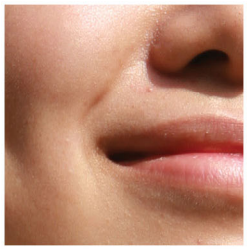
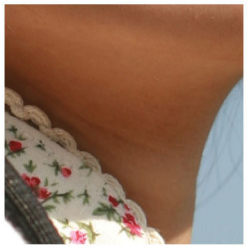




Western Placer Unified School District

Employee Benefit Guide
Effective July 1, 2021—June 30, 2022

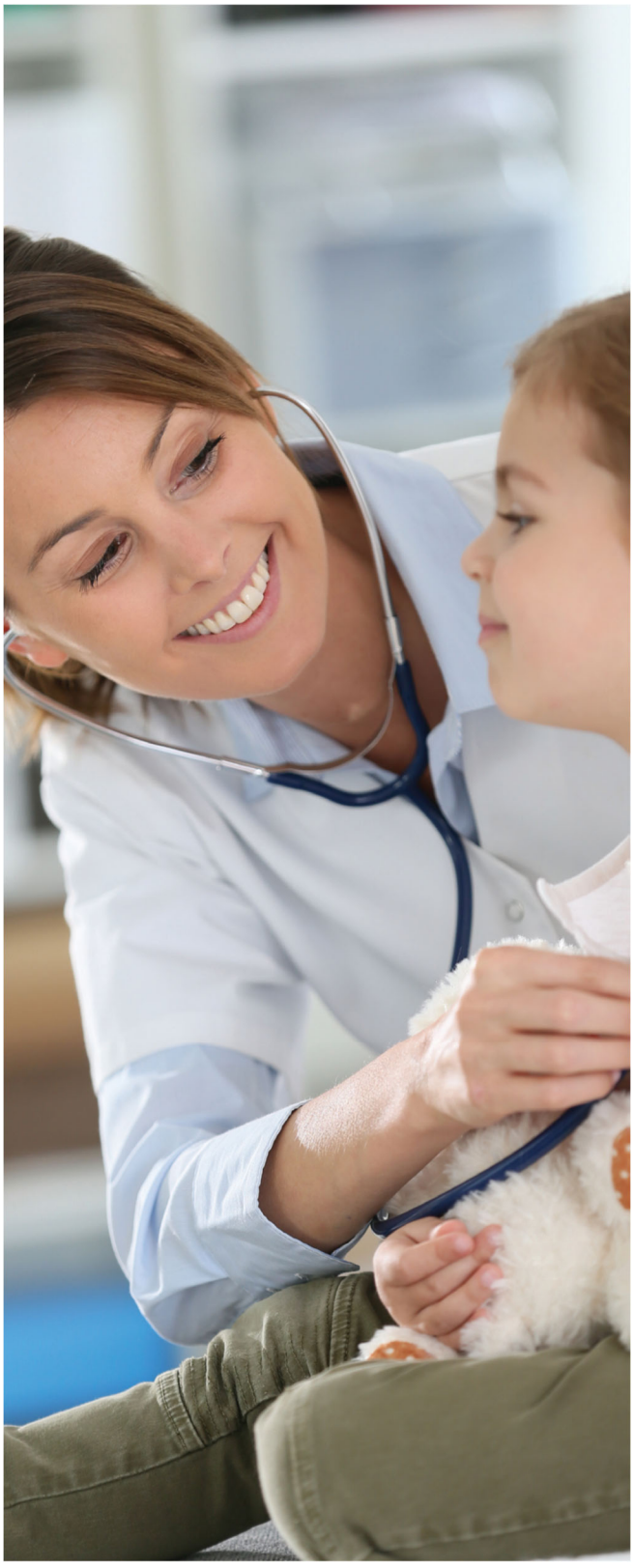
Schools Insurance Group

Who To Contact

The quickest way to find answers to your benefits questions is to go directly to the source. This contact list includes web addresses and phone numbers for the administrators of each of our benefit plans. The insurance company can verify benefits and coverage or copayment information. We suggest you contact the insurance company prior to seeking care should you have any questions regarding your benefits.

BENEFIT AND CARRIER	MEMBER SERVICES	WEBSITE
MEDICAL		
Kaiser	800-464-4000	www.kp.org
Western Health Advantage	888-563-2250	www.ChooseWHA.com/SIG
Sutter Health Plus	855-315-5800	www.SutterHealthPlus.org/schools-insurance-group.html
Blue Shield of CA PPO	855-599-2649	www.BlueShieldCA.com
Blue Shield of CA TRIO ACO HMO	855-829-3566	www.BlueShieldCA.com
DENTAL		
Delta Dental	866-499-3001	www.DeltaDentalins.com
VISION		
Vision Service Plan	800-877-7195	www.vsp.com
LIFE AND DISABILITY		
The Hartford	Contact your District Benefit Coordinator for more info.	
HEALTH SAVINGS ACCOUNT (HSA)		
Optum Bank	844-326-7967	www.optumbank.com
SCHOOLS INSURANCE GROUP	800-442-4199	www.SchoolsInsuranceGroup.com
Kelley Henry	Ext. 201	KelleyH@SIGAuburn.com
Melissa Gianopulos	Ext. 202	MelissaG@SIGAuburn.com

In this Guide



About This Guide

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

This guide has been prepared to assist you in making informed decisions regarding your employee benefits. We urge you to read this guide carefully and keep it as a reference.

Great care has been taken to ensure that this guide is accurate. However, oversights can occur or condensed summaries can be misinterpreted. If there is a difference between this overview and the official plan documents governing the plans, the plan documents will prevail.

The benefit highlights in this Guide are summaries of the most frequently asked about benefits. The charts do not explain out-of-pocket maximums, exclusions, or limitations, nor does it list all benefits and Cost Sharing. For a complete explanation, please refer to the EOC (Evidence of Coverage).

Eligibility for Benefits

Please check with your school district for information on your eligibility date. The following family members may be enrolled in the medical, dental and vision programs:

- Your legal spouse
- Your qualified domestic partner (under California law)
- Your children or the children of your qualified domestic partner until age 26 on medical, dental and vision

For the purpose of our benefit plans, your children include:

- Your dependent child who is incapable of self support because of a mental or physical disability
- Natural and adopted children
- Stepchildren
- Any other children you support for whom you are the legal guardian or for whom you are required to provide coverage as the result of a qualified medical child support order

Making Changes to Your Benefits

During Open Enrollment you can change your benefit choices. Open Enrollment is during the months prior to your benefits renewal and includes changes which are effective July 1st. Your decisions remain in effect for twelve months unless you have a qualifying life event as defined by the IRS. Qualifying events include:

- The addition of a dependent through birth, adoption or marriage
- The loss of other “group” coverage
- The loss of a dependent through divorce or death, or if your child reaches the maximum age limit for coverage
- A change in you or your spouse’s employment status from full-time to part-time or vice versa
- A change in your employment
- A substantial change in your benefits coverage or a spouse’s coverage
- The addition or separation of a qualified domestic partner
- Change in eligibility for Medicaid or Children’s Health Insurance Program (CHIP) subsidy

Any benefit changes must be consistent with the type of event you experience. If you gain a dependent, you can add them to your benefits but that qualifying event does not allow you to drop another dependent from benefits. For example, if you have a baby, you can add the baby to your medical plan but you could not drop a spouse from the plan.

If you experience a family status change and want to change your benefits, you MUST contact Human Resources **within 30 days of the status change.**

Blue Shield of CA — Networks

Trio ACO HMO Network

Blue Shield of California has partnered with providers and hospitals in the Trio Network to ensure that all aspects of patient care is more connected. Working together with Blue Shield, providers in the Trio ACO HMO Network are committed to delivering a better coordinated, effective, and efficient care experience to members. Nevada County Trio ACO HMO Network includes:

- Hill Physicians Medical Group
- Mercy Medical Group (Includes Dignity)
- Sierra Nevada Memorial Hospital

Like a traditional HMO, your PCP will direct your care and provide referrals to specialists.

To find a doctor or medical groups in other counties, please visit www.blueshieldca.com/networkTrioHMO or call 855-829-3566.

trio HMO

PPO Network

National PPO network that includes Dignity Health, Sutter Health, and UC Davis. You have access to in and out of network providers and facilities, but you will get the most coverage when accessing in-network providers and facilities. You do not need a referral to see a specialist, but you can manage your own care with the assistance of tools that can be found on the website, using the app, or calling member services.

To find a doctor or facility, please visit www.blueshieldca.com or call 888-256-1915.

Blue Shield of CA Trio ACO HMO

Services with the Blue Shield **Trio HMO** plan must be obtained from a participating provider or hospital and is only available for employees in California. The doctor you choose must be a primary care physician (PCP) - Internal Medicine, Family/General Medicine or Pediatric Medicine. Your PCP will refer you to see a specialist when needed. The information listed is only a brief summary. For complete details refer to the carrier plan documents. Visit www.BlueShieldCA.com/networktriohmo or call 855-829-3566 to find Blue Shield TRIO participating providers.

Medical Plan Options	**Trio HMO—Narrow Network**
Calendar Year Deductible	$1,500 Individual / $3,000 Family
Calendar Year Out-of-Pocket Maximum	$2,000 Individual / $4,000 Family
Preventive Services	
Routine Preventive Care / Physical Examinations	No Charge
Well-Child Visits	No Charge
Prenatal Care Visits and First Postpartum Visit	No Charge
Professional Services	
Primary Care Visits / Specialty Care Visits	$15 copay
Teladoc Consultation	$0 per consult
Chiropractic & Acupuncture Benefits	30 visits combined per year—$10 per visit
Outpatient Services	
Outpatient Surgery / Outpatient Procedures	5% ambulatory surgery center / 15% hospital setting after deductible
Urgent care center	$15 copay
X-Ray	No Charge
Lab Tests	No Charge
MRI, CT Scans, PET Scans	No Charge
Hospitalization	
Hospital inpatient services	10% coinsurance after deductible
Emergency Room	$100 copay
Ambulance Services	$100 copay
Behavioral Health Services	
Outpatient mental health & substance abuse	$15 per visit
Inpatient mental health & substance abuse	10% coinsurance after deductible
Prescription Drug Services	**Plan Pharmacy (up to 30 days)**
Tier 1	$15 per prescription
Tier 2	$30 per prescription
Tier 3	$45 per prescription
Tier 4	20% up to $250 per Rx
Mail Order	2 times above copay, up to 90 day supply

Blue Shield of CA PPO—$2800 HDHP

HSA Compatible

Medical Plan Options	Full PPO Savings Embedded Deductible 2700 / 2800 / 5200	
	In-Network	**Out-of-Network**
Calendar Year Deductible	$2,700 Ind. / $2,800 Ind. In a Family / $5,200 Family	
Calendar Year Out-of-Pocket Maximum	$5,000 Ind. / $10,000 Fam.	$10,000 Ind. / $20,000 Fam.
Preventive Services	No Charge	Not Covered
Professional Services	***AFTER DEDUCTIBLE***	***AFTER DEDUCTIBLE***
Primary Care Visits / Specialty Care Visits	20% coinsurance	40% coinsurance
Teladoc Consultation	$0 per consult	Not Covered
Outpatient Services		
Outpatient Surgery / Outpatient Procedures	10% ambulatory surgery center / 20% hospital setting	40% coinsurance
Urgent care center	20% coinsurance	40% coinsurance
X-Ray	20% coinsurance	40% coinsurance
Lab Tests	20% coinsurance	40% coinsurance
MRI, CT Scans, PET Scans	20% coinsurance	40% coinsurance
Hospitalization		
Hospital inpatient services	$100 per admit + 20% coinsurance	40% coinsurance
Emergency Room	$100 per visit + 20% coinsurance	$100 per visit + 20% coinsurance
Behavioral Health Services		
Outpatient mental health & substance abuse	20% coinsurance	40% coinsurance
Inpatient mental health & substance abuse	$100 per admit + 20% coinsurance	40% coinsurance
Prescription Drug Services	**Participating Pharmacy**	**Non-Participating Pharmacy**
Tier 1	$10 copay	25% + $10 copay
Tier 2	$25 copay	25% + $25 copay
Tier 3	$40 copay	25% + $40 copay
Tier 4	30% coinsurance up to $250 per Rx	30% coins. up to $250 + 25% per Rx
Mail Order	2x copay for up to 90 day supply	Not Covered

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 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 schedules such as a percentage of reasonable and customary or a percentage of Medicare. Contact your claims payer or insurer for more information. 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.

Blue Shield of CA PPO—$4000 HDHP

HSA Compatible

Medical Plan Options	Full PPO Savings Embedded Deductible 4000	
	In-Network	**Out-of-Network**
Calendar Year Deductible	$4,000 Ind. / $8,000 Fam.	
Calendar Year Out-of-Pocket Maximum	$5,500 Ind. / $11,000 Fam.	$10,000 Ind. / $20,000 Fam.
Preventive Services	No Charge	Not Covered
Professional Services	***AFTER DEDUCTIBLE***	***AFTER DEDUCTIBLE***
Primary Care Visits / Specialty Care Visits	20% coinsurance	50% coinsurance
Teladoc Consultation	$0 per consult	Not Covered
Outpatient Services		
Outpatient Surgery / Outpatient Procedures	10% ambulatory surgery center / 20% hospital setting	50% coinsurance
Urgent care center	20% coinsurance	50% coinsurance
X-Ray	20% coinsurance	50% coinsurance
Lab Tests	20% coinsurance	50% coinsurance
MRI, CT Scans, PET Scans	20% coinsurance	50% coinsurance
Hospitalization		
Hospital inpatient services	$100 per admit + 20% coinsurance	50% coinsurance
Emergency Room	$100 per visit + 20% coinsurance	$100 per visit + 20% coinsurance
Behavioral Health Services		
Outpatient mental health & substance abuse	20% coinsurance	50% coinsurance
Inpatient mental health & substance abuse	$100 per admit + 20% coinsurance	50% coinsurance
Prescription Drug Services	**Participating Pharmacy**	**Non-Participating Pharmacy**
Tier 1	$10 copay	25% + $10 copay
Tier 2	$25 copay	25% + $25 copay
Tier 3	$40 copay	25% + $40 copay
Tier 4	30% coinsurance up to $250 per Rx	30% coins. up to $200 + 25% per Rx
Mail Order	2x copay for up to 90 day supply	Not Covered

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 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 schedules such as a percentage of reasonable and customary or a percentage of Medicare. Contact your claims payer or insurer for more information. 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.

Blue Shield of California offers Teladoc:
Access to licensed doctors 24/7 by phone or video

Get care when and where you need it through your Blue Shield health plan. As a Blue Shield member, you have access to Teladoc's national network of U.S. board-certified physicians, licensed in California. Whenever you need care, Teladoc® doctors are available 24/7 by phone or video.

Use Teladoc

- If you're considering the ER or urgent care center for a non-emergency
- When on vacation, a business trip, or away from home
- For short-term prescription refills

Get the care you need

Teladoc doctors can treat many medical conditions including:

- Cold and flu symptoms
- Allergies
- Bronchitis
- Respiratory infection
- Sinus problems
- And more

Meet the doctors

All Teladoc doctors:

- Are practicing primary care physicians, pediatricians, and family physicians
- Have an average of 20 years of experience
- Are board certified and licensed
- Are credentialed every three years

Get started with Teladoc

❶ Set up account

Visit **www.teladoc.com/bsc**, complete the required information, and click on *Set up account*. You can also call Teladoc at **1-800-Teladoc** (835-2362) for help.

❷ Provide medical history

Your medical history provides Teladoc doctors with the information they need to make an accurate diagnosis.

Web: Log in to **www.teladoc.com/bsc** and click *Update medical history*.

Mobile: Visit **Teladoc.com/mobile** to download the app. Log in, go to the menu icon on the top left, and click *Medical Info*.

Phone: Teladoc can help you complete your medical history over the phone. Call **1-800-Teladoc** (835-2362).

❸ Request a consult

Once your account is set up, request a consult anytime you need care.

Trio HMO/PPO

Talk to a doctor anytime for a copay of $0

Mail service prescriptions

Blue Shield of California provides access to the mail service drug benefit through CVS Caremark Mail Service Pharmacy™. It offers you the convenience of receiving up to a 90-day supply of covered maintenance drugs,* delivered to your home or office, with no charge for shipping. Using mail service can save you money, too. For some plans, when you order a 90-day supply of covered maintenance drugs, you pay only for the cost of two 30-day supplies at a participating retail pharmacy. Please consult your plan and benefit documents.

Filling your prescription through the mail service pharmacy is easy

Step 1: Register with CVS Caremark

To receive covered medications from CVS Caremark, you must first register and provide basic information such as your name, shipping address, payment method, and drug allergies. You can register:

- **Online** – At www.caremark.com.
- **By phone** – Call CVS Caremark at (866) 346-7200 [TTY: 711].
- **By mail** – Print and complete the CVS Caremark mail service order form by going to **blueshieldca.com/pharmacy**, clicking on *Member resources,* and selecting *Pharmacy forms.*

Step 2: Send your prescription to CVS Caremark

Once you are registered, CVS Caremark will need your prescription. You can send it:

- **Electronically** – Ask your doctor to send an electronic prescription for a 90-day supply to CVS Caremark. This is called "e-prescribing" and is the simplest way to send a prescription.
- **By phone or fax** – Ask your doctor to submit your prescription for a 90-day supply to CVS Caremark by calling (800) 378-5697 or faxing (800) 378-0323.
- **By mail** – Mail your prescription, completed mail service order form, and payment to:

  CVS Caremark
  P.O. BOX 659541
  San Antonio, TX 78265-9541

Step 3: CVS Caremark delivers

Please allow 10 to 14 business days to receive your covered maintenance medications from CVS Caremark. Once your prescription is on file at CVS Caremark, please allow five to eight business days to receive refills of your covered medications.

Refilling your mail service prescriptions

- **Online** – Ordering refills is convenient, fast, and easy at www.caremark.com. Register online to receive refill reminders and other important updates.
- **By phone** – Call (866) 346-7200 [TTY: 711] and follow the telephone prompts for the automated reorder system. Customer care representatives are available 24 hours a day, seven days a week, 365 days a year.
- **By mail** – Complete the CVS Caremark refill order form included in your last medication shipment, and mail it along with payment to:

  CVS Caremark
  P.O. BOX 659541
  San Antonio, TX 78265-9541

* Generally, the drugs provided through mail service are drugs that you take on a regular basis, for a chronic or long-term medical condition.

Wellvolution

Unveiling your personal proven path to real health

Tap into decades of research and leading technology for a more productive and healthy lifestyle

Wellvolution® offers the largest curated collection of scientifically-backed apps and programs designed to help you:

- Prevent and reverse disease
- Manage stress
- Sleep better
- Eat healthier
- Move more
- Ditch cigarettes

A digital health platform and in-person support network

Focus
Stay on track and progress along the proven path

Support
Receive digital reminders, motivation, and engagement

Results
All backed by real science for real, positive changes

Wellvolution

blue california

Take charge of your health

Online and in-person programs for both general well-being and disease reversal

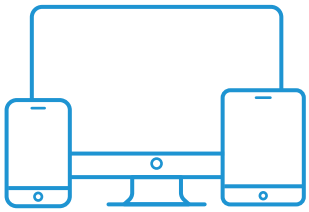
Proven and backed by doctors' methods for results

Largest curated collection of scientifically-backed apps

A personal health coach, taking guesswork out of the health strategy

A new way to achieve health goals

Included with most health plans at no additional cost



To discover your proven path, visit **wellvolution.com**.

Kaiser Permanente $25D (Chiro)

KAISER PERMANENTE®

Services with the Kaiser HMO plan must be obtained from a participating provider or hospital. Select a doctor at a Kaiser facility near you. The doctor you choose must be a primary care physician (PCP) - Internal Medicine, Family/General Medicine or Pediatric Medicine. Your PCP will refer you to see a specialist when needed. Most Kaiser locations offer multiple services under one roof. That means you may be able to see your PCP, get an X-ray, visit the lab and fill your prescription all in the same place. The information listed is only a brief summary. For complete details refer to the carrier plan documents. Visit www.kp.org or call (800) 464-4000 to find Kaiser participating providers.

Plan Design	**In-Network Only**
Calendar Year Deductible	None
Calendar Year Out-of-Pocket Maximum	$1,500 Individual / $3,000 Family
Preventive Services	
Routine Preventive Care / Physical Examinations	No Charge
Well-Child Visits	No Charge
Prenatal Care Visits and First Postpartum Visit	No Charge
Office Visits	
Primary Care Visits / Specialty Care Visits	$25 copay
Telemedicine	No Charge
Lab & X-Ray	No Charge
Chiropractic (up to 30 visits per year)	$10 copay
Acupuncture Benefits (physician referred only)	$25 copay
Hospitalization Services	
Emergency Room (copay waived if admitted)	$100
Urgent care visit	$25 copay
Hospital inpatient services	No Charge
Mental Health Services	
Outpatient mental health & substance abuse	$25 copay
Inpatient mental health & substance abuse	No Charge
Prescription Drug Services	**Plan Pharmacy (up to 30 days)**
Most Generic Items	$10 copay
Most Brand Items	$25 copay
Specialty Items	20% (not to exceed $150) for up to a 30-day supply
Mail Order (up to 100 day supply)	2 times retail cost

This is a summary of the most frequently asked about benefits. This chart does not explain benefits. Cost Sharing, out-of-pocket maximums, exclusions, or limitations, nor does it list all benefits and Cost Sharing. For a complete explanation, please refer to the EOC (Evidence of Coverage).

Kaiser Permanente HSA Plan

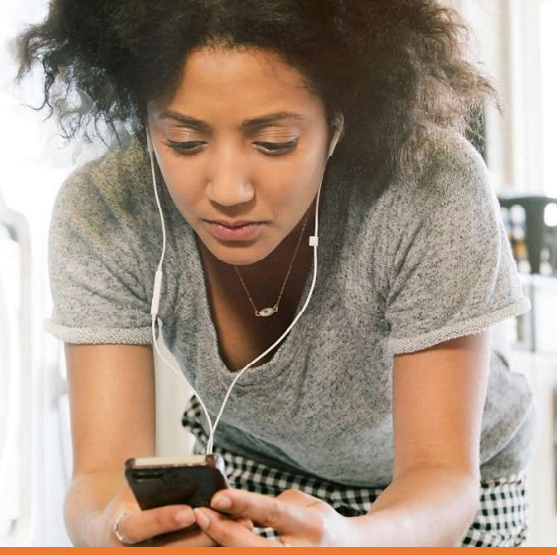
Services with the Kaiser HMO plan must be obtained from a participating provider or hospital. Select a doctor at a Kaiser facility near you. The doctor you choose must be a primary care physician (PCP) - Internal Medicine, Family/General Medicine or Pediatric Medicine. Your PCP will refer you to see a specialist when needed. Most Kaiser locations offer multiple services under one roof. That means you may be able to see your PCP, get an X-ray, visit the lab and fill your prescription all in the same place. The information listed is only a brief summary. For complete details refer to the carrier plan documents. Visit www.kp.org or call (800) 464-4000 to find Kaiser participating providers.

Plan Design	**In-Network Only**
Calendar Year Deductible	$2,000 Individual / $2,800 Ind. In fam. / $4,000 Family
Calendar Year Out-of-Pocket Maximum	$3,000 Individual / $6,000 Family
Preventive Services	
Routine Preventive Care / Physical Examinations	No Charge (deductible waived)
Well-Child Visits	No Charge (deductible waived)
Prenatal Care Visits and First Postpartum Visit	No Charge (deductible waived)
Office Visits	***AFTER DEDUCTIBLE***
Primary Care Visits / Specialty Care Visits	$30 copay after deductible
Telemedicine	No charge after deductible
Lab & X-Ray	$10 per encounter after deductible
Chiropractic	Not Covered
Acupuncture Benefits (physician referred only)	$30 copay after deductible
Hospitalization Services	
Emergency Room (copay waived if admitted)	$100 copay after deductible
Urgent care visit	$30 copay after deductible
Hospital inpatient services	$250 per admission after deductible
Outpatient surgery	$150 per procedure after deductible
Mental Health Services	
Outpatient mental health & substance abuse	$30 copay after deductible
Inpatient mental health & substance abuse	$250 per admission after deductible
Prescription Drug Services	**Retail (up to 30 days)**
Most Generic Items	$10 copay after combined deductible
Most Brand Items	$30 copay after combined deductible
Specialty Items	20% (not to exceed $150) per Rx after combined deductible
Mail Order (up to 100 day supply)	2 times retail cost

This is a summary of the most frequently asked about benefits. This chart does not explain benefits. Cost Sharing, out-of-pocket maximums, exclusions, or limitations, nor does it list all benefits and Cost Sharing. For a complete explanation, please refer to the EOC (Evidence of Coverage).

Skip the trip

Let our pharmacy come to you.



Get your prescriptions delivered to your door – quickly and conveniently.[1]

3 easy ways to get started

- Visit **kp.org/pharmacy**.
- Sign in to the Kaiser Permanente app.
- Call **1(888) 218-6245** (TTY **711**)

Why choose home delivery?

- **Save time.** No traffic, no lines.
- **Save money** on a 3-month supply for the price of 2 months[2] – plus no-cost shipping.
- **Easily track** when your orders will ship,[3] where they're at, and what they'll cost.

[1]Some prescriptions are not available through the mail-order pharmacy.
[2]May vary by plan type. Check your plan benefits for more information.
[3]This feature is only available when you order online or on the app. You may need to opt in to receive notifications.

KAISER PERMANENTE®

Please recycle. 365421736 September 2019

Sutter Health Plus $25 Copay

Sutter Health Plus
Your Health Plan

Services with the Sutter Health Plus HMO plan must be obtained from a participating provider or hospital. Select a contracting Physician Group near you. The doctor you choose must be a primary care physician (PCP) - Internal Medicine, Family/General Medicine or Pediatric Medicine. Your PCP will refer you to see a specialist when needed. The information listed is only a brief summary. For complete details refer to the carrier plan documents. Visit www.SutterHealthPlus.org or call (855) 315-5800 to find participating providers.

Plan Design	In-Network Only	
Calendar Year Deductible	None	
Calendar Year Out-of-Pocket Maximum	$1,500 Individual / $3,000 Family	
Preventive Services		
Routine Preventive Care / Physical Examinations	No Charge	
Well-Child Visits	No Charge	
Prenatal Care Visits and First Postpartum Visit	No Charge	
Office Visits		
Primary Care Visits / Specialty Care Visits	$25 copay	
Lab & X-Ray	$20 copay lab / $20 copay x-ray	
MRI, CT, PET Scans	$50 copay	
Acupuncture Benefits & Chiropractic *(up to 20 visits per year combined)*	$15 copay	
Hospitalization Services		
Emergency Room (copay waived if admitted)	$100 copay	
Urgent care visit	$25 copay	
Hospital inpatient services	No Charge	
Mental Health Services		
Outpatient mental health & substance abuse	$25 copay	
Inpatient mental health & substance abuse	No Charge	
Prescription Drug Services	**Retail 30 day supply**	**Mail order 100 day supply**
Generic Items	$10 copay	$20 copay
Preferred brand Items	$30 copay	$60 copay
Non-Preferred brand Items	$60 copay	$120 copay
Specialty Drugs (see EOC for details)	20% up to $100/script	

This is a summary of the most frequently asked about benefits. This chart does not explain benefits. Cost Sharing, out-of-pocket maximums, exclusions, or limitations, nor does it list all benefits and Cost Sharing. For a complete explanation, please refer to the EOC (Evidence of Coverage).

Sutter Health Plus 1500 HSA

Sutter Health Plus
Your Health Plan

Services with the Sutter Health Plus HMO plan must be obtained from a participating provider or hospital. Select a contracting Physician Group near you. The doctor you choose must be a primary care physician (PCP) - Internal Medicine, Family/General Medicine or Pediatric Medicine. Your PCP will refer you to see a specialist when needed. The information listed is only a brief summary. For complete details refer to the carrier plan documents. Visit www.SutterHealthPlus.org or call (855) 315-5800 to find participating providers.

Plan Design	In-Network Only
Calendar Year Deductible	$1,500 Individual / $2,800 Ind. in family / $3,000 Family
Calendar Year Out-of-Pocket Maximum	$3,000 Individual / $3,000 Ind. In family / $6,000 Family
Preventive Services	
Routine Preventive Care / Physical Examinations	No Charge (deductible waived)
Well-Child Visits	No Charge (deductible waived)
Prenatal Care Visits and First Postpartum Visit	No Charge (deductible waived)
Office Visits	***AFTER DEDUCTIBLE***
Primary Care Visits / Specialty Care Visits	No charge after deductible
Lab & X-Ray	No charge after deductible
Acupuncture Benefits (physician referred only)	No charge after deductible
Hospitalization Services	
Emergency Room (copay waived if admitted)	No charge after deductible
Urgent care visit	No charge after deductible
Hospital inpatient services	$50 copay after deductible
Outpatient surgery	No charge after deductible
Mental Health Services	
Outpatient mental health & substance abuse	No charge after deductible
Inpatient mental health & substance abuse	$50 copay after deductible
Prescription Drug Services	**Retail (up to 30 days) or Mail Order (up to 100 day s)**
	AFTER MEDICAL DEDUCTIBLE
Generic Items	No charge after deductible
Preferred brand Items	No charge after deductible
Non-Preferred brand Items	No charge after deductible
Specialty Drugs (see EOC for details)	No charge after deductible

This is a summary of the most frequently asked about benefits. This chart does not explain benefits. Cost Sharing, out-of-pocket maximums, exclusions, or limitations, nor does it list all benefits and Cost Sharing. For a complete explanation, please refer to the EOC (Evidence of Coverage).

Sutter Health Plus 2500 HSA

Services with the Sutter Health Plus HMO plan must be obtained from a participating provider or hospital. Select a contracting Physician Group near you. The doctor you choose must be a primary care physician (PCP) - Internal Medicine, Family/General Medicine or Pediatric Medicine. Your PCP will refer you to see a specialist when needed. The information listed is only a brief summary. For complete details refer to the carrier plan documents. Visit www.SutterHealthPlus.org or call (855) 315-5800 to find participating providers.

Plan Design	In-Network Only	
Calendar Year Deductible	$2,500 Individual / $2,800 Ind. in family / $5,000 Family	
Calendar Year Out-of-Pocket Maximum	$4,000 Individual / $4,000 Ind. In family / $8,000 Family	
Preventive Services		
Routine Preventive Care / Physical Examinations	No Charge (deductible waived)	
Well-Child Visits	No Charge (deductible waived)	
Prenatal Care Visits and First Postpartum Visit	No Charge (deductible waived)	
Office Visits	***AFTER DEDUCTIBLE***	
Primary Care Visits / Specialty Care Visits	20% coinsurance	
Lab & X-Ray	20% coinsurance	
Acupuncture Benefits	20% coinsurance	
Hospitalization Services		
Emergency Room (copay waived if admitted)	20% coinsurance	
Urgent care visit	20% coinsurance	
Hospital inpatient services	20% coinsurance	
Outpatient surgery	20% coinsurance	
Mental Health Services		
Outpatient mental health & substance abuse	20% coinsurance	
Inpatient mental health & substance abuse	20% coinsurance	
Prescription Drug Services	**Retail 30 day supply**	**Mail order 100 day supply**
Generic Items	***AFTER MEDICAL DEDUCTIBLE***	
Preferred brand Items	$10 copay	$20 copay
Non-Preferred brand Items	$30 copay	$60 copay
Specialty Drugs (see EOC for details)	$60 copay	$120 copay
	20% up to $100/script	

This is a summary of the most frequently asked about benefits. This chart does not explain benefits. Cost Sharing, out-of-pocket maximums, exclusions, or limitations, nor does it list all benefits and Cost Sharing. For a complete explanation, please refer to the EOC (Evidence of Coverage).

PHARMACY BENEFITS

Managing Your Prescriptions

Sutter Health Plus partners with Express Scripts® for prescription drug benefits, including retail, mail order and specialty prescriptions.

Retail Pharmacy

Pick up your prescription drugs at most independent pharmacies and chains where you may already shop—CVS Pharmacy, Raley's, Bel Air, Safeway and Walgreens, to name a few.

With the Smart90® program, you can pick up a 90-day supply of your maintenance drugs at a participating retail pharmacy. While you still pay three copays for your 90-day supply, Smart90 may reduce trips to the pharmacy. For a list of participating pharmacies, search Find a Pharmacy on the Express Scripts guest website.

Mail Order Pharmacy

Sign up for mail order pharmacy service through Express Scripts Pharmacy℠ and receive:

- Up to a 100-day supply, as your benefit plan allows, of your maintenance prescription drugs for the cost of two retail copays
- Free standard shipping of your prescription drugs

Specialty Pharmacy

Specialty drugs are purchased through Accredo®. These drugs are mailed to your home at no cost.

Express Scripts Guest Website

View sample pharmacy cost sharing for some of our most popular benefit plan designs through the guest website, as well as:

- Find a Pharmacy
- Price a Medication tool
- Sutter Health Plus formulary
- Mail order pharmacy information

Visit *sutterhealthplus.org/pharmacy*

Sutter Health Plus
Your Health Plan

Transferring Your Prescriptions

If you are new to Sutter Health Plus and you or your covered dependents currently pick up prescription drugs from a pharmacy outside the Express Scripts network, follow these steps to transfer your prescriptions.

Before Your Effective Date

Check to see if you have refills left on your active prescriptions:

- If you have refills available, fill them through your current health plan before your effective date to ensure you have an adequate supply on hand until you establish care with your new Sutter Health Plus provider
- If you do not have refills available, contact your current prescribing provider as soon as possible; refill your prescription through your current pharmacy before your effective date

Request a written prescription for your new pharmacy to fill on or after your new health plan effective date.

Check the Sutter Health Plus Formulary to see if your prescription drug requires a prior authorization; if so you will need to know about the Medication Continuity of Care process described in your *Evidence of Coverage and Disclosure Form.*

After Your Effective Date

If you have refills available, take your prescription bottle to an Express Scripts network pharmacy for up to a 30-day supply. The Express Scripts network pharmacy will work with your current pharmacy to transfer your prescription.

If you have a written prescription from a provider, take it to a network pharmacy for up to a 30-day supply.

If you take a prescription on a regular basis, consider using mail order fulfillment through Express Scripts Pharmacy. You may obtain up to a three-month supply, as your benefit plan allows, of your maintenance prescription drugs for the cost of a two-month retail supply.

If you take specialty medications, you must fill your prescription through Accredo.

For more information about your pharmacy benefits, including retail, mail order and specialty drugs, please contact Express Scripts Customer Service at **1-877-787-8661** or visit ***express-scripts.com.***

Western Health Advantage Premier 25

Services with the Western Health Advantage HMO plan must be obtained from a participating provider or hospital. Select a contracting Physician Group near you. The doctor you choose must be a primary care physician (PCP) - Internal Medicine, Family/General Medicine or Pediatric Medicine. Your PCP will refer you to see a specialist when needed. The information listed is only a brief summary. For complete details refer to the carrier plan documents. Visit www.WesternHealth.com or call (888) 563-2250 to find Western Health Advantage participating providers.

Plan Design	In-Network Only	
Calendar Year Deductible	None	
Calendar Year Out-of-Pocket Maximum	$1,500 Individual / $2,500 Family	
Preventive Services		
Routine Preventive Care / Physical Examinations	No Charge	
Well-Child Visits	No Charge	
Prenatal Care Visits and First Postpartum Visit	No Charge	
Office Visits		
Primary Care Visits / Specialty Care Visits	$25 copay	
Lab & X-Ray	No Charge	
Acupuncture Benefits & Chiropractic *(up to 20 visits per year for each service)*	$15 copay	
Hospitalization Services		
Emergency Room (copay waived if admitted)	$100 copay	
Urgent care visit	$35 copay	
Hospital inpatient services	No Charge	
Outpatient surgery	$100 copay	
Mental Health Services		
Outpatient mental health & substance abuse	$25 copay	
Inpatient mental health & substance abuse	No Charge	
Prescription Drug Services	**Retail 30 day supply**	**Mail order 90 day supply**
Tier 1	$10 copay	$25 copay
Tier 2	$30 copay	$75 copay
Tier 3	$50 copay	$125 copay

This is a summary of the most frequently asked about benefits. This chart does not explain benefits. Cost Sharing, out-of-pocket maximums, exclusions, or limitations, nor does it list all benefits and Cost Sharing. For a complete explanation, please refer to the EOC (Evidence of Coverage).

Western Health Advantage 1800 HSA

Services with the Western Health Advantage HMO plan must be obtained from a participating provider or hospital.
Select a contracting Physician Group near you. The doctor you choose must be a primary care physician (PCP) - Internal Medicine, Family/ General Medicine or Pediatric Medicine. Your PCP will refer you to see a specialist when needed. The information listed is only a brief summary. For complete details refer to the carrier plan documents. Visit www.WesternHealth.com or call (888) 563-2250 to find Western Health Advantage participating providers.

Plan Design	In-Network Only	
Calendar Year Deductible	$1,800 Individual / $2,800 Ind. In Family / $3,600 Family	
Calendar Year Out-of-Pocket Maximum	$3,600 Individual / $3,600 Ind. In Family / $7,200 Family	
Preventive Services		
Routine Preventive Care / Physical Examinations	No Charge (deductible waived)	
Well-Child Visits	No Charge (deductible waived)	
Prenatal Care Visits and First Postpartum Visit	No Charge (deductible waived)	
Office Visits	***AFTER DEDUCTIBLE***	
Primary Care Visits / Specialty Care Visits	No charge after deductible	
Lab & X-Ray	No charge after deductible	
Acupuncture Benefits (physician referred only)	No charge after deductible	
Hospitalization Services		
Emergency Room (copay waived if admitted)	No charge after deductible	
Urgent care visit	No charge after deductible	
Hospital inpatient services	No charge after deductible	
Outpatient surgery	No charge after deductible	
Mental Health Services		
Outpatient mental health & substance abuse	No charge after deductible	
Inpatient mental health & substance abuse	No charge after deductible	
Prescription Drug Services	**Retail 30 day supply**	**Mail order 90 day supply**
	AFTER MEDICAL DEDUCTIBLE	
Tier 1	No charge after deductible	No charge after deductible
Tier 2	$30 copay	$75 copay
Tier 3	$50 copay	$125 copay

This is a summary of the most frequently asked about benefits. This chart does not explain benefits. Cost Sharing, out-of-pocket maximums, exclusions, or limitations, nor does it list all benefits and Cost Sharing. For a complete explanation, please refer to the EOC (Evidence of Coverage).

Western Health Advantage 2800/40 HSA

Services with the Western Health Advantage HMO plan must be obtained from a participating provider or hospital. Select a contracting Physician Group near you. The doctor you choose must be a primary care physician (PCP) - Internal Medicine, Family/General Medicine or Pediatric Medicine. Your PCP will refer you to see a specialist when needed. The information listed is only a brief summary. For complete details refer to the carrier plan documents. Visit www.WesternHealth.com or call (888) 563-2250 to find Western Health Advantage participating providers.

Plan Design	In-Network Only	
Calendar Year Deductible	$2,800 Individual / $5,600 Family	
Calendar Year Out-of-Pocket Maximum	$4,000 Individual / $8,000 Family	
Preventive Services		
Routine Preventive Care / Physical Examinations	No Charge (deductible waived)	
Well-Child Visits	No Charge (deductible waived)	
Prenatal Care Visits and First Postpartum Visit	No Charge (deductible waived)	
Office Visits	***AFTER DEDUCTIBLE***	
Primary Care Visits / Specialty Care Visits	$40 copay	
Lab & X-Ray	No charge after deductible	
Acupuncture Benefits	No charge after deductible	
Hospitalization Services		
Emergency Room (copay waived if admitted)	$100 copay	
Urgent care visit	$50 copay	
Hospital inpatient services	$500 per day	
Outpatient surgery	$250 copay	
Mental Health Services		
Outpatient mental health & substance abuse	$500 per day copay	
Inpatient mental health & substance abuse	$40 copay	
Prescription Drug Services	**Retail 30 day supply**	**Mail order 90 day supply**
	AFTER MEDICAL DEDUCTIBLE	
Generic Items	$10 copay	$25 copay
Preferred brand Items	$30 copay	$75 copay
Non-Preferred brand Items	$50 copay	$125 copay

This is a summary of the most frequently asked about benefits. This chart does not explain benefits. Cost Sharing, out-of-pocket maximums, exclusions, or limitations, nor does it list all benefits and Cost Sharing. For a complete explanation, please refer to the EOC (Evidence of Coverage).

Western Health Advantage

PRESCRIPTION BENEFITS

FILLING PRESCRIPTIONS

- **Pick up at the pharmacy:** You can fill most prescription medications at any retail pharmacy. Get the most savings by going to one of thousands of retail pharmacies in OptumRx's network, which includes large national chains and many local pharmacies.
- **Options for the medications you take regularly:** Save time and money by obtaining a 90-day supply through OptumRx's mail-order pharmacy program or by using the Select90 program at Walgreens or CVS Pharmacy.
- **More on mail order:** Refill your prescription online or by phone and get it delivered straight to your home. There is no charge for standard shipping. To get started, ask your doctor to send an electronic prescription to OptumRx, register at optumrx.com, download the OptumRx App, or call 844.568.4150.
- **Specialty medications:** To ensure you get started on your medications in a timely manner, you are able to pick up two initial fills at local retail pharmacies, with some exceptions (a drug may be limited by the FDA and/or the manufacturer to a specific specialty pharmacy, for example). All other fills will be limited to WHA's exclusive specialty pharmacy network.
- **Optum Specialty Pharmacy:** If you have a prescription for a specialty medication with Optum Specialty Pharmacy, you will be automatically enrolled into OptumRx's clinical management program. All specialty medications are shipped at no cost to your doctor's office or your home, depending on who administers the medication. Optum's patient care coordinators and pharmacists are highly trained to understand your special therapy needs. You have 24-hour-a-day access to registered pharmacists who review lab results and check for side effects or drug interactions. To get started call 855.427.4682 or visit specialty.optumrx.com.

ONLINE SERVICES

- **OptumRx App and OptumRx.com:** Find a network pharmacy, check medication coverage, track home delivery orders, renew or refill your prescriptions and more—and do it whenever you need to, day or night. Get the app by searching for OptumRx in the App store or Google Play.
- **Automatic Refills:** You can enroll any qualifying medications in the automatic refill program. OptumRx will automatically fill and send your medications right to your home. They'll notify you when your medications are ready to ship.
- **Medication Reminders:** Never miss a dose with the My Medication Reminders™ tool. You can set your own customized notification schedules to receive text message reminders from OptumRx.

LEARN MORE ABOUT PRESCRIPTION BENEFITS | Visit **mywha.org/RX** or call **888.563.2250** for assistance

advantage you

Getting Access to Care

WHA covers virtual care visits

To meet the changing needs of our members, WHA's clinical provider network is offering alternatives to the traditional in-person office visit with your primary care physician (PCP) or a specialist. Telehealth services may vary based on your medical group and/or doctor. Today, many doctors in WHA's network are offering extended hours to support their patients virtually, whether by phone, tablet or laptop. Contact your doctor's office first to learn about available virtual care options.

When a WHA clinical provider does offer telehealth services, you will have the same cost-sharing that you would have for an office visit. You can refer to your plan's copayment summary—at **mywha.org** or using the MyWHA Mobile App—for cost-sharing amounts for in-person services and virtual visits.

If you can't (or don't want to) leave your home to get care, you have options.

Nurse advice line

Through Nurse24, WHA provides members 24/7 access to a confidential advice line staffed with registered nurses. For no additional cost, you can speak directly with a nurse at **877.793.3655** or chat securely online via **mywha.org/nurse24**. Registered nurses are available to answer your health questions and help with best treatment or next steps including direct referrals to disease management nurses.

Behavioral health services available virtually

Magellan Health, WHA's behavioral health care partner, is also offering telehealth options:

- **Virtual visits:** Virtual behavioral health services provide accessibility during social distancing with flexible appointment times, and are offered at the cost of an office visit.
- **Magellan 24-hour crisis line:** Members can call 800.327.7451 at no charge to get help in coping with feelings of fear, sadness, anger and hopelessness. Crisis line callers will speak directly to a masters-level, certified licensed mental health clinician.

When you need immediate care...see reverse for options and details.

Western Health Advantage

LEARN MORE | Visit **mywha.org/virtualvisits** or call WHA Member Services at **888.563.2250**

When you need immediate care

WHA has care options for when you need it most. If an urgent care situation arises while you are in WHA's service area, start by calling your PCP—any time of the day, including evenings and weekends. Your doctor or an on-call doctor may provide you with home care remedies, offer a virtual visit or, if necessary, direct you to seek care at the emergency room or your medical group's contracted urgent care center.

If you cannot wait to reach your doctor, but unsure whether to go to either an urgent care center or the emergency room, use this guide to help you decide:

URGENT CARE IS BEST FOR...

Minor injuries and common illnesses, such as:

- Cuts and abrasions, including stitches
- Muscle sprains and strains
- Sinus problems and cold/flu symptoms
- Pink eye infection
- Urinary tract infection
- Skin infections and rashes

If you feel you need urgent care...

To keep your care coordinated, it's always best to try and reach your doctor first or seek nurse advice from Nurse24. However, WHA gives you backup options for immediate care.

New for 2021: Connect virtually with Teladoc®

There are times when you can't go in to your doctor's office. WHA members now have the option of getting care virtually in non-emergency situations by offering 24/7 virtual urgent care through Teladoc, the global leader in telemedicine. From anywhere at any time (even when you are traveling), you can reach a doctor 24/7 by secure video chat or phone—often within 10 to 15 minutes—to get a diagnosis and treatment.

Teladoc lets you connect with an urgent care healthcare professional for minor injuries and illnesses such as cold or flu, minor cuts or burns, muscle strains or sprains, upset stomach or skin rashes, without having to go to an urgent care facility. To access Teladoc's website or mobile app visit our website at **mywha.org/Teladoc** for details.

Seek care at an urgent care center

If you are near your home or work, be sure to go to a facility affiliated with your PCP's medical group. Search Facilities online at **mywha.org/directory**; choose Urgent Care Centers and then filter by location and medical group.

EMERGENCY CARE IS BEST FOR...

Life-threatening or serious conditions, such as:

- Stroke or heart attack
- Head trauma
- Serious chest or abdominal pain
- Severe bleeding
- Broken bones
- Difficulty breathing

If you feel that you need emergency care...

- **Call or text 911 for help.** If you believe you are experiencing a life-threatening emergency or condition, call 911 immediately or go directly to the nearest hospital emergency room. Note: If you text 911, be sure to clearly explain your emergency and location.
- **Call your doctor.** Your PCP may be able to call ahead to alert the emergency room that you are on the way and explain your condition, which may help expedite your care once you are there.

If you are outside WHA's service area and hospitalized because of an emergency, WHA covers those services. However, you must notify WHA within twenty-four (24) hours or as soon as possible to avoid any billing issues. If you are unable to make the call, have someone else make it for you, such as a family member, friend or hospital staff member.

Follow-up care after an emergency room visit is not considered an "emergency" situation. If you receive emergency treatment from an emergency room physician or non-participating provider and then return for follow-up care, you are responsible for the cost of the service.

HEALTH SAVINGS ACCOUNT

A Health Savings Account (HSA) is a tax-favored account used in conjunction with your HSA compatible medical plan. You can save on premiums, taxes and future expenses. You can also invest your funds for even greater earning potential. HSAs also promote positive changes in spending behavior by giving you a more active role in your healthcare.

Premium Costs: HSA compatible health plans generally have lower premiums than traditional plans, which could save significant dollars each year. To maximize your savings and fund your HSA, consider using the money saved by enrolling in the less expensive HDHP plan.

Tax Savings: HSAs allow you to contribute funds on a pre-tax or tax deductible basis, which you may use to pay for eligible medical expenses. Any interest you earn on the monies is also non-taxable.

Investment Options: HSA dollars can be invested for increased earning potential. There are various investment options. Your invested funds can be withdrawn to pay for medical expenses, if needed.

Type of Coverage	2021 IRS Limits for Contribution
Employee Only Plan	$ 3,600
Family Plan	$ 7,200

MAXIMUM CONTRIBUTIONS

The IRS sets the maximum contribution limits for the Health Saving Accounts.

CATCH-UP CONTRIBUTIONS

Individuals age 55 and over can make catch-up contributions of $1,000.

Some Examples of Eligible Expenses:

- Acupuncture
- Doctor's fees
- Dental treatments
- Dermatologist
- Hospital bills
- Lab fees
- Psychiatrist, Psychologist
- Vision Care
- Weight loss programs (for a specific disease diagnosed by physician)
- Menstrual care products— new!
- Certain over-the-counter medications— new!

Information regarding Section 125 and Imputed Income

About Your Premiums

Any contributions you make for you and your IRS dependents' medical, dental and vision plan coverage is automatically deducted from your paycheck on a pre-tax basis per IRS guidelines under Section 125. This decreases your taxable earnings and can increase your take-home pay. Your elections remain in effect and can not be changed for twelve months or the remainder of the group plan year, whichever occurs first, unless you have a qualifying life event as defined by the IRS. Qualifying life events are listed on page 5 of the Employee Benefits Guide.

Imputed Income

Because the IRS does not recognize domestic partners or their children (unless they qualify as dependents under Section 152) for tax filing purposes, we are required to "impute" the value of these benefits and report that value as taxable income to the employee. The applicable amount will be added back into your paycheck as taxable income and you will pay taxes on that amount.

Delta Dental Plan IB

With the PPO Plan, you can visit any dentist, but you pay less out-of-pocket when you choose an In-Network PPO dentist. If dental services are expected to exceed $300, we encourage you to obtain a "pre-determination of benefits." Your dentist office can submit this request for you to the carrier prior to receiving services. This will give you an estimate of what your out-of-pocket costs will be in advance of having the procedure performed.

Visit www.deltadentalins.com or call 866-499-3001 to find participating **PPO** providers.

PLAN DESIGN

In this incentive plan, Delta Dental pays 70% of the contract allowance for covered diagnostic, preventive and basic services and 70% of the 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%.

Benefits*	In-Network ** PPO dentists	Out-of-Network** Premier & Non-Delta Dentists
Calendar Year Maximum	**$2,200 per person per calendar year**	**$2,000 per person per calendar year**
Calendar Year Deductible	**None**	
	Plan Pays	**Plan Pays**
Diagnostic & Preventive Exams, cleanings, x-rays	70% - 100%	70% - 100%
Basic Services Fillings, simple tooth extractions, sealants	70% - 100%	70% - 100%
Endodontics (root canals) **Periodontics (gum treatment)** **Oral Surgery**	70% - 100%	70% - 100%
Major Services Crowns, inlays, onlays & cast restorations	70% - 100%	70% - 100%
Prosthodontics Bridges and dentures	50%	50%
Orthodontic Benefits Dependent Children	50%	50%
Orthodontic Lifetime Maximum	$1,000 lifetime maximum per person	$1,000 lifetime maximum per person
Dental Accident	100% (separate $1,000 max per person per calendar year)	100% (separate $1,000 max per person per calendar year)

* Limitations or waiting periods may apply for some benefits; some services may be excluded from your plan. Reimbursement is based on Delta Dental contract allowances and not necessarily each dentist's actual fees.

** Reimbursement is based on PPO contracted fees for PPO dentists, Premier contracted fees for Premier dentists and program allowance for non-Delta Dental dentists.

This is a summary of the most frequently asked about benefits. This chart does not explain benefits. Cost Sharing, out-of-pocket maximums, exclusions, or limitations, nor does it list all benefits and Cost Sharing. For a complete explanation, please refer to the EOC (Evidence of Coverage).

VSP Vision Plan 12/12/12 $10 Copayment

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.

Copays	**Exam**	**$10**
	Prescription Glasses	**$10**
	Contact Lens fitting & evaluation	**Max $60**
Frequency	**Exam**	**Once every 12 months**
	Lenses or contact lenses	**Once every 12 months**
	Frame	**Once every 12 months**
	In-Network	**Out-of-Network**
Exam	**100% after copay**	**Reimbursed up to $50**
Lenses		
Single	**100% after copay**	**Reimbursed up to $50**
Bifocal	**100% after copay**	**Reimbursed up to $75**
Trifocal	**100% after copay**	**Reimbursed up to $100**
Frame	**$150 allowance + 20% off amount over allowance**	**Reimbursed up to $70**
Contact Lenses *(in lieu of lens/frame)*		
Elective	**$150 allowance for contacts and lens exam (fitting and evaluation) + 15% off contact lens exam**	**Reimbursed up to $105**
Medically Necessary	**100% after copay**	**Reimbursed up to $210**

Extra savings and discounts include: 20-30% off additional glasses and sunglasses, guaranteed pricing on retinal screening, and discounted laser vision correction from available contracted facilities. For more information about these discounts, please visit www.VSP.com or call 800-877-7195.

This is a summary of the most frequently asked about benefits. This chart does not explain benefits, cost sharing, exclusions, or limitations, nor does it list all of the benefits and cost sharing. For a complete explanation, please refer to the EOC (Evidence of Coverage).

Contact Us... Anytime, Anywhere

No-cost, confidential solutions to life's challenges.

Confidential Emotional Support

Our highly trained clinicians will listen to your concerns and help you or your family members with any issues, including:

- Anxiety, depression, stress
- Grief, loss and life adjustments
- Relationship/marital conflicts

Work-Life Solutions

Our specialists provide qualified referrals and resources for just about anything on your to-do list, such as:

- Finding child and elder care
- Hiring movers or home repair contractors
- Planning events, locating pet care

Legal Guidance

Talk to our attorneys for practical assistance with your most pressing legal issues, including:

- Divorce, adoption, family law, wills, trusts and more

Need representation? Get a free 30-minute consultation and a 25% reduction in fees.

Financial Resources

Our financial experts can assist with a wide range of issues. Talk to us about:

- Retirement planning, taxes
- Relocation, mortgages, insurance
- Budgeting, debt, bankruptcy and more

Online Support

GuidanceResources® Online is your 24/7 link to vital information, tools and support. Log on for:

- Articles, podcasts, videos, slideshows
- On-demand trainings
- "Ask the Expert" personal responses to your questions

Your ComPsych® GuidanceResources® program offers someone to talk to and resources to consult whenever and wherever you need them.

Call: 844.582.2327
TTY: 800.697.0353

Your toll-free number gives you direct, 24/7 access to a GuidanceConsultant℠, who will answer your questions and, if needed, refer you to a counselor or other resources.

Online: guidanceresources.com
App: GuidanceResources® Now
Web ID: SIGEAP

Log on today to connect directly with a GuidanceConsultant about your issue or to consult articles, podcasts, videos and other helpful tools.

24/7 Support, Resources & Information

Contact Your GuidanceResources® Program

Call: 844.582.2327
TTY: 800.697.0353
Online: guidanceresources.com
App: GuidanceResources® Now
Web ID: SIGEAP

CREATE YOUR FREE ACCOUNT: grokker.com/sigwellness

Meet your on-demand video wellbeing app!

All SIG employees and families can enjoy unlimited, anytime/anywhere access to Grokker.

Grokker is designed to delight and inspire, regardless of your skill level, abilities, and goals. With over 4,000 on-demand wellbeing videos and a consumer-centric user experience, Grokker makes it fun and easy to move more, eat better, improve your sleep, support your emotional health, and manage financial stress.

Exercise | Mental Health | Sleep | Nutrition | Financial well-being

Stunning 4K video. Grokker's patented HD video programs are fully contextual and personalized, taking into account your physical health, mental/emotional health, and social connectedness to deliver content that's a perfect fit.

4000+ videos. 100+ programs.

Clear instruction, achievable results. From activity duration to recommended schedules, Grokker's programs provide users with a start-to-finish plan to achieve their health and wellbeing goals. All you have to do is enter when you want to start and how long you want the program to last. Grokker does the rest, automatically adding the chosen program to your calendar and sending reminders with direct links to that day's episode.

Community support. Engage with coworkers and over 130 global Grokker Experts in the community for seamless support and motivation.

Create your free account: grokker.com/sigwellness

GLOSSARY OF KEY TERMS

Coinsurance – The member and insurance company share the cost of covered procedures in a specific ratio (e.g., member pays 20% and the insurance company pays 80%). This is primarily used in medical and dental PPO plans. If the plan has a deductible, coinsurance does not apply until it has been met.

Copayment – A specific dollar amount you pay to the provider or pharmacy when receiving services or prescriptions.

Deductible – The amount you must pay before the insurance company begins paying benefits on your behalf. The deductible is generally waived for preventive visits and services that require a copayment, including prescription drugs.

Explanation of Benefits (EOB) – A notice sent to the covered person after a claim for payment has been processed by the insurance company. The form explains the action taken on the claim. This explanation usually indicates the amount paid, the benefits available, reasons for denying payment or the claims appeal process.

Formulary – A list containing the names of certain prescription drugs that a medical plan covers when dispensed to its members who have drug coverage through a participating pharmacy. You can obtain a list of formulary medications covered under your plan by visiting the carrier websites referenced on the "Who to Contact" page.

HMO – With this type of medical or dental plan, all care - except emergency services - must be coordinated through a Primary Care Physician (PCP) and/or medical group. Failure to coordinate care through a PCP may result in loss of benefit and greatly increase the amount of money that the member will have to pay for care. Each family member can have a different PCP and they can be changed monthly.

Imputed Income – The IRS has ruled that a domestic partner or same-sex spouse is not a legal spouse for tax purposes. Employers are obligated to report and withhold taxes on the value of benefits provided to a domestic partner and the domestic partner's children. The applicable amount is treated as taxable income to the employee and added back into an employee's paycheck as taxable income. Imputed income also applies to the premiums that employers pay on your behalf for life insurance coverage amounts in excess of $50,000 and LTD benefits. This premium is added to your gross income for tax purposes.

In-Network – All medical, dental and vision carriers have a designated network of doctors or dentists. These providers have agreed to discounted fees with the insurance carrier. In turn, you generally pay a lower percentage of the costs, resulting in less out-of-pocket cost.

Mail Order Prescriptions – A benefit that allows you to order certain maintenance drugs at a reduced cost. You receive multiple months' worth of medication by mail.

Non-formulary – A drug or medication not included on the formulary list of the health insurance plan. If covered, these medications have a higher copay or cost to the member.

Out-of-Network – Medical, dental and vision providers who do not agree to accept the negotiated rates offered by insurance companies. A member may pay higher copays and/or deductibles to see an out-of-network provider or have no coverage at all.

Out-of-Pocket Maximum - Generally, the maximum amount of money a member will have to pay each year. The out-of-pocket maximum most often applies to coinsurance. An individual who meets the out-of-pocket maximum may still be responsible for copays.

PCP – Primary Care Physician. A doctor who is your first point of contact and who must coordinate your care and refer you to specialists. Primarily required by medical or dental HMO plans.

Preferred Provider Organization (PPO) – A type of medical or dental plan that gives members the flexibility to see any provider. If a member chooses an in-network provider or hospital, they will typically have to pay less out-of-pocket.

Pre-determination of Benefits – An estimate reflecting the amount of money an insurance company intends to pay on a member's behalf for a particular procedure. This generally applies to medical and dental plans.

Usual Customary and Reasonable (UCR) – The range of usual fees for comparable services charged by professionals in a geographic area. If your provider charges more than the reasonable and customary fee, you may be responsible for paying the difference. This is often referred to as "Balance Billing".

2021-2022 Annual Notices

****IMPORTANT****
Please be sure to read each of the notices on the following pages. If you have any questions or would like to obtain additional information, please contact Human Resources.

The Newborns' and Mothers' Health Protection Act of 1996

The Newborns' and Mothers' Health Protection Act of 1996 prohibits group and individual health insurance policies from restricting benefits for any hospital length of stay for the mother or newborn child in connection with childbirth; (1) following a normal vaginal delivery to less than 48 hours, and (2) following a cesarean section, to less than 96 hours. Health insurance policies may not require that a provider obtain authorization from the health insurance plan or the issuer for prescribing any such length of stay. Regardless of these standards, an attending health care provider may, in consultation with the mother, discharge the mother or newborn child prior to the expiration of such minimum length of stay.

Further, a health insurer or health maintenance organizations may not:

- deny to the mother or newborn child eligibility, or continued eligibility, to enroll or to renew coverage under the terms of the plan, solely to avoid providing such length of stay coverage
- provide monetary payments or rebates to mothers to encourage such mothers to accept less than the minimum coverage
- provide monetary incentives to an attending medical provider to induce such provider to provide care inconsistent with such length of stay
- require a mother to give birth in a hospital
- restrict benefit for any portion of a period within a hospital length of stay described in this notice.

These benefits are subject to the plan's regular deductible and co-pay. For further details, refer to your Summary Plan Description.

The Women's Health and Cancer Rights Act of 1998

The Women's Health and Cancer Rights Act of 1998 requires your employer to notify you, as a participant or beneficiary of the Health and Welfare Plan, of your rights related to benefits provided through the plan in connection with a mastectomy. You, as a participant or beneficiary, have rights to coverage to be provided in a manner determined in consultation with your attending physician 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
- prosthesis and treatment of physical complications of the mastectomy, including lymph edema.

These benefits are subject to the plan's regular deductible and copay. For further details, refer to your Summary Plan Description.

Important Notice from Schools Insurance Group About Your Prescription Coverage
Prescription Drug Coverage and Medicare

Medicare Part D

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Schools Insurance Group 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 four 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. The Carrier has determined that the prescription drug coverage offered by **Blue Shield of California (Trio ACO HMO, $2700 HSA plan)** are, 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.

3. The carrier has determined that the prescription drug coverage offered by the **Blue Shield of California 4000 HSA plan** is, on average for all plan participants, NOT expected to pay out as much as standard Medicare prescription drug coverage pays. Therefore, your coverage is considered Non-Creditable Coverage. This is important because, most likely, you will get more help with your drug costs if you join a Medicare drug plan, than if you only have prescription drug coverage from the Blue Shield 4000 HSA plan. This also is important because it may mean that you may pay a higher premium (a penalty) if you do not join a Medicare drug plan when you first become eligible.

4. You can keep your current coverage from **Blue Shield of California 4000 HSA plan**. However, because your coverage is non-creditable, you have decisions to make about Medicare prescription drug coverage that may affect how much you pay for that coverage, depending on if and when you join a drug plan. When you make your decision, you should compare your current coverage, including what drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area. Read this notice carefully - it explains your options.

When Can You Join a Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 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 Group coverage will not be affected. You can keep this coverage if you elect part D.

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

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

You should also know that if you drop or lose your current coverage with Schools Insurance Group 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…

For further information please contact human resources (listed below). 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 Schools Insurance Group 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).

Date:	July 1, 2021
Name of Entity/Sender:	Schools Insurance Group
Contact--Position/Office:	Melissa Gianopulos, Benefits Administrator
Address:	550 High St #201, Auburn, CA 95603
Phone Number:	(530) 823-9582

HIPAA Protecting Your Health Information Privacy Rights

Your employer is committed to the privacy of your health information. The administrators of your Group 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 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 the Plan carrier directly.

HIPAA Special Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself or your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage). However, you must request enrollment within "31 days" after you or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, this special enrollment opportunity will not be available when other coverage ends unless you provide a written statement now explaining the reason that you are declining coverage for yourself or your dependent(s). Failing to accurately complete and return this form for each person for whom you are declining coverage will eliminate this special enrollment opportunity for the person(s) for whom a statement is not completed, even if other coverage is currently in effect and is later lost. In addition, unless you indicate in the statement that you are declining coverage because other coverage is in effect, you will not have this special enrollment opportunity for the person(s) covered by the statement. (See the paragraph below, however, regarding enrollment in the event of marriage, birth, adoption or placement for adoption.)

If you have a new dependent as result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must enroll within "31 days" after the marriage, birth, adoption, or placement for adoption.

A special enrollment opportunity may be available in the future if you or your dependents lose other coverage. This special enrollment opportunity will not be available when other coverage ends, however, unless you provide a written statement now explaining the reason that you are declining coverage for yourself or your dependent(s). Failing to accurately complete and return this form for each person for whom you are declining coverage will eliminate this special enrollment opportunity for the person(s) for whom a statement is not completed, even if other coverage is currently in effect and is later lost. In addition, unless you indicate in the statement that you are declining coverage because other coverage is in effect, you will not have this special enrollment opportunity for the person(s) covered by the statement. (See the paragraph above, however, regarding enrollment in the event of marriage, birth, adoption or placement for adoption.)

Effective April 1, 2009 special enrollment rights also exist in the following circumstances:

- If you or your dependent experience a loss of eligibility for Medicaid or your State Children's Health Insurance Program (SCHIP) coverage; or

- If you or your dependents become eligible for premium assistance under an option state Medicaid or SCHIP program that would pay the employee's portion of the health insurance premium.

Note: In the two above listed circumstances only, you or your dependents will have sixty (60) days to request special enrollment in the group health plan coverage. An individual must request this special enrollment within sixty (60) days of the loss of coverage described at bullet one, and within sixty (60) days of when eligibility is determined as described in bullet two.

To request special enrollment or obtain additional information, contact Human Resources.

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, 2021. Contact your State for more information on eligibility –

ALABAMA-Medicaid	CALIFORNIA-Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp Phone: 916-445-8322 Email: hipp@dhcs.ca.gov
ALASKA-Medicaid	**COLORADO-Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program HIBI Customer Service: 1-855-692-6442
ARKANSAS-Medicaid	**FLORIDA-Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

GEORGIA-Medicaid

Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp
Phone: 678-564-1162 ext 2131

INDIANA-Medicaid

Healthy Indiana Plan for low-income adults 19-64
Website: http://www.in.gov/fssa/hip/
Phone: 1-877-438-4479
All other Medicaid
Website: https://www.in.gov/medicaid/
Phone 1-800-457-4584

IOWA-Medicaid and CHIP (Hawki)

Medicaid Website:
https://dhs.iowa.gov/ime/members
Medicaid Phone: 1-800-338-8366
Hawki Website:
http://dhs.iowa.gov/Hawki
Hawki Phone: 1-800-257-8563
HIPP Website:
https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp
HIPP Phone: 1-888-346-9562

KANSAS-Medicaid

Website: https://www.kancare.ks.gov/
Phone: 1-800-792-4884

KENTUCKY-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://kidshealth.ky.gov/Pages/index.aspx

Phone: 1-877-524-4718

Kentucky Medicaid Website: https://chfs.ky.gov

LOUISIANA-Medicaid

Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp
Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)

MAINE-Medicaid

Enrollment Website:
https://www.maine.gov/dhhs/ofi/applications-forms
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

MASSACHUSETTS-Medicaid and CHIP

Website: https://www.mass.gov/info-details/masshealth-premium-assistance-pa
Phone: 1-800-862-4840

MINNESOTA-Medicaid

Website:
https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp
Phone: 1-800-657-3739

MISSOURI-Medicaid

Website:
http://www.dss.mo.gov/mhd/participants/pages/hipp.htm
Phone: 573-751-2005

MONTANA-Medicaid

Website:
http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: 1-800-694-3084

NEBRASKA-Medicaid

Website: http://www.ACCESSNebraska.ne.gov
Phone: 1-855-632-7633
Lincoln: 402-473-7000
Omaha: 402-595-1178

NEVADA-Medicaid

Medicaid Website: http://dhcfp.nv.gov
Medicaid Phone: 1-800-992-0900

NEW HAMPSHIRE-Medicaid

Website: https://www.dhhs.nh.gov/oii/hipp.htm
Phone: 603-271-5218
Toll free number for the HIPP program: 1-800-852-3345, ext 5218

NEW JERSEY-Medicaid and CHIP	SOUTH DAKOTA-Medicaid
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	Website: http://dss.sd.gov Phone: 1-888-828-0059
NEW YORK-Medicaid	**TEXAS-Medicaid**
Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831	Website: http://gethipptexas.com/ Phone: 1-800-440-0493
NORTH CAROLINA-Medicaid	**UTAH-Medicaid and CHIP**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
NORTH DAKOTA-Medicaid	**VERMONT-Medicaid**
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
OKLAHOMA-Medicaid and CHIP	**VIRGINIA-Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: https://www.coverva.org/hipp/ Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-855-242-8282
OREGON-Medicaid	**WASHINGTON-Medicaid**
Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
PENNSYLVANIA-Medicaid	**WEST VIRGINIA-Medicaid**
Website: https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx Phone: 1-800-692-7462	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
RHODE ISLAND-Medicaid and CHIP	**WISCONSIN-Medicaid and CHIP**
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
SOUTH CAROLINA-Medicaid	**WYOMING-Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	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, 2021, 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 1/31/2023)

Patient Protection Disclosure

HMO plans generally require the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. Until you make this designation, the plan will designate one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the Insurance Carrier.

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

You do not need prior authorization from your Insurance Carrier or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact your Insurance Carrier.

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 6-30-2023)

PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

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. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

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

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax 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 meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.[1]

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

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact your Human Resources Department.

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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.

[1] An employer-sponsored 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.

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 Western Placer		4. Employer Identification Number (EIN) 94-1599904
5. Employer address 600 Sixth Street, Suite 400		6. Employer phone number 916-645-5131
7. City Lincoln	8. State CA	9. ZIP code 95648
10. Who can we contact about employee health coverage at this job? Debbie McKinnon or Rhia Zinzun		
11. Phone number (if different from above)	12. Email address dmckinnon@wpusd.org or rzinzun@wpusd.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:

☒ Some employees. Eligible employees are:

Full Time employees working 20 or more hours

- With respect to dependents:

☒ 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.

☒ 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.

Model General Notice of COBRA Continuation Coverage Rights

** Continuation Coverage Rights Under COBRA**

Introduction

You're getting this notice because you recently gained coverage under a group health plan (Schools Insurance Group). 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.

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 Schools Insurance Group, 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. Contact your employer and/or COBRA Administrator for procedures for this notice, including a description of any required information or documentation.

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. [*Add description of any additional Plan procedures for this notice, including a description of any required information or documentation, the name of the appropriate party to whom notice must be sent, and the time period for giving notice.*]

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

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

If you have questions
Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact 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.

Plan contact information

Schools Insurance Group, Attn: COBRA Administration

550 High St., Suite 201, Auburn, CA 95603

1-800-442-4199 x202

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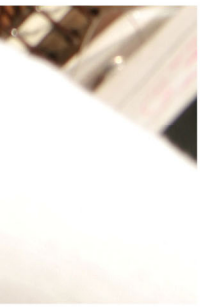

This benefit summary prepared by

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