Schools Insurance Group

2024 Employee Benefit Guide

Eureka Union School District

BENEFITS OVERVIEW

IN THIS GUIDE

We are proud to offer a comprehensive benefits package to eligible employees. The complete benefits package is briefly summarized in this booklet. Documents from the carriers will give you more detailed information about each of these programs.

You may have a cost share for some benefits and other benefits may be provided at no cost to you. In addition, you may have access to voluntary benefits with reasonable group rates that you can purchase through payroll deductions.

Eligibility for Benefits:

Please check with your Benefits Coordinator for information on your eligibility date.

Eligible dependents are your spouse or domestic partner, children under age 26 and disabled dependents of any age.

Making Changes to your Benefits:

Elections made now will remain until the next open enrollment unless you or your family members experience a qualifying event. If you experience a qualifying event, you must contact HR within 30 days. 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

If you have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please see page 43 - 44 for more details.

CONTACT INFORMATION

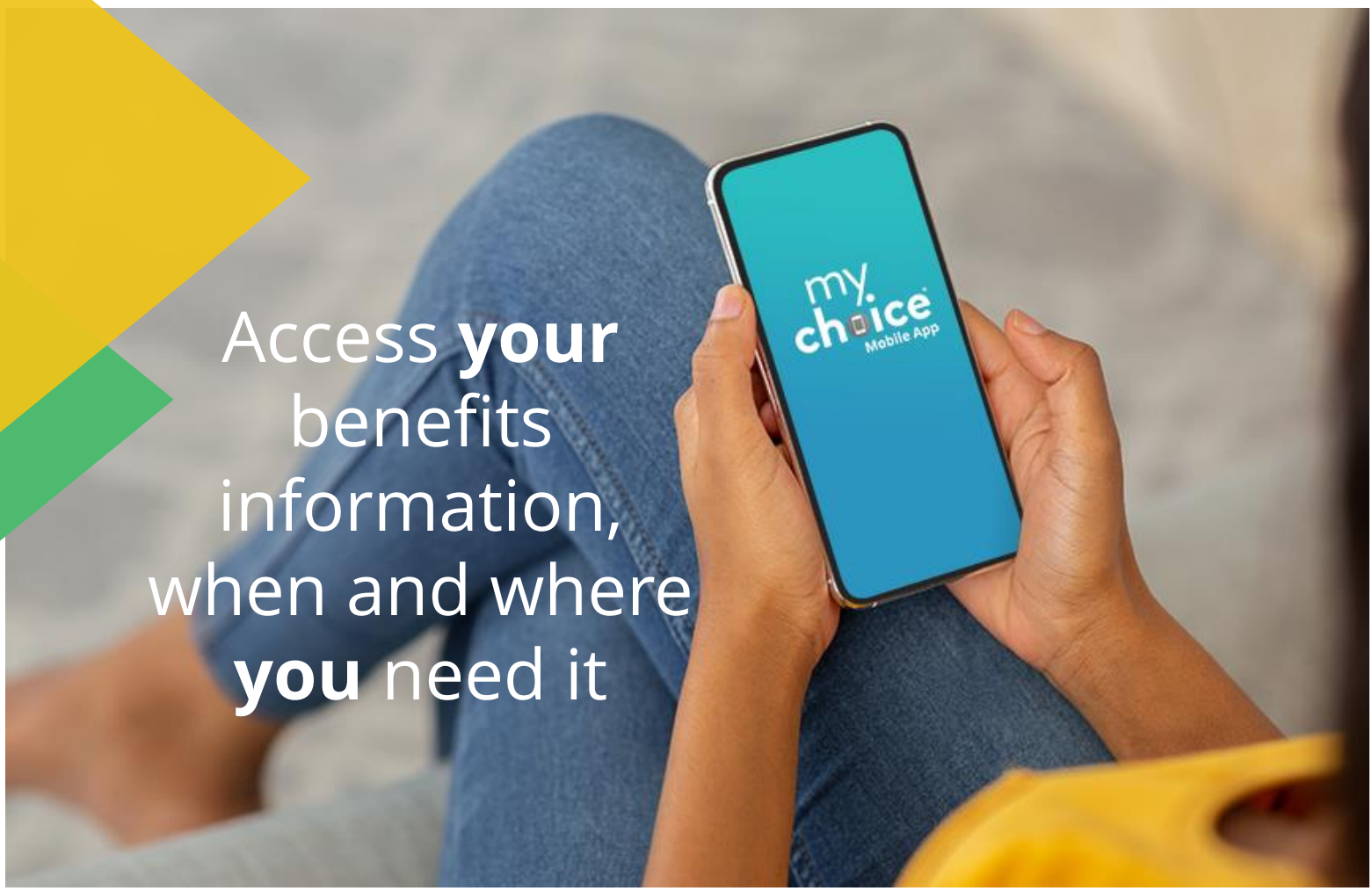
Who To Contact

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.

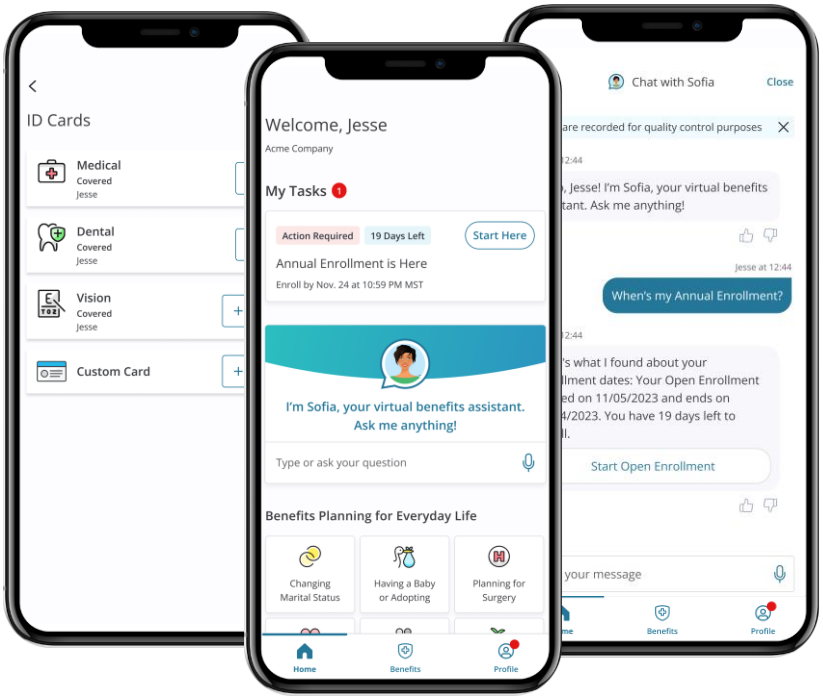
BENEFIT	ADMINISTRATOR	PHONE	WEBSITE/EMAIL
Medical	Kaiser Permanente	800.464.4000	www.kp.org
	Sutter Health Plus	855.315.5800	www.SutterHealthPlus.org
	Western Health Advantage	888.563.2250	www.ChooseWHA.com/SIG
Dental	Delta Dental	866.499.3001	www.DeltaDentalins.com
Vision	VSP	800.877.7195	www.vsp.com
Health Savings Account	Optum Bank	844.326.7967	www.optumbank.com
Life and AD&D, Disability	The Hartford	Contact your District Benefit Coordinator for more information	
Employee Assistance Program	supportlinc	888.881.5462	www.supportlinc.com
Financial Wellness	Prudential	877.444.5606	www.prudential.com/SIG
Schools Insurance Group	Melissa Gianopulos Kelley Henry	530.823.9582 ext 202 530.823.9582 ext 201	melissag@sigauburn.com kelleyh@sigauburn.com

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

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



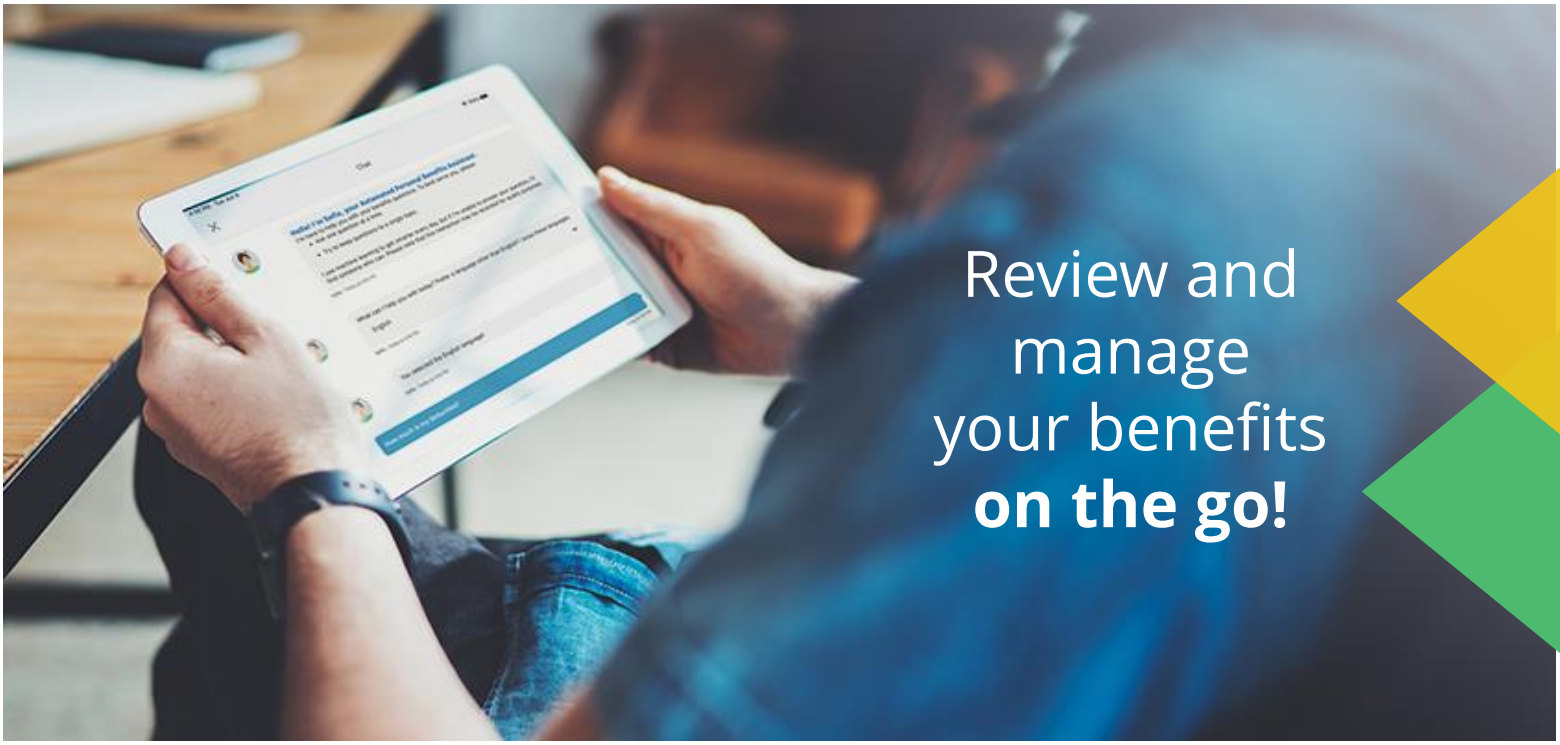
Access **your** benefits information, when and where **you** need it



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

benefitsolver®

mychoice® Mobile App



Access your benefits information on the MyChoice® benefits app!

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

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

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

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

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

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

mychoice® Mobile App

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

Understanding the Differences Between Medical Plans

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

Definitions of Medical Plans:

1. Traditional HMO (Health Maintenance Organization) Plan:

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

2. Hospital Only Deductible HMO (DHMO) Plan:

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

3. HDHP (High Deductible Health Plan) Plan:

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

For more definitions, please refer to the glossary at the end of this benefit guide.

Key Differences:

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

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

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

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

Definitions of Spending Accounts:

1. Health Savings Account (HSA)

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

2. Flexible Spending Accounts (FSA)

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

Kaiser Permanente $25 HMO (Chiro)

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 / $50 copay	
Telemedicine	No Charge	
Lab & X-Ray	No Charge	
Chiropractic (up to 30 visits per year)	$10 copay	
Acupuncture Benefits	Not Covered	
Hospitalization Services		
Emergency Room (copay waived if admitted)	$100	
Urgent care visit	$25 copay	
Hospital inpatient services	$250 copay per admission	
Outpatient Surgery	$100 copay	
Mental Health Services		
Outpatient mental health & substance abuse	$25 copay	
Inpatient mental health & substance abuse	$250 copay per admission	
Prescription (Rx) Drug Services	**Retail 30 Day Supply**	**Mail Order 100 Day Supply**
Most Generic Items	$10 copay	$20 copay
Calendar Year Rx Deductible (*does not apply to generics*)	$100 Individual / $200 Family	
Most Brand Items	$25 copay after Rx deductible	$50 copay after Rx deductible
Specialty Items	20% (not to exceed $150) for up to a 30-day supply after Rx 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).

Kaiser Permanente $1000 Deductible HMO 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	$1,000 Individual / $2,000 Family	
Calendar Year Out-of-Pocket Maximum	$3,000 Individual / $6,000 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	$20 copay	
Telemedicine	No Charge	
Lab & X-Ray	$10 copay	
Chiropractic (up to 30 visits per year)	$10 copay	
Acupuncture Benefits	$10 copay	
Hospitalization Services		
Emergency Room	20% after deductible	
Urgent care visit	$20 copay	
Hospital inpatient services	20% after deductible	
Outpatient Surgery	20% after deductible	
Mental Health Services		
Outpatient mental health & substance abuse	$20 copay	
Inpatient mental health & substance abuse	20% after deductible	
Prescription (Rx) Drug Services	**Retail 30 Day Supply**	**Mail Order 100 Day Supply**
Most Generic Items	$10 copay	$20 copay
Most Brand Items	$30 copay	$60 copay
Specialty Items	20% (not to exceed $250) for up to a 30-day supply	

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Kaiser Permanente $2000 HDHP HMO 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 / $3,200 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	Not Covered
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).

Kaiser Permanente $3000 HDHP HMO 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	$3,000 Individual / $3,200 Ind. In fam. / $6,000 Family
Calendar Year Out-of-Pocket Maximum	$5,250 Individual / $5,250 Ind. In fam. / $10,500 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	$30 copay after deductible
Specialty Care Visits	$50 copay after deductible
Telemedicine	No charge after deductible
Lab & X-Ray	$10 per encounter after deductible
Chiropractic	Not Covered
Acupuncture Benefits	Not Covered
Hospitalization Services	
Emergency Room (copay waived if admitted)	30% after deductible
Urgent care visit	$30 copay after deductible
Hospital inpatient services	30% after deductible
Outpatient surgery	30% after deductible
Mental Health Services	
Outpatient mental health & substance abuse	Individual: $30 copay per visit after deductible; Group: $15 copay per visit after deductible & $5 copay per visit after deductible
Inpatient mental health & substance abuse	30% after deductible
Prescription Drug Services	**Retail (up to 30 days)**
Most Generic Items	$15 copay after deductible
Most Brand Items	$30 copay after deductible
Specialty Items	20% (not to exceed $250) per Rx after 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).

Save time with prescription delivery

Did you know? Most medications can be delivered to your door.*

- Delivery in 3 to 5 days at no cost
- Same-day or next-day delivery for an additional fee

Get started

at **kp.org/pharmacy** or on the **Kaiser Permanente app**.

*Some exclusions apply. For more information, contact the pharmacy. Same-day and next-day prescription delivery services may be available for an additional fee. These services are not covered under your health plan benefits and may be limited to specific prescription drugs, pharmacies, and delivery addresses. Order cutoff times and delivery days may vary by pharmacy location. Kaiser Permanente is not responsible for delivery delays by mail carriers. Kaiser Permanente may discontinue same-day and next-day prescription delivery services at any time without notice and other restrictions may apply. Medi-Cal and Medicaid beneficiaries should ask your local pharmacy for more information.

KAISER PERMANENTE®

613666924 March 2021

Your costs during preventive care visits

Preventive care visits can help you stay healthy. Depending on your plan, most of these visits are covered at no cost. But if you have symptoms of a health condition, you may need diagnostic or treatment services. If that happens, you may get a bill for those additional services.

Preventive care

The purpose of a preventive care visit is to help keep you healthy and uncover possible health problems early.

Examples

- Blood pressure screening for all adults
- Colorectal cancer screening for adults over 50
- Type 2 diabetes screening for adults with high blood pressure
- Immunizations for children from birth to 18 years

What you'll pay

For most members, preventive care visits are covered at no cost.

Learn more

For a full list of preventive care services, visit **kp.org/prevention**.

Diagnostic or treatment services

Any care or service that's used to diagnose or treat a health problem is not considered preventive. These services are given in response to symptoms of a health condition.

Examples

- Some prescription drugs, which may be used to treat or manage a condition you already have
- Lab tests or X-rays
- Procedures, like removing a mole or getting stitches

What you'll pay

Diagnostic or treatment services may result in a bill – which may include a copay, coinsurance, or deductible.

Learn more

For questions about a medical bill, visit **kp.org/mybenefits** or call **1-800-464-4000,** 24/7 (closed holidays) or **711** (TTY). We also offer payment plans and financial assistance for members who qualify.

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

KAISER PERMANENTE®

525495827 September 2020

Sutter Health Plus HMO $25 Copay

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	$25 copay	
Specialty Care Visits	$50 copay	
Lab & X-Ray	$20 copay	
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	$250 copay per admission	
Outpatient surgery	$100 copay	
Mental Health Services		
Outpatient mental health & substance abuse	$25 copay	
Inpatient mental health & substance abuse	$250 copay per admission	
Prescription (Rx) Drug Services	**Retail 30 Day Supply**	**Mail Order 100 Day Supply**
Generic Items	$10 copay	$20 copay
Calendar Year Rx Deductible (*does not apply to generics*)	$100 Individual / $200 Family	
Preferred Brand Items	$30 copay after Rx deductible	$60 copay after Rx deductible
Non-Preferred Brand Items	$60 copay after Rx deductible	$120 copay after Rx deductible
Specialty Items	20% (not to exceed $100) for up to a 30-day supply after Rx 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 $1000 Deductible HMO

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	$1,000 Individual / $1,000 Ind. in family / $2,000 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	
Well-Child Visits	No Charge	
Prenatal Care Visits and First Postpartum Visit	No Charge	
Office Visits		
Primary Care Visits	PCP Office visit: $20 copay; Sutter Walk-in care / Telehealth: $10 copay;	
Specialty Care Visits	Specialist Office visit: $20 copay; Telehealth: $10 copay	
Lab & X-Ray	Lab: $20 copay; X-ray: $10 copay	
MRI, CT, PET Scans	$50 copay	
Acupuncture Benefits & Chiropractic *(up to 20 visits per year combined)*	Covered	
Hospitalization Services		
Emergency Room (copay waived if admitted)	20% coinsurance after deductible	
Urgent care visit	$20 copay	
Hospital inpatient services	20% coinsurance after deductible	
Outpatient surgery	20% coinsurance after deductible	
Mental Health Services		
Outpatient mental health & substance abuse	Individual Office visit: $20 copay; Group / Telehealth Office visit: $10 copay; Other Outpatient Services: 20% coinsurance after deductible	
Inpatient mental health & substance abuse	20% coinsurance after deductible	
Prescription (Rx) 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	20% (not to exceed $100) for up to a 30-day supply	

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Sutter Health Plus $1600 HDHP HMO

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	$1,600 Individual / $3,200 Ind. in family / $3,200 Family
Calendar Year Out-of-Pocket Maximum	$3,200 Individual / $3,200 Ind. in family / $6,400 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 days)**
	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 HDHP HMO

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 / $3,200 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 after deductible	
Lab & X-Ray	20% coinsurance after deductible	
Acupuncture Benefits	20% coinsurance after deductible	
Hospitalization Services		
Emergency Room (copay waived if admitted)	20% coinsurance after deductible	
Urgent care visit	20% coinsurance after deductible	
Hospital inpatient services	20% coinsurance after deductible	
Outpatient surgery	20% coinsurance after deductible	
Mental Health Services		
Outpatient mental health & substance abuse	20% coinsurance after deductible	
Inpatient mental health & substance abuse	20% coinsurance after deductible	
Prescription Drug Services	**Retail 30 Day Supply**	**Mail Order 100 Day Supply**
	AFTER MEDICAL DEDUCTIBLE	
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).

What is Preventive Care?

Preventive care helps to protect against disease and to provide early detection of certain health conditions. Talk to your provider or care team about what is right for you.

Covered Preventive Services

Sutter Health Plus covers a variety of preventive care services at no cost share*, which may include:

- Comprehensive preventive care visits and counseling, including well-woman exams
- Family planning counseling and services
- Hearing exams
- Maternity and newborn care
- Routine preventive imaging services and laboratory tests
- Screening tests
- Smoking cessation counseling and interventions
- Some drugs and supplies, including specific vitamin and mineral supplements
- Vaccines and immunizations
- Well-child preventive care exams

Preventive vs. Diagnostic Care

Recognizing the difference between preventive care and diagnostic care is important. The goal of preventive care is disease prevention and early detection. Diagnostic care involves evaluation and treatment of known or suspected conditions. When you receive diagnostic care, you may incur out-of-pocket costs based on your health plan coverage.

Here are a few examples of how a service may be either preventive or diagnostic care, depending on the situation:

PREVENTIVE CARE	DIAGNOSTIC CARE
Screening mammogram for women age 40 and over when there are no symptoms or previous breast disease diagnosis	Mammogram after suspicious results are found on a screening mammogram or when signs of possible breast disease are present
Diabetes screening using a lab test to check if a person has a high blood sugar level and possible diabetes	Diabetes monitoring done on a routine basis using lab tests to check blood sugar control
Colonoscopy when no symptoms are present and there is no personal history of colon disease	Colonoscopy when symptoms are present or there is a history of colon disease

**Check your* Evidence of Coverage and Disclosure Form *for details*

Pharmacy Benefits

Managing Your Prescriptions

Sutter Health Plus partners with CVS Caremark® 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.

Mail Order Pharmacy

Sign up for mail order pharmacy service through CVS Caremark Mail Service 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 CVS Specialty®. These drugs are mailed to your home at no cost.

CVS Caremark 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
- Check Drug Costs
- Sutter Health Plus Formulary
- Mail Order Pharmacy Information

Visit *sutterhealthplus.org/pharmacy*

Sutter Health Plus
Your Health Plan

Western Health Advantage Prime HMO $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.

Benefits	**In-Network Only**	
Calendar Year Deductible	None	
Calendar Year Out-of-Pocket Maximum	$1,500 Individual / $2,500 Family	
Preventive Care	No Charge	
Office Visits		
Primary Care Physician Office Visits	$25 copay	
Specialist Physician Office Visits	$50 copay	
Lab & X-Ray	No copay	
Acupuncture (up to 20 visits per year)	$15 copay	
Chiropractic Care (up to 20 visits per year)	$15 copay	
Hospitalization Services		
Emergency room (copay waived if admitted)	$100 copay	
Urgent care visit	$35 copay	
Hospital inpatient services	$250 copay per admission	
Outpatient surgery	$100 copay	
Mental Health Services		
Outpatient mental health and substance abuse	$25 copay	
Inpatient mental health and substance abuse	$250 copay per admission	
Prescription (Rx) Drug Services	**Retail 30 Day Supply**	**Mail Order 90 Day Supply**
Tier 1	$10 copay	$25 copay
Calendar Year Rx Deductible (does not apply to generics)	$100 Individual / $200 Family	
Tier 2	$30 copay after Rx deductible	$75 copay after Rx deductible
Tier 3	$50 copay after Rx deductible	$125 copay after Rx 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).

Western Health Advantage $1000 Deductible HMO

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.

Benefits	In-Network Only	
Calendar Year Deductible	$1,000 Individual / $2,000 Family	
Calendar Year Out-of-Pocket Maximum	$3,000 Individual / $6,000 Family	
Preventive Care	No Charge	
Office Visits		
Primary Care Physician Office Visits	$20 copay	
Specialist Physician Office Visits	$20 copay	
Lab & X-Ray	No copay	
Acupuncture (up to 20 visits per year)	$15 copay	
Chiropractic Care (up to 20 visits per year)	$15 copay	
Hospitalization Services		
Emergency room (copay waived if admitted)	20% coinsurance after deductible	
Urgent care visit	$50 copay	
Hospital inpatient services	20% coinsurance after deductible	
Outpatient surgery	$250 copay after deductible	
Mental Health Services		
Outpatient mental health and substance abuse	20% coinsurance after deductible	
Inpatient mental health and substance abuse	Professional: $20 copay; Other outpatient services: No Charge	
Prescription (Rx) 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
Self-injectable specialty drugs	20% (not to exceed $100) for up to a 30-day supply	

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 HDHP HMO

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.

Benefits	**In-Network Only**	
Calendar Year Deductible	$1,800 Individual / $3,200 Ind. In Family / $3,600 Family	
Calendar Year Out-of-Pocket Maximum	$3,600 Individual / $3,600 Ind. In Family / $7,200 Family	
Preventive Care	No Charge (Deductible Waived)	
Office Visits	*AFTER DEDUCTIBLE*	
Primary Care Physician Office Visits	No copay after deductible	
Specialist Physician Office Visits	No copay after deductible	
Lab & X-Ray	No copay after deductible	
Acupuncture/Chiro (up to 20 visits per year)	No copay after deductible	
Hospitalization Services		
Emergency room (copay waived if admitted)	No copay after deductible	
Urgent care visit	No copay after deductible	
Hospital inpatient services	No copay after deductible	
Outpatient surgery	No copay after deductible	
Mental Health Services		
Outpatient mental health and substance abuse	No copay after deductible	
Inpatient mental health and substance abuse	No copay after deductible	
Prescriptions	**Retail 30 Day Supply**	**Mail Order 90 Day Supply**
Drug Deductible	*AFTER COMBINED MEDICAL DEDUCTIBLE*	
Tier 1	None	None
Tier 2	$30 copay	$75 copay
Tier 3	$50 copay	$125 copay
Self-injectable specialty drugs	No Charge	

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 HDHP HMO

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.

Benefits	**In-Network Only**	
Calendar Year Deductible	$2,800 Individual / $3,200 Ind. In Family / $5,600 Family	
Calendar Year Out-of-Pocket Maximum	$4,000 Individual /$4,000 Ind. In Family / $8,000 Family	
Preventive Care	No Charge (Deductible Waived)	
Office Visits	*AFTER DEDUCTIBLE*	
Primary Care Physician Office Visits	$40 copay after deductible	
Specialist Physician Office Visits	$40 copay after deductible	
Lab & X-Ray	No copay after deductible	
Acupuncture/Chiro (up to 20 visits per year)	No copay after deductible	
Hospitalization Services		
Emergency room (copay waived if admitted)	$100 copay after deductible	
Urgent care visit	$50 copay after deductible	
Hospital inpatient services	$500 per day copay after deductible	
Outpatient surgery	$250 copay after deductible	
Mental Health Services		
Outpatient mental health and substance abuse	$500 per day copay after deductible	
Inpatient mental health and substance abuse	$40 copay after deductible	
Prescriptions	**Retail 30 Day Supply**	**Mail Order 90 Day Supply**
Drug Deductible	*AFTER COMBINED MEDICAL DEDUCTIBLE*	
Tier 1	$10 copay	$25 copay
Tier 2	$30 copay	$75 copay
Tier 3	$50 copay	$125 copay
Self-injectable specialty drugs	20% (not to exceed $100) for up to a 30-day supply	

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).

You've got choices for getting the care you need, **wherever you are, whenever you need it.**

All WHA plans include choices for accessing care — virtual care, urgent and emergency care, and care that travels with you — whether you are on a vacation or attending college outside of WHA's service area. You should never have to worry about access to care for yourself and your family.

western health

visit • mywha.org/careoptions

call • 916.563.2250; 888.563.2250 toll-free; TTY 711

EMERGENCY CARE

If you or a family member experiences a life-threatening condition:

- **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.
- **Go to the hospital:**
  Even when outside WHA's service area and hospitalized because of an emergency, WHA covers those services. However, you (or a family, friend, or hospital staff member) must notify WHA within 24 hours. Follow-up care after an emergency room visit is not considered an "emergency," and you may be responsible for the cost of that service.

  See **mywha.org/ER** for more information.

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
- Loss of consciousness, severe dizziness

URGENT CARE

In an urgent care situation, you have two options:

- **In-network Urgent Care Center:**
  To keep your care coordinated, it's always best to try and reach your doctor's office first. They can help you find a WHA network facility affiliated with your PCP's medical group. Search under Facilities online at **mywha.org/directory**; choose Urgent Care Centers and then filter by location and medical group.
- **Virtual 24/7 Urgent Care:**
  In the service area or away from home, 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® connects you with a healthcare professional for minor injuries and illnesses. Visit **mywha.org/Teladoc** to access the Teladoc website and download their mobile app.

Urgent Care is best for...

Minor injuries and common illnesses, such as:

- Cuts and abrasions, including stitches
- Muscle sprains and strains (or falls)
- Sinus problems
- Cold/flu symptoms (sore throat, coughs)
- Pink eye, ear infections
- Urinary tract infection
- Skin infections and rashes

When receiving urgent care telehealth services through Teladoc, all services shall be provided consistent with existing appointment standards and access requirements. If your plan has out-of-area benefits, members can access services either via telehealth or on an in-person basis. Certain conditions apply. Review your plan documents available at **mywha.org** for details on cost-sharing and balance billing protections.

CARE WHILE TRAVELING

If you get injured or sick while traveling outside WHA's service area or even globally, your health plan covers emergency services, and offers the support of **Assist America** at no added cost. Anytime you travel 100 miles or more away from home and for less than 90 days, their 24/7 operations center can assist WHA members in the event of an emergency while traveling.

Just a few of the support services include:

- Global network of medical providers for consultation, prescription assistance, and evaluation
- Critical care monitoring and case management
- Emergency medical evacuation
- Care of minor children
- Legal help and interpreters
- Lost luggage and document assistance
- Pre-trip information

Visit **mywha.org/travel** to download the Assist America Mobile App for a one-touch connection to the Assist America operations center. You can also call Assist America's 24/7 Operations Center at 800.872.1414 (toll-free within the U.S.) or 609.986.1234 (collect call from outside the U.S.).

CARE FOR COLLEGE STUDENTS

When your child heads off to college, there's so much to think about and ensuring they know how to handle health issues on their own is important for a parent's peace of mind. Fortunately, WHA allows dependent students away from home to continue their coverage.

Routine care is covered when provided by a network practitioner, which may require choosing a new PCP close to school (if in WHA's service area) or traveling back to WHA's service area during holiday breaks for most services. When a trip home isn't an option, virtual visits are available with most PCPs and specialty providers.

ON-THE-GO RESOURCES

MyWHA Mobile App • mywha.org/apps

Medical Group Portals • mywha.org/connect

Partners in Care • mywha.org/partners

western health

HEALTH SAVINGS ACCOUNT

A Health Savings Account (HSA) is a tax-favored account used in conjunction with your HDHP/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: HDHP/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	2024 IRS Limits for Contribution
Employee Only Plan	$4,150
Family Plan	$8,300

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
- Certain over-the-counter medications

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 2 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 IIB

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%
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).

DELTA DENTAL®

SmileWay®
Your smile. Your health. Your way.

Support for chronic conditions

Your plan offers additional dental coverage to support your overall health

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

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

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

SmileWay® Wellness Benefits[1]

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

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

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

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

deltadentalins.com/enrollees

EF89A #133959A (rev. 11/22)

VSP Vision Plan 12/12/24 $0 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** **Prescription Glasses** **Contact Lens fitting & evaluation**	**$0** **$0** **Max $60**
Frequency	**Exam** **Lenses or contact lenses** **Frame**	**Once every 12 months** **Once every 12 months** **Once every 24 months**
	In-Network	**Out-of-Network**
Exam	**100% after copay**	**Reimbursed up to $50**
Lenses **Single** **Bifocal** **Trifocal**	 **100% after copay** **100% after copay** **100% after copay**	 **Reimbursed up to $50** **Reimbursed up to $75** **Reimbursed up to $100**
Frame	**$200 allowance + 20% off amount over allowance**	**Reimbursed up to $70**
Contact Lenses ***(in lieu of lens/frame)*** **Elective** **Medically Necessary**	 **$200 allowance for contacts and lens exam (fitting and evaluation) + 15% off contact lens exam** **100% after copay**	 **Reimbursed up to $105** **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, 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).

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

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

In-the-moment support

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

Financial expertise

Consultation and planning with a financial counselor.

Legal consultation

By phone or in-person with a local attorney.

Short-term counseling

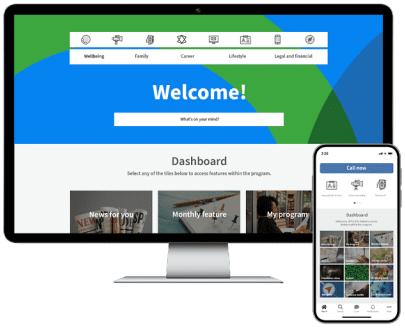
Access up to **three (3) no-cost counseling sessions**, in-person or via video, to resolve stress, depression, anxiety, work-related pressures, relationship issues or substance abuse.

Convenience resources

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

Confidentiality

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



Your web portal and mobile app

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

Convenient, on-the-go support

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

Start with Navigator

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

supportlinc
EMPLOYEE ASSISTANCE

Download the mobile app today!

888-881-5462

supportlinc.com
group code:
sig






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

SIGWellness

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

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

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

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

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

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

Prudential can help you plan for a brighter future

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

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

Coming Soon

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

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

Prudential

1046999-00001-00

Experience a clear path to financial planning

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

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

…And inspirational…

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

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

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

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

A Convenient Way to Achieve Financial Wellness

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

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

Solution to reduce debt and financial stress

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

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

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

Planning and Guidance

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

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

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

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

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

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

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".

PATIENT PROTECTIONS DISCLOSURE

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

For children, you may designate a pediatrician as the primary care provider.
You do not need prior authorization from Kaiser Permanente / Sutter Health Plus / Western Health Advantage 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 Kaiser Permanente at 800.464.4000 or www.kp.org / Sutter Health Plus at 855.315.5800 or www.SutterHealthPlus.org / Western Health Advantage at 888.563.2250 or www.ChooseWHA.com/SIG.

WOMEN'S HEALTH & CANCER RIGHTS ACT

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

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under the plan. Therefore, the following deductibles and coinsurance apply:

Plan 1: Kaiser Permanente $25D (Chiro) (Individual: 0% coinsurance and $0 deductible; Family: 0% coinsurance and $0 deductible)

Plan 2: Kaiser Permanente $1000 DHMO Plan (Individual: 20% coinsurance and $1,000 deductible; Family: 20% coinsurance and $2,000 deductible)

Plan 3: Kaiser Permanente $2000 HDHP Plan (Individual: 0% coinsurance and $2,000 deductible; Per Family Member: 0% coinsurance and $3,200 deductible; Family: 0% coinsurance and $4,000 deductible)

Plan 4: Kaiser Permanente $3000 HDHP Plan (Individual: 30% coinsurance and $3,000 deductible; Per Family Member: 30% coinsurance and $3,200 deductible; Family: 30% coinsurance and $6,000 deductible)

Plan 5: Sutter Health Plus $25 Copay (Individual: 0% coinsurance and $0 deductible; Family: 0% coinsurance and $0 deductible)

Plan 6: Sutter Health Plus $1000 DHMO (Individual: 20% coinsurance and $1,000 deductible; Per Family Member: 20% coinsurance and $1,000 deductible; Family: 20% coinsurance and $2,000 deductible)

Plan 7: Sutter Health Plus $1600 HDHP (Individual: 0% coinsurance and $1,600 deductible; Per Family Member: 0% coinsurance and $3,200 deductible; Family: 0% coinsurance and $3,200 deductible)

Plan 8: Sutter Health Plus $2500 HDHP (Individual: 20% coinsurance and $2,500 deductible; Per Family Member: 20% coinsurance and $3,200 deductible; Family: 20% coinsurance and $5,000 deductible)

Plan 9: Western Health Advantage Prime $25 (Individual: 0% coinsurance and $0 deductible; Family: 0% coinsurance and $0 deductible)

Plan 10: Western Health Advantage $1000 DHMO (Individual: 20% coinsurance and $1,000 deductible; Family: 20% coinsurance and $2,000 deductible)

Plan 11: Western Health Advantage $1800 HDHP (Individual: 0% coinsurance and $1,800 deductible; Per Family Member: 0% coinsurance and $3,200 deductible; Family: 0% coinsurance and $3,600 deductible)

Plan 12: Western Health Advantage $2800/$40 HDHP (Individual: 0% coinsurance and $2,800 deductible; Per Family Member: 0% coinsurance and $3,200 deductible; Family: 0% coinsurance and $5,600 deductible)

If you would like more information on WHCRA benefits, please call your Plan Administrator at 530.823.9582 ext 202 or melissag@sigauburn.com.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

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

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, 2024. Contact your State for more information on eligibility –

ALABAMA – Medicaid	**ALASKA – Medicaid**
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid	**CALIFORNIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**FLORIDA – Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

GEORGIA – Medicaid	INDIANA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162, Press 2	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)	**KANSAS – Medicaid**
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	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
KENTUCKY – Medicaid	**LOUISIANA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 kEmail: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kynect.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	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	**MASSACHUSETTS – Medicaid and CHIP**
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid	**MISSOURI – Medicaid**
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005

MONTANA – Medicaid	NEBRASKA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
NEVADA – Medicaid	**NEW HAMPSHIRE – Medicaid**
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 5218
NEW JERSEY – Medicaid and CHIP	**NEW YORK – 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: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**OREGON – Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	**RHODE ISLAND – Medicaid and CHIP**
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP)(pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	**SOUTH DAKOTA – Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS – Medicaid	**UTAH – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
VERMONT – Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924

WASHINGTON – Medicaid	WEST VIRGINIA – Medicaid and CHIP
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP	**WYOMING – Medicaid**
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

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

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
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 1/31/2026)

HIPAA NOTICE OF PRIVACY PRACTICES REMINDER

Protecting Your Health Information Privacy Rights
Schools Insurance Group is committed to the privacy of your health information. The administrators of the Schools Insurance 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 and your rights under the law are described in the Plan's Notice of Privacy Practices. You may receive a copy of the Notice of Privacy Practices by contacting Melissa Gianopulos - Eligibility Coordinator at 530.823.9582 ext 202 or melissag@sigauburn.com.

HIPAA SPECIAL ENROLLMENT RIGHTS

Schools Insurance Group Health Plan Notice of Your HIPAA Special Enrollment Rights

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

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

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

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

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

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

To request special enrollment or to obtain more information about the plan's special enrollment provisions, contact Melissa Gianopulos - Eligibility Coordinator at 530.823.9582 ext 202 or melissag@sigauburn.com.

Important Warning

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

NOTICE OF CREDITABLE COVERAGE

Important Notice from Schools Insurance Group

About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with 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 two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. **Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.**
2. **Schools Insurance Group has determined that the prescription drug coverage offered by the medical plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.**

When Can You Join a Medicare Drug Plan?

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

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

What Happens to Your Current Coverage if You Decide to Join a Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current Schools Insurance Group coverage will not be affected. You can keep this coverage if you elect part D.

If you do decide to join a Medicare drug plan and drop your current Schools Insurance 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…

Contact the person listed below for further information. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through 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).

Remember: Keep this Creditable Coverage Notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date:	**July 01, 2024**
Name of Entity/Sender:	**Schools Insurance Group**
Contact—Position/Office:	**Melissa Gianopulos - Eligibility Coordinator**
Office Address:	**550 High Street, Suite 201** **Auburn, California 95603** **United States**
Phone Number:	**530.823.9582 ext 202**

COBRA GENERAL NOTICE

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

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

Introduction

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

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

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

What is COBRA continuation coverage?

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

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

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

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. You must provide this notice to: Melissa Gianopulos.

How is COBRA continuation coverage provided?

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

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

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

Disability extension of 18-month period of COBRA continuation coverage

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

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

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

Are there other coverage options besides COBRA Continuation Coverage?

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

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

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

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

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

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

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

If you have questions

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

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

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
Melissa Gianopulos - Eligibility Coordinator
550 High Street, Suite 201
Auburn, California 95603
United States
530.823.9582 ext 202

COBRA Administrator
P&A Group
(716) 852-2611
cobra@padmin.com

MARKETPLACE NOTICE

Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: General Information

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

What is the Health Insurance Marketplace?

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

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

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

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

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

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

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

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

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

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

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

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

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

What about Alternatives to Marketplace Health Insurance Coverage?

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

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

How Can I Get More Information?

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

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.

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.

<table>
<tr><td colspan="2">3. Employer name
Eureka Union School District</td><td colspan="2">4. Employer Identification Number (EIN)
94-6002089</td></tr>
<tr><td colspan="2">5. Employer address
5455 Eureka Road</td><td colspan="2">6. Employer phone number
916-774-1205</td></tr>
<tr><td colspan="2">7. City
Granite Bay</td><td>8. State
California</td><td>9. ZIP code
95746</td></tr>
<tr><td colspan="4">10. Who can we contact about employee health coverage at this job?
Benefits Coordinator</td></tr>
<tr><td colspan="2">11. Phone number (if different from above)</td><td colspan="2">12. Email address
tparker@eurekausd.org</td></tr>
</table>

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 or Part Time employees working 20 or more hours per week

- 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.

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