugs	
• Plan Pharmacy *(Up to a 30-day supply)*	
– Generic	$10 copay
– Brand	$30 copay
• Mail-order *(Up to a 100-day supply)*	
– Generic	$20 copay
– Brand	$60 copay

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Medical (continued)

Plan Benefits	Kaiser Permanente HMO HDHP w/ HSA Certificated Employees & Early Retirees
***See page 32 for setting up a HSA account through UMB Healthcare Services.**	
General Plan Information	
• Annual Deductible/Individual	$1,800 per calendar year
• Annual Deductible/Family	$3,600 (Each member in a family of two or more members) $7,200 (Entire family of two or more members) per calendar year
• Coinsurance	100% after calendar year deductible
• Office Visit/Exam	100% after calendar year deductible
• Outpatient Specialist Visit	100% after calendar year deductible
• Annual Out-of-Pocket Limit/Individual	$3,600 per calendar year
• Annual Out-of-Pocket Limit/Family	$3,600 (Each member in a family of two or more members) $7,200 (Entire family of two or more members) per calendar year
• Deductible Included in Out-of-Pocket Limits	Yes
• Lifetime Plan Maximum	Unlimited
• Primary Care Physician Election Required	Yes
Outpatient Services	
Preventive Services	
• Well-Child Care	100% (deductible does not apply)
• Immunizations	100% (deductible does not apply)
• Well Woman Exams	100% (deductible does not apply)
• Mammograms	100% (deductible does not apply)
• Adult Periodic Exams with Preventive Tests	100% (deductible does not apply)
• Diagnostic X-Ray and Lab Tests	100% after calendar year deductible
Maternity Care	
• Pregnancy and Maternity Care *(Pre-Natal Care)*	100% (deductible does not apply)
Inpatient Hospital Services	
• Inpatient Hospitalization	100% after calendar year deductible
• Pre-Authorization of Services Required	Yes
• Semi-Private Room & Board; Including Services and Supplies	100% after calendar year deductible
Surgical Services	
• Outpatient Facility Charge	100% after calendar year deductible
Emergency Services	
• Emergency Room	100% after calendar year deductible
Ambulance	
• Air	100% after calendar year deductible
• Ground	100% after calendar year deductible
Urgent Care	
• Urgent Care Facility	100% after calendar year deductible
Mental Health Benefits	
• Inpatient Care	100% after calendar year deductible
• Outpatient Care	100% after calendar year deductible

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Medical (continued)

Plan Benefits	Kaiser Permanente HMO HDHP w/ HSA Certificated Employees & Early Retirees
***See page 32 for setting up a HSA account through UMB Healthcare Services.**	
Substance Abuse	
Inpatient Care	
• Inpatient Hospitalization	100% after calendar year deductible
• Inpatient Detoxification Services	100% after calendar year deductible
Outpatient Care	
• Outpatient Services	100% after calendar year deductible
Prescription Drug Benefits	
• Prescription Drug Deductible	Subject to plan deductible
• Prescription Drug Annual Out-of-Pocket Limit/Individual	Will accrue to annual OOP Max
• Prescription Drug Annual Out-of-Pocket Limit/Family	Will accrue to annual OOP Max
• Generic	$10 copay after calendar year deductible
• Preferred Specialty	$30 copay after calendar year deductible
• Brand *(Formulary/Preferred)*	$30 copay after calendar year deductible
• Brand *(Non-Formulary/Non-preferred)*	$30 copay after calendar year deductible
• Number of Days Supply	30 days
Mail Order	
• Brand *(Formulary/Preferred)*	$60 copay after calendar year deductible
• Brand *(Non-Formulary/Non-preferred)*	$60 copay after calendar year deductible
• Number of Days Supply for Mail Order	100 days
Other Services and Supplies	
• Durable Medical Equipment & Prosthetic Devices	100% after calendar year deductible
• Home Health Care	100% after calendar year deductible
• Skilled Nursing or Extended Care Facility	100% after calendar year deductible
• Hospice Care	100% after calendar year deductible
• Chiropractic Services	Not covered
• Acupuncture	Must be referred
Hearing	
• Screening	100% after calendar year deductible
• Aid(s)	Not covered
Infertility	
• Diagnosis	See Plan Certificate
• Treatment	See Plan Certificate
Outpatient Rehabilitative Therapy Services	
• Physical	100% after calendar year deductible
• Occupational	100% after calendar year deductible
• Speech	100% after calendar year deductible

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Medical (continued)

Eligible Employees & Early Retirees

Plan Benefits	Western Health Advantage HMO 250 MHP Certificated Employees & Early Retirees
Lifetime Maximum	Unlimited
Maximum Out of Pocket	$1,500 Individual/$2,500 Family
Preventive Services	
• Routine Physical	No charge
• Well Baby/Immunizations	No charge
Physician/Diagnostic Services	
• Office Visits *(including specialists)*	$20 copay
• Lab & X-ray & Diagnostic Test	No charge
• Prenatal/Postnatal Office Visits	No charge
Hospital Services	
• Semi-Private Room & Board	$250 copay
• Outpatient Surgery *(facility)*	$100 copay
• Emergency Room *(waived if admitted)*	$125 copay
• Urgent Care	$35 copay
Other Services	
• Ambulance	No charge if medically necessary
• Durable Medical Equipment	20% copay when medically necessary*
Prescription Drugs	
• Plan Pharmacy *(Up to a 30-day supply)*	
– Generic	$10 copay
– Brand	$30 copay
– Non-Formulary	$50 copay
• Mail-order *(Up to a 90-day supply)*	
– Generic	$20 copay
– Brand	$60 copay
– Non-Formulary	$100 copay

* Copayments do not contribute to the out-of-pocket maximum (unless required for the management or treatment diabetes or pediatric asthma supplies and equipment). Percentage copayment amounts are based on WHA's contracted rate.

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Medical (continued)

Eligible Employees & Early Retirees

Plan Benefits	Western Health Advantage HMO Advantage 0/40/30% Certificate Employees & Early Retirees
Lifetime Maximum	Unlimited
Maximum Out of Pocket	$3,000 Individual/$5,000 Family
Preventive Services	
• Routine Physical	No charge
• Well Baby/Immunizations	No charge
Physician/Diagnostic Services	
• Office Visits *(including specialists)*	$40 copay
• Lab & X-ray & Diagnostic Test	No charge
• Prenatal/Postnatal Office Visits	No charge
Hospital Services	
• Semi-Private Room & Board	$100 copay
• Outpatient Surgery *(facility)*	30% coinsurance
• Emergency Room *(waived if admitted)*	$100 copay
• Urgent Care	$50 copay
Other Services	
• Ambulance	No charge if medically necessary
• Durable Medical Equipment	20% copay when medically necessary*
Prescription Drugs	
• Plan Pharmacy *(Up to a 30-day supply)*	
– Generic	$10 copay
– Brand	$30 copay
– Non-Formulary	$50 copay
• Mail-order *(Up to a 90-day supply)*	
– Generic	$20 copay
– Brand	$60 copay
– Non-Formulary	$100 copay

* Copayments do not contribute to the out-of-pocket maximum (unless required for the management or treatment diabetes or pediatric asthma supplies and equipment). Percentage copayment amounts are based on WHA's contracted rate.

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Medical (continued)

Plan Benefits	Western Health Advantage HMO HDHP w/HSA Certificated Employees & Early Retirees
*** See page 33 for setting up a HSA account through Health Equity.**	
General Plan Information	
• Annual Deductible/Individual	$1,800 per calendar year
• Annual Deductible/Family	$3,200 (Each member of a family of two or more members) $3,600 (Entire family of two or more members) per calendar year
• Coinsurance	100% after calendar year deductible
• Office Visit/Exam	100% after calendar year deductible
• Outpatient Specialist Visit	100% after calendar year deductible
• Annual Out-of-Pocket Limit/Individual	$3,600 per calendar year
• Annual Out-of-Pocket Limit/Family	$3,600 (Each member of a family of two or more members) $7,200 (Entire family of two or more members) per calendar year
• Deductible Included in Out-of-Pocket Limits	Yes
• Lifetime Plan Maximum	Unlimited
• Primary Care Physician Election Required	Yes
Outpatient Services	
Preventive Services	
• Well-Child Care	100% (deductible doesn't apply)
• Immunizations	100% (deductible doesn't apply)
• Well Woman Exams	100% (deductible doesn't apply)
• Mammograms	100% (deductible doesn't apply)
• Adult Periodic Exams with Preventive Tests	100% (deductible doesn't apply)
• Diagnostic X-Ray and Lab Tests	100% after calendar year deductible
Maternity Care	
• Pregnancy and Maternity Care *(Pre-Natal Care)*	100% (deductible doesn't apply)
Inpatient Hospital Services	
• Inpatient Hospitalization	100% after calendar year deductible
• Pre-Authorization of Services Required	Yes
• Semi-Private Room & Board; Including Services and Supplies	100% after calendar year deductible
Surgical Services	
• Outpatient Facility Charge	100% after calendar year deductible
Emergency Services	
• Emergency Room	100% after calendar year deductible
Ambulance	
• Air	100% after calendar year deductible
• Ground	100% after calendar year deductible
Urgent Care	
• Urgent Care Facility	100% after calendar year deductible
Mental Health Benefits	
• Inpatient Care	100% after calendar year deductible
• Outpatient Care	100% after calendar year deductible

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Medical (continued)

Plan Benefits	Western Health Advantage HMO HDHP w/HSA Certificated Employees & Early Retirees
*** See page 33 for setting up a HSA account through Health Equity.**	
Substance Abuse	
• Inpatient Care	
– Inpatient Hospitalization	100% after calendar year deductible
– Inpatient Detoxification Services	100% after calendar year deductible
• Outpatient Care	
– Outpatient Services	100% after calendar year deductible
Prescription Drug Benefits	
• Prescription Drug Deductible	Subject to plan deductible
• Prescription Drug Annual Out-of-Pocket Limit/Individual	Will accrue to annual OOP Maximum
• Prescription Drug Annual Out-of-Pocket Limit/Family	Will accrue to annual OOP Maximum
– Generic	100% after calendar year deductible
– Preferred Generic	
– Preferred Specialty	$100 copay after calendar year deductible
– Non-preferred Specialty	
– Brand *(Formulary/Preferred)*	$30 copay after calendar year deductible
– Brand *(Non-Formulary/Non-preferred)*	$50 copay after calendar year deductible
• Number of Days Supply	30 days
Mail Order	
• Mail Order Mandatory	N/A
– Generic	100% after calendar year deductible
– Preferred Generic	
– Preferred Specialty	
– Non-preferred Specialty	
– Brand *(Formulary/Preferred)*	$60 copay after calendar year deductible
– Brand *(Non-Formulary/Non-preferred)*	$100 copay after calendar year deductible
• Number of Days Supply for Mail Order	90 days
Other Services and Supplies	
• Durable Medical Equipment & Prosthetic Devices	100% after calendar year deductible
• Home Health Care	100% after calendar year deductible
• Skilled Nursing or Extended Care Facility	100% after calendar year deductible
• Hospice Care	100% after calendar year deductible
• Chiropractic Services	$15 copay; 20 visits per calendar year
• Acupuncture	$15 copay; 20 visits per calendar year
Hearing	
• Screening	100% after calendar year deductible
• Aid(s)	
Infertility	
• Diagnosis	See Plan Certificate
• Treatment	See Plan Certificate
Outpatient Rehabilitative Therapy Services	
• Physical	100% after calendar year deductible
• Occupational	100% after calendar year deductible
• Speech	100% after calendar year deductible

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Medical (continued)

Eligible Employees & Early Retirees

Plan Benefits	Sutter Health Plus HMO ML 81 Certificated Employees & Early Retirees
Lifetime Maximum	Unlimited
Maximum Out of Pocket	$1,500 Individual/$3,000 Family
Preventive Services	
• Routine Physical	No charge
• Well Baby/Immunizations	No charge
Physician/Diagnostic Services	
• Office Visits *(including specialists)*	$20 copay
• Lab & X-ray & Diagnostic Test	Lab: $20 copay; X-Ray: No charge
• Prenatal/Postnatal Office Visits	No charge
Hospital Services	
• Semi-Private Room & Board	$250 copay
• Outpatient Surgery *(facility)*	$100 copay
• Emergency Room *(waived if admitted)*	$100 copay
• Urgent Care	$20 copay
Other Services	
• Ambulance	$50 copay per trip
• Durable Medical Equipment	20% copay
Prescription Drugs	
• Plan Pharmacy *(Up to a 30-day supply)*	
– Generic	$10 copay
– Brand	$30 copay
– Non-Formulary	$60 copay
• Mail-order *(Up to a 100 day supply)*	
– Generic	$20 copay
– Brand	$60 copay
– Non-Formulary	$120 copay

* Copayments do not contribute to the out-of-pocket maximum (unless required for the management or treatment diabetes or pediatric asthma supplies and equipment). Percentage copayment amounts are based on WHA's contracted rate.

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Medical (continued)

2025 Certificated HMO Plans

Benefits	Kaiser HMO	Kaiser DHMO	Kaiser H.S.A. $1,800	WHA Advantage 0/20/250A	WHA Advantage 0/40/30%	WHA Western $1800 HDHP (H.S.A.)	Sutter Health Plus ML81
Calendar Year Deductible							
• Individual	$0	$1,000	$1,800	$0	$0	$1,800	$0
• Family	$0	$2,000	$3,600/$7,200	$0	$0	$3,200/$3,600	$0
Maximum Calendar Year Copay or Coinsurance							
• Individual	$1,500	$3,000	$3,600	$1,500	$3,000	$3,600	$1,500
• Family	$3,000	$6,000	$7,200	$3,000	$5,000	$7,200	$3,000
Services							
• Preventive Services *(Adult Exams/Well Child Care/ Immunizations/Well Woman visits/Vision-Hearing Screening)*	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge
• Office Visit/Specialist Visit/ Telehealth Visit/Urgent Care	$30/$40/$0/$30	$30/$40/$0/$20	No Charge after deductible	$20 copay	$40 copay	No Charge after deductible	$20 copay / $10 copay Sutter Walk In
• Diagnostic X-Ray/Lab Tests *(Non-Preventive)*	No Charge	$10 copay	No Charge after deductible	No Charge	No Charge	No Charge after deductible	$20 copay
• Outpatient Facility Charge	$100 copay per procedure	20%, after deductible	No Charge after deductible	$100 copay	30% Copay	No Charge after deductible	$100 copay
• Inpatient Hospitalization	$250 copay per admit	20%, after deductible	No Charge after deductible	$250 copay per admit	30% Copay	No Charge after deductible	$250 copay per admit
• Emergency Room *(waived if admit)*	$125 copay	20%, after deductible	No Charge after deductible	$100 copay	$100 copay	No Charge after deductible	$100 copay
• Durable Medical Equipment & Prosthetic Devices	No Charge	20% copay no deductible	No Charge after deductible	20% copay	20% copay	No Charge after deductible	20% coinsurance
• Chiropractic Services	Not Covered	Not Covered	Not Covered	$15 copay up to 20 visits/ calendar year combined	$15 copay up to 20 visits/calendar year combined	$15 copay up to 20 visits/calendar year combined	$15 copay; 20 combined visits per calendar year
• Acupuncture	Must be referred	Must be referred	Not Covered				

Medical (continued)

2025 Certificated HMO Plans (continued)

Benefits	Kaiser HMO	Kaiser DHMO	Kaiser H.S.A. $1,800	WHA Advantage 0/20/250A	WHA Advantage 0/40/30%	WHA Western $1800 HDHP (H.S.A.)	Sutter Health Plus ML81
Pharmacy							
• Retail	30 day supply	100 day supply	100 day supply	30 day supply	30 day supply	30 day supply	30 days supply
– Generic	$10	$10	$10	$10	$10	$0	$10
– Preferred Brand	$20	$30	$30	$30	$30	$30	$30
– Non-Preferred Brand	$30	$30	$30	$50	$50	$50	$60
– Specialty	$30	$30	$30	$100	$100	$100	20% up to $250/Rx
• Mail Order	100 day supply	100 day supply	100 day supply	100 day supply	100 day supply	100 day supply	100 days supply
– Generic	$10	$10	$10	$20	$20	$0	$20
– Preferred Brand	$60	$30	$30	$60	$60	$60	$60
– Non-Preferred Brand	$60	$30	$30	$100	$100	$100	$120

Medical (continued)

Plan Benefits	United Healthcare PPO – Plan BPFJ Certificated Employees & Early Retirees	
	In-network	**Out-of-network**
General Plan Information		
• Annual Deductible/Individual	$400	$400
• Annual Deductible/Family	$800	$800
• Coinsurance	10%	40%
• Office Visit/Exam	$20 copay	40% after deductible
• Outpatient Specialist Visit	$30 copay	40% after deductible
• Annual Out-of-Pocket Limit/Individual	$2,000	$4,000
• Annual Out-of-Pocket Limit/Family	$4,000	$8,000
Outpatient Services		
Preventive Services		
• Well-Child Care	No charge	40% after deductible
• Immunizations	No charge	40% after deductible
• Well Woman Exams	No charge	40% after deductible
• Mammograms	No charge	40% after deductible
• Adult Periodic Exams with Preventive Tests	No charge	40% after deductible
• Diagnostic X-Ray and Lab Tests	No charge; advanced imaging 10% after deductible	40% after deductible
Maternity Care		
• Pregnancy and Maternity Care *(Pre-Natal Care)*	No charge	40% after deductible
Inpatient Hospital Services		
• Inpatient Hospitalization	10% after deductible	40% after deductible
• Semi-Private Room & Board; Including Services and Supplies	10% after deductible	40% after deductible
Surgical Services		
• Outpatient Facility Charge	10% after deductible	40% after deductible, OON-limits apply
Emergency Services		
• Emergency Room	$250 copay per visit	$250 copay per visit
Ambulance		
• Ground	10% after deductible	10% after deductible
Urgent Care		
• Urgent Care Facility	$50 copay	40% after deductible
Mental Health Benefits		
• Inpatient Care	10% after deductible	40% after deductible
• Outpatient Care	$20 copay	40% after deductible
• Substance Abuse		
Inpatient Care		
• Inpatient Hospitalization	10% after deductible	40% after deductible
• Inpatient Detoxification Services	10% after deductible	40% after deductible
Outpatient Care		
• Outpatient Services	$20 copay	40% after deductible

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Medical (continued)

Plan Benefits	United Healthcare PPO – Plan BPFJ Certificated Employees & Early Retirees	
Prescription Drug Benefits		
• Prescription Drug Deductible	N/A	N/A
• Prescription Drug Annual Out-of-Pocket Limit/Individual	Will accrue to annual OOP Max	Will accrue to annual OOP Max
• Prescription Drug Annual Out-of-Pocket Limit/Family	Will accrue to annual OOP Max	Will accrue to annual OOP Max
• Generic	$7 copay	$7 copay
• Preferred Specialty	Matches Retail In-Network	Not covered
• Brand *(Formulary/Preferred)*	$20 copay	$20 copay
• Brand *(Non-Formulary/Non-preferred)*	$35 copay	$35 copay
• Number of Days Supply	31 days	31 days
Mail Order		
• Generic	$0 copay	Not covered
• Brand *(Formulary/Preferred)*	$40 copay	Not covered
• Brand *(Non-Formulary/Non-preferred)*	$70 copay	Not covered
• Number of Days Supply for Mail Order	90 days	90 days
Other Services and Supplies		
• Durable Medical Equipment & Prosthetic Devices	10% after deductible	Not covered
• Home Health Care	10% after deductible	40% after deductible
• Skilled Nursing or Extended Care Facility	No charge after deductible	No charge after deductible
• Hospice Care	10% after deductible	40% after deductible
Outpatient Rehabilitative Therapy Services		
• Physical	$20 copay	Not covered
• Occupational	$20 copay	Not covered
• Speech	$20 copay	Not covered

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Tools
myuhc.com
California

Choosing a network physician just got simpler.

Finding a doctor, specialist or facility couldn't be easier. Just follow the steps below.

1 Go to myuhc.com®.

- Select **Find a Doctor.**
- Select **Medical Directory.**
- Select **All UnitedHealthcare Plans.**

2 Select your plan type.

UnitedHealthcare SignatureValue® or HMO plans.

- Select **SignatureValue Plans.**
- Select **Medical Directory.**
- Select the state in which you live.
- Select your network from the list provided.
- Enter your ZIP code or city and state.

UnitedHealthcare Navigate®, Select Plus or Core plans.

- Select **Navigate, Select Plus** or **Core.**
- Enter your ZIP code or city and state.
- Search by physician name, medical group, clinic, facility, specialty or condition.

3 Search by people or place.

To search by people:

Select between **Primary Care, Specialty Care** or **Medical Groups.***

- For **Primary Care:** Select a type of **Primary Provider** (Family Doctor, Generalist, Internist, etc.).
- For **Specialty Care:** Select a type of **Specialist** (Acupuncturist, Allergist/Immunologist, etc.).
- For **Medical Groups:** Select your **Medical Group Name.**

To search by place:

Select between **Hospitals, Specialty Centers, Labs and Imaging*** or **Clinics.***

- For **Hospitals:** Select the **Location.**
- For **Specialty Centers:** Select which type of **Specialty Center** (Birth Centers, Blood Banks, Community Clinics, etc.).
- For **Clinics:** Select between **Convenience Clinic** or **Urgent Care Clinic.**
- For **Labs and Imaging:** Select between **Imaging Centers** or **Lab Locations.**

Formal HMO product names.

Signature: UnitedHealthcare SignatureValue®
Advantage: UnitedHealthcare SignatureValue Advantage
Alliance: UnitedHealthcare SignatureValue Alliance
Focus: UnitedHealthcare SignatureValue Focus
Harmony: UnitedHealthcare SignatureValue Harmony

CONTINUED

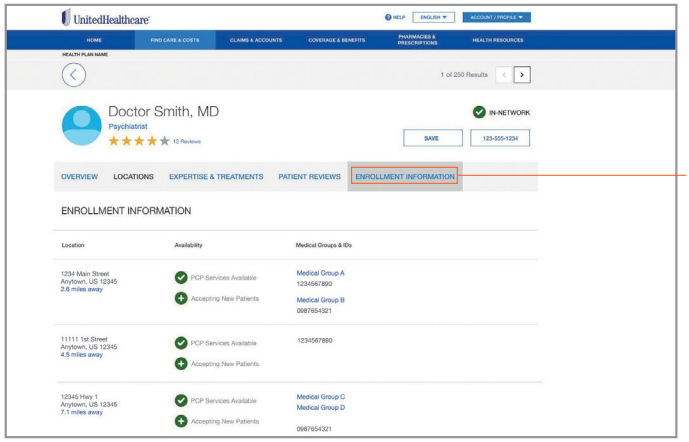
* For Core/Select Plus/Navigate only.

UnitedHealthcare®

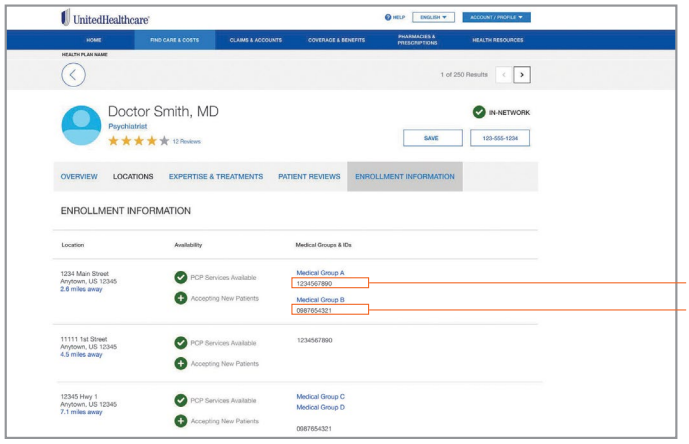
Medical (continued)

Note:

- Members will need to select a primary care physician (PCP) at the time of enrollment. If you do not select a PCP during enrollment, a PCP in your geographic area who is accepting new patients will be assigned.
- Once a PCP has been selected, click on the **Enrollment Information** tab.



Under the **Enrollment Information** tab, you will find the Provider ID number. Please indicate the primary care physician's name and 10-digit ID number on your enrollment form.



Important: Some PCPs may have more than one ID number based on their medical group, location or hospital affiliation. Please be sure you select the ID number that aligns with the medical group, location and hospital of your choice.

Medical (continued)

Post 65 Retirees Only (Certificated)

Plan Benefits	Kaiser Permanente Senior Advantage HMO $5
	Member Responsibility
Lifetime Maximum	Unlimited
Maximum Out of Pocket	$1,500 Individual/$3,000 Family
Preventive Services	
• Routine Physical	No charge
Physician/Diagnostic Services	
• Office Visits	$5 copay
• Lab & X-ray & Diagnostic Test	No charge
Hospital Services	
• Semi-Private Room & Board	No charge
• Outpatient Surgery	$5 copay
• Emergency Rooms *(waived if admitted with 24 hours)*	$20 copay
• Urgent Care	$5 copay
Other Services	
• Ambulance	No charge
• Durable Medical Equipment	No charge
Vision Services	$175 allowance for each eyewear purchased at a Plan Medical Office
Prescription Drugs	
• Generic *(Up to a 100-day supply)*	$5 copay
• Brand *(Up to a 100-day supply)*	$10 copay

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2025 CalPERS – HMO & PPO Basic Plans (Classified Only)

Region 1

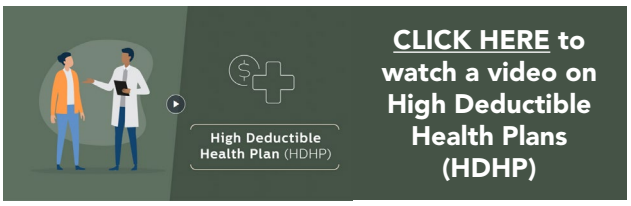
The following pages include all of the plans offered by CalPERS. Please note that not all plans are available to Washington USD. Here is a list of the plans offered to the district:

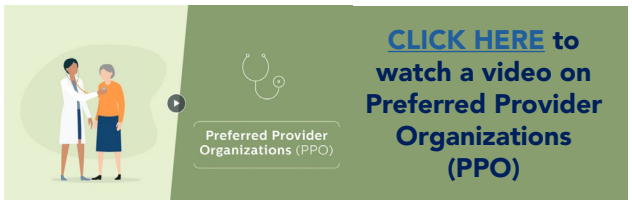
HMO Plans

- Anthem Blue Cross Del Norte
- Anthem Blue Cross Select
- Anthem Blue Cross Traditional
- Blue Shield Access+
- Blue Shield Access+ EPO
- Blue Shield Trio
- Kaiser Permanente
- United Healthcare SignatureValue Alliance
- United Healthcare Harmony
- Western Health Advantage

PPO Plans

- PERS Gold PPO
- PERS Platinum PPO





2025 CalPERS – EPO & HMO Basic Plans (Classified Only)

For more details about the benefits provided by a specific plan, refer to that plan's Evidence of Coverage (EOC) booklet. All benefits subject to regulatory approval.

Benefits	Anthem Blue Cross Select HMO Traditional HMO	Blue Shield Access+ HMO EPO Trio HMO	Health Net	Kaiser Permanente	Sharp Performance Plus	UnitedHealthcare SignatureValue Alliance & Harmony	Western Health Advantage HMO
Calendar Year Deductible							
• Individual	N/A	N/A	N/A	N/A	N/A	N/A	N/A
• Family	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Maximum Calendar Year Copay or Coinsurance *(excluding pharmacy)*							
• Individual	$1,500 (copay)	$1,500 (copay)	$1,500 (copay)	$1,500 (copay)	$1,500 (copay)	$1,500 (copay)	$1,500 (copay)
• Family	$3,000 (copay)	$3,000 (copay)	$3,000 (copay)	$3,000 (copay)	$3,000 (copay)	$3,000 (copay)	$3,000 (copay)
Hospital *(including Mental Health and Substance Abuse)*							
• Deductible *(per admission)*	N/A	N/A	N/A	N/A	N/A	N/A	N/A
• Inpatient	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge
• Outpatient Facility/ Surgery Services	No Charge	No Charge	No Charge	$15	No Charge	No Charge	No Charge
Emergency Services							
• Emergency Room Deductible	N/A	N/A	N/A	N/A	N/A	N/A	N/A
• Emergency *(copay waived if admitted as an inpatient or for observation as an outpatient)*	$50	$50	$50	$50	$50	$50	$50
• Non-Emergency *(copay waived if admitted as an inpatient or for observation as an outpatient)*	$50	$50	$50	$50	$50	$50	$50

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2025 CalPERS – EPO & HMO Basic Plans (Classified Only) (continued)

For more details about the benefits provided by a specific plan, refer to that plan's Evidence of Coverage (EOC) booklet. All benefits subject to regulatory approval.

Benefits	Anthem Blue Cross Select HMO Traditional HMO	Blue Shield Access+ HMO EPO Trio HMO	Health Net	Kaiser Permanente	Sharp Performance Plus	UnitedHealthcare SignatureValue Alliance & Harmony	Western Health Advantage HMO
Physician Services *(including Mental Health and Substance Abuse)*							
• Office Visits *(copay for each service provided)*	$15	$15	$15	$15	$15	$15	$15
• Inpatient Visits	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge
• Outpatient Visits	$15	$15	$15	$15	$15	$15	$15
• Urgent Care Visits	$15	$15	$15	$15	$15	$15	$15
• Preventive Services	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge
• Surgery/Anesthesia	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge
Diagnostic X-ray/Lab	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge
Prescription Drugs							
• Deductible	N/A	N/A	N/A	N/A	N/A	N/A	N/A
• Retail Pharmacy *(30-day supply)*	Tier 1: $5 Tier 2: $20 Tier 3: $50	Tier 1: $5 Tier 2: $20 Tier 3: $50 Tier 4: $30	Tier 1: $5 Tier 2: $20 Tier 3: $50	Generic: $5 Brand: $20	Tier 1: $5 Tier 2: $20 Tier 3: $50	Tier 1: $5 Tier 2: $20 Tier 3: $50	Tier 1: $5 Tier 2: $20 Tier 3: $50
• Retail Preferred Pharmacy Maintenance Medications *(90-day supply)*	N/A	Tier 1: $10 Tier 2: $40 Tier 3: $100 Tier 4: $60	N/A	N/A	N/A	N/A	N/A
• Mail Order Pharmacy Program *(not to exceed 90-day supply for maintenance drugs)*	Tier 1: $10 Tier 2: $40 Tier 3: $100	Tier 1: $10 Tier 2: $40 Tier 3: $100 Tier 4: $60	Tier 1: $10 Tier 2: $40 Tier 3: $100	Generic: $10 Brand: $40 (31-100 day supply)	Tier 1: $10 Tier 2: $40 Tier 3: $100	Tier 1: $10 Tier 2: $40 Tier 3: $100	Tier 1: $10 Tier 2: $40 Tier 3: $100
• Mail order maximum copayment per person per calendar year	$1,000	$1,000	$1,000	N/A	$1,000	$1,000	$1,000

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2025 CalPERS – EPO & HMO Basic Plans (Classified Only) (continued)

For more details about the benefits provided by a specific plan, refer to that plan's Evidence of Coverage (EOC) booklet. All benefits subject to regulatory approval.

Benefits	Anthem Blue Cross Select HMO Traditional HMO	Blue Shield Access+ HMO EPO Trio HMO	Health Net	Kaiser Permanente	Sharp Performance Plus	UnitedHealthcare SignatureValue Alliance & Harmony	Western Health Advantage HMO
Durable Medical Equipment	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge
Infertility Testing/ Treatment	50% of Covered Charges	50% of Covered Charges	50% of Covered Charges	50% of Covered Charges	50% of Covered Charges	50% of Covered Charges	50% of Covered Charges
Occupational /Physical /Speech Therapy							
• Inpatient *(hospital or skilled nursing facility)*	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge
• Outpatient *(office and home visits)*	$15	$15	$15	$15	$15	$15	$15
Diabetes Services							
• Glucose monitors	Coverage varies	No Charge	Coverage varies	No Charge	Coverage varies	Coverage varies	Coverage varies
• Self-management training	$15	$15	$15	$15	$15	$15	$15
Acupuncture	$15/visit (acupuncture/ chiropractic; combined 20 visits per calendar year)	$15/visit (acupuncture/ chiropractic; combined 20 visits per calendar year)	$15/visit (acupuncture/ chiropractic; combined 20 visits per calendar year)	$15/visit (acupuncture/ chiropractic; combined 20 visits per calendar year)	$15/visit (acupuncture/ chiropractic; combined 20 visits per calendar year)	$15/visit (acupuncture/ chiropractic; combined 20 visits per calendar year)	$15/visit (acupuncture/ chiropractic; combined 20 visits per calendar year)
Chiropractic	$15/visit (acupuncture/ chiropractic; combined 20 visits per calendar year)	$15/visit (acupuncture/ chiropractic; combined 20 visits per calendar year)	$15/visit (acupuncture/ chiropractic; combined 20 visits per calendar year)	$15/visit (acupuncture/ chiropractic; combined 20 visits per calendar year)	$15/visit (acupuncture/ chiropractic; combined 20 visits per calendar year)	$15/visit (acupuncture/ chiropractic; combined 20 visits per calendar year)	$15/visit (acupuncture/ chiropractic; combined 20 visits per calendar year)
Pregnancy & Maternity Care	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge

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2025 CalPERS – PPO Basic Plans (Classified Only)

For more details about the benefits provided by a specific plan, refer to that plan's Evidence of Coverage (EOC) booklet. All benefits subject to regulatory approval.

Benefits	PERS Gold		PERS Platinum		PORAC (Association Plan)	
	PPO	Non-PPO	PPO	Non-PPO	PPO	Non-PPO
Calendar Year Deductible						
• Individual	$1,000 [1,3]	$2,500 [3]	$500 [3]	$2,000 [3]	$300	$600
• Family	$2,000 [1,3]	$5,000 [3]	$1,000 [3]	$4,000 [3]	$900	$1,800
Maximum Calendar Year Copay or Coinsurance *(excluding pharmacy)*						
• Individual	$3,000 (coinsurance)	Unlimited	$2,000 (coinsurance)	Unlimited	$2,000	$2,000
• Family	$6,000 (coinsurance)	Unlimited	$4,000 (coinsurance)	Unlimited	$4,000	$4,000
Hospital *(including Mental Health and Substance Abuse)*						
• Deductible *(per admission)*	N/A	N/A	$250	$250	N/A	N/A
• Inpatient	20% [2]	40% [4]	10%	40% [4]	20%	20% [4]
• Outpatient Facility/ Surgery Services	20%	40% [4]	10%	40% [4]	20%	20% [4]
Emergency Services						
• Emergency Room Deductible	$50 (applies to hospital emergency room facility charge only)		$50 (applies to hospital emergency room facility charge only)		N/A	
• Emergency	20% (applies to other services such as physician, x-ray, lab, etc.)		10% (applies to other services such as physician, x-ray, lab, etc.)		20%	
• Non-Emergency	20%	40%	10%	40%	50%	
	(payment for physician charges only; emergency room facility charge is not covered)		(payment for physician charges only; emergency room facility charge is not covered)		(for non-emergency services provided by hospital emergency room)	

1 Incentives available to reduce individual deductible (max. $500) or family deductible (max. $1,000) include getting a biometric screening ($100 credit), receiving a flu shot ($100 credit), getting a non-smoking certification ($100 credit), getting a virtual second opinion ($100 credit), and getting a condition care certification ($100 credit).

2 Coinsurance waived for deliveries if enrolled in Included Health's maternity program.

3 Deductible is not transferable between PERS Gold and PERS Platinum.

4 Of the allowable amount as defined in the EOC.

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2025 CalPERS – PPO Basic Plans (Classified Only) (continued)

For more details about the benefits provided by a specific plan, refer to that plan's Evidence of Coverage (EOC) booklet. All benefits subject to regulatory approval.

Benefits	PERS Gold		PERS Platinum		PORAC (Association Plan)	
	PPO	Non-PPO	PPO	Non-PPO	PPO	Non-PPO
Physician Services *(including Mental Health and Substance Abuse)*						
• Office Visits *(copay for each service provided)*	$35 [1]	40% [3]	$20 [2]	40% [3]	$10/$35 [2]	20% [3]
• Inpatient Visits	20%	40% [3]	10%	40% [3]	20%	20% [3]
• Outpatient Visits	$35	40% [3]	$20	40% [3]	20%	20% [3]
• Urgent Care Visits	$35	40% [3]	$35	40% [3]	$35	20% [3]
• Preventive Services	No Charge	40% [3]	No Charge	40% [3]	No Charge	
• Surgery/Anesthesia	20%	40% [3]	10%	40% [3]	20%	20% [3]
Diagnostic X-Ray/Lab	20% [4]	40% [3]	10% [4]	40% [3]	20%	20% [3]

1 Reduced to $10 when seen by primary physician.
2 $35 for specialist visit.
3 Of the allowable amount as defined in the EOC.
4 For lab services only — no charge when using Quest Diagnostic or Labcorp.

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2025 CalPERS – PPO Basic Plans (Classified Only) (continued)

For more details about the benefits provided by a specific plan, refer to that plan's Evidence of Coverage (EOC) booklet. All benefits subject to regulatory approval.

Benefits	PERS Gold		PERS Platinum		PORAC (Association Plan)	
	PPO	Non-PPO	PPO	Non-PPO	PPO	Non-PPO
Prescription Drugs						
• Deductible	N/A		N/A		N/A	
• Retail Pharmacy *(30-day supply)*	Tier 1: $5 Tier 2: $20 Tier 3: $50		Tier 1: $5 Tier 2: $20 Tier 3: $50		Generic: $10 Brand Formulary: $25 Non-Formulary: $45 Compound: $45	
• Retail Preferred Pharmacy Maintenance Medications *(90-day supply)*	N/A		N/A		N/A	
• Mail Order Pharmacy Program *(not to exceed 90-day supply for maintenance drugs)*	Tier 1: $10 Tier 2: $40 Tier 3: $100		Tier 1: $10 Tier 2: $40 Tier 3: $100		Generic: $20 Brand Formulary:$40 Non-Formulary:$75	N/A
• Mail Order Maximum Copayment Per Person Per Calendar Year	$1,000		$1,000		N/A	
Durable Medical Equipment	20%	40% [1]	10%	40% [1]	20%	20% [1]
	(pre-certification required for specific equipment)		(pre-certification required for the purchase of equipment priced at $1,000 or more)			

1 Of the allowable amount as defined in the EOC

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2025 CalPERS – PPO Basic Plans (Classified Only) (continued)

For more details about the benefits provided by a specific plan, refer to that plan's Evidence of Coverage (EOC) booklet. All benefits subject to regulatory approval.

Benefits	PERS Gold		PERS Platinum		PORAC (Association Plan)	
	PPO	Non-PPO	PPO	Non-PPO	PPO	Non-PPO
Infertility Testing/Treatment	50%		50%		50%	50% [2]
Occupational / Physical / Speech Therapy						
• Inpatient *(hospital or skilled nursing facility)*	No Charge		No Charge		20%	20% [2]
• Outpatient *(office and home visits)*	20%	40% (Occupational therapy: 20%)	10%	40% (Occupational therapy: 10%)	20%	20% [2]
	(pre-certification required for more than 24 visits)		(Pre-certification required for more than 24 visits)			
Diabetes Services						
• Glucose monitors	Coverage Varies		Coverage Varies		Coverage Varies	
• Self-management training	$20 [1]	40% [2]	$20 [1]	40% [2]	$20	60% [2]
Acupuncture	$15/Visit	40% [2]	$15/Visit	40% [2]	20%	20% [2]
	(acupuncture/chiropractic; combined 20 visits per calendar year)		(acupuncture/chiropractic; combined 20 visits per calendar year)		(acupuncture/chiropractic; combined 20 visits per calendar year)	
Chiropractic	$15/Visit	40% [2]	$15/Visit	40% [2]	20%	20% [2]
	(acupuncture/chiropractic; combined 20 visits per calendar year)		(acupuncture/chiropractic; combined 20 visits per calendar year)		(acupuncture/chiropractic; combined 20 visits per calendar year)	
Pregnancy & Maternity Care	20%	40%	10%	40%	80%	80%

1 $35 for specialist visit.

2 Of the allowable amount as defined in the EOC.

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Dental

Delta Dental pays 70% for Diagnostic, Preventive, Basic, Crowns, Inlays, Onlays, and Cast Restoration benefits during the first calendar year of your eligibility. The coinsurance increases 10% each year you visit a dentist until you reach 100%. If you do not visit the dentist and the plan is not used, the coinsurance will not increase. The coinsurance will drop back to 70% if you lose eligibility and then become eligible again.

Benefits	Delta Dental	
	Member Responsibility	
	PPO	Non-PPO
Deductible	None	None
Per Calendar Year Maximum	$1,700	$1,500
Diagnostic & Preventive Services		
• Oral examinations, cleanings, X-rays, examinations of tissue biopsy, fluoride treatment, space maintainers, and specialist consultations	70% - 100%	70% - 100%
Basic Services		
• Oral surgery *(extractions), fillings, root canals, periodontic (gum) treatment, tissue removal (biopsy)*, and sealants	70% - 100%	70% - 100%
Major Services		
• Crowns, jackets and other cast restorations	70% - 100%	70% - 100%
• Prosthodontic Benefits: Bridges, partial and full Dentures and Implants	50%	50%
• Dental Accident Benefits: $1,000 Max Per Calendar Year	100%	100%
Orthodontics		
• Child only $1,500 Lifetime maximum	50%	50%

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Vision

Benefits	Superior Vision Base Plan	
	In-Network	Out-of-Network
Exam copay	$0	
Materials copay	$0	
Contact Lens Fitting	$30	
Services/Frequency		
Exam	12 Months	
Frames	24 Months	
Contact Lens Fitting	12 Months	
Lenses	24 Months	
Contact Lenses	24 Months	
Exams		
• Vision Exam (MD)	Covered in full	Up to $40
• Vision Exam (OD)	Covered in full	Up to $30
Lenses		
• Single	Covered in full	Up to $32
• Bifocal	Covered in full	Up to $42
• Trifocal	Covered in full	Up to $58
• Polycarbonate for Dept. Children	Covered in full	Not Covered
Frames		
• Frames	$130 retail allowance then 20% off remaining balance	Up to $48
Contacts		
• Necessary & in lieu of glasses	$130 retail allowance	Up to $80
• Disposable Contact Lenses	10% off retail cost	10% off retail cost

Discount Features:

Superior Vision has a nationwide network of refractive surgeons and leading LASIK networks who offer members a discount. These discounts range from 15%-50%.

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

Vision (continued)

Benefits	Superior Vision Buy-Up Plan	
	In-Network	Out-of-Network
Exam copay	$0	
Materials copay	$0	
Contact Lens Fitting	$30	
Services/Frequency		
Exam	12 Months	
Frames	12 Months	
Contact Lens Fitting	12 Months	
Lenses	12 Months	
Contact Lenses	12 Months	
Exams		
• Vision Exam (MD)	Covered in full	Up to $40
• Vision Exam (OD)	Covered in full	Up to $30
Lenses		
• Single	Covered in full	Up to $32
• Bifocal	Covered in full	Up to $42
• Trifocal	Covered in full	Up to $58
• Polycarbonate for Dept. Children	Covered in full	Not Covered
• Progressive	Covered in full	Not Covered
Frames		
• Frames	$175 retail allowance then 20% off remaining balance	Up to $72
Contacts		
• Necessary & in lieu of glasses	$150 retail allowance	Up to $100
• Disposable Contact Lenses	10% off retail cost	10% off retail cost

Discount Features:

Superior Vision has a nationwide network of refractive surgeons and leading LASIK networks who offer members a discount. These discounts range from 15%-50%.

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

Kaiser HSA for HDHP

UMB Healthcare Services

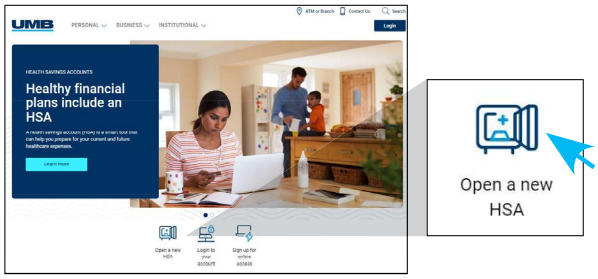
EMPLOYER NAME
Washington Unified School District
ENROLLMENT VERIFICATION NUMBER
THA0001 ~ 160749

UMB HSA Online Enrollment Guide

Before you start, make sure you have the following required information available:

- Your physical address (you must have a physical address to open the account, but you may also enter a P.O. Box in "mailing address"), phone number, email address
- Your Date of Birth and Social Security number
- DOB & SS# for your spouse and/or dependents (age 18 or older) if requesting additional debit cards
- Employer verification code and program start date, provided by your employer

Note: You will not choose your beneficiary during enrollment. You will do this the first time you log on to your HSA.



Follow the six-step online enrollment process:

STEP 1: Enrollment Verification Number

Use the unique link provided by your employer, which will take you to Step 2, or go to **UMB.com/HSA** and click on "**Open a new HSA**" and enter Enrollment Verification # provided by your employer.

STEP 2: Eligibility Requirements

Before proceeding, you will be prompted to confirm your eligibility to enroll in an HSA. This confirmation is performed by asking a series of questions. If you answer correctly based on the IRS requirements for eligibility, you will be able to proceed to Step 3.

STEP 3: Account Owner Personal Information

This step contains "sub-screens" that will capture all your personal information, verify your email address (UMB will send a code to your email), and allow you to input additional cardholders, if desired (spouse and/or dependents). **Note**: you must input a physical address to open your HSA or you will get an error message.

STEP 4: Review and Consent to Disclosures

In this step you will be required to open the disclosure documents and consent before you can continue. The documents will open in PDF format.

STEP 5: Verify & Submit Enrollment Information

You will be given a final opportunity to review all the information you typed in before your enrollment is transmitted to UMB for CIP review (Customer Identification Program, as required by Section 326 of the USA PATRIOT ACT, and UMB's CIP policy).

STEP 6: Confirmation

Based on the results during the session, you will get one of the following screens:

Complete Enrollment
The account is created (IF YOU GET THIS SCREEN, NO ADDITIONAL DOCUMENTATION IS REQUIRED).

Incomplete Enrollment
A message will appear indicating that UMB needs additional documentation from you (a copy of your social security card and driver's license) before we can open your account. The message provides three options (request a secure email link, fax or U.S. mail) for sending documentation copies to UMB.
Note: Your account will not be opened during this session. Your account will remain in pending status and unable to accept contributions until UMB receives the requested documentation and opens your account manually.

Once you have completed enrollment, within 5-7 business days you will receive two envelopes in the mail:

1. Your welcome letter with your account number, log on instructions, and additional information about your UMB HSA
2. HSA debit card including additional cards you ordered during your online enrollment session.

Once you receive your welcome letter, you may set up your online access, log in to your account and choose your beneficiary(s).

For questions or more information call 1.866.520.4HSA (4472).

WHA HSA for HDHP

Health Equity is the Western Health Advantage HSA Vendor for Washington USD.

Contact Employer Services:

- 24 hrs. per day / 7 days a week
- 877-300-4987
- memberservices@healthequity.com

Also included are some helpful links for both the Employer and Employees below:

Breakdown of the fees:

- Members have no charge for electronic statements if they register online.
- Paper Statements are $1.00 per month
- Hard Copy Checks are $2.00 per check
- **If Members sign up for EFT for reimbursements –** there is no charge.
- If members leave, they are subject then to a monthly admin fee of $3.95.

Additional helpful links:

For Employee Education:

https://learn.healthequity.com/wha/hsa/

- Employee education site, videos, collaterals, tutorials, calculators, etc.
- E-member guide
- Investments and tools
- Investment guide
- Employee level HSA mechanics webinar series
- Capability enhancements
- Custom plan cost estimators are free

Basic Life & AD&D

Lincoln Financial Group

As an eligible employee with WUSD you are provided employer paid Life and Accidental Death & Dismemberment (AD&D) insurance. All eligible employees are automatically enrolled in Life/AD&D plans.

Employee Basic Life Insurance

- Benefit amount of $10,000
- Guaranteed Issue amount $10,000
- 100% paid by WUSD

Accidental Death and Dismemberment (AD&D)

- Benefit amount of $10,000
- Guaranteed Issue amount $10,000
- 100% paid by WUSD

In addition to death benefit, AD&D coverage provides specified benefits for a covered accidental bodily injury that directly causes dismemberment.

In the event of death that occurs from a covered accident—both Life and AD&D benefits would be payable.

Please refer to the Lincoln Financial Group Life Insurance documents for complete plan descriptions.

REMINDER:

Don't forget to update your beneficiary information!

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

Employee Assistance Program

Lincoln Financial Group

All benefit eligible employees with WUSD are provided with an employer paid Employee Assistance Plan (EAP) through Lincoln. All eligible employees are automatically enrolled in this coverage.

Life is full of challenges and sometimes balancing it is difficult. The EAP is there when you need it. Lincoln offers the appropriate assistance for a wide range of issues and provides referrals to professional counselors or services that can help you resolve emotional health, family and work issues. Everything is kept completely confidential.

All members of your household can utilize the benefits of this program.

Telephonic and online support services:

- Toll-free access 24/7 to a master's level intake, providing access and triage
  - Counseling, legal, financial, work-life and/or convenience services
  - Crisis intervention support
- Access to password protected interactive online websites
  - Includes information on a wide range of topics, helpful tools, assessments, and the ability to confidentially email issues to a Ask a Guidance Consultant

Counseling Services:

- Six face-to-face sessions per person, per issue/year
- Local, in-person EAP assessment, referral, and counseling
- Community resource referrals to supplement EAP counseling, such as support meetings and sliding scale resources
- Matching employees with a network provider based on individual preference

Legal Services:

- Unlimited telephonic support for information from an attorney and unlimited referrals
- One free 30-minute consultation with a network attorney over the phone or in person
- Discount of 25% off of published fees when in-person representation is necessary

Financial Services:

- Unlimited telephonic support by a financial expert for budgeting and other common financial issues
- Unlimited referrals to a network of financial experts

Work-Life Services:

- Unlimited telephonic support for customized research
- Tailored educational materials
- Referrals for childcare, adoption, and eldercare; additional referrals available for personal convenience, education, and pet care
  - Resource and information research available on a wide range of topics

Online Member Services | www.guidanceresources.com | Company code: Lincoln

Toll Free Call | 855-327-4463

Available 24/7

BenefitBridge

BenefitBridge is a web-based portal that is available year-round not just at open enrollment.

Here's what you can do on BenefitBridge:

- View Current Plan Year Benefits
- Compare Plan Options
- Enroll in Benefits
- **Colonial Supplemental Benefits now offered in BenefitBridge!**
  Follow this link for plan descriptions, informative videos, and sample pricing:
  https://www.buildingblocksforbusiness.com/colonial/
- Add or Remove Dependents/Beneficiaries
- Message Center
- Update My Account Info
- Available 24/7 via the Internet
- **Resource Center:** Health Insurance Basics, Medicare, Glossary, Media Resources

Colonial Life Supplemental Benefits are now offered in BenefitBridge!

Click each of the following product names for plan descriptions, informative videos, and sample pricing:

- **Accident Insurance –** helps offset the unexpected medical expenses, such as emergency room fees, deductibles and copayments, that can result from a covered accident.
- **Cancer Insurance –** helps offset the out-of-pocket medical and indirect non-medical expenses related to cancer diagnosis and treatment.
- **Hospital Confinement Indemnity Insurance* –** helps with the rising costs associated with a covered hospital confinement or covered outpatient surgery such as deductibles and copayments.
- **WellCard Savings –** Schedule your appointment with a Benefits Advisor and get discounts for your entire Family!

*IMPORTANT: This is a fixed indemnity policy, NOT health insurance.

This fixed indemnity policy may pay you a limited dollar amount if you're sick or hospitalized. You're still responsible for paying the cost of your care.

- The payment you get isn't based on the size of your medical bill.
- There might be a limit on how much this policy will pay each year.
- This policy isn't a substitute for comprehensive health insurance.
- Since this policy isn't health insurance, it doesn't have to include most Federal consumer protections that apply to health insurance.

Looking for comprehensive health insurance?

- **Visit HealthCare.gov** or call **1-800-318-2596** (TTY: 1-855-889-4325) to find health coverage options.
- To find out if you can get health insurance through your job, or a family member's job, contact the employer.

Questions about this policy?

- For questions or complaints about this policy, contact your State Department of Insurance. Find their number on the National Association of Insurance Commissioners' website (naic.org) under "Insurance Departments."
- If you have this policy through your job, or a family member's job, contact the employer.

BenefitBridge (continued)

Washington Unified School District Online Benefits Enrollment is easy with BenefitBridge!

Need Help?

For assistance with enrollment related to your benefits, please contact Building Blocks at 844-624-1380 ext. 1 to schedule a one-on-one session where a Benefit Advisor can assist with your enrollment and answer questions regarding your benefits, Mon - Fri, 8:00 AM - 5:00 PM, PST. You may also request a personal appointment here: https://washingtonusdbb4b.youcanbook.me/.

For BenefitBridge technical assistance only, please contact BenefitBridge Customer Care at 800-814-1862; Mon - Fri, 8:00 AM - 5:00 PM PST or email benefitbridge@keenan.com.

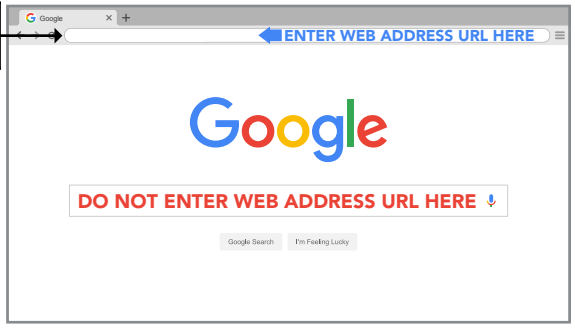
Here's what you can do on BenefitBridge:

- View Current Plan Year Benefits
- Compare Plan Options
- Enroll in Benefits
- Resource Center: Health Insurance Basics, Medicare, Glossary, Media Resources
- Add or Remove Dependents/ Beneficiaries
- Message Center
- Update My Account Info
- Available 24/7 via the Internet

Registration and Login

Already have login credentials?

1. Login to **BenefitBridge** at www.benefitbridge.com/washington
2. Forgot your Username or Password? Click on **"Forgot Username/Password?"**

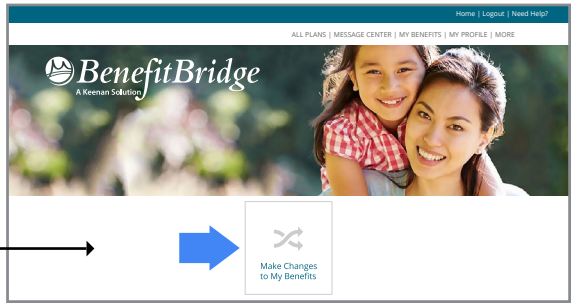


Need to create login credentials?

1. In the **address bar**, type www.benefitbridge.com/washington **(Not in the Google, Yahoo, Bing, etc. search engine field)**
2. Click the **Enter** key, then follow the instructions below to register:
   - **STEP 1:** Select **"Register"** to **Create an Account**
     - **You will need to create an account using your first and last names as they appear on your payroll statement.**
   - **STEP 2:** Create a **Username** and **Password**
   - **STEP 3:** Select a picture, as instructed
   - **STEP 4:** Select **"Continue"** to access **BenefitBridge**

Enrolling in Benefits

Access your enrollment via the **"Make Changes to My Benefits"** button



Call Building Blocks at 844-624-1380 ext. 3 for live Agent Assistance for all Benefits!

Building Blocks - Colonial Life

WASHINGTON USD

COLONIAL BENEFIT BOOKLET

HOW DO I ENROLL?

A Building Blocks Benefit Advisor will assist you via a screen share enrollment which requires access to a computer and internet!

WHAT IS THE WELLCARD?

After completing your enrollment session with Building Blocks, you will receive complimentary membership to the WellCard Savings Program which has discounts on Medical, Pharmacy, Vision & Dental Care, Health & Wellness, Pet Discounts, and more!

SCAN THE QR CODE TO SCHEDULE NOW!

CALL BUILDING BLOCKS TO SCHEDULE

844-624-1380 EXT. 1

ACCIDENT

For a covered accident, policyholders receive cash benefits for use as they see fit.

CANCER

A plan designed to pay cash benefits that can be used to help offset cancer-related expenses.

CRITICAL ILLNESS

For a covered critical illness, policyholders receive a lump sum cash benefit to use as they see fit.

MEDICAL BRIDGE/HOSPITAL CONFINEMENT

Pays cash amounts to help with the non-covered expenses of a hospital stay.

All products with this symbol have Guaranteed Issue available!

scheduling@bbforb.com

https://washingtonusdbb4b.youcanbook.me/

Flexible Spending Accounts (FSA)

Navia Benefit Solutions FSA

All eligible full-time employees have the option of participating in our Navia Flexible Spending Accounts for medical and dependent care reimbursement. Flexible spending accounts, under Section 125 of the Internal Revenue Service, allow employees to set aside pre-tax dollars to pay for out-of-pocket, eligible health care and dependent care expenses, as well as your contributions for dependent medical, dental, and vision premiums.

Health Care

Your health care account may not exceed $3,200 each plan year per household.

Flexible Spending Accounts utilize the "Use it or Lose It" rule, which means all medical services for reimbursement must occur between January 1, 2025 and December 31, 2025.

Dependent Care

Your dependent care account may not exceed $5,000 each calendar year per household ($2,500 if married and filing separately).

All Dependent Day Care expenses must be incurred between January 1, 2025 and December 31, 2025.

"Use-It-or-Lose-It" Rule

All claims MUST be submitted no later than March 31, 2026 (90 days from the end of plan year) for reimbursement. Any funds left unclaimed on March 31, 2026 will be forfeited. Washington Unified School District has elected to offer a $500 rollover option, which will allow you to roll over up to $500 of unused contributions into the next plan year. Be conservative when making elections.

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

HRA, FSA, HSA numbers are reflected for the 2024 calendar year. 2025 amounts are not typically determined until after the release of the Benefit Guide. Employees making elections for the 2025 year should keep this in mind.

Important Notices

No Surprises Act Notice

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

Newborns' and Mothers' Health Protection Act (NMHPA)

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

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

Your plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services, including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema. For more information, you should review the Summary Plan Description or call your Plan Administrator at 916.375.7604 ext. 7 (ext. 4001 if calling internally) for more information.

Patient Protections

The medical plan requires the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. Until you make this designation, the plan will designate one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, please contact your Plan Administrator at 916.375.7604 ext. 7 (ext. 4001 if calling internally) for more information.

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

You do not need prior authorization from the plan or any other person (including a primary care provider) to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, please contact your Plan Administrator at 916.375.7604 ext. 7 (ext. 4001 if calling internally) for more information.

Networks/Claims/Appeals

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

COBRA Continuation Coverage

This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under covered medical, dental, and vision plans (the "Plan"). **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

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

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

WHAT IS COBRA CONTINUATION COVERAGE?

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

If you are an employee, you will become a Qualified Beneficiary if you lose coverage under the Plan because of the following Qualifying Events:

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

If you are the spouse of an employee, you will become a Qualified Beneficiary if you lose your coverage under the Plan because of the following Qualifying Events:

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

Your dependent children will become Qualified Beneficiaries if they lose coverage under the Plan because of the following Qualifying Events:

- The parent-employee dies;
- The parent-employee's employment ends for any reason other than their gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or,
- The child stops being eligible for coverage under the Plan as a "dependent child."

WHEN IS COBRA CONTINUATION COVERAGE AVAILABLE?

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

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

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

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

NOTICE AND ELECTION PROCEDURES

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

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

ELECTION AND ELECTION PERIOD

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

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

HOW IS COBRA CONTINUATION COVERAGE PROVIDED?

Once the Plan Administrator receives notice that a Qualifying Event has occurred, COBRA continuation coverage will be offered to each of the Qualified Beneficiaries. Each Qualified Beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation on behalf of their dependent children.

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

DISABILITY EXTENSION OF THE 18-MONTH PERIOD OF COBRA CONTINUATION COVERAGE

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

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

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

OTHER OPTIONS BESIDES COBRA CONTINUATION COVERAGE

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

ENROLLMENT IN MEDICARE INSTEAD OF COBRA

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

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

[1] https://www.medicare.gov/basics/get-started-with-medicare/sign-up/when-does-medicare-coverage-start

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

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

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

IF YOU HAVE QUESTIONS

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

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

KEEP YOUR PLAN INFORMED OF ADDRESS CHANGES

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

EFFECTIVE DATE OF COVERAGE

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

COST OF CONTINUATION COVERAGE

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

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

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

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

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

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

Uniformed Services Employment and Reemployment Rights Act (USERRA)

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

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

Note: If you lose eligibility for any reason during the Plan Year, your contributions to your Health and/or Dependent Care FSAs will end as of the date your eligibility terminates. You may submit claims for reimbursement from your FSAs for expenses incurred during the Plan Year prior to your eligibility termination. You must submit claims for reimbursement from your Health and/or Dependent Care FSAs no later than 90 days after the date your eligibility terminates. Any balance remaining in your FSAs will be forfeited after claims submitted prior to this date have been processed.

Special Enrollment Rights Notice

CHANGES TO YOUR HEALTH PLAN ELECTIONS

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

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

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

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

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

For information about Special Enrollment Rights, please contact:

Washington Unified School District
Benefits Department
30 Westacre Road
West Sacramento, CA 95691

Phone: (916) 375-7604 ext. 7
(ext. 4001 if calling internally)

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

Washington Unified School District Group Health Plan (Plan) maintains a Notice of Privacy Practices that provides information to individuals whose protected health information (PHI) will be used or maintained by the Plan. If you would like a copy of the Plan's Notice of Privacy Practices, please contact the Benefits Department at 916.375.7604 ext. 7 (ext. 4001 if calling internally).

Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: GENERAL INFORMATION

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

WHAT IS THE HEALTH INSURANCE MARKETPLACE?

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

Open Enrollment for health insurance coverage through Covered California will begin on November 1, 2024, and end on January 31, 2025. For more information on Open Enrollment and other opportunities to enroll, visit www.coveredca.com or KeenanDirect at 855-653-3626 or www.KeenanDirect.com.

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

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

You may qualify to save money and lower your monthly premium, but only if your employer does not offer you coverage, offers medical coverage that is not "Affordable," or does not provide "Minimum Value." If the lowest cost plan from your employer that would cover you (and not any other members of your family) is more than 8.39% (for 2024) of your household income for the year, then that coverage for you is not Affordable. **Note**: The IRS will update the applicable percentage for 2025. Affordability for dependent family members is determined separately and is based on the total cost of family coverage. Moreover, if the medical coverage offered covers less than 60% of the benefits costs, then the plan does not provide Minimum Value.

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

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

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

STATES WITH INDIVIDUAL MANDATE

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

PART B: INFORMATION ABOUT HEALTH COVERAGE OFFERED BY YOUR EMPLOYER

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

3. Employer name Washington Unified School District	**4. Employer Identification Number (EIN)** 68-0343642	
5. Employer address 930 Westacre Road	**6. Employer phone number** 916.375.7604 ext. 7 (ext. 4001 if calling internally)	
7. City West Sacramento	**8. State** CA	**9. ZIP code** 95691
10. Who can we contact about employee health coverage at this job? Benefits Department		
11. Phone number (if different from above)	**12. Email address**	

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

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

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your State may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs, but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

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

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial 877-KIDS-NOW or www.insurekidsnow.gov to find out how to apply. If you qualify, ask your State if it has a program that might help you pay the premiums for an employer-sponsored plan.

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

If you live in one of the following States, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2024. Contact your State for more information on eligibility.

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

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

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

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

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

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

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

INDIANA – Medicaid
Website: https://www.in.gov/medicaid/
Or http://www.in.gov/fssa/dfr/
Family and Social Services Administration
Phone: 800-403-0864
Member Services Phone: 800-457-4584

Important Notices (continued)

IOWA – Medicaid and CHIP (Hawki)
Medicaid Website: https://hhs.iowa.gov/programs/welcome-iowa-medicaid
Medicaid Phone: 800-338-8366
Hawki Website: http://hhs.iowa.gov/programs/welcome-iowa-medicaid/iowa-health-link/hawki
Hawki Phone: 800-257-8563
HIPP Website:
https://hhs.iowa.gov/programs/welcome-iowa-medicaid/free-service/hipp
HIPP Phone: 888-346-9562

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

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

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

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

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

MINNESOTA – Medicaid
Website: https://mn.gov/dhs/health-care-coverage/
Phone: 800-657-3672

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

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

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

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

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

NEW JERSEY – Medicaid and CHIP
Medicaid Website:
http://www.state.nj.us/humanservices/dmahs/clients/medicaid/
Phone: 800-356-1561
CHIP Premium Assistance Phone: 609-631-2392
CHIP Website: http://www.njfamilycare.org/index.html
CHIP Phone: 800-701-0710 (TTY: 711)

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

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

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

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

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

PENNSYLVANIA – Medicaid and CHIP
Website: https://www.dhs.pa.gov/en/services/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html
Phone: 800-692-7462
CHIP Website: https://www.dhs.pa.gov/CHIP/Pages/CHIP.aspx
CHIP Phone: 800-986-KIDS (5437)

Important Notices (continued)

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

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

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

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

UTAH – Medicaid and CHIP
Utah's Premium Partnership for Health Insurance (UPP)
Website: https://medicaid.utah.gov/upp/
Email: upp@utah.gov
Phone 888-222-2542
Adult Expansion Website: https://medicaid.utah.gov/expansion/

Utah Medicaid Buyout Program
Website: https://medicaid.utah.gov/buyout-program/
CHIP Website: https://chip.utah.gov/

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

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

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

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

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

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

To see if any other states have added a premium assistance program since July 31, 2024, or for more information on special enrollment rights, contact either:

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

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

Important Notice from Washington Unified School District About Your Prescription Drug Coverage and Medicare

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

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

- **Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or 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.**
- **Washington Unified School District has determined that the prescription drug coverage offered by the Washington Unified School District Medical Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.**

WHEN CAN YOU JOIN A MEDICARE DRUG PLAN?

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

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

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

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

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

WHEN WILL YOU PAY A HIGHER PREMIUM (PENALTY) TO JOIN A MEDICARE DRUG PLAN?

You should also know that if you drop or lose your current coverage with **Washington 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.

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 **Washington Unified School District** changes. You also may request a copy of this notice at any time.

Date:	October 4, 2024
Name of Entity / Sender:	Washington Unified School District
Contact:	Benefits Department
Address:	930 Westacre Road West Sacramento, CA 95691
Phone:	916.375.7604 ext. 7 (ext. 4001 if calling internally)

FOR MORE INFORMATION ABOUT YOUR OPTIONS UNDER MEDICARE PRESCRIPTION DRUG COVERAGE…

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

For more information about Medicare prescription drug coverage:

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

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them 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 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).

Glossary

Affordable Care Act and Patient Protection (ACA)

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

Allowed Amount

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

Balance Billing

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

Brand Name Drug

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

COBRA (Consolidated Omnibus Budget Reconciliation Act)

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

Children's Health Insurance Program (CHIP)

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

Claim

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

Coinsurance

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

Copayment (Copay)

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

Comprehensive Coverage

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

Deductible

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

Formulary

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

Generic Drug

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

High-Deductible Health Plan (HDHP)

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

Glossary (continued)

Health Savings Account (HSA)

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

Health Reimbursement Arrangements (HRAs)

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

In-Network

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

Non-Preferred Provider

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

Out-of-Pocket Maximum

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

Out-Of-Network

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

Out-Of-Pocket Limit

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

Plan Year

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

Preferred Provider

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

Premium

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

Preventive Care

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

Qualifying Life Event

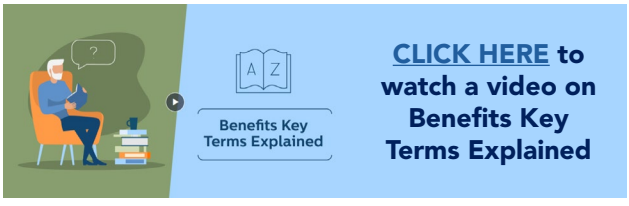
A change in your life that can make you eligible for a Special Enrollment Period to enroll in health coverage. Examples of qualifying life events include moving to a new state, certain changes in your income, and changes in your family size.

Skilled Nursing Care

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

Urgent Care

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



Contact Information

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

Plan	Plan Number	Phone Number	Web Site
Medical			
• Kaiser Permanente HMO / Senior Advantage	1086	800-464-4000	www.kp.org
• Kaiser Permanente HDHP		800-390-3507	www.kp.org
• Western Health Advantage HMO / HSA	106876	888-563-2250	www.westernhealth.com **Provider Search:** www.westernhealth.com/search-for-providers
• United Healthcare PPO	BPFJ	866-633-2446	www.myuhc.com
• Sutter Health Plus	TBD	855-315-5800	www.sutterhealthplus.org
• CalPERS		888-225-7377	www.calpers.ca.gov
Dental			
• Delta Dental	18481	866-499-3001	www.deltadentalins.com
Vision			
• Superior Vision	34004	800-507-3800	www.superiorvision.com
Employee Assistance Program (EAP)			
• Lincoln Financial Group	10181511	855-327-4463	www.guidanceresources.com **Company Code:** Lincoln
Basic Life / AD&D, Optional Life			
• Lincoln Financial Group	10181511	800-423-2765	www.lfg.com
Flexible Spending Accounts (FSA)			
• Navia Benefit Solutions		866-535-9227	www.NaviaBenefits.com
Other Voluntary Insurance Products			
• Colonial Life		702-463-2600	http://www.buildingblocksforbusiness.com

Benefits Department

Call 916-375-7604 Ext. 7 (Ext. 4001 if calling internally)