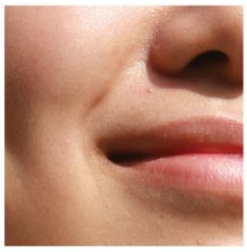
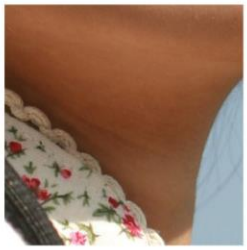





2026

Benefit Summary

Eureka Union

SIG Schools Insurance Group

About Your Benefits

We are committed to providing a comprehensive and affordable benefits package to you and your family. Review this guide to learn about your options so you can make the most of your Schools Insurance Group benefits. If you have any questions, feel free to reach out to your district's Benefit Coordinator.

Table of Contents

Eligibility and Enrollment

You are eligible to participate in Schools Insurance Group's benefits, please check with your Benefits Coordinator for information on your eligibility date. If you enroll for benefits, you may also cover your:

- Legal spouse
- Children up to age 26
- Unmarried children of any age who are mentally or physically disabled

You have 30 days from your hire date to log on to **BenefitSolver** and enroll. Your benefits begin on the 1st of the month in which you are eligible.

If you have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please see Notice of Creditable Coverage in Legal Notices

Making Changes to Your Benefits

Each year, you have the opportunity to make changes to your benefits during open enrollment. You may make mid-year changes to your benefits only if you have a qualifying life event. Examples of qualifying life events include:

- Marriage or divorce
- Birth or adoption of a child
- Change in a dependent's eligibility status
- Change in employment status for you or your dependents resulting in the loss/gain of coverage
- A significant change in the cost or coverage of your dependent's benefits
- Change in the cost of dependent care (for dependent care flexible spending accounts only)
- Death of a dependent

You have 30 days from the date of the event to log on to **BenefitSolver** and make the change. Keep in mind, the changes you make must be directly related to the event.

This document is an outline of the coverage provided under your employer's benefit plans based on information provided by your company. It does not include all the terms, coverage, exclusions, limitations, and conditions contained in the official Plan Document, applicable insurance policies and contracts (collectively, the "plan documents"). The plan documents themselves must be read for those details. The intent of this document is to provide you with general information about your employer's benefit plans. It does not necessarily address all the specific issues which may be applicable to you. It should not be construed as, nor is it intended to provide, legal advice. To the extent that any of the information contained in this document is inconsistent with the plan documents, the provisions set forth in the plan documents will govern in all cases. If you wish to review the plan documents or you have questions regarding specific issues or plan provisions, you should contact your Human Resources/Benefits Department.

Contact Information

Benefit	Vendor	Phone	Website or Email
Medical	Kaiser Permanente	800.464.4000	https://choose.kaiserpermanente.org/sig/home
	Sutter Health Plan	855.315.5800	https://www.sutterhealthplan.org/schools-insurance-group
	Western Health Advantage	888.563.2250	www.choosewha.com/sig
Dental	Delta Dental	866.499.3001	www.DeltaDentalins.com
	Personify Health	800.442.7247	www.personifyhealth.com
Vision	VSP	800.877.7195	www.vsp.com
Health Savings Account	Optum Bank	844.326.7967	www.optumbank.com
Life and AD&D	The Hartford	Contact your District Benefits Coordinator	
Employee Assistance Program	SupportLinc	888.881.5462	www.supportlinc.com
Financial Wellness	Prudential	877.444.5606	www.prudential.com/SIG
District Contact	Human Resources	916.774.1206	humanresources@eurekausd.org
BenefitSolver			www.benefitsolver.com

Medical Coverage – Local HMOs

Terms to Know

- **Copay** - A set dollar amount you pay for a covered healthcare service, usually when you receive the service.
- **Deductible** - What you pay out of pocket for certain healthcare services before the plan begins to pay a portion.
- **Coinsurance** - Your share of the costs of covered healthcare services after you reach the deductible. You pay a percentage of the cost, and the medical plan pays the rest.
- **Out-of-pocket Maximum** - What you have to pay before the plan pays 100% of your covered costs.
- **Network** - The facilities and providers the medical plan has contracted with to provide healthcare services. In-network providers typically provide services at a lower negotiated rate. If you receive services from a provider that is **In-Network** it will cost you significantly less than going to a provider that is **Out-of-Network**.
- **Formulary Drug List**: A drug formulary is a list of generic and brand-name drugs that have been evaluated for safety and effectiveness, and that your insurance company considers “best choices”.
- **Generic Drugs**: FDA approved and shown to be just as safe and effective as their more expensive brand-name counterparts.
- **Brand Name Drugs**: Carriers regularly review the latest prescription drugs on the market and maintains a list of brand name drugs that are clinically effective and not cost-restrictive.
- **Specialty Drugs**: Specialty drugs are typically used to treat chronic conditions like cancer or multiple sclerosis. These drugs tend to be more expensive and usually require special handling and monitoring. If you take a specialty medication, you could save money by using the carrier’s mail-order pharmacy. You can register for mail-order pharmacy by logging on to www.kp.org / www.SutterHealthPlan.org / www.ChooseWHA.com/SIG.

How the Plans Work

You can choose from the following networks: Kaiser Permanente / Sutter Health Plan / Western Health Advantage. Each plan covers 100% of the cost for preventive care services like annual physicals and routine immunizations. The way you pay for care is different with each plan. These plans are HMOs meaning you have access to in-network care only, unless it’s an emergency. Your care will be directed by your designated primary care physician and you will need a referral to see most other providers.

Traditional HMO: This Plan has set copays for most, if not all services. You will pay copays until you reach your annual out-of-pocket maximum.

DHMO: This Plan has a deductible that applies to hospital services, otherwise there are set copays for most, if not all other services. You will pay your deductible for hospital related services and copays until you reach your annual out-of-pocket maximum.

HDHP: The High Deductible Health Plans (HDHP) have a higher deductible than traditional plans, meaning you pay more out-of-pocket costs before the insurance starts covering expenses. Preventive care services, such as annual check-ups and screenings, are covered at 100% with no cost to you. However, all other services are subject to the deductible, requiring you to pay the full cost until the deductible is met. These plans typically have lower monthly premiums are HSA-compatible, allowing you to save pre-tax dollars in a Health Savings Account to cover qualified medical expenses.

Telemedicine

Getting to the doctor when you're sick is never easy. That’s why your carrier offers telemedicine for non-emergency care. You can connect with a U.S board-certified medical professional by phone or video chat.

Finding In-network Providers & Telemedicine Options

- Log on to www.kp.org or call 800.464.4000 to find providers in the Kaiser Permanente network.
- Log on to www.SutterHealthPlan.org or call 855.315.5800 to find providers in the Sutter Health Plan network.
- Log on to www.ChooseWHA.com/SIG or call 888.563.2250 to find providers in the Western Health Advantage network.

Medical Coverage

You have a choice of four medical plans through Kaiser Permanente - the **HDHP** and **HMO plans**. Review the chart below for the amount you will pay for the medical service listed.

Kaiser Permanente Traditional HMO

	Traditional HMO
	In Network
Calendar Year Deductible (Individual/Family)	None
Calendar Year Out-of-pocket Maximum (Individual/Family)	$1,500 / $3,000
Preventive Care	No Charge
Office Visits Telemedicine Primary Care Urgent Care Specialist	 No Charge $25 copay per visit $25 copay per visit $50 copay per visit
Emergency Room (copay waived if admitted)	$100 copay per visit
Hospital Inpatient Services	$250 copay per admission
Outpatient Surgery	$100 copay per visit
Chiropractic (up to 30 visits per year)	$10 copay per visit
Outpatient Mental Health & Substance Abuse	$25 copay per visit
Inpatient Mental Health & Substance Abuse	$250 copay per admission
Prescription Drug Services	
Calendar Year Rx Deductible (Individual/Family)	$100 (does not apply to generics)
Retail (30-day Supply) Generic Drugs (Tier 1) Preferred / Non - Preferred Brand Drugs (Tier 2) Specialty drugs (Tier 4)	 $10 copay $25 copay after Rx deductible 20% (not to exceed $150) after Rx deductible
Mail-order (100-day Supply) Generic Drugs (Tier 1) Preferred / Non - Preferred Brand Drugs (Tier 2)	 $20 copay $50 copay after Rx deductible

Medical Coverage

Kaiser Permanente 1000 DHMO

	1000 DHMO
	In Network
Calendar Year Deductible (Individual/Family)	$1,000 / $2,000 $1,000 Ind. in a family
Calendar Year Out-of-pocket Maximum (Individual/Family)	$3,000 / $6,000 $3,000 Ind. in a family
Preventive Care	No Charge
Office Visits Telemedicine Primary Care Urgent Care Specialist	 No Charge $20 copay per visit $20 copay per visit $20 copay per visit
Emergency Room	20% after deductible
Hospital Inpatient Services	20% after deductible
Outpatient Surgery	20% after deductible
Chiropractic (up to 30 visits per year)	$10 copay per visit
Outpatient Mental Health & Substance Abuse	Individual: $20 copay per visit; Group: $10 copay per visit (MH) $5 copay per visit (SA)
Inpatient Mental Health & Substance Abuse	20% after deductible
Prescription Drug Services	
Retail (30-day Supply) Generic Drugs (Tier 1) Brand Drugs (Tier 2) Specialty drugs (Tier 4)	 $10 copay $30 copay 20% (not to exceed $250)
Mail-order (100-day Supply) Generic Drugs (Tier 1) Brand Drugs (Tier 2)	 $20 copay $60 copay

Medical Coverage

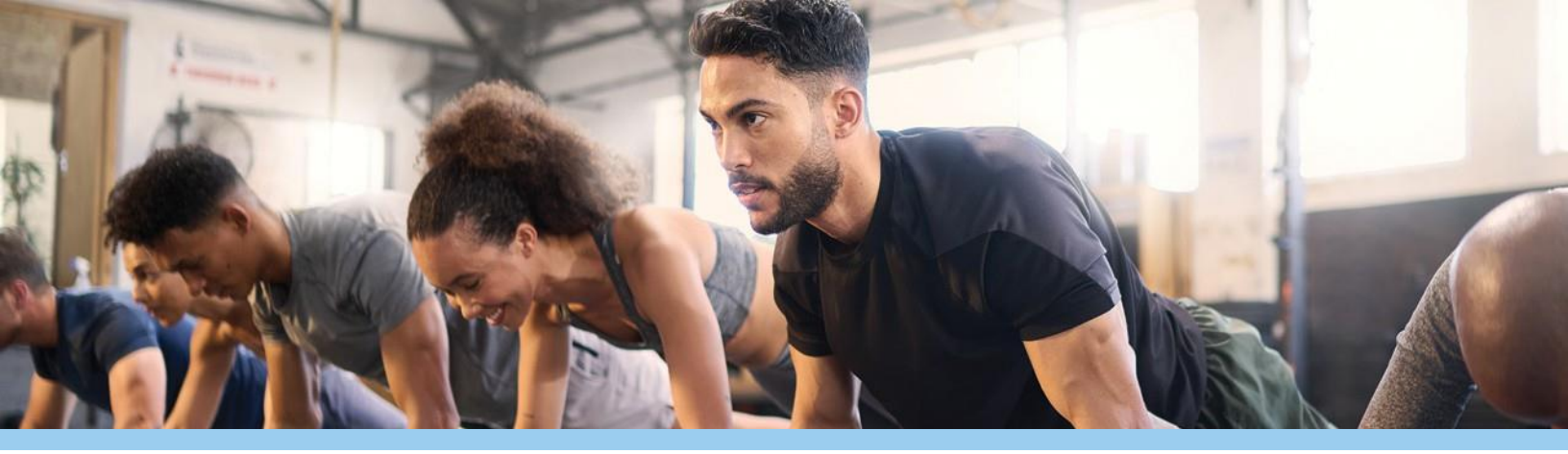
Kaiser Permanente 2000 HDHP HMO

	2000 HDHP HMO
	In Network
Calendar Year Deductible (Individual/Family)	$2,000 / $4,000 $3,400 Ind. in a family
Calendar Year Out-of-pocket Maximum (Individual/Family)	$3,400 / $6,400
Preventive Care	No Charge
Office Visits Telemedicine Primary Care Urgent Care Specialist	 0% after deductible $30 copay after deductible $30 copay after deductible $30 copay after deductible
Emergency Room (copay waived if admitted)	$100 copay after deductible
Hospital Inpatient Services	$250 copay per admission after deductible
Outpatient Surgery	$150 copay per procedure after deductible
Chiropractic	Not Covered
Outpatient Mental Health & Substance Abuse	$30 copay after deductible
Inpatient Mental Health & Substance Abuse	$250 copay per admission after deductible
Prescription Drug Services	
Retail (30-day Supply) Generic Drugs (Tier 1) Preferred / Non - Preferred Brand Drugs (Tier 2) Specialty drugs (Tier 4)	 $10 copay after combined deductible $30 copay after combined deductible 20% (not to exceed $150) per Rx after combined deductible
Mail-order (100-day Supply) Generic Drugs (Tier 1) Preferred / Non - Preferred Brand Drugs (Tier 2)	 $20 copay after combined deductible $60 copay after combined deductible

Medical Coverage

Kaiser Permanente 3000 HDHP HMO

	3000 HDHP HMO
	In Network
Calendar Year Deductible (Individual/Family)	$3,000/$6,000 $3,400 Ind. in a family
Calendar Year Out-of-pocket Maximum (Individual/Family)	$5,350/$10,700 $5,350 Ind. in a family
Preventive Care	No Charge
Office Visits Telemedicine Primary Care Urgent Care Specialist	 0% after deductible $30 copay per visit after deductible $30 copay per visit after deductible $50 copay per visit after deductible
Emergency Room (copay waived if admitted)	30% after deductible
Hospital Inpatient Services	30% after deductible
Outpatient Surgery	30% after deductible
Chiropractic	Not Covered
Outpatient Mental Health & Substance Abuse	Individual: $30 copay per visit after deductible; Group: $15 copay per visit after deductible (MH) $5 copay per visit after deductible (SA)
Inpatient Mental Health & Substance Abuse	30% after deductible
Prescription Drug Services	
Retail (30-day Supply) Generic Drugs (Tier 1) Preferred / Non - Preferred Brand Drugs (Tier 2) Specialty drugs (Tier 4)	 $15 copay after deductible $30 copay after deductible 20% (not to exceed $250) per Rx after deductible
Mail-order (100-day Supply) Generic Drugs (Tier 1) Preferred / Non - Preferred Brand Drugs (Tier 2)	 $30 copay after deductible $60 copay after deductible



Whole-body health made easier

Get help reaching your wellness goals

Choose a One Pass Select Affinity fitness plan that fits your lifestyle

Make a commitment to your overall well-being by joining One Pass Select Affinity from Optum.[1] Choose a fitness plan and get unlimited access to all locations available within that plan, plus extensive digital resources.

- 5 membership tiers with different monthly fees[2]
- 19,000+ gym locations and boutique studios
- 24,000+ on-demand and livestreamed classes
- Digital tools to track progress and an AI workout builder
- Add unlimited family and friends (18 years and older)
- No long-term contracts —change tiers monthly or cancel within 30 days
- Groceries and household essentials delivered with Walmart+ and Shipt

Save on wellness services

Kaiser Permanente members can access Optum's affinity musculoskeletal program.[3]

Get 20% off chiropractors, acupuncturists, and massage therapists when you visit a participating provider and show your Kaiser Permanente ID card.

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1. The services described above are not covered under your health plan benefits and are not subject to the terms set forth in your *Evidence of Coverage* or other plan documents. These services may be discontinued at any time without notice. **2.** In Colorado, eligible employees who have the One Pass Select program have access to the classic tier after paying a $100 annual fee. Employees with the classic tier may access other tiers within the gym network after paying an additional fee. In Hawaii, members pay a $200 annual fee to access the classic tier (aka Fit Rewards program). Members who work out for 45 days for at least 30 minutes each session over the year will earn a $200 reward. Only 1 training session per day counts toward the 45-day total. **3.** See note 1.

Kaiser Permanente health plans around the country: Kaiser Foundation Health Plan, Inc., in Northern and Southern California and Hawaii · Kaiser Foundation Health Plan of Colorado · Kaiser Foundation Health Plan of Georgia, Inc., Nine Piedmont Center, 3495 Piedmont Road NE, Atlanta, GA 30305 · Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc., in Maryland, Virginia, and Washington, D.C., 4000 Garden City Drive, Hyattsville, MD 20785 · Kaiser Foundation Health Plan of the Northwest, 500 NE Multnomah St., Suite 100, Portland, OR 97232 · Kaiser Foundation Health Plan of Washington or Kaiser Foundation Health Plan of Washington Options, Inc., 2715 Naches Ave. SW, Renton, WA 98057

Learn more at **kp.org/exercise**

KAISER PERMANENTE®

1765453513 October 2025

Caring for the whole you

Mental health and addiction care services

Mental health care goes hand-in-hand with all the care we provide.

Primary care

Talk to your primary care doctor about any mental health or substance use concerns anytime. Your doctor can assess your needs and connect you with the right care.

Specialty care

Visit **kp.org/mentalhealthservices** for information on available options and how to make an appointment with a Kaiser Permanente mental health care professional —no referral needed. This includes dedicated help for those struggling with alcohol or drugs. If you or someone you love needs support, talk to your doctor or visit **kp.org/addiction**.

Self-care and wellness resources

You have access to many tools, including self-care apps that can help with stress, anxiety, and sleep — available at no cost. You can also try wellness coaching, join a health class,[1] and take online self-assessments. Visit **kp.org/wellnessresources** to learn more.

Connected care

Your entire Kaiser Permanente care team is connected to each other, and to you, through your electronic health record. So, it's easy for our doctors to consult with one another about your care. Your team may include many health professionals to support you, including:

- Primary care doctors
- Psychiatrists
- Therapists
- Addiction medicine specialists

Common conditions

We provide assessment and treatment for a variety of mental, emotional, and substance use issues, including but not limited to:

- Anxiety and stress
- Attention deficit hyperactivity disorder (ADHD)
- Autism spectrum disorders
- Bipolar disorder
- Depression
- Eating disorders
- Obsessive-compulsive disorder (OCD)
- Personality disorders
- Postpartum depression
- Post-traumatic stress disorder (PTSD)
- Schizophrenia
- Sleep problems
- Substance use disorders

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Support and resources

You can count on us to help guide you throughout your journey with a wide range of treatment. These include but aren't limited to:

- Classes and support groups[1]
- Digital wellness resources
- Healthy lifestyle programs
- Integration with primary care
- Intensive outpatient services
- Inpatient services
- Outpatient services
- Preventive care
- Recovery and social support
- Self-care apps
- Wellness coaching

Self-care at your fingertips

It's common to struggle with everyday life sometimes. These no-cost self-care apps can help you with stress, sleep, depression, focus, and more.[2,3]

Calm is the number one app for sleep, meditation, and relaxation.[4]

Headspace provides live text-based emotional support coaching and hundreds of self-guided resources.[5]

Many ways to get care

You can connect with a mental health or substance use professional when and where it works for you.

- **24/7 advice:** Speak to licensed care professionals who can help connect you with a clinician, schedule appointments, and offer immediate care guidance
- **Video visit:** Face-to-face care from a clinician on your smartphone or computer[6]
- **E-visit:** Online questionnaire to provide a personalized care plan[7]
- **Phone appointment:** High-quality care over the phone —just like an in-person visit[6]
- **Email:** Message your Kaiser Permanente doctor's office with nonurgent health questions anytime
- **In-person:** Meet with a clinician for personalized care

No matter how you reach out, you can get connected to the right care.

To understand your care options and connect to the support you need, visit **kp.org/mentalhealthservices**.

For emergency care

If you think you have a medical or psychiatric emergency, call 911 or go to the nearest hospital.[8]

1. Some classes may require a fee. **2.** The apps and services described above are not covered under your health plan benefits, are not a Medicare-covered benefit, and are not subject to the terms set forth in your *Evidence of Coverage* or other plan documents. The apps and services may be discontinued at any time. **3.** Calm and Headspace can be used by members 13 and over. **4.** Calm is the number one app for sleep, meditation, and relaxation. Learn more at calm.com/blog/about. **5.** Eligible Kaiser Permanente members can text with a coach using the Headspace app for 90 days per year. After the 90 days, members can continue to access the other services available on the Headspace app for the remainder of the year at no cost. **6.** When appropriate and available. **7.** Mental health e-visits are not currently available in Colorado. **8.** If you believe you have an emergency medical condition, call 911 or go to the nearest hospital. For the complete definition of an emergency medical condition, please refer to your *Evidence of Coverage* or other coverage documents.

Kaiser Foundation Health Plan, Inc., in Northern and Southern California and Hawaii · Kaiser Foundation Health Plan of Colorado · Kaiser Foundation Health Plan of Georgia, Inc., Nine Piedmont Center, 3495 Piedmont Road NE, Atlanta, GA 30305 · Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc., in Maryland, Virginia, and Washington, D.C., 4000 Garden City Drive, Hyattsville, MD 20785 · Kaiser Foundation Health Plan of the Northwest, 500 NE Multnomah St., Suite 100, Portland, OR 97232 · Kaiser Foundation Health Plan of Washington or Kaiser Foundation Health Plan of Washington Options, Inc., 2715 Naches Ave. SW, Renton, WA 98057

Learn more at **kp.org/mentalhealth**

KAISER PERMANENTE®

1585717910 March 2025

Medical Coverage

You have a choice of four medical plans through Sutter Health Plan - the **HDHP** and **HMO plans**. Review the chart below for the amount you will pay for the medical service listed.

Sutter Health Plan Traditional HMO

	Traditional HMO
	In Network
Calendar Year Deductible (Individual/Family)	None
Calendar Year Out-of-pocket Maximum (Individual/Family)	$1,500 / $3,000 $1,500 Ind. in a family
Preventive Care	No Charge
Office Visits Telemedicine (PCP / Specialist) Primary Care Urgent Care Specialist	 $10 copay per visit / $25 copay per visit $25 copay per visit $25 copay per visit $50 copay per visit
Emergency Room	Facility: $100 copay per visit; Professional: 0%
Hospital Inpatient Services	$250 copay per admission
Outpatient Surgery	$100 copay per visit
Chiropractic	$15 copay (20 visits)
Outpatient Mental Health & Substance Abuse	Individual Office Visit: $25 copay per visit; Group Office Visit: $12.50 copay per visit; Telehealth Office Visit: $10 copay per visit; Other Outpatient Services: 0%
Inpatient Mental Health & Substance Abuse	Facility: $250 copay per admission; Professional: 0%
Prescription Drug Services	
Calendar Year Rx Deductible (Individual/Family)	$100 / $200 $100 Ind. in a family
Retail (30-day Supply) Tier 1 (Most generic drugs and low-cost preferred brand name drugs) Tier 2 (Preferred brand name drugs and non-preferred generic drugs) Tier 3 (Non-preferred brand name drugs) Tier 4 (Specialty drugs)	 $10 copay per prescription $30 copay per prescription after Rx deductible $60 copay per prescription after Rx deductible 20% (not to exceed $100 per prescription) after Rx deductible
Mail-order (100-day Supply) Tier 1 (Most generic drugs and low-cost preferred brand name drugs) Tier 2 (Preferred brand name drugs and non-preferred generic drugs) Tier 3 (Non-preferred brand name drugs)	 $20 copay per prescription $60 copay per prescription after Rx deductible $120 copay per prescription after Rx deductible

Sutter Walk-in care: $10 copay per visit

Note: Retail: covers up to a 30-day supply through a CVS Health® contracted retail network pharmacy and covers up to a 100-day supply of maintenance drugs, at two times the retail copay, through the CVS Health Retail-90 Network. Mail Order/home delivery service: covers up to a 100-day supply of maintenance drugs, at two times the retail copay, through the CVS Caremark® Mail Service Pharmacy. Specialty Pharmacy: covers up to a 30-day supply of specialty drugs through CVS Specialty®. Specialty drugs are not exclusive to Tier 4 and, regardless of tier placement, have the same fill requirements.

Medical Coverage

Sutter Health Plan 1000 DHMO

	1000 DHMO
	In Network
Calendar Year Deductible (Individual/Family)	$1,000 / $2,000 $1,000 Ind. in a family
Calendar Year Out-of-pocket Maximum (Individual/Family)	$3,000 / $6,000 $3,000 Ind. in a family
Preventive Care	0%
Office Visits Telemedicine (PCP / Specialist) Primary Care Urgent Care Specialist	 $10/$20 copay per visit $20 copay per visit $40 copay per visit (Ded. Does not apply) $40 copay per visit
Emergency Room	20% after deductible
Hospital Inpatient Services	20% after deductible
Outpatient Surgery	20% after deductible
Chiropractic	$15 copay (20 visits)
Outpatient Mental Health & Substance Abuse	Individual Office Visit: $20 copay per visit; Group Office Visit / Telehealth Office Visit: $10 copay per visit; Other Outpatient Services: 20% after deductible
Inpatient Mental Health & Substance Abuse	20% after deductible
Prescription Drug Services	
Retail (30-day Supply) Tier 1 (Most generic drugs and low-cost preferred brand name drugs) Tier 2 (Preferred brand name drugs and non-preferred generic drugs) Tier 3 (Non-preferred brand name drugs) Tier 4 (Specialty drugs)	 $10 copay per prescription $30 copay per prescription $75 copay per prescription 20% up to $250 per prescription
Mail-order (100-day Supply) Tier 1 (Most generic drugs and low-cost preferred brand name drugs) Tier 2 (Preferred brand name drugs and non-preferred generic drugs) Tier 3 (Non-preferred brand name drugs)	 $20 copay per prescription $60 copay per prescription $150 copay per prescription

Sutter Walk-in care: $10 copay per visit
Note: Retail: covers up to a 30-day supply through a CVS Health® contracted retail network pharmacy and covers up to a 100-day supply of maintenance drugs, at two times the retail copay, through the CVS Health Retail-90 Network.
Mail Order/home delivery service: covers up to a 100-day supply of maintenance drugs, at two times the retail copay, through the CVS Caremark® Mail Service Pharmacy.
Specialty Pharmacy: covers up to a 30-day supply of specialty drugs through CVS Specialty®. Specialty drugs are not exclusive to Tier 4 and, regardless of tier placement, have the same fill requirements.

Medical Coverage

Sutter Health Plan 1750 HDHP HMO

	1750 HDHP HMO
	In Network
Calendar Year Deductible (Individual/Family)	$1,750 / $3,500 $3,400 Ind. in a family
Calendar Year Out-of-pocket Maximum (Individual/Family)	$3,500 / $7,000 $3,500 Ind. in a family
Preventive Care	No Charge
Office Visits Telemedicine Primary Care Urgent Care Specialist	 0% after deductible 0% after deductible 10% coinsurance 0% after deductible
Emergency Room	10% coinsurance
Hospital Inpatient Services	10% coinsurance
Outpatient Surgery	10% coinsurance
Chiropractic	Not Covered
Outpatient Mental Health & Substance Abuse	Individual Office Visit / Group Office Visit / Telehealth Office Visit: No Charge; Other Outpatient Services: 10% coinsurance
Inpatient Mental Health & Substance Abuse	Facility: 10% coinsurance; Professional: No Charge
Prescription Drug Services	
Retail (30-day Supply) Tier 1 (Most generic drugs and low-cost preferred brand name drugs) Tier 2 (Preferred brand name drugs and non-preferred generic drugs) Tier 3 (Non-preferred brand name drugs) Tier 4 (Specialty drugs)	 $10 copay per prescription $30 copay per prescription $75 copay per prescription 10% coinsurance up to $250 per prescription
Mail-order (100-day Supply) Tier 1 (Most generic drugs and low-cost preferred brand name drugs) Tier 2 (Preferred brand name drugs and non-preferred generic drugs) Tier 3 (Non-preferred brand name drugs)	 $20 copay per prescription $60 copay per prescription $150 copay per prescription

Sutter Walk-in care: 0% after deductible

Note: Retail: covers up to a 30-day supply through a CVS Health® contracted retail network pharmacy and covers up to a 100-day supply of maintenance drugs, at two times the retail copay, through the CVS Health Retail-90 Network.

Mail Order/home delivery service: covers up to a 100-day supply of maintenance drugs, at two times the retail copay, through the CVS Caremark® Mail Service Pharmacy.

Specialty Pharmacy: covers up to a 30-day supply of specialty drugs through CVS Specialty®. Specialty drugs are not exclusive to Tier 4 and, regardless of tier placement, have the same fill requirements.

Medical Coverage

Sutter Health Plan 2500 HDHP HMO

	2500 HDHP HMO
	In Network
Calendar Year Deductible (Individual/Family)	$2,500 / $5,000 $3,400 Ind. in a family
Calendar Year Out-of-pocket Maximum (Individual/Family)	$4,000 / $8,000 $4,000 Ind. in a family
Preventive Care	No Charge
Office Visits	
Telemedicine	20% after deductible
Primary Care	20% after deductible
Urgent Care	20% after deductible
Specialist	20% after deductible
Emergency Room	20% after deductible
Hospital Inpatient Services	20% after deductible
Outpatient Surgery	20% after deductible
Chiropractic	Not Covered
Outpatient Mental Health & Substance Abuse	20% after deductible
Inpatient Mental Health & Substance Abuse	20% after deductible
Prescription Drug Services	
Retail (30-day Supply)	
Tier 1 (Most generic drugs and low-cost preferred brand name drugs)	$10 copay per prescription
Tier 2 (Preferred brand name drugs and non-preferred generic drugs)	$30 copay per prescription
Tier 3 (Non-preferred brand name drugs)	$75 copay per prescription
Tier 4 (Specialty drugs)	20% up to $250 per prescription
Mail-order (100-day Supply)	
Tier 1 (Most generic drugs and low-cost preferred brand name drugs)	$20 copay per prescription
Tier 2 (Preferred brand name drugs and non-preferred generic drugs)	$60 copay per prescription
Tier 3 (Non-preferred brand name drugs)	$150 copay per prescription

Sutter Walk-in care: 20% after deductible

Note: Retail: covers up to a 30-day supply through a CVS Health® contracted retail network pharmacy and covers up to a 100-day supply of maintenance drugs, at two times the retail copay, through the CVS Health Retail-90 Network.

Mail Order/home delivery service: covers up to a 100-day supply of maintenance drugs, at two times the retail copay, through the CVS Caremark® Mail Service Pharmacy.

Specialty Pharmacy: covers up to a 30-day supply of specialty drugs through CVS Specialty®. Specialty drugs are not exclusive to Tier 4 and, regardless of tier placement, have the same fill requirements.

Sutter Health Plan

Take Charge of Your Health

As a Sutter Health Plan member*, you have access to Vida Health at no additional cost. Vida is a virtual health program designed to help you lose or maintain a healthy weight, and to manage or prevent chronic conditions including diabetes, high blood pressure and high cholesterol — all from the comfort of your home.

Care That Fits Your Life

- **Personalized Support:** Connect with accredited health coaches and registered dietitians through one-on-one video visits and in-app messaging.
- **Comprehensive Tools:** Track food, exercise, sleep habits and more. Access healthy recipes, actionable digital health insights and integrate third-party devices and apps.
- **Prevention Focus:** Address prediabetes and other risk factors early to help prevent chronic disease.
- **Chronic Condition Management:** Get expert guidance and monitoring for weight loss, diabetes and other conditions.
- **Convenient Access:** All resources are available through your mobile app, making it easy to stay on track wherever you are.

Working Together for Your Health

If your doctor prescribes drugs for weight loss, they must submit a prior authorization to CVS Caremark® for weight loss drugs coverage. Members age 18 and older must enroll in the Vida comprehensive weight loss program and meet monthly engagement requirements to qualify for coverage of weight loss drugs.* Vida can provide additional information about weight loss drug prior authorization criteria.

Enroll Today

You can self-enroll by visiting **vida.com/sutterhealthplan** or by calling Vida Member Support at **833-732-2242**.

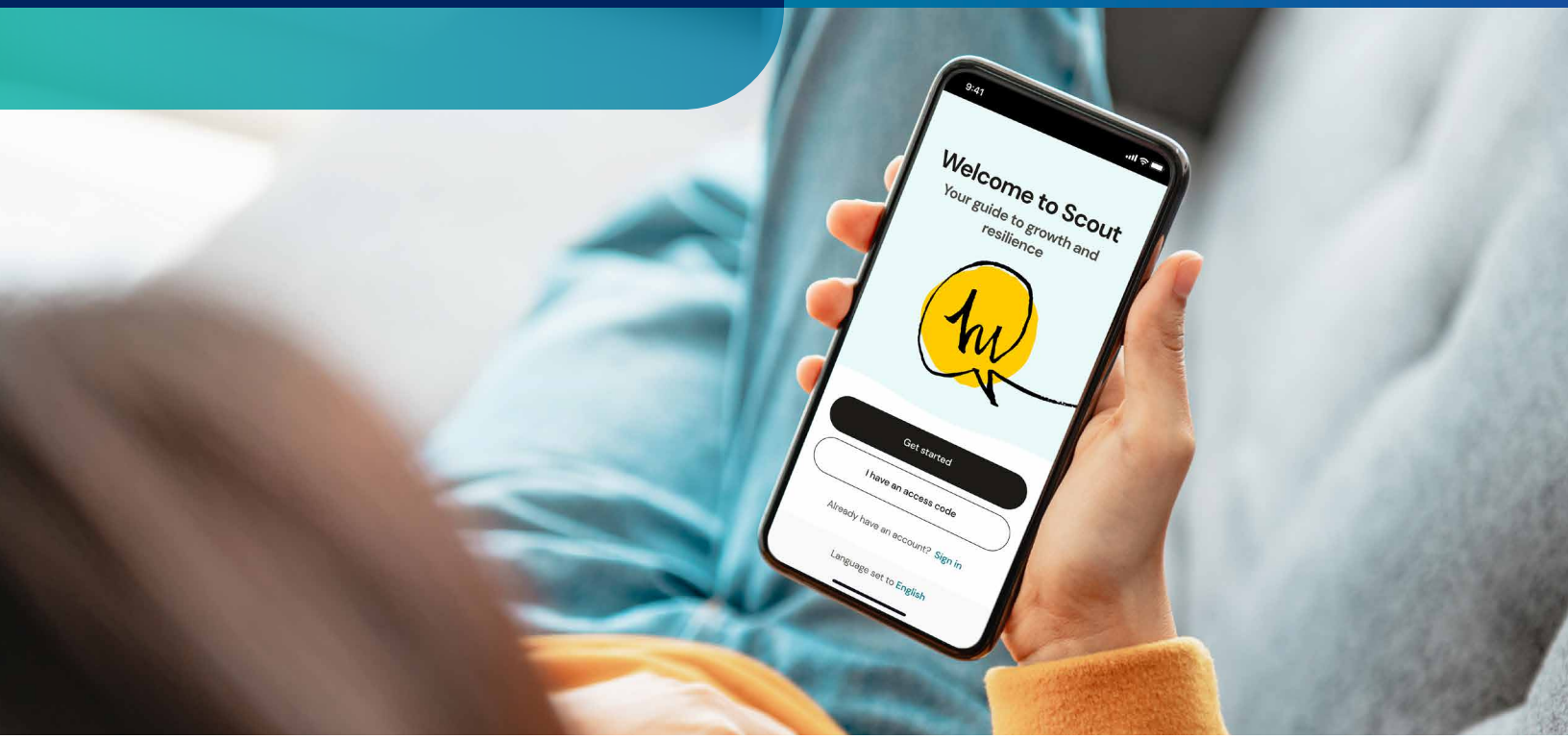
* Vida is available to all members 18 and older. Some exclusions and limitations apply.

PM-MK-26-015

Customer Service **855-315-5800**
Visit **sutterhealthplan.org**

Scout by Sutter Health

Resiliency and Mental Health Tools for Youth



Sutter Health Plan members have access to Scout at no cost.

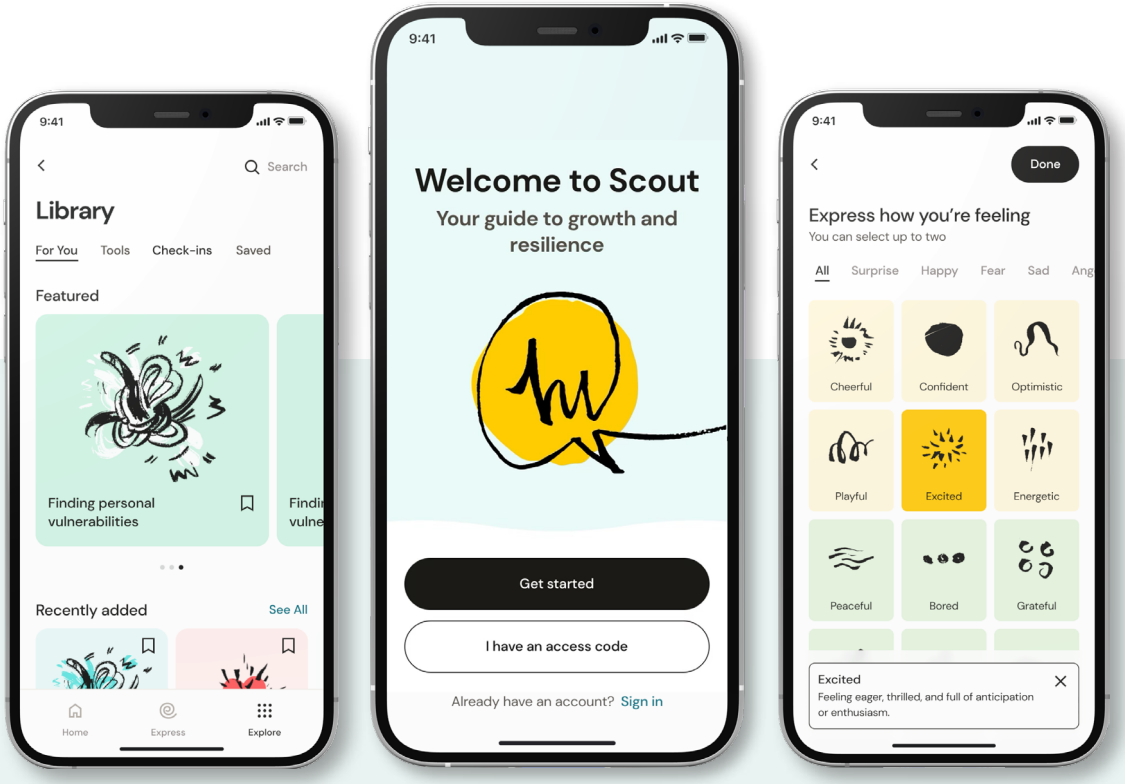
Scout is a personalized digital program that helps teens and young adults, ages 13–22, build resilience to manage everyday mental health. It's also for their champions (parents, caregivers and families) so they can better understand and support the young people they care about.

Scout is different from coaching and therapy by offering interactive, tools, tips and exercises to help meet life's challenges and develop an early understanding of difficult emotions and mental health stressors through key features:

- **Weekly education:** Take a guided journey with Scout or learn at your own pace.
- **Feelings tracker:** Express yourself to receive helpful and personalized content.
- **Trends & insights:** Learn more about yourself and your feelings over time.
- **Tips, tools & activities:** Build new skills and strengthen mental resilience.
- **Reminders & nudges:** Stay on track and achieve your mental health goals.
- **Support resources:** Find resources to get the help you need, when you need it.

Sutter Health Plan

Getting Started



1

Download the free Scout app from the App Store or Google Play

2

Open the app and click "I have an access code"

3

Enter the access code **SCOUTSHP**

4

Create your profile

For more information, visit **scout.sutterhealth.org**.

Medical Coverage

You have a choice of three medical plans through Western Health Advantage - the **HDHP** and **HMO plans**. Review the chart below for the amount you will pay for the medical service listed.

Western Health Advantage Traditional HMO

	Traditional HMO
	In Network
Calendar Year Deductible (Individual/Family)	None
Calendar Year Out-of-pocket Maximum (Individual/Family)	$1,500 / $3,000
Preventive Care	0%
Office Visits Telemedicine Primary Care Urgent Care* Specialist	 $25 copay $25 copay $30 copay / $35 copay $50 copay
Emergency Room (copay waived if admitted)	$100 copay
Hospital Inpatient Services	$250 copay per admission
Outpatient Surgery	$100 copay
Chiropractic (up to 20 visits per year)	$15 copay
Outpatient Mental Health & Substance Abuse	$25 copay
Inpatient Mental Health & Substance Abuse	$250 copay per admission; Professional services: $0 copay
Prescription Drug Services	
Calendar Year Rx Deductible (Individual/Family)	$100 / $100 (does not apply to generics)
Retail (30-day Supply) Tier 1 (Preferred generic and certain preferred brand name medications) Tier 2 (Preferred brand name or non-preferred generic medications) Tier 3 (Non-preferred medications) Tier 4 (Specialty medications specialty drugs and other higher-cost drugs)	 $10 copay $30 copay after Rx deductible $50 copay after Rx deductible $100 copay after Rx deductible
Mail-order (100-day Supply) Tier 1 (Preferred generic and certain preferred brand name medications) Tier 2 (Preferred brand name or non-preferred generic medications) Tier 3 (Non-preferred medications)	 $20 copay $60 copay after Rx deductible $100 copay after Rx deductible

* Urgent care virtual visit / Urgent care center

Medical Coverage

Western Health Advantage 1000 DHMO

	1000 DHMO
	In Network
Calendar Year Deductible (Individual/Family)	$1,000 / $2,000 $1,000 Ind. in a family
Calendar Year Out-of-pocket Maximum (Individual/Family)	$5,000 / $10,000 $5,000 Ind. in a family
Preventive Care	0%
Office Visits Telemedicine Primary Care Urgent Care Specialist	 $20 copay per visit; Urgent care: $25 copay per visit $20 copay per visit $50 copay per visit $20 copay per visit
Emergency Room (copay waived if admitted)	20% after deductible
Hospital Inpatient Services	20% after deductible
Outpatient Surgery	Office: $20 copay per visit; Facility: $250 copay per visit after deductible
Chiropractic (up to 20 visits per year)	$15 copay per visit
Outpatient Mental Health & Substance Abuse	$20 copay per visit
Inpatient Mental Health & Substance Abuse	20% after deductible
Prescription Drug Services	
Retail (30-day Supply) Tier 1 (Preferred generic and certain preferred brand name medications) Tier 2 (Preferred brand name or non-preferred generic medications) Tier 3 (Non-preferred medications) Tier 4 (Specialty medications specialty drugs and other higher-cost drugs)	 $10 copay $30 copay $50 copay $100 copay
Mail-order (100-day Supply) Tier 1 (Preferred generic and certain preferred brand name medications) Tier 2 (Preferred brand name or non-preferred generic medications) Tier 3 (Non-preferred medications)	 $20 copay $60 copay $100 copay

Medical Coverage

Western Health Advantage 1800 HDHP HMO

	1800 HDHP HMO
	In Network
Calendar Year Deductible (Individual/Family)	$1,800 / $3,600 $3,400 Ind. in a family
Calendar Year Out-of-pocket Maximum (Individual/Family)	$3,600 / $7,200 $3,600 Ind. in a family
Preventive Care	0%
Office Visits Telemedicine Primary Care Urgent Care Specialist	 $0 copay after deductible $0 copay after deductible $0 copay after deductible $0 copay after deductible
Emergency Room (copay waived if admitted)	$0 copay after deductible
Hospital Inpatient Services	$0 copay after deductible
Outpatient Surgery	$0 copay after deductible
Chiropractic (up to 20 visits per year)	$0 copay after deductible
Outpatient Mental Health & Substance Abuse	$0 copay after deductible
Inpatient Mental Health & Substance Abuse	$0 copay after deductible
Prescription Drug Services	
Retail (30-day Supply) Tier 1 (Preferred generic and certain preferred brand name medications) Tier 2 (Preferred brand name or non-preferred generic medications) Tier 3 (Non-preferred medications) Tier 4 (Specialty medications specialty drugs and other higher-cost drugs)	 None $30 copay after deductible $50 copay after deductible $100 copay after deductible
Mail-order (90-day Supply) Tier 1 (Preferred generic and certain preferred brand name medications) Tier 2 (Preferred brand name or non-preferred generic medications) Tier 3 (Non-preferred medications)	 None $60 copay after deductible $100 copay after deductible

Medical Coverage

Western Health Advantage 2800 HDHP HMO

	2800 HDHP HMO
	In Network
Calendar Year Deductible (Individual/Family)	$2,800 / $5,600 $3,400 Ind. in a family
Calendar Year Out-of-pocket Maximum (Individual/Family)	$6,500 / $13,000 $6,500 Ind. in a family
Preventive Care	0%
Office Visits Telemedicine Primary Care Urgent Care Specialist	 $40 copay after deductible $40 copay after deductible $50 copay after deductible $40 copay after deductible
Emergency Room (copay waived if admitted)	$100 copay after deductible
Hospital Inpatient Services	$500 per day copay after deductible
Outpatient Surgery	$250 copay after deductible
Chiropractic (up to 20 visits per year)	$0 copay after deductible
Outpatient Mental Health & Substance Abuse	$40 copay after deductible
Inpatient Mental Health & Substance Abuse	$500 per day copay after deductible
Prescription Drug Services	
Retail (30-day Supply) Tier 1 (Preferred generic and certain preferred brand name medications) Tier 2 (Preferred brand name or non-preferred generic medications) Tier 3 (Non-preferred medications) Tier 4 (Specialty medications specialty drugs and other higher-cost drugs)	 $10 copay after deductible $30 copay after deductible $50 copay after deductible $100 copay after deductible
Mail-order (90-day Supply) Tier 1 (Preferred generic and certain preferred brand name medications) Tier 2 (Preferred brand name or non-preferred generic medications) Tier 3 (Non-preferred medications)	 $20 copay after deductible $60 copay after deductible $100 copay after deductible

westernhealth ADVANTAGE | virta

Yes. You *can* reverse type 2 diabetes.

In only one year, Virta patients see an average of[1]:

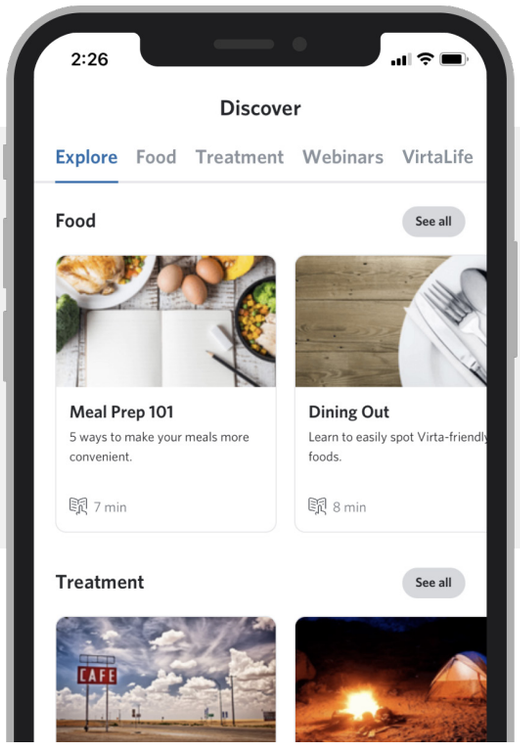
63% medication reduction | **1.3pt** HbA1c reduction | **12%** weight loss

No matter the time of year, if you are part of an eligible plan,* you can enroll in Virta. Virta is a research-backed treatment that can help you lose weight and reverse type 2 diabetes.

The Virta difference

Unlike other diabetes treatments, Virta goes beyond just treating the symptoms of the disease. On Virta, you learn how to change how you eat so that your body burns fat for energy, instead of sugar/carbohydrates. This can help you naturally lower your blood sugar and reduce the need for diabetes medication. It also can help you lose weight and live a healthier life.

Western Health Advantage fully covers the cost of Virta.*



Learn more:

www.virtahealth.com/join/wha

**Virta is available to Western Health Advantage members between the ages of 18 and 79 who are enrolled in an eligible Western Health Advantage health plan. This benefit is currently being offered to those with type 2 diabetes.*

1 Hallberg SJ, McKenzie AL, Williams P, et al. Effectiveness and Safety of a Novel Care Model for the Management of Type 2 Diabetes at One Year: An Open Label, Non-Randomized, Controlled Study. Diabetes Ther. 2018.

Optum

westernhealth ADVANTAGE

Support that puts **you at the center**

When you're going through a tough time, take a moment to pause and remember you don't have to do it alone. Your behavioral health benefits provide support that's personalized to you – wherever you are on your health journey – and make figuring out where to start easy.

Take the first step now.

Scan the code or visit **liveandworkwell.com**. Register or sign in with your HealthSafe ID to access your personalized plan benefits. To browse as a guest, enter access code WHA, or call the number listed on your health plan ID card.

Your behavioral health benefits can help with in-the-moment challenges and ongoing mental health concerns including:

- ADHD
- Anxiety
- Autism
- Compulsive habits
- Coping with grief and loss
- Depression
- Eating disorders
- LGBTQ+ care
- Parenting issues
- Relationship challenges
- Stress
- Substance use disorders
- And more

Explore your behavioral health benefits

With 24/7 in-the-moment support, the Calm Health app, coaching and more, there are plenty of ways to start reducing stress and finding your way to feeling better.

In-the-moment support

Call 800-765-6820 anytime to speak with an emotional wellbeing specialist who'll listen to what you're going through. They can help with stress, anxiety, work-life issues and more.

Help finding the right support

Get connected to the care you need. Our emotional wellbeing specialists make it easier to figure out which programs and support are right for you. You can also visit **liveandworkwell.com** and we'll recommend care options based on your goals and benefits.

Broad behavioral health network

When you need to see a behavioral health provider, you have access to a nationwide network of licensed specialists – including clinicians specializing in substance use, trauma, pediatrics, LGBTQ+ care and more. Appointments are available in person and virtually.

Virtual coaching

Work one-on-one with a dedicated mental health coach for support with depression, anxiety, relationship and self-esteem challenges, ADHD and more. Between online sessions, you'll have unlimited in-app messaging with your coach. It's available at no cost to youth, adults and families.

Support for families

Connect with an emotional wellbeing specialist trained in pediatric and family needs for help understanding your benefits and finding care. Specialists are trained to provide support for school individualized education program (IEP) and 504 plans.

Calm Health

In addition to many features from the popular Calm app, Calm Health includes content and programs created by psychologists to help you work toward wellbeing goals like sleeping better, managing stress, being more resilient, and starting and building a mindfulness habit. It's available through your benefits at no additional cost to you.

Case management and outreach

If you have complex mental health or substance use needs, the Case Management Team can help you coordinate care and achieve wellness goals. They may even reach out if you've been in the hospital or need extra assistance.

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If you or someone you know has thoughts about suicide, seek help right away. To talk with a trained counselor, you can call the 988 Suicide & Crisis Lifeline anytime. If you or someone you know is in immediate danger, call 911 – or go to the closet emergency room.

Calm and Calm Health should not be used for urgent care needs. If you are experiencing a medical emergency, call 911 or go to the nearest emergency room. If you are experiencing a non-life-threatening mental health crisis, call or text 988. Calm and Calm Health are not intended to diagnose or treat depression, anxiety, or any other mental or physical health condition. The use of Calm or Calm Health is not a substitute for care by a physician or other health care provider. Any questions that you may have regarding the diagnosis, care or treatment of a health condition should be directed to your physician or health care provider. Calm and Calm Health are mental wellness products. Participation is voluntary and subject to the Calm and Calm Health terms of use.

Optum does not recommend or endorse any treatment or medications, specific or otherwise. The information provided is for educational purposes only and is not meant to provide medical advice or otherwise replace professional advice. Consult with your clinician, physician or mental health care provider for specific health care needs, treatment or medications. Certain treatments may not be included in your insurance benefits. Check your health plan regarding your coverage of services.

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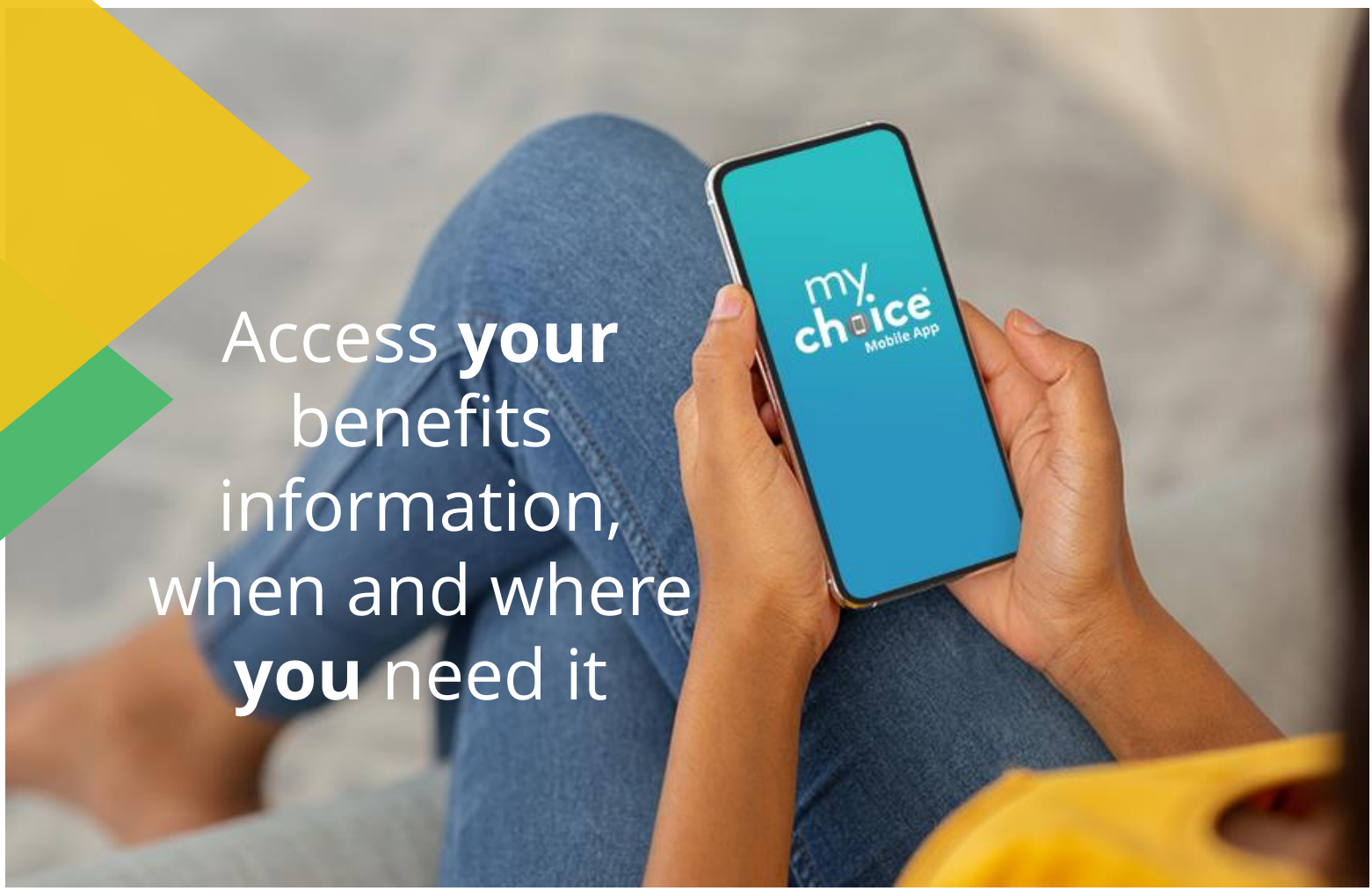
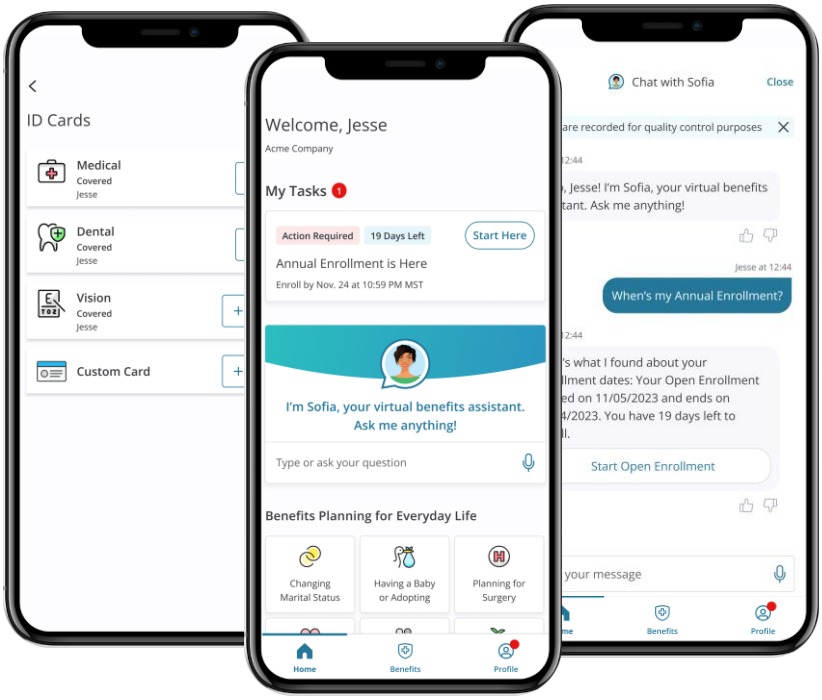


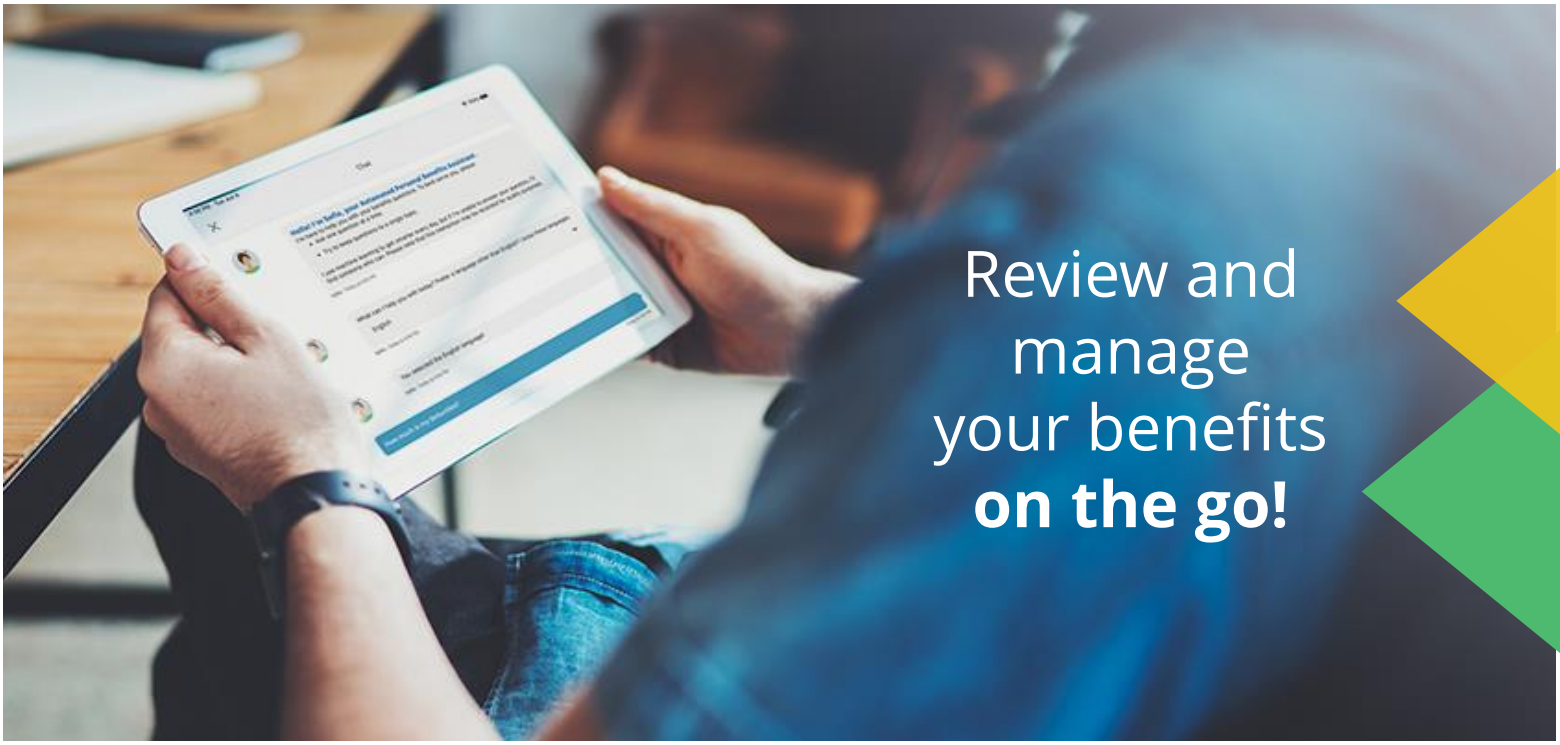
Access **your** benefits information, when and where **you** need it



A sleek design, easy navigation, and access to important messages makes managing your health benefits a breeze.

Schools Insurance Group

mychoice® Mobile App



Access your benefits information on the MyChoice® benefits app!

This is one app that will make your life much easier. Here are some of the valuable features the MyChoice benefits app offers you:

Plan Details – View your medical, dental and vision plans, and voluntary and supplementary benefits.

Beneficiaries – View and change all listed primary and contingent beneficiaries for applicable insurance policies.

Document Upload – Snap and upload important documents in a breeze!

Instant ID Access – Never be caught without your ID card again.

Do all this with a few taps of a finger, plus much more!

mychoice Mobile App

Scan the code to download the MyChoice benefits app to your device today!

Understanding the Difference Between HMO Medical Plans

When it comes to selecting a medical plan, it's important to understand the differences between the options available. This page aims to provide a clear distinction between HMO (Health Maintenance Organization), Deductible HMO, and HDHP (High Deductible Health Plan) plans. By understanding the unique features and benefits of each plan, you can make informed decisions about your healthcare coverage.

Definitions of Medical Plans:

1. **Traditional HMO (Health Maintenance Organization) Plan:**
   - An HMO plan is a type of managed care health insurance plan with in-network coverage only.
   - It requires members to choose a primary care physician (PCP) who coordinates all healthcare services.
   - Referrals from the PCP are typically required to see specialists.
   - The Traditional HMO plan has low out-of-pocket costs and no deductible.

2. **Hospital Only Deductible HMO (DHMO) Plan:**
   - A Hospital Only Deductible HMO plan is a variation of the traditional HMO plan.
   - It operates similarly to an HMO plan, requiring members to choose a primary care physician.
   - Members must meet a deductible before the plan starts covering hospital related services.
   - Once the deductible is met, members pay a 20% coinsurance up to the maximum out-of-pocket.
   - Other services on the plan offers low copays
   - Referrals from the PCP are usually required for specialist visits.

3. **HDHP (High Deductible Health Plan) Plan:**
   - An HDHP plan is a type of health insurance plan with a higher deductible than traditional plans, which must meet the IRS mandated limits.
   - It offers lower monthly premiums but higher out-of-pocket costs.
   - HDHP plans are typically paired with a Health Savings Account (HSA) to help cover medical expenses.
   - The deductible must be met before the plan starts covering most services.
   - Preventive care is covered without requiring the deductible to be met.

Health Savings Account (HSA)

Paying for Health Care

Schools Insurance Group offers several ways to set aside pre-tax dollars to pay for medical, prescription drug, dental and vision care expenses. The health care accounts available to you depend on the medical plan you choose.

	Health Savings Account (HSA)
What medical plan can I choose?	HDHP
What expenses are eligible?	Medical, prescription drug, dental and vision care (See IRS Publication 502 for the types of expenses that may be eligible)
When can I use the funds?	Funds are available as you contribute to the account
Can I roll over funds each year?	Yes, funds roll over from year to year and are yours to keep (even if you leave the company or retire)
How do I pay for eligible expenses?	With your Optum Bank debit card (you can also submit claims for reimbursement online at www.optumbank.com)
How much can I contribute each year?	$4,400 for individual coverage or $8,750 for family coverage (this total includes company funding) and additional $1,000 for catch up contributions in 2026
Can I change my contributions throughout the year?	Yes, you can log on to www.optumbank.com to change your per-paycheck contributions at any time

Note: By law, you are not allowed to contribute to an HSA if you have disqualifying coverage, such as Medicare or a general purpose health FSA.

What Are the Tax Implications of an HSA?

Contributions to your HSA reduce your taxable income, and qualified medical expenses are never taxed. All money set aside in an HSA grows tax-deferred until age 65, when funds can be withdrawn for any non-medical purpose at ordinary tax rates, or tax-free when used for medical expenses. You may contribute additional funds to your HSA ($1,000 per tax year) if you will be 55 years or older by December 31. Learn more at www.optumbank.com.

Spending Accounts

Key Differences:

Plan Type	Does it have a deductible?	When does the deductible apply?	Is it HSA compatible?	Is it FSA compatible?	Can it be paired with voluntary plans?
Traditional HMO	No	N/A	No	Yes*	Yes
Hospital Only Deductible HMO	Yes	Must be met before hospital related services are covered	No	Yes*	Yes
HDHP HMO	Yes	Must be met before most services are covered	Yes	Limited purpose FSA only*	Yes

*Check with your Benefit Coordinator to confirm if your district offers a FSA.

Note: The information provided in the table is a general overview and may vary depending on specific plan details. Employees are encouraged to review their plan documents for accurate and up-to-date information.

Understanding spending accounts like Health Savings Accounts (HSAs) and Flexible Spending Accounts (FSAs) is crucial when selecting a medical plan. Before choosing, consider if the plan is compatible with a spending account. Please review the specific rules and guidelines from your plan administrator for a clear understanding of your spending account options. Consider your healthcare needs, anticipated expenses, and tax implications when deciding which account is most suitable for you.

Definitions of Spending Accounts:

1. **Health Savings Account (HSA)**

   - Only compatible with HDHP Plans
   - Individuals contribute pre-tax dollars
   - HSA funds can be used to pay for qualified medical expenses as deemed by the IRS (Publication 502)
   - HSA funds roll over from year to year and can be taken with you if you change employers or retire
   - HSAs offer the potential for long-term savings and investment growth.
   - Contains annual contribution limits

2. **Flexible Spending Accounts (FSA)**

   - FSAs are an employer-sponsored benefit using pre-tax dollars from an employee's paycheck
   - FSA funds can be used to pay for qualified medical expenses as deemed by the IRS (Publication 502)
   - FSAs have a "use-it-or-lose-it" rule, meaning dollars that are contributed must generally be used by the end of the year.
   - FSAs are not portable
     - Check with your Benefit Coordinator to:
     - Confirm if your district offers an FSA
     - Confirm if your district offers a limited purpose FSA, compatible with an HSA
     - Confirm contribution limits

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Why an HDHP with an HSA may be the right choice for you

Explore reasons for enrolling in a qualifying high-deductible health plan (HDHP) paired with a health savings account (HSA).

When it's time to select your health plan, the choice is usually between two types:

1. A traditional copay plan with a paid provider organization (PPO)
2. A qualifying high-deductible health plan coupled with a health savings account

Choosing an HDHP and funding a health savings account is often the financial winner because you get:

- Income tax-free savings to cover a variety of qualified medical expenses now and into the future
- Typically lower premiums
- More control of your health care dollar

While everyone's plan options are different, when you line them up side by side, a qualifying high-deductible health plan with a funded HSA is the better deal in many scenarios. This can be true for both planned expenses as well as the unplanned. Often, the lower premiums combined with the tax savings end up costing you less than paying the higher premiums and copays in a traditional plan.

Have questions?

Visit optumbank.com or download the mobile app.

Dental Coverage

You are offered dental coverage through Delta Dental. Review the chart below for the amount Delta Dental will pay for the dental service listed.

Delta Dental Plan IIB

	Dental Plan IIB	
	In Network	**Out of Network**
Calendar Year Deductible (Individual/Family)	None	None
Calendar Year Maximum (Per Person)	$2,200	$2,000
Diagnostic & Preventive Services (exams, cleanings and x-rays)	70 - 100%	70 - 100%
Basic Services (fillings, posterior composites and sealants)	70 - 100%	70 - 100%
Major Services (crowns, onlays and cast restorations)	70 - 100%	70 - 100%
Orthodontia	Not Covered	Not Covered

In this incentive plan, Delta Dental pays 70% of the PPO contract allowance for covered diagnostic, preventive and basic services and 70% of the PPO contract allowance for major services during the first year of eligibility. The coinsurance percentage will increase by 10% each year (to a maximum of 100%) for each enrollee if that person visits the dentist at least once during the year. If an enrollee does not use the plan during the calendar year, the percentage remains at the level attained the previous year. If an enrollee becomes ineligible for benefits and later regains eligibility, the percentage will drop back to 70%.

Finding In-network Dentists
You pay less for services when you use a dentist in the Delta Dental network. You can find an in-network dentist by visiting www.DeltaDentalins.com or calling 866.499.3001.

DELTA DENTAL®

SmileWay®
Your smile. Your health. Your way.

Support for chronic conditions

Your plan offers additional dental coverage to support your overall health

Chronic conditions and the medications used to treat them can impact your oral health. If you or a covered family member has been diagnosed with a chronic medical condition like diabetes, cancer or rheumatoid arthritis, you may benefit from additional teeth and gum cleanings.

Take advantage of expanded coverage to help safeguard your oral health. To qualify, you or a covered family member must be diagnosed with any of the following:

- Amyotrophic lateral sclerosis (ALS)
- Cancer
- Chronic kidney disease
- Diabetes
- Heart disease
- HIV/AIDS
- Huntington's disease
- Joint replacement
- Lupus
- Opioid misuse and addiction
- Parkinson's disease
- Rheumatoid arthritis
- Sjögren's syndrome
- Stroke

SmileWay® Wellness Benefits[1]

100% coverage	One periodontal scaling and root planing procedure per quadrant (D4341 or D4342) per calendar or contract year[2]
Four of the following (any combination) per calendar or contract year:[2]	
100% coverage	Prophylaxis (teeth cleaning) (D1110 or D1120)
	Periodontal maintenance procedure (D4910)
	Scaling in presence of moderate or severe gingival inflammation (D4346)

[1] Known as SmileWay Enhanced Benefits in Texas.
[2] This coverage is subject to any applicable maximums and deductibles under the terms and conditions outlined in your plan's Evidence of Coverage. Please review your plan booklet for specific details about your coverage.

Delta Dental PPO™ is underwritten by Delta Dental Insurance Company in AL, DC, FL, GA, LA, MS, MT, NV and UT and by not-for-profit dental service companies in these states: CA — Delta Dental of California; PA, MD – Delta Dental of Pennsylvania; NY — Delta Dental of New York, Inc.; DE — Delta Dental of Delaware, Inc.; WV — Delta Dental of West Virginia, Inc. In Texas, Delta Dental Insurance Company provides a dental provider organization (DPO) plan.

Opt in by visiting
www1.deltadentalins.com/smileway
or by calling Customer Service
Monday through Friday.

deltadentalins.com/enrollees

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EF89A #133959A (rev. 11/22)

Dental Indemnity Plan Coverage

You are offered a dental plan through Personify Health. Review the information below for how this Dental Indemnity Plan will pay for the dental service.

Good dental care is essential to your overall health. The Indemnity Dental Plan, administered by Personify Health, offers flexibility by allowing you to visit any dentist without network restrictions. Reimbursement is based on Usual, Customary, and Reasonable (UCR) charges, ensuring fair coverage for services.

However, this plan does not include dental network discounts, meaning your maximum reimbursement may not go as far as with a network-based plan. While it's a great option for those who currently see an out-of-network dentist and value flexibility, consider the potential impact of higher out-of-pocket costs when choosing your dental care.

Personify Health Dental Indemnity Plan

	Dental Indemnity Plan
	Any Licensed Dental Provider
Calendar Year Deductible (Individual/Family)	None
Calendar Year Maximum (Per Person)	$2,500
Diagnostic & Preventive Services (exams, cleanings and x-rays)	100%
Basic Services (fillings and sealants, endodontics, periodontics, oral surgery)	100%
Major Services (crowns, onlays and cast restorations)	90%
Orthodontia (Dependent children)	50%
Orthodontia Lifetime Maximum (Per Person)	$1,000

personify HEALTH

Everything at your fingertips!

myCareHC

Your all-in-one healthcare platform

Accessing your benefits has never been easier with **myCareHC**—the all-inclusive platform for your healthcare journey by Personify Health. Whether you're looking to track your claims, work on your wellbeing or get answers about your health plan, **myCareHC** has you covered. Visit **myCareHC.com** for online access or use the mobile app!

Scan the QR code to download the **myCareHC** app today!

Use the myCareHC member portal to:

Stay informed. Access important announcements on the home page and receive notifications about programs that match your interests.

Track claims. Access claim information and check claim status on the **My Claims** page.

View your ID card. Access a digital copy of your insurance card anytime, anywhere.

Get help. Connect with Member Services through messaging or live chat. Get answers to questions about your health plan and save important conversations bystarring them.

Find care and costs. Search for providers and compare medical costs, making it even easier to prioritize your healthcare.

© Personify Health 2025 0125

Vision Coverage

Schools Insurance Group's vision plan through VSP covers routine eye exams and helps you pay for glasses or contact lenses. Review the chart below for the amount you will pay for the vision service listed.

Using your VSP Benefit is easy!

1. Register at vsp.com. Once your plan is effective, review your benefit information.
2. Find an eye care provider who's right for you. VSP.com or call 800.877.7195
3. At your appointment, tell them you have VSP. There's no ID card required. If you obtain services from an In-Network provider, there are no claim forms to complete. However, if you obtain services from an Out-of-Network provider, you may need to pay and submit for claims reimbursement according to the schedule below.

VSP Vision Plan 12/12/24 $0 Copayment

	Vision Plan 12/12/24 $0 Copayment	
	In Network	**Out of Network Reimbursements**
Eye Exam (Once every 12 months)	$0 copay	Up to $50
Lenses (Once every 12 months) Single Vision Bifocal Trifocal	 $0 copay $0 copay $0 copay	 Up to $50 Up to $75 Up to $100
Frames (Once every 24 months)	Featured frame brands: $220 allowance; Frame: $200 allowance; 20% savings on the amount over your allowance; Walmart/Sam's Club/Costco frame: $110 allowance	Up to $70
Contact Lenses (Once every 12 months) Contacts Contact lens exam (fitting and evaluation)	 $200 allowance Up to $60 copay	 Up to $105 N/A

Finding In-network Eye Doctors
You can find an in-network eye doctor in the VSP network by visiting www.vsp.com or calling 800.877.7195.

Emotional wellbeing and work-life balance resources to keep you at your best

SupportLinc offers expert guidance to help you and your family address and resolve everyday issues.

In-the-moment support

Reach a licensed clinician by phone 24/7/365 for immediate assistance.

Financial expertise

Consultation and planning with a financial counselor.

Legal consultation

By phone or in-person with a local attorney.

Short-term counseling

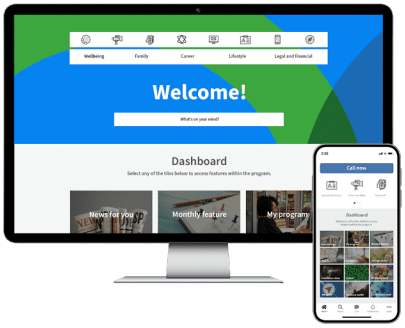
Access up to **three (3) no-cost counseling sessions**, in-person or via video, to resolve stress, depression, anxiety, work-related pressures, relationship issues or substance abuse.

Convenience resources

Referrals for child and elder care, home repair, housing needs, education, pet care and so much more.

Confidentiality

Strict confidentiality standards ensure no one will know you have accessed the program without your written permission except as required by law.



Your web portal and mobile app

- The one-stop shop for program services, information and more.
- Discover on-demand training to boost wellbeing and life balance.
- Find search engines, financial calculators and career resources.
- Explore thousands of articles, tip sheets, self-assessments and videos.

Convenient, on-the-go support

- **Textcoach®**
  Personalized coaching with a licensed counselor on mobile or desktop.
- **Animo**
  Self-guided resources to improve focus, wellbeing and emotional fitness.
- **Virtual Support Connect**
  Moderated group support sessions on an anonymous, chat-based platform

Start with Navigator

Take the guesswork out of your emotional fitness! Visit your web portal or mobile app to complete the short Mental Health Navigator survey. You'll immediately receive personalized guidance to access support and resources.

supportlinc EMPLOYEE ASSISTANCE

Download the mobile app today!

888-881-5462

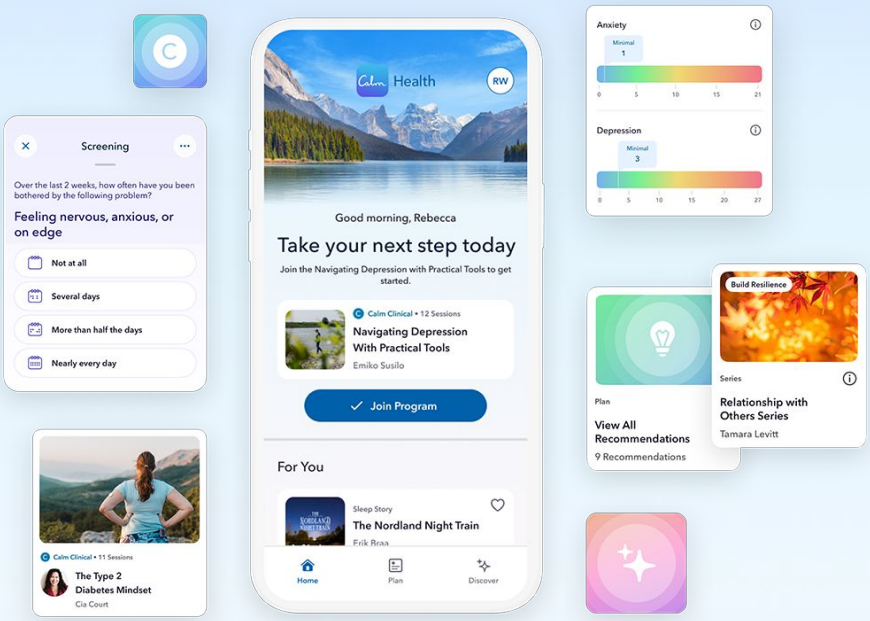
supportlinc.com
group code:
sig

Calm Health

SIGWellness

Introducing Calm Health

Calm Health helps you better understand the relationship between your mental and physical health — and then provides you with a personalized plan to support both.



- Programs developed by psychologists that address life experiences, health conditions, and occupation-specific challenges
- Short screenings to tailor your experience
- Best of Calm resources for mindfulness support
- Personalized recommendations for relevant resources

To download the Calm Health app, scan the QR code or visit the App Store or Google Play Store.

Then, follow the instructions below to sign up:

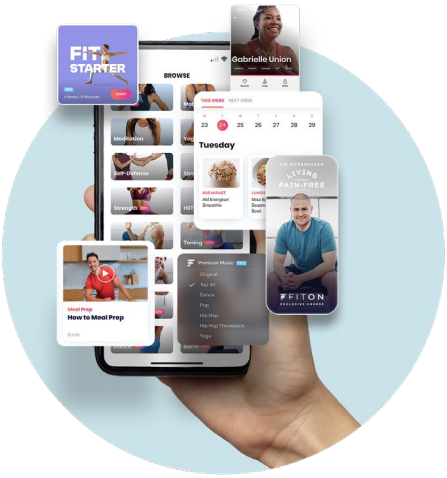
- Log in with your existing Calm account or create a new Calm account
- Enter sigwellness-calm-health as your access code
- Verify your eligibility by entering your First Name, Last Name, and DOB.

Need help? Reach out to the Calm Health Support Team at support@calmhealth.com with any questions.

FITON HEALTH

SIGWellness

#1 Health & Fitness Platform – all in one place. Gain unlimited access to the best digital fitness & wellness content.



Get Started

1. Go to: **fitonhealth.com/register**
2. Enter your email & choose a password
3. Follow the instructions on the next screen to verify your eligibility and complete registration.

Please note that **sign up is not supported on the mobile app**. You must sign up through a web browser at fitonhealth.com/register.

Get Active

After signing in, click the **Digital** tab to access unlimited on-demand workouts, meditations, wellness and nutrition content.

Find exactly what you're in the mood for by browsing all our available options:

- **Genre**: cardio, strength, yoga, etc.
- **Length**: 5, 10, 15, 20, 30 or 45 min
- **Intensity**: low, medium or high
- **Trainer**: choose from 50+ experts
- Challenges, Experiences, and more!

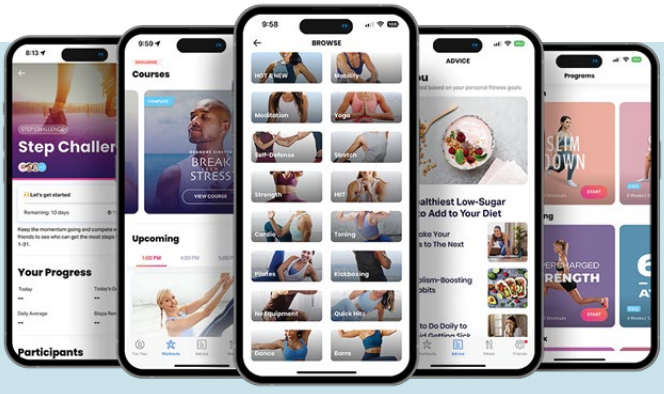
Plus so much more...

On-demand fitness and wellness classes

Nutrition programs with 500+ exclusive recipes

Step & workout challenges to help keep you motivated

Invite & workout with friends and co-workers



Have Questions?

fitonhealth.com/help

support@fitonhealth.com

fitonhealth.com/members






Don't Let Short-Term Decisions Derail Your Long-Term Financial Goals – Let Us Help

SIGWellness

Everyone wants to be financially secure and have the resources they need to live life on their own terms. Like most Americans, you know it's important to take the right steps to be financially secure to protect what matters most to you. The trick is finding the time and know-how to plan for it, and perhaps more important, finding someone you can trust to point you in the right direction.

You can do it. We can help put you on the right path.

Would you be able to cover a $1,000 emergency right now?

59% of Americans don't have enough savings to cover a $1,000 emergency.[1]

If you or your spouse lost your job, how long would your savings last?

41% of individuals describe themselves as feeling financially secure.[1]

Prudential can help you plan for a brighter future

Prudential offers easy-to-understand financial education seminars that addresses important financial issues for every stage of your life.

Hosted by Prudential financial professionals, these seminars are a great way to focus on the financial topics that matter most to you.

Coming Soon

Watch for upcoming seminars that will provide valuable information to help you reach your financial goals.

Reach out to your district Wellness Champ for upcoming seminars or **www.schoolsinsurancegroup.com** under the events section.

Prudential

1046999-00001-00

Experience a clear path to financial planning

People think Prudential's Financial Wellness Education is valuable…[2]

- **96%** would recommend the program to a co-worker or a friend.[3]
- **96%** said the speaker was easy to understand.
- **94%** said the information was valuable.

…And inspirational…

- **97%** plan to maximize their employee benefits.
- **98%** will create a budget.
- **98%** plan to create or update a will.

Do you know how much money you'll need to cover basic expenses when you retire?

The median retirement savings in the US was just $65,000 in 2019.[4]

AARP estimates that you need about 80% of pre-retirement income to retire.[5]

A Convenient Way to Achieve Financial Wellness

Visit **www.prudential.com/SIG** to access articles, tools, and videos on topics such as budgeting, debt management, life insurance, estate planning strategies, college funding, and saving for retirement

This digital portal also includes a web tool that provides individuals support with **student loan debt** and an option to refinance. The student loan assistance tool can be located on the tools page of the digital portal.

Solution to reduce debt and financial stress

If you're struggling with debt and credit issues, you don't have to do it alone – you can take advantage of a free credit counseling & debt management session from GreenPath.

Based on your unique situation, you will receive recommendations for how to get out of debt, along with a personalized action plan. This may include entering into a debt management plan, which carries a monthly service fee, where GreenPath works with you to repay your debt in full.

Call 877-444-5606 to schedule a free debt consultation today.

Planning and Guidance

Prudential's financial professionals are available to meet with you one-on-one to answer questions related to your overall financial wellness and help you understand what you need to accomplish in order to meet your goals. These meetings are 30 minutes in length and complimentary.

[1] Bankrate January 2020 Financial Security Index Survey. https://www.bankrate.com/banking/savings/financial-security-january-2020/

[2] Results based on feedback provided by 55,168 participants from January 2015 through October 2020.

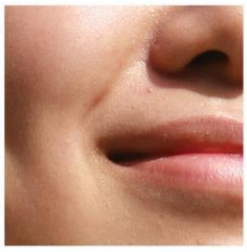
[3] Positive ratings of "very satisfied" or "extremely satisfied."

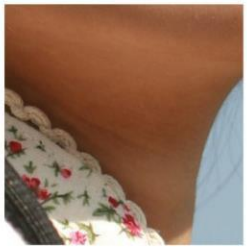
[4] The 2019 Survey of Consumer Finances. https://www.federalreserve.gov/econres/scfindex.htm

[5] AARP - https://www.aarp.org/retirement/planning-for-retirement/info-2020/how-much-money-do-you-need-to-retire.html

Access to GreenPath debt management services and Vault student loan assistance services are provided through Prudential Workplace Solutions Group Services, LLC ("PWSGS"). The student loan assistance services are provided by Student Loan Benefits, Inc., doing business as Vault. GreenPath and Vault are third-party providers that are not subsidiaries or affiliates of Prudential.
Debt Management and credit counseling services and Student loan assistance services are not part of any employee benefit plan and are provided through a voluntary, individually selected program that is not a group insurance product or a retirement product. Access to Financial Wellness products, services, seminars and tools is not conditioned upon the purchase of insurance or retirement products or services from any Prudential company.
Prudential Workplace Solutions Group Services, LLC ("PWSGS") provides access to a number of Financial Wellness products, services, seminars and tools offered by PWSGS, its affiliates or third parties. PWSGS is a subsidiary of Prudential Financial, Inc. PWSGS is not a licensed insurance company, does not provide insurance products or services and does not provide financial, investment or other advice. Individuals should consult appropriate professionals when making financial, investment and tax decisions.
Prudential, the Prudential logo, the Rock symbol, and Prudential Pathways are service marks of Prudential Financial, Inc., and its related entities, registered in many jurisdictions worldwide.






2026

Annual Enrollment Notices & Disclosures

Eureka Union

SIG Schools Insurance Group

Table of Contents

Legal Notices & Disclosures — Page

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please see pages 11-13 where Notice of Creditable Coverage begin for more details.

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PATIENT PROTECTIONS DISCLOSURE

The Eureka Union Health Plan generally requires the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. Until you make this designation, Kaiser Permanente / Sutter Health Plan / Western Health Advantage designates one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the Kaiser Permanente at 800.464.4000 or www.kp.org / Sutter Health Plan at 855.315.5800 or www.SutterHealthPlan.org / Western Health Advantage at 888.563.2250 or www.ChooseWHA.com/SIG

For children, you may designate a pediatrician as the primary care provider.
You do not need prior authorization from Kaiser Permanente / Sutter Health Plan / Western Health Advantage / Blue Shield of CA or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the Kaiser Permanente at 800.464.4000 or www.kp.org / Sutter Health Plan at 855.315.5800 or www.SutterHealthPlan.org / Western Health Advantage at 888.563.2250 or www.ChooseWHA.com/SIG

WOMEN'S HEALTH & CANCER RIGHTS ACT

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 ("WHCRA"). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

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

If you would like more information on WHCRA benefits, please call your Plan Administrator at 916.774.1206 or humanresources@eurekausd.org.

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NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

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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 **1-877-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 **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2026. Contact your State for more information on eligibility –

ALABAMA – Medicaid	ALASKA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid	**CALIFORNIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	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 (CHP+)	**FLORIDA – Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

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GEORGIA – Medicaid	INDIANA – 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	Health Insurance Premium Payment Program All other Medicaid Website: https://www.in.gov/medicaid/ http://www.in.gov/fssa/dfr/ Family and Social Services Administration Phone: 1-800-403-0864 Member Services Phone: 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	**KANSAS – Medicaid**
Medicaid Website: Iowa Medicaid | Health & Human Services Medicaid Phone: 1-800-338-8366 Hawki Website: Hawki - Healthy and Well Kids in Iowa | Health & Human Services Hawki Phone: 1-800-257-8563 HIPP Website: Health Insurance Premium Payment (HIPP) | Health & Human Services (iowa.gov) HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
KENTUCKY – Medicaid	**LOUISIANA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kynect.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	Louisiana Medicaid Website: https://www.ldh.la.gov/healthy-louisiana Medicaid Customer Service Line: 1-888-342-6207 Louisiana Medicaid email: healthy@la.gov Louisiana Health Insurance Premium Program (LaHIPP) Website: https://www.ldh.la.gov/lahipp LaHIPP phone: 1-877-697-6703 LaHIPP email: La.HIPP@la.gov LaHIPP fax: 1-888-716-9787 LaHIPP mailing address: 100 Crescent Centre Parkway, Suite 1000 Tucker, GA 30084
MAINE – Medicaid	**MASSACHUSETTS – Medicaid and CHIP**
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid	**MISSOURI – Medicaid**
Website: https://mn.gov/dhs/health-care-coverage/ Phone: 1-800-657-3672	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005

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MONTANA – Medicaid	NEBRASKA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
NEVADA – Medicaid	**NEW HAMPSHIRE – Medicaid**
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 15218 Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov
NEW JERSEY – Medicaid and CHIP	**NEW YORK – Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Phone: 1-800-356-1561 CHIP Premium Assistance Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710 (TTY: 711)	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**OREGON – Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	**RHODE ISLAND – Medicaid and CHIP**
Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	**SOUTH DAKOTA - Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059

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TEXAS – Medicaid	UTAH – Medicaid and CHIP
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493	Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/ Email: upp@utah.gov Phone: 1-888-222-2542 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	**VIRGINIA – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427	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/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP	**WYOMING – Medicaid**
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since January 31, 2026, or for more information on special enrollment rights, contact either:

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

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

Paperwork Reduction Act Statement

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

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

OMB Control Number 1210-0137 (expires 3/31/2026)

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HIPAA NOTICE OF PRIVACY PRACTICES REMINDER

Protecting Your Health Information Privacy Rights
Eureka Union is committed to the privacy of your health information. The administrators of the Eureka Union Health Plan (the "Plan") use strict privacy standards to protect your health information from unauthorized use or disclosure.

The Plan's policies protecting your privacy rights and your rights under the law are described in the Plan's Notice of Privacy Practices. You may receive a copy of the Notice of Privacy Practices by contacting Human Resources at 916.774.1206 or humanresources@eurekausd.org.

HIPAA SPECIAL ENROLLMENT RIGHTS

Eureka Union Health Plan Notice of Your HIPAA Special Enrollment Rights

Our records show that you are eligible to participate in the Eureka Union Health Plan (to actually participate, you must complete an enrollment form and pay part of the premium through payroll deduction).

A federal law called HIPAA requires that we notify you about an important provision in the plan - your right to enroll in the plan under its "special enrollment provision" if you acquire a new dependent, or if you decline coverage under this plan for yourself or an eligible dependent while other coverage is in effect and later lose that other coverage for certain qualifying reasons.

Loss of Other Coverage (Excluding Medicaid or a State Children's Health Insurance Program). If you decline enrollment for yourself or for an eligible dependent (including your spouse) while other health insurance or group health plan coverage is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 31 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

Loss of Coverage for Medicaid or a State Children's Health Insurance Program. If you decline enrollment for yourself or for an eligible dependent (including your spouse) while Medicaid coverage or coverage under a state children's health insurance program is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within 60 days after your or your dependents' coverage ends under Medicaid or a state children's health insurance program.

New Dependent by Marriage, Birth, Adoption, or Placement for Adoption. If you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your new dependents. However, you must request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

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Eligibility for Premium Assistance Under Medicaid or a State Children's Health Insurance Program – If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan, you may be able to enroll yourself and your dependents in this plan. However, you must request enrollment within 60 days after your or your dependents' determination of eligibility for such assistance.

To request special enrollment or to obtain more information about the plan's special enrollment provisions, contact Human Resources at 916.774.1206 or humanresources@eurekausd.org.

Important Warning

If you decline enrollment for yourself or for an eligible dependent, you must complete our form to decline coverage. On the form, you are required to state that coverage under another group health plan or other health insurance coverage (including Medicaid or a state children's health insurance program) is the reason for declining enrollment, and you are asked to identify that coverage. If you do not complete the form, you and your dependents will not be entitled to special enrollment rights upon a loss of other coverage as described above, but you will still have special enrollment rights when you have a new dependent by marriage, birth, adoption, or placement for adoption, or by virtue of gaining eligibility for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan, as described above. If you do not gain special enrollment rights upon a loss of other coverage, you cannot enroll yourself or your dependents in the plan at any time other than the plan's annual open enrollment period, unless special enrollment rights apply because of a new dependent by marriage, birth, adoption, or placement for adoption, or by virtue of gaining eligibility for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan.

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NOTICE OF CREDITABLE COVERAGE

Important Notice from Eureka Union

About Your Prescription Drug Coverage and Medicare

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

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

1. **Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.**
2. **Eureka Union has determined that the prescription drug coverage offered by the 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 Eureka Union coverage will not be affected. You can keep this coverage if you elect part D.

If you do decide to join a Medicare drug plan and drop your current Eureka Union coverage, be aware that you and your dependents may be able to get this coverage back.

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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 Eureka Union 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 Eureka Union changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage…

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

For more information about Medicare prescription drug coverage:

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

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit 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).

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Date: July 01, 2026
Name of Entity/Sender: Eureka Union
Contact—Position/Office: Human Resources
Office Address: 5455 Eureka Road
Granite Bay 95746
Phone Number: 916.774.1206

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COBRA GENERAL NOTICE

Model General Notice of COBRA Continuation Coverage Rights
(For use by single-employer group health plans)

**** Continuation Coverage Rights Under COBRA****

Introduction

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

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

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

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

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

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

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

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

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

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

When is COBRA continuation coverage available?

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

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

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to: Human Resources.

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How is COBRA continuation coverage provided?

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

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

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

Disability extension of 18-month period of COBRA continuation coverage

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

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

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

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicare, 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/**.

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

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period[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.

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

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

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

If you have questions

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

Keep your Plan informed of address changes

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

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

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Plan contact information

Eureka Union
Human Resources
5455 Eureka Road
Granite Bay 95746
916.774.1206

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MARKETPLACE NOTICE

Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: General Information

Even if you are offered health coverage through your employment, you may have other coverage options through the Health Insurance Marketplace ("Marketplace"). To assist you as you evaluate options for you and your family, this notice provides some basic information about the Health Insurance Marketplace and health coverage offered through your employment.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options in your geographic area.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium and other out-of-pocket costs, but only if your employer does not offer coverage, or offers coverage that is not considered affordable for you and doesn't meet certain minimum value standards (discussed below). The savings that you're eligible for depends on your household income. You may also be eligible for a tax credit that lowers your costs.

Does Employment-Based Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that is considered affordable for you and meets certain minimum value standards, you will not be eligible for a tax credit, or advance payment of the tax credit, for your Marketplace coverage and may wish to enroll in your employment-based health plan. However, you may be eligible for a tax credit, and advance payments of the credit that lowers your monthly premium, or a reduction in certain cost-sharing, if your employer does not offer coverage to you at all or does not offer coverage that is considered affordable for you or meet minimum value standards. If your share of the premium cost of all plans offered to you through your employment is more than 9.12%[1] of your annual household income, or if the coverage through your employment does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit, and advance payment of the credit, if you do not enroll in the employment-based health coverage. For family members of the employee, coverage is considered affordable if the employee's cost of premiums for the lowest-cost plan that would cover all family members does not exceed 9.12% of the employee's household income.[1] [2]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered through your employment, then you may lose access to whatever the employer contributes to the employment-based coverage. Also, this employer contribution -as well as your employee contribution to employment-based coverage- is generally excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis. In addition, note that if the health coverage offered through your employment does not meet the affordability or minimum value standards, but you accept that coverage anyway, you will not be eligible for a tax credit. You should consider all of these factors in determining whether to purchase a health plan through the Marketplace.

[1] Indexed annually; see https://www.irs.gov/pub/irs-drop/rp-22-34.pdf for 2023.

[2] An employer-sponsored or other employment-based health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs. For purposes of eligibility for the premium tax credit, to meet the "minimum value standard," the health plan must also provide substantial coverage of both inpatient hospital services and physician services.

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When Can I Enroll in Health Insurance Coverage through the Marketplace?

You can enroll in a Marketplace health insurance plan during the annual Marketplace Open Enrollment Period. Open Enrollment varies by state but generally starts November 1 and continues through at least December 15.

Outside the annual Open Enrollment Period, you can sign up for health insurance if you qualify for a Special Enrollment Period. In general, you qualify for a Special Enrollment Period if you've had certain qualifying life events, such as getting married, having a baby, adopting a child, or losing eligibility for other health coverage. Depending on your Special Enrollment Period type, you may have 60 days before or 60 days following the qualifying life event to enroll in a Marketplace plan.

There is also a Marketplace Special Enrollment Period for individuals and their families who lose eligibility for Medicaid or Children's Health Insurance Program (CHIP) coverage on or after March 31, 2023, through July 31, 2024. Since the onset of the nationwide COVID-19 public health emergency, state Medicaid and CHIP agencies generally have not terminated the enrollment of any Medicaid or CHIP beneficiary who was enrolled on or after March 18, 2020, through March 31, 2023. As state Medicaid and CHIP agencies resume regular eligibility and enrollment practices, many individuals may no longer be eligible for Medicaid or CHIP coverage starting as early as March 31, 2023. The U.S. Department of Health and Human Services **is offering a temporary Marketplace Special Enrollment period to allow these individuals to enroll in Marketplace coverage.**

Marketplace-eligible individuals who live in states served by HealthCare.gov and either- submit a new application or update an existing application on HealthCare.gov between March 31, 2023 and July 31, 2024, and attest to a termination date of Medicaid or CHIP coverage within the same time period, are eligible for a 60-day Special Enrollment Period. **That means that if you lose Medicaid or CHIP coverage between March 31, 2023, and July 31, 2024, you may be able to enroll in Marketplace coverage within 60 days of when you lost Medicaid or CHIP coverage.** In addition, if you or your family members are enrolled in Medicaid or CHIP coverage, it is important to make sure that your contact information is up to date to make sure you get any information about changes to your eligibility. To learn more, visit HealthCare.gov or call the Marketplace Call Center at 1-800-318-2596. TTY users can call 1-855-889-4325.

What about Alternatives to Marketplace Health Insurance Coverage?

If you or your family are eligible for coverage in an employment-based health plan (such as an employer-sponsored health plan), you or your family may also be eligible for a Special Enrollment Period to enroll in that health plan in certain circumstances, including if you or your dependents were enrolled in Medicaid or CHIP coverage and lost that coverage. Generally, you have 60 days after the loss of Medicaid or CHIP coverage to enroll in an employment-based health plan, but if you and your family lost eligibility for Medicaid or CHIP coverage between March 31, 2023 and July 10, 2023, you can request this special enrollment in the employment-based health plan through September 8, 2023. Confirm the deadline with your employer or your employment-based health plan.

Alternatively, you can enroll in Medicaid or CHIP coverage at any time by filling out an application through the Marketplace or applying directly through your state Medicaid agency. Visit https://www.healthcare.gov/medicaid-chip/getting-medicaid-chip/ for more details.

How Can I Get More Information?

For more information about your coverage offered through your employment, please check your health plan's summary plan description or contact Human Resources.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit **HealthCare.gov** for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

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PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer name Eureka Union		4. Employer Identification Number (EIN) 94-6002089
5. Employer address 5455 Eureka Road		6. Employer phone number 916.774.1206
7. City Granite Bay	8. State California	9. ZIP code 95746
10. Who can we contact about employee health coverage at this job? Human Resources		
11. Phone number (if different from above)	12. Email address humanresources@eurekausd.org	

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:

  ☐ All employees. Eligible employees are:

  X Some employees. Eligible employees are:
  Full or Part Time employees working 20 or more hours per week

- With respect to dependents:
  X We do offer coverage. Eligible dependents are:
  Same and opposite sex Spouse
  Same sex Domestic Partner (registered with the State)
  Dependent Children up to age 26 for medical coverage

  ☐ We do not offer coverage.

X If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, **HealthCare.gov** will guide you through the process. Here's the employer information you'll enter when you visit **HealthCare.gov** to find out if you can get a tax credit to lower your monthly premiums.

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Disclaimer

The amount the plan pays for covered services provided by non-network providers is based on a maximum allowable amount for the specific service rendered. Although your plan stipulates an out-of-pocket maximum for out-of-network services, please note the maximum allowed amount for an eligible procedure may not be equal to the amount charged by your out-of-network provider. Your out-of-network provider may bill you for the difference between the amount charged and the maximum allowed amount. This is called balance billing and the amount billed to you can be substantial. The out-of-pocket maximum outlined in your policy will not include amounts in excess of the allowable charge and other non-covered expenses as defined by your plan. The maximum reimbursable amount for non-network providers can be based on a number of schedules such as a percentage of reasonable and customary or a percentage of Medicare. The plan document or carrier's master policy is the controlling document, and this Benefit Highlight does not include all of the terms, coverage, exclusions, limitations, and conditions of the actual plan language. Contact your claims payer or insurer for more information.

This document is an outline of the coverage proposed by the carrier(s), based on information provided by your company. It does not include all of the terms, coverage, exclusions, limitations, and conditions of the actual contract language. The policies and contracts themselves must be read for those details. Policy forms for your reference will be made available upon request.

The intent of this document is to provide you with general information regarding the status of, and/or potential concerns related to, your current employee benefits environment. It does not necessarily fully address all of your specific issues. It should not be construed as, nor is it intended to provide, legal advice. Questions regarding specific issues should be addressed by your general counsel or an attorney who specializes in this practice area.

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