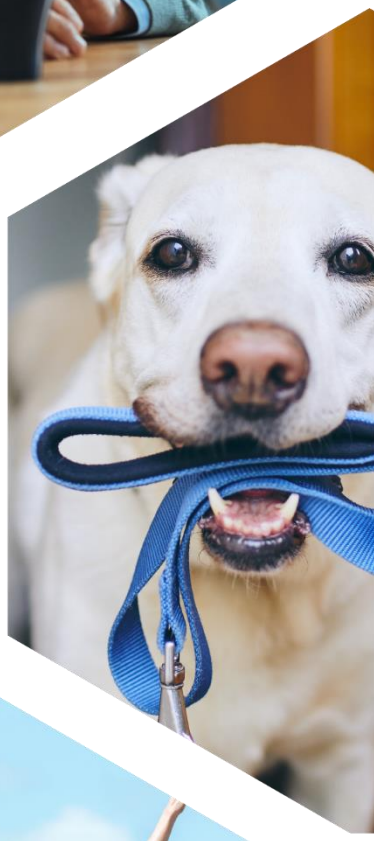
San Diego Unified
SCHOOL DISTRICT

Retirees



Benefits Information Guide

2024

Welcome to the San Diego Unified School District 2024 Retiree Benefits Program!

We know your benefits are important to you and your entire family, and we are proud to offer a generous and comprehensive benefits package to eligible retirees and their eligible dependents. This is why we developed a benefits program that will meet the broad needs of our retirees and their families. The programs referenced in this booklet are meant to keep you healthy and productive, while also giving you options to plan for and protect yourself in the future. Offering competitive and cost effective benefits to San Diego Unified School District's retirees is important. It is a way for us to say "thank you" for contributing to the underlying success of the District.

The District is a member of the California Schools Voluntary Employees Benefits Association (VEBA). Membership provides additional resources for you and your enrolled dependents.

To get the most out of your retiree health benefits program, we encourage you to review this booklet in its entirety.

Enclosed you will find:

- Who is eligible to participate
- How to enroll and how to make changes during the year, if applicable
- Each benefit and a summary of what is covered under the plan
- The Insurance Companies who administer our benefits and how to contact them if you need assistance

If you have any questions about the retiree health benefits described herein or would like more information, please refer to your plan documents and insurance booklets or contact the District's Employee Benefits Department.

We're here to help!

If you have any questions at all,
please contact the District's
Employee Benefits Department.

Phone: 619-725-8130
Email: employeebenefits@sandi.net

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

Discover Your Benefits

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

Before You Retire: Retiree Checklist

Planning to Retire? Here is a checklist to get you started…

- ✓ Visit CalSTRS/CalPERS web sites for information specific to planning your retirement. Use the calculators available on those web sites to estimate your monthly benefit.
- ✓ CalSTRS members: Six months before retiring, submit your Service Retirement Application and other required forms online through myCalSTRS account.
- ✓ CalPERS members: Six months before retiring, fill out and mail the Retirement Allowance Estimate Request. Three months before retiring, submit your completed retirement application and required documents to CalPERS online through myCalPERS account.
- ✓ Submit your Resignation/Retirement/Separation Notice to your immediate supervisor with your retirement effective date. This notice is available on the Human Resource Services web page under Human Resources Forms.
- ✓ If you are 65 or older: Three months prior to retirement, enroll in Medicare Parts A and B with the Social Security Administration. **This is extremely important prior to enrolling in the District retiree health plan.**
- ✓ The San Diego Unified School District Benefits Department will mail out a package that will include information about all of your options to continue Health and Life Insurance as a District Retiree. Visit our Retiree benefits webpage (Sandiegounified.org/departments/benefits/Retiree Benefits) for additional information.

Important

This is not meant to be an all exhaustive list of what employees should be doing to plan for retirement. It is highly recommended you review requirements by visiting the pension system web sites and talking to a benefits counselor.

Employee Benefits

Website: www.sandiegounified.org/departments/benefits

Phone: 619-725-8130

Email: employeebenefits@sandi.net

CalPERS

Website: www.calpers.ca.gov

Phone: 888-CalPERS (888-225-7377)

Human Resources

Website: www.sandiegounified.org/departments/human_resources

Phone: 619-725-8000

CalSTRS

Website: www.calstrs.com

Phone: 800-228-5453 or 916-414-1099

Fiscal Control: 403(b) & 457(b)

Website: www.sandiegounified.org/departments/controller/fiscal_control

Phone: 619-725-7679

Social Security Administration

Website: www.ssa.gov

Phone: 800-772-1213

Eligibility & Enrollment

Who Can Enroll?

A retiree from the San Diego Unified School District may continue medical and dental benefits provided the retiree:

- Was enrolled in District-sponsored medical and dental benefits plans immediately preceding retirement, and
- Receives a monthly service retirement benefit from the California Public Employees' Retirement System (CalPERS) or the California State Teachers' Retirement System (CalSTRS), and
- Payment of premium is received within 31 days of the date coverage would normally terminate, and
- Has been continuously enrolled in a District-sponsored medical and dental plan since retirement.

Eligible retirees may also choose to enroll eligible family members, including:

- For medical and dental:
  - A legal spouse who is not on active duty as a member of the Armed Forces, and
  - A Domestic Partner (DP) who is not on active duty as a member of the Armed Forces and who is not legally married to another individual.
- For medical only:
  - An eligible retiree's child (including any stepchild, legally adopted child, or the biological child of the retiree's spouse or domestic partner, or child for whom the retiree is named legal guardian by court order) who has not reached their 26th birthday, is not covered for benefits as an employee of the District, and is not on active duty as a member of the armed forces.
  - An eligible retiree's child (including any stepchild, legally adopted child, or the biological child of the retiree's spouse or domestic partner, or child for whom the retiree is named legal guardian by court order) who is at least 26 years of age, is primarily dependent upon the retiree for support and maintenance and is incapable of self-sustaining employment because of a mental or physical disability and has been approved by the medical benefits plan i.e., Kaiser or UnitedHealthcare, as being totally disabled prior to reaching age 26.

Your COBRA Rights

Retirees and dependents who were enrolled in a District-sponsored dental and vision plan may be eligible to independently continue benefits, for up to 18 additional months based on their rights under the federal COBRA law, by paying the full monthly premiums (plus 2%) to the District. Enrollment must be made through the District within 60 days of a retiree's separation from the District.

Tax Implications for Domestic Partnerships and Covered Dependents

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

Premiums for children:

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

Dependent Eligibility Verification Requirements

Eligible Dependent Type	Eligible Dependent Definition	Required Documentation for Proof of Eligibility
Legal Spouse	Legally married spouse as defined by State law	• If married less than one year, please provide copy of marriage certificate • If married more than one year, please provide copy of the first two pages of the most recent Federal Tax Return with signature of Employee and Spouse (blackout financial information)**
State-Registered Domestic Partner (RDP)	Same-sex or opposite-sex domestic partner age 18 or older	• If California Certificate of Domestic Partnership (CCDP) was issued by the California Secretary of State within the last year, please provide a copy • If CCDP was issued more than one year ago, please provide copy of the most recent CA State Tax Return with signature of Employee and RDP (blackout financial information)**
Unregistered Domestic Partner	Same-sex domestic partner age 18 or older who meet District requirements in their Declaration of Domestic Partnership	• San Diego Unified School District Declaration of Domestic Partnership (including joint residence and financial interdependence documentation) and Domestic Partner Health Care Enrollment Statement
Biological Child	Direct biological child (under age 26)	• Government-issued Birth Certificate reflecting that the child is the Employee's child, or • A copy of the first two pages of the most recent Federal Tax Return tax return with signature of Employee listing child as dependent (blackout financial information) **
Stepchild	Direct biological child (under age 26) from a spouse/Domestic Partner's prior marriage	• Government-issued Birth Certificate reflecting that the child is the Spouse/Domestic Partner's child, or • A copy of the first two pages of the most recent Federal Tax Return tax return with signature of Employee listing child as dependent (blackout financial information) **
Adopted Child	Adopted child under age 26	• Government-issued Adoption Order, AND government issued Birth Certificate, or • Foreign adoption approved by the INS or legal adoption documents from foreign country AND home government-issued Birth Certificate
Guardianship Child	Persons under the age of 18 for whom you have legal guardianship	• Court Order of Legal Guardianship, AND a copy of the first two pages of the most recent Federal Tax Return tax return with signature of Employee listing child as dependent (blackout financial information).** Excludes temporary guardianship orders.
Disabled Child	Disabled child age 26 or older for whom you have the legal responsibility to care	• Notice of disability determination from medical carrier prior to attaining age 26 AND child documentation (biological/step/adopted/guardianship), or • Notice of disability determination from the Social Security Administration prior to attaining age 26 AND child documentation (biological/step/adopted/guardianship)

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

Please contact Employee Benefits if you do not have any of the suggested documents above for your eligible dependent.

** Copies of most recent Tax Returns must include the signature page and be for the tax year prior to adding the dependents. This document provides proof of dependent eligibility only if your filing status is married (either jointly or separately).

When Does Coverage Begin?

Benefits for newly eligible retirees will commence as outlined below:

- Retiree's benefits become effective the day following the day benefits cease as an active employee.
- Eligible family members' benefits will commence on the date the retiree's benefits commence or the date the family member becomes an eligible family member, whichever is later.

Initial Enrollment Period?

New Retirees must enroll in benefits **within 31 days** of becoming an eligible retiree.

Open Enrollment?

Each autumn, the District provides an Open Enrollment opportunity to review and make changes to your benefits, including:

- Transferring to a different medical or dental plan
- Adding or dis-enrolling eligible family members

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

No Dual Coverage Allowed Under District Sponsored Medical Plans

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

Family members may not be covered by more than one eligible retiree / employee's medical plan. For example, if one parent works for the District and the other parent has retired, both parents cannot cover their children.

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

Be Prepared & Return Your Enrollment Forms!

- You must enroll within 31 days of your retirement date.
- Turn in your election form for medical and dental benefits in one of four easy ways:

Scan and e-mail to:	employeebenefits@sandi.net
Fax to:	**619.725.8132**
Mail or walk-in to:	Employee Benefits – SDUSD 4100 Normal St., Room 1150A San Diego, CA 92103

- Return your enrollment forms along with supporting documentation to the Employee Benefits Department immediately to ensure timely enrollment.
- As you enroll, you will also need to provide personal information, such as Social Security numbers and dates of birth, for any eligible dependents you would like to cover under your Medical or Dental Plan.
- Benefit enrollment forms and informational materials are available online at www.sandiegounified.org/departments/benefits/retiree_benefits.

What if My Needs Change During the Year?

Good news! You are permitted to make changes to your benefits outside of the open enrollment period if you have Qualified Family Status change as defined by the IRS. Generally, you may add or remove dependents from your benefits, as well as add, drop, or change coverage if you submit your request for change within **31 days** of the IRS-Qualified Family Status Change. Change in status examples include:

- Marriage, divorce or legal separation.
- Birth or adoption of a child.
- Death of a dependent.
- You or your dependent's loss or gain of coverage through our organization or another employer.
- You enroll, or intend to enroll, in a Qualified Health Plan (QHP) through the State Marketplace or Federal Exchange, and it is effective no later than the day immediately following the revocation of your employer-sponsored coverage.
- Change in residence affecting eligibility or access to HMO health care services. If your change during the year is a result of the loss of eligibility or enrollment in Medicaid, Medicare or state health insurance programs, you must submit the request for change within 60 days.

For a complete explanation of an IRS-Qualified Family Status Change events, please refer to the "Legal Information Regarding Your Plans" contents on found in back pages of this booklet.

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

Please note!

If you do not enroll a Dependent **within 31 days** of the date the Dependent becomes eligible, you must wait until the District's next Open Enrollment to enroll the dependent, unless you have a subsequent IRS-Qualified Family Status change during the plan year.

IF YOU ARE ON A NON-MEDICARE PLAN AND A DEPENDENT MOVES OUTSIDE OF YOUR HMO'S SERVICE AREA, PLEASE NOTIFY THE DISTRICT BENEFITS OFFICE REGARDING AVAILABLE OPTIONS FOR COVERAGE SINCE THE HMO WILL ONLY COVER EXPENSES RELATED TO EMERGENCY OR URGENT CARE.

Out-Of-Area Dependents Plans

The chart below describes what plans are available to your out-of-area dependents, based on the plan you enroll in and their out-of-area address.

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

How Does it Work?

VEBA will assist in matching your out-of-area dependent's health plan as closely as possible to the health plan you enroll in. Sometimes, your out-of-area dependent(s) may need to be placed/enrolled in another plan. This will ensure your dependent(s) have access to a provider network wherever they live.

Here's What You Need to Know:

1. You must provide your dependent's out-of-area address to the district's benefits office. This will ensure the dependent is placed in an out-of-area plan that has a local provider network. Contact the Employee Benefits Department to request a benefits enrollment/change form.
2. The monthly premium cost for a dependent is subject to change if the dependent is enrolled in an out-of-area plan.
3. The plan your dependent is enrolled in is based on their out-of-area address.
4. Dependents will remain on their out-of-area plan unless they change their permanent address. This means they cannot switch back to your HMO or PPO plan if they return home for a short period, such as winter, spring, or summer break.
5. Dependents who are enrolled in an HMO plan must choose a PCP within 30 miles of their out-of-area address.

Please remember, if you are in an HMO plan, we will try to keep your dependent in an HMO plan. However, based on your dependent's address, we may have to enroll them in the out-of-area PPO plan.

****New ID cards will be issued by the carrier and sent to the Retiree's address.**

If A Dependent Loses Eligibility

You are responsible for dis-enrolling any dependent who loses eligibility (e.g., divorce, termination of a domestic partnership, death) **within 31 days** of the dependent's eligibility status change.

In many cases, dependents losing coverage will be entitled to continue coverage under COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985). They also may want to explore their options through the health insurance Marketplace established under the Affordable Care Act. They can find information for California at www.coveredca.com or by calling 800.300.1506.

Regardless of the timing of notice to the District, coverage for an ineligible dependent will end on the last day of the month in which the dependent loses eligibility (subject to any continued coverage option available and elected).

Contributions/Premium Payments for Benefits

Health premiums are paid by retirees and billed/debited by the District on a monthly basis. Premiums are based upon a calendar year and are subject to change each year. Premiums are due the first of the month for each month of benefits. If you are eligible to receive a subsidy from your union, your monthly invoice or the amount debited will reflect the appropriate reduction in your monthly premium due for medical benefits. The first payment is due the date benefits terminate as an active employee. If a retiree does not make payments when due, the benefits will cease at the end of the month for which the retiree made the last payment. If benefits are allowed to terminate, they cannot be reinstated. To make the payment process easier, the District offers an electronic payment program. To participate in this program, the retiree must complete and return a Debit Authorization for Benefit Premiums Form to the District.

Termination of Benefits

A retiree's benefits cease the earliest of:

- For retirees on a non-Medicare plan, the first day of a month for which the retiree submits a cancellation notice or does not make required premium payments to the District by the last day of the month, or
- Medicare Advantage group medical plans follow Medicare-imposed guidelines and have specific requirements for termination. Medicare Advantage group medical plans may not be retroactively terminated. The retiree must give the plan thirty (30) day written advance notice of the termination. The retiree is responsible for all premiums prior to the date of termination.
- The last day of the month in which the retiree dies.

IMPORTANT: If medical and/or dental benefits are terminated, the benefits may not be reinstated in the future.

Benefits of a dependent terminate on the date the retiree's benefits terminate or the date the dependent ceases to qualify as an eligible dependent, whichever is earlier.

Surviving Dependents Benefits

In the event the retiree dies, please contact the Employee Benefits Department within thirty (30) days of the death regarding information on eligibility for surviving dependent benefits.

Medical Coverage for those not in Medicare Parts A & B (under age 65)

Which plan type is right for you?

Use the chart below to help compare medical plan options and determine which would be the best for you and your family. The plan options available to retirees under age 65 are the same plans currently offered to active employees.

	HMO	HMO	PPO
	Kaiser	United Healthcare	UMR NexusACO Select Plus
Required to select and use a Primary Care Physician (PCP)	Yes	Yes	No
Seeing a Specialist	PCP referral required in most cases	PCP referral required in most cases	No referral required
Deductible Required	No	• Deductible is not required for Network 1, 3 or the CS VEBA Alliance HMO • CS VEBA Alliance and UHC Harmony Journey HMO HRA plans do include a deductible	Yes, in most cases
Claims Process	Typically handled by providers	Typically handled by providers	PPO providers will submit claims You submit claims for other services
Other Important Tips	• This plan requires that you see a Kaiser doctor to receive coverage • Out-of-Network services without proper PCP referral will not be covered	• These plans require that you see a doctor from a medical group available under your particular HMO plan to receive coverage • Out-of-Network services without proper PCP referral will not be covered	• You may choose in or out of network care; however, in-network care provides you a higher level of benefit • Out of network providers will bill the balance to the member for amounts not paid by UnitedHealthcare

The Options Are the Same in Terms of:

- Free in-network preventive care
- Emergencies are covered worldwide but employees likely will have to pay first and then be reimbursed by the carrier
- Access to Teledoc Medical which offers expert opinions to all enrolled members on topics such as Critical Care Support, Ask the Expert, In-Depth Medical Review and Find A Doctor where you can learn more about best-in-class providers
- Access to OptumHealth Employee Assistance Program (EAP) and WorkLife Services. The EAP provides short-term, problem-focused counseling in addition to access to referral services for a range of issues from parenting and childcare to money management.
- Chiropractic / Acupuncture care through OptumHealth for both Kaiser and UHC members. A referral from your primary physician is not required. However, Optum will determine if services are medically necessary. To find a provider near you, contact OptumHealth at 1.800.428.6337 or search online at www.MyOptumPhysicalHealthofCA.com.

The Options Differ from Each Other in Terms of:

- The deductibles, copayments, and out-of-pocket maximums
- The prescription drug administration and plan designs
- The networks of doctors and facilities you may use.

For eligible individuals who are entitled to Medicare, the District offers Medicare Advantage HMO plans through Kaiser and UnitedHealthcare (UHC) and a Medicare Advantage PPO through UHC. Please refer to pages 23-25 for information on these options.

You should carefully evaluate your family circumstances before selecting medical plan coverage.

Your Medical Plan Options for Those Not Enrolled in Medicare Parts A & B

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

Using the Kaiser HMO Plan

As a member of the Kaiser Permanente Health Maintenance Organization (HMO) plan, you will receive your medical care from an integrated network of physicians and specialists at a Kaiser medical office, Kaiser medical center or affiliated hospital near you. Additional information regarding the Kaiser Permanente HMO is outlined below:

- You may choose a primary care doctor for yourself or your family members by reviewing a physician's profile at kp.org/chooseyourdoctor, or receive assistance in selecting a physician and scheduling your first appointment by calling 888.956.1616 (for Southern CA)
- Initial referrals for most specialty care services will be coordinated by your Kaiser primary care physician. However, many departments such as OB/GYN, Optometry, Psychiatry and Addiction Medicine allow for self-referral
- There are no deductibles with the Kaiser Permanente HMO and no claim forms to submit unless you receive emergency services outside of a plan facility
- Preventive care is covered at 100%

An abbreviated schedule of covered services under the Kaiser Permanente HMO plan is listed on page 18. For a complete listing of covered services for each plan, please refer to your Kaiser Evidence of Coverage (EOC).

Kaiser offers many ways to get care:

- Telephone appointments and after-hours care with primary care physicians and specialists: Call 1.800.290.5000 to make a telephone appointment
- 24/7 Nurse Advice Line to see what type of care you need: Call 1.800.290.5000 M-F 7am to 7pm, and 1.888.576.6225 after 7pm and on weekends
- Kaiser Telehealth – Schedule a Phone or Video Appointments on your mobile device or computer for primary care, pediatrics, OB/GYN, allergy or psychiatry; your regular office copay will apply. Download Kaiser's app at your device's app store. Type in KP or Kaiser Permanente. Visit: kp.org/getcare
- Target Clinic (provided by Kaiser) Visit: kp.org/scal/targetclinic
- Email your physician for simple, direct communications securely through kp.org
- Travel Line when you are away from home and need medical care: call 1.951.268.3900 for assistance

Kaiser Out of State Access for Retirees

Effective 01/01/24, retirees will have access to Kaiser in all states in which it offers services: Hawaii, Washington, Colorado, Oregon, Maryland, Washington D.C. and Georgia. Coverage currently was only available in Colorado and Hawaii if not using services as a visiting member. Contact the Employee Benefits Department for plan specific application forms and rates.

Using the UnitedHealthcare (UHC) HMO Plans

These HMOs operate as follows:

- You and your family members ALL must enroll in the same HMO plans for the entire year
- You and your family members can select different PCPs and/or medical groups within the network you choose. You can also change PCPs or medical groups within the network you choose during the year by contacting UHC.
- You cannot change your HMO plan unless you have an IRS-Qualified Family Status Change (e.g. change in address affecting eligibility or access)
- With the exception of an OB/GYN specialist who is affiliated with your selected medical group, you must receive a referral from your PCP before receiving services from a specialist who must be affiliated with your Medical Group
- Services may require a fixed-dollar or percentage payment up-front, referred to as a copay or coinsurance
- There are no annual deductibles, except for the Signature Value Alliance and Journey-Harmony HMOs
- You do not have to submit claim forms to UHC unless you receive emergency care from a non-plan provider
- Any services rendered out-of-network without the proper referral from your PCP will not be covered
- The UnitedHealthcare Alliance Journey HMO and Harmony Journey HMO plans includes a proprietary; member-owned HealthInvest HRA (funded by CA Schools VEBA) which gives you a flexible savings option for future health care costs. The money in the HRA (Health Reimbursement Account) is yours to keep and can be used for current qualified medical expenses plus qualified medical expenses after leaving the plan or the District.

UHC Performance Network 1	UHC CS VEBA Alliance HMO $20/$250A	UHC Performance Network 3	UHC CS VEBA Alliance Journey HMO	UHC Harmony Journey HMO
Sharp Rees-Stealy MG	Scripps Clinic	Scripps Clinic	Scripps Clinic	Sharp Rees-Stealy MG
Sharp Community MG *(Includes Graybill and Arch Health Partners*	Scripps Coastal Medical Center	Scripps Coastal Medical Center	Scripps Coastal Medical Center	Sharp Community MG *(Includes Graybill and Arch Health Partners*
Rady Children's Health Network	Scripps Physicians MG	Rady Children's Health Network	Scripps Physicians MG	UCSD MG
Optum Care	Rady Children's Health Network		Rady Children's Health Network	
	Optum Care		Optum Care	
	Mercy Physicians MG		Mercy Physicians MG	
	Greater Tri-Cities MG		Greater Tri-Cities MG	
	UCSD MG		UCSD MG	

Fertility Solutions with Kindbody

Kindbody is a comprehensive family-building benefit for UHC HMO and UMR PPO plan subscribers. Kindbody provides diverse end-to-end fertility services —including fertility assessments, IVF, and IUI. In addition to clinical guidance, they offer dedicated Kindbody care navigation, digital tools, and education to help members maneuver their personalized path to parenthood.

Since your needs may span many phases, Kindbody isn't just a fertility benefit. They offer menopause support and dynamic, integrated holistic support that goes beyond a traditional treatment plan.

Note: Employees and spouses/partners enrolled on the California Schools VEBA sponsored Kaiser plan will have access to VEBA discounted rates at Kindbody Signature clinics. Additionally, VEBA members seeking services for fertility preservation (i.e., egg freezing) will have access to discounted rates at Kindbody Signature clinics. These direct discounts are offered directly by Kindbody and not through the California Schools VEBA benefit program.

Find out more at kindbody.com/activate.

Health Reimbursement Accounts (HRA)

Below is important information regarding the Heath Reimbursement Accounts (HRA) issued with UHC Alliance Journey HMO with HRA and Journey Harmony HMO with HRA plans:

HealthInvest HRA Rules

- You will be issued a debit card to access your member-owned Gallagher HealthInvest HRA (Health Reimbursement Account).
- You may use the HRA funds to pay for any IRS-qualified out-of-pocket expenses as specified in IRS Code Section 213(d) for out-of-pocket expenses incurred by you or your IRS-qualified dependents as specified in IRS Code Section 152. Examples include copays, deductibles and coinsurance required in your medical, dental and vision plans, orthodontia and hearing aids.
- The HRA is "portable," which means the account balance continues to be yours even if you change to another health plan and leave the District.
- You have the ability to invest the HRA in a menu of funds offered by Gallagher.
- To obtain more information and to file claims, you may download the HealthInvest app (HRAgo) or go to the following website: HealthInvestHRA.com.
- A Summary Plan Description (SPD) can be found on the District Benefits webpage for the HealthInvest HRA.

UHC CS VEBA Alliance-Journey HMO

- The 2024 contributions for the Alliance Journey plan will be $2,000 for single coverage, $2,000 for two-party, and $2,000 for family.

UHC Harmony-Journey HMO

- For 2024, contribution amounts for the Harmony Journey plan will be $1,000 for single coverage, $1,600 for two-party, and $2,200 for family.

Funds will be distributed on or before March 1, 2024. To learn more, call 844-342-5505 or visit healthinvesthra.com

Using the UMR NexusACO Select Plus PPO Plan

With a Preferred Provider Organization (PPO) plan, you have greater flexibility and choice to use both in-network and out-of-network physicians. However, you are encouraged to receive services from in-network doctors, specialists or facilities. By doing so, you obtain a higher level of benefit than if services were rendered from an out-of-network provider. Additional important information regarding the use of the PPO plan includes:

- The Nexus ACO has in-network providers divided into "Tier 1" and "Other" providers. Your out-of-pocket expenses will be lowest when using a Tier 1 provider, higher for Other In-Network providers and highest for Out-of-Network providers. Members can also save money when using an In-Network freestanding lab, x-ray or outpatient care center. Members should look for the "Free-Standing Facility" indicator to find locations near them.
- Members are encouraged to choose a Primary Care Physician (PCP) for each covered family member similar to an HMO, but they can still seek services at any doctor or facility without a referral from their PCP.
- Certain services, such as doctor's visits, may require a fixed-dollar payment up-front, referred to as a copay.
- Before the insurance company will pay certain medical expenses, such as hospital expenses, you may be required to pay a specific amount, referred to as the calendar year deductible, before benefits are paid.
- Once the deductible has been fulfilled, UMR will pay a large percentage of the cost of your care, known as coinsurance. You are then responsible for the remaining cost up to the calendar year out-of-pocket maximum.
- VEBA and UHC have arranged for a special program that eliminates the deductible, coinsurance and copays for certain hospital-based surgeries through Carrum Health when the surgery is performed at a Carrum Health contracted hospital. This includes spine, orthopedic, coronary artery bypass graft (CABG) and bariatric surgery. Visit carrum.me/CSVEBA for more information.
- myHealthcare **Cost Estimator** tool helps employees estimate their cost before you see the doctor; visit www.myuhc.com or Health4Me App
- Claim forms are submitted to UMR on your behalf by the service provider, when services are received from within the network.

How to Find a UnitedHealthcare Network Provider

Before you go to the doctor or receive health care services, make sure your doctor, facility or specialist is participating in your plan's network. This may ensure you receive the highest level of benefit and could reduce your health care costs. Check out the instructions below to find out how to perform a "Provider Search" for your plan or call UnitedHealthcare at 1.888.586.6365 to speak with a representative.

UnitedHealthcare HMO Providers

1. Go to whyuhc.com/csveba
2. Select "Search for a Provider" that appears near the top of the page.
3. Scroll down and choose from the plan options.
4. Select "Continue"
5. Select "Change Location" and enter zip code, then select "Update Location"
6. Now you can search by People, Places, Service and Treatments, or Care by Condition

UMR NexusACO PPO Plan Providers

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

How to Find an OptumHealth Chiropractic / Acupuncture Provider

For those enrolled with Kaiser or UHC, Chiropractic and Acupuncture benefits are provided by OptumHealth Physical Health of California, which has more than 2,700 network providers in California.

Three ways to find a provider:

1. Go to the Provider Locator search at www.myoptumhealthphysicalhealthofca.com and select "Provider Locator". Choose "California Schools VEBA" from the dropdown menu for Plan/Product.

2. Call Optum Member Services at 1.800.428.6337 (5 a.m. to 5 p.m., Monday – Friday) for the most current and up to date information.

3. Call the provider directly to schedule an appointment and verify they are part of the Optum network for VEBA.

Kaiser members will receive a member ID card from OptumHealth. UHC members use their UHC member ID card.

Fertility Solutions with Kindbody

California Schools VEBA offers Kindbody as your fertility, family-building, and menopause benefit. Kindbody is a comprehensive family-building benefit for UHC HMO and UMR PPO plan subscribers. If you are looking to grow your family or need assistance in your post-reproductive years, there is support. Kindbody provides diverse end-to-end fertility services —including fertility assessments, IVF, and IUI. In addition to clinical guidance, they offer dedicated Kindbody care navigation, digital tools, and education to help members maneuver their personalized path to parenthood. You can take comfort in knowing the full spectrum of benefits are provided in a safe, welcoming, and confidential environment.

Since your needs may span many phases, Kindbody isn't just a fertility benefit. They offer menopause support and dynamic, integrated holistic support that goes beyond a traditional treatment plan.

Your Kindbody Benefit Includes:

- Up to 1 full KindCycle including in vitro fertilization (IVF), intrauterine insemination (IUI) with fertility medication through KindbodyRx
- Conception, fertility, and male assessments to help you learn more about your fertility
- 6 sessions of virtual holistic health services; support includes menopause, mental well-being, nutrition, doula/birth coaches, lactation support, back-to-work care, and more
- Access to Kindbody's menopause program offering specialty providers who will support women experiencing menopause; services include lifestyle assessment, hormone testing, and virtual holistic sessions
- Dedicated Kindbody Care Navigation Team
- Access to Kindbody's full suite of services and network of partner clinics
- Access to Kindbody's library of resources, videos, events, and support groups
- A personalized patient portal

Note: Employees and spouses/partners enrolled on the California Schools VEBA sponsored Kaiser plan will have access to VEBA discounted rates at Kindbody Signature clinics. Additionally, VEBA members seeking services for fertility preservation (i.e., egg freezing) will have access to discounted rates at Kindbody Signature clinics. These direct discounts are offered directly by Kindbody and not through the California Schools VEBA benefit program.

How to Get Started with Kindbody

1. Head to kindbody.com/activate
2. Create your Kindbody account using your first name and last name as it appears in your employer's system and any email address
3. Confirm eligibility by entering your Access Code: **KINDCSVEBA** and Unique User ID as follows:
   • Employee: First Name + Last Name + -E + last four digit of your social security number (Example: JaneDoe-E1234)
   • Spouse/domestic partner: First Name + Last Name + -D + last four digit of the spouse/domestic partner's social security number (Example: JonDoe-D5678)

1:1 Concierge Support 855-950-2053 x Option 3
For more information, or if you have any questions, email employeebenefits@kindbody.com

Prescription Drug (Rx) Benefits

Many FDA-approved prescription medications are covered through the benefits program. Your prescription drug benefits depend on which medical option you select. Refer to the plan summaries for cost information. Kaiser and UnitedHealthcare have a drug formulary, or preferred list of prescription drugs, including both generic and brand name medications. Important information regarding your prescription drug coverage is outlined below:

Kaiser HMO Members

Employees enrolled in Kaiser have prescription drug coverage through Kaiser.

- There is a $10 copay for all covered prescriptions, for up to a 100-day supply.
- All medicine must be obtained from a Kaiser pharmacy or through Kaiser's mail order program.

UnitedHealthcare Members

Employees enrolled in a UHC plan have prescription drug coverage through Express Scripts. You will receive a separate ID card from Express Scripts for you to use at your pharmacy. You must use an Express Scripts participating pharmacy or their online mail order service.

- The UnitedHealthcare plan(s) include a 3-tier prescription benefit through Express Scripts
- Tiered prescription drug plans require varying levels of payment depending on the drug's tier, and your copayment or coinsurance will be higher with a higher tier number.
- Tier 1 prescriptions offer the greatest value compared to other drugs that treat the same conditions and are often the lowest cost. These are typically formulary generic medications.
- Tier 2 drugs are generally formulary brand name with a moderate copayment. Some drugs may also be Tier 2 because they are "preferred" among other drugs that treat the same conditions.
- Tier 3 drugs are a higher copayment compared to the lower tiers, as they are higher cost, non-formulary drugs. Some drugs on this list may have a generic counterpart in Tier 1 or Tier 2.

To see a current listing of formulary medicines log onto www.express-scripts.com. After registering, click on Prescriptions, followed by Price a Medication.

Express Scripts has an **Express Advantage Network** (EAN) of pharmacies that offer greater discounts on prescription medication. The prescription medication copays shown in the schedule on the following pages are for EAN pharmacies. These include Costco, Walmart, K-Mart, Ralphs, Rite-Aid and Vons and many independent pharmacies.

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

The EAN network and Smart90 network does not include CVS, Walgreens, Target and some independent pharmacies.

For medicine dispensed from non-EAN pharmacies, the copays are $5.00 higher than those shown in the schedule on the following pages. Visit www.express-scripts.com for a complete list of **EAN** and **Smart90** pharmacies.

For members on longer-term medications (over 3 months), the use of Express Scripts' Mail Order pharmacy is encouraged. If a member chooses to obtain such medicine at a local retail pharmacy beyond the third refill of the prescription (other than at a Costco, Rite-Aid or Sharp-Rees Stealy retail pharmacy), the copays will be doubled for a 30-day supply.

If a member receives brand-name medication when a generic equivalent is available, the member will pay the generic medication copay plus the entire price difference in cost between the brand-name medication and the generic equivalent, even if the physician prescribes "Dispense as Written."

Many drugs in the following three classes are available both over-the-counter (OTC) and through a physician's prescription. As a result, medicine in these three classes is no longer covered under the Express Scripts pharmacy benefits program. Therefore, you will pay the entire cost of these medicines even if they are prescribed by a physician and obtained from a pharmacy. The classes are:

- **Antihistamines** (Examples: Citirizine, Loratadine, and Fexofenadine)
- **Intranasal Steroids**
- **Proton Pump Inhibitors** (Examples: Nexium, Prilosec and Protonix)

Express Scripts has implemented a new program for Specialty Medicine called SaveonSP effective October 1, 2019. This program is designed to save members money by reducing or eliminating out-of-pocket costs on certain specialty medicines. More than 150 specialty medications will be available at no cost when members enroll in the program and have these specialty medicines dispensed by the Express Scripts mail order provider, Accredo. Members on these medicines will receive a letter to sign up for SaveOnSP. **Members who do not enroll in the program will be subject to increased copays for specialty medicine. These copays can range from $700 to more than $7,000 per month.**

Why Pay More for Prescriptions?

There are a few ways you might save money through the Prescription Drug plan:

- **Use Generic Drugs:** Talk to your doctor or pharmacist about trying generic drugs, which contain the same active ingredients as the brand-name equivalent at a fraction of the cost.
- **Use Mail Order:** If you take long-term medications for chronic conditions such as high blood pressure, diabetes, and/or depression, you could save time and money by utilizing your mail order service for your medications. Up to a 90-day supply of your medication will be shipped directly to your home. Ask your doctor to write you a 90-day prescription to use Mail Order. Please contact Express Scripts for more information about their mail order service for UnitedHealthcare members.

  UHC members can get the same mail order discounts at Rite Aid, Costco and Sharp-Rees Stealy retail pharmacies.

  Note: This offer does not apply to specialty medications that MUST BE filled through Express Scripts' Specialty Pharmacy, Accredo.
- **Price Compare:** Some pharmacies, such as those at warehouse clubs or discount stores, may offer less expensive prescriptions than others. By calling ahead, you may determine which pharmacy provides the most competitive price.

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

(1) The specialty care physician copay applies if therapy is provided by a physician other than the patient's primary care physician.
(2) Copays are $5 higher for medicine obtained from Non-EAN pharmacies.
(3) Plan participants pay 100% of the cost for certain drugs that are available over-the-counter, i.e., Proton Pump inhibitors, Antihistamines & Intranasal Steroids
(4) Subject to minimum $40, maximum $175 for retail; and minimum $80, maximum $350 for mail order
(5) See page 15 for special requirements for "Specialty Medicine"

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

Plan Highlights

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

(1) **Deductible Waived**
(2) The specialty care physician copay applies if therapy is provided by a physician other than the patient's primary care physician.
(3) Copays are $5 higher for medicine obtained from Non-EAN pharmacies.
(4) Plan participants pay 100% of the cost for certain drugs that are available over-the-counter, i.e., Proton Pump inhibitors, Antihistamines & Intranasal Steroids
(5) Subject to minimum $40, maximum $175 for retail; and minimum $80, maximum $350 for mail order
(6) See page 15 for special requirements for "Specialty Medicine"

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

Plan Highlights

UMR NexusACO Select Plus PPO

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

(1) Out-of-pocket maximum is based on the maximum allowable charge the carrier allows. This does not include any balance billing that may occur when using an out-of-network provider.

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

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

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

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

Benefits Information on the Go

Kaiser Permanente – On the Go!

The KP mobile app gives you a suite of tools to use on the go! Use this application with your Kaiser Permanente user ID and password to:

- See your health history at your fingertips.
- Refill prescriptions for yourself or another member.
- Check the status of your prescription order.
- Schedule, view, and cancel appointments.
- Access your message center to email your doctor or another KP department.
- Find KP locations and facilities near you.

Search for Kaiser's mobile app in the App Store or Google Play to get started!

Kaiser TeleHealth

Schedule a Phone or Video Appointments on your mobile device or computer for primary care, pediatrics, OB/GYN, allergy or psychiatry; your regular office copay will apply.

Download Kaiser's app at your device's app store. Type in KP or Kaiser Permanente. Visit: kp.org/getcare (or call 1.833.574.2273 for assistance in making a video appointment).

UnitedHealthcare's Health4Me App!

UnitedHealthcare's Health4Me mobile application will help you manage your health care easier and faster! Use the app to:

- Search for Quick Care, either urgent care or emergency room services
- View and share your member ID card.
- Access your account balance and check the status of benefit amounts, such as your deductible and
- out-of-pocket maximum.
- View the latest claims for your plan.

Search for the Health4Me mobile app in the App Store or Google Play to get started!

UnitedHealthcare HMO Virtual Visits

If you are enrolled in any UHC HMO plan, you can obtain medical assistance from the comfort of your home. To help reduce barriers to care, beginning January 1, 2024, VEBA will waive copays across all networks for virtual visits with approved providers for all UHC HMO plans.

This program provides convenient and affordable care for symptoms such as the flu, allergies, sore throat, pink eye and more. Virtual appointments are available to UHC HMO plan members for a $0 copay through these designated networks: Optum, AmWell, Dr. on Demand, and Teladoc. Various cost shares applies for all other VEBA plans. To learn more or to get started, visit www.uhc.com/virtualvisits

VEBA Member Benefits

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

Contact VEBA Advocacy when you…

- Are experiencing trouble with a doctor or insurance carrier
- Need help getting a referral or second opinion
- Have quality of care or other escalated issues
- Billing/Denial of Claim: When you receive a bill that may be incorrect or are billed for covered services
- Second Opinion: If you would like a second opinion from a different provider after receiving a diagnosis or treatment plan.
- Prescription Issues: Any issues with prescriptions including denials, copays, prior authorization for prescriptions or issues with an Rx carrier.

Questions about what your VEBA benefits can do for you and your family?
Call 888-276-0250 or visit vebaonline.com/contact

VEBA Resource Center (VRC)

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

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

Teladoc Medical (formally Best Doctors)

Your expert medical services with Best Doctors will now be provided by Teladoc Medical Experts to offer the same great medical advice, but with easier access. Get the answers you need from world-renowned experts by web, phone or app at no additional cost to you. It provides free consultations with medical experts so you can make sure you have the right diagnosis and treatment when you have a serious, complex medical condition. This program is for members covered under any District offered medical plan.

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

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

For more information, visit teladoc.com/medical-experts

Medical Coverage for those with Medicare Parts A & B

General Information about Medicare

Medicare is a health insurance program for:

- People age 65 and over
- People under 65 with certain disabilities
- People of any age with End-Stage Renal Disease (ESRD)-permanent kidney failure requiring dialysis or a kidney transplant

Whether you are turning 65 or are older than 65 (still working but about to retire), you have an opportunity to enroll in Medicare. Individuals enrolling for coverage to be effective when they turn 65 can enroll three months before the month they turn 65, the month of their birthday or three months after their birth month. Individuals who work beyond age 65 and are covered by District medical benefits should begin the process of enrolling three months before the month they plan on retiring from the District.

Eligibility requirements include:

- You or your spouse have worked for at least 10 years (40 quarters) in Medicare-covered employment, and
- You're a U.S. citizen or permanent resident for at least five years
- Even if you're not collecting Social Security yet, you're eligible to join at age 65 or later

When Medicare coverage begins for those enrolling for coverage to begin at age 65: If your birthday is not the first day of a month, Medicare coverage begins the first of the month in which you turn 65 if you enroll that month or during the 3 months before turning 65. If your birthday is on the first day of the month, your Medicare coverage starts the first day of the prior month.

If you continue your medical coverage through San Diego Unified School District ("SDUSD") by enrolling in a Medicare Advantage Plan, it is still necessary to enroll in Medicare Parts A and B; however, it is not necessary to enroll in an independent **Medicare Part D** plan (prescription drug coverage). The Medicare Advantage medical plans offered by the District include prescription drug coverage.

Important!

Please note that if you enroll in another Medicare Advantage plan or a stand-alone Medicare Part D prescription drug plan after your enrollment in a District plan, you will be disenrolled from your Medicare Advantage Plan provided through the District.

* Please consult the Social Security Administration to verify eligibility in Medicare Parts A and B at 1.800.772.1213 or www.socialsecurity.gov. *You **cannot** enroll in Medicare through the SDUSD Employee Benefits Department.*

IMPORTANT DISTRICT ENROLLMENT INFORMATION:

The SDUSD Medicare plan enrollment form must be completed and submitted with a copy of your Medicare ID Card/Medicare Entitlement Letter to the Employee Benefits Department, no later than the 15th of the month prior to the start of your Medicare plan to ensure a timely enrollment. *Delayed enrollment may result in a substantial increase to your monthly premium and loss of your Retiree Medical Benefits Fund ("subsidy"), if applicable*. For an overview of available plans and for Medicare Advantage plan rates and detailed plan information visit www.sandiegounified.org/departments/benefits/retiree_benefits. If the rate for your choice of coverage is not included, please contact the Employee Benefits Department at 619.725.8130 or by email at employeebenefits@sandi.net, Monday – Friday from 8:00 a.m – 5:00 p.m.

To ensure timely enrollment:

- **Contact** the Social Security Administration 3 months prior to your 65th birthday month to enroll in Medicare Parts A & B.
- **Review** plan options and medical premium rate sheets on the Retiree Benefits page on the District website.
- **Complete** the Medicare plan enrollment form (forms are not automatically mailed; please contact the District to obtain the applicable form). For your convenience, you may also find the enrollment forms on www.sandiegounified.org/departments/benefits/retiree_benefits. If you cover a dependent(s), you must select a Medicare Advantage plan with the same carrier as the dependent plan.
- **Attach** the required copy of your Medicare A & B ID Card/Entitlement Letter to your enrollment form.

Medical Coverage for those in Medicare Parts A & B

IMPORTANT INFORMATION REGARDING CERTIFICATE OF CREDITABLE COVERAGE

Members will receive an annual "Certificate of Creditable Coverage" from our third party administrator, California Schools Voluntary Employee Benefits Association (VEBA), as required by Federal Law. If you are on Medicare or have a dependent on Medicare, please keep this certification in your permanent records.

YOUR MEDICAL PLAN OPTIONS FOR THOSE ENROLLED IN MEDICARE PARTS A & B

Retirees entitled to Medicare have three available Medicare Advantage plan options through VEBA/SDUSD:

1. Kaiser Senior Advantage HMO plan for those living in the California, Hawaii and Colorado Kaiser HMO service areas and who are enrolled in Medicare Parts A and B

2. UnitedHealthcare (UHC) Medicare Advantage HMO plan for those living in the Southern California UHC HMO service area and who are enrolled in Medicare Parts A and B

3. UnitedHealthcare (UHC) Group Medicare Advantage PPO plan for retirees enrolled in Medicare Parts A and B and who wish to have the freedom to obtain routine medical care outside of the local service area. This plan is available nationwide. You can see any provider (network or out-of-network) at the same cost share as long as they accept the plan and have not opted out of or been excluded from Medicare. However, you must use pharmacies in UHC's network for covered prescription medication.

For all three options, Medicare beneficiaries must assign all of their Medicare benefits to the health plan you select, i.e., Kaiser or UnitedHealthcare.

- For couples where either the retiree or spouse has Medicare Parts A and B, but the other partner does not, all plans need to be with the same health carrier.

Medicare Advantage Plan Highlights for those Enrolled in Medicare Parts A & B (Age 65+)

Plan Highlights	Kaiser Senior Advantage HMO	UHC Medicare Advantage HMO	UHC Medicare Advantage PPO
	In-Network Only	In-Network Only	In-Network Only
Calendar Year Medical Plan Deductibles	None	None	None
Calendar Year Maximum Medical Out-of-pocket			
Per Individual	$1,500 / Individual	$2,400 / Individual	$2,000 / Individual
Professional Services			
Physician Office Visits – Primary Care Physician	$10 copay	$10 copay	$10 copay
Physician Office Visits – Specialty Care Physician	$10 copay	$10 copay	$10 copay
Preventive Care Exam	No charge	No charge	No charge
Outpatient Basic Diagnostic X-ray and Lab	No charge	No charge	No charge
Outpatient Physical / Rehabilitation Therapy(	$10 copay	$10 copay	$10 copay – Up to 36 Sessions / 36 weeks per lifetime
Routine Chiropractic Services	$10 copay	$5 copay – Up to 12 visits/year	$5 copay - Up to 12 visits/year
Annual Hearing Exam	$10 copay	No charge (1x / Year)	No charge
Hearing Aids	Not covered	Plan pays up to $500 allowance (Every 3 years)	Plan pays up to $1,000 allowance (Every 3 years)
Annual Eye Exam	$10 copay	$10 copay	$10 copay
Eyewear – Every 24 months	Plan pays up to $150 eyewear allowance every 2 years	Plan pays up to $130 eyewear allowance or $175 contacts lenses allowance every 2 years	Plan pays up to $130 eyewear allowance or $175 contacts lenses allowance every 2 years
Durable Medical Equipment	No charge	No charge	No charge
Hospital Services			
Inpatient	No charge	No charge	No charge
Outpatient Surgery	$10 copay	No charge	No charge
Emergency Room (Copay Waived if Admitted)	$50 copay	$50 copay	$50 copay
Urgent Care	$10 copay	$10 copay	$10 copay
Ambulance	No charge	No charge	No charge
Skilled Nursing Facility (up to 100 days per benefit period	No charge	No charge	No charge
Home Health Care	No charge	No charge	No charge
Hospice (Other than Rx and Respite Care)	No charge	No charge	No charge
Mental Health & Substance Abuse			
Mental Health (outpatient / inpatient)	$10 copay / No charge	$10 copay / No charge	$10 copay / $0 – Up to 190 days/lifetime
Retail Prescription Drugs Up to a→	100-day supply	30-day supply	30-day supply
Tier 1 – Generic	$10 copay	$7 copay	$5 copay
Tier 2 – Formulary /Preferred Brand Name	$10 copay	$14 copay	$25 copay
Tier 3 – Non-Formulary Brand Name	N/A	$14 copay	$40 copay
Mail Order Prescription Drugs Up to a→	100-day supply	90-day supply	90-day supply
Tier 1 – Generic	$10 copay	$14 copay	$10 copay
Tier 2 – Formulary /Preferred Brand Name	$10 copay	$28 copay	$50 copay
Tier 3 – Non-Formulary Brand Name	N/A	$28 copay	$80 copay

The above information is merely a brief description of the major benefits offered through the District. It is not intended to alter or expand benefits, rights or liabilities as set forth in the official plan document contracts. Please refer to the Summary of Benefits or Evidence of Coverage for each plan for complete details of Plan benefits, limitations and exclusions.

Dental Plan

A smile is the nicest thing you can wear.

Dental benefits are another important element of your overall health. With proper care, your teeth can and should last a lifetime. The District offers three choices of dental plans to eligible retirees. The retiree pays the full cost of coverage on a monthly basis.

Using the Dental HMO and PPO Plan

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

Using the Plans

If you decide to enroll in either of the Dental HMO plans, you and your enrolled eligible dependents must first select a primary care dentist who participates in that network. To receive benefits in the Dental HMO plan, your dental care must either be provided by or referred to a specialist by your primary care dentist. If you receive services from any other dentist, you will be responsible for paying the entire dental bill yourself.

The Delta Dental PPO provides you and your eligible dependents with the flexibility to choose any licensed dentist or specialist. Your share of the cost of services depends on whether you use a dentist in Delta Dental's PPO network or an out-of-network dentist. If you choose a PPO dentist, you'll receive the highest level of benefit from the plan versus an out-of-network dentist who has not agreed to provide services at the negotiated rate. Additionally, no claim forms are required when using in-network PPO dentists. If you go to a dentist not affiliated with Delta Dental, you may have to pay the dentist's total fee and then submit your claim form to Delta Dental for reimbursement.

Kaiser and UHC Medicare Advantage medical plans automatically include a basic dental benefit which cannot be waived. Please contact the carrier directly i.e. Kaiser or UnitedHealthcare for additional information regarding these dental plans.

TIP

Choose your Primary Care Dentist

It's important to carefully select a dental provider, and based on the plan you enroll in, the best choice for you may vary. To determine whether your dentist is in or out of your insurance network, go to www.deltains.com or www.westerndental.com and search the Provider Network.

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

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

1. 70% of the PPO contracted fee schedule for both Delta Premier Dentists and Non-Delta Dental dentists

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

Vision Plan

Keep a clear focus on your sight.

This separate vision benefit is available only for retirees who elected to continue vision coverage for a maximum of 18 months based upon their rights under the Federal COBRA law within 60 days after retirement. Coverage for medical care for your eyes, such as eye infection, injury or glaucoma is provided through your medical plan. Please review the summary of benefits for your medical plan to see if it also includes any vision exam or hardware benefit.

Your Vision Plan

Vision coverage is offered by VSP Vision Care as a Preferred Provider Organization (PPO) plan. The plan has coverage for routine eye exams, frames and lenses.

Using the Plan

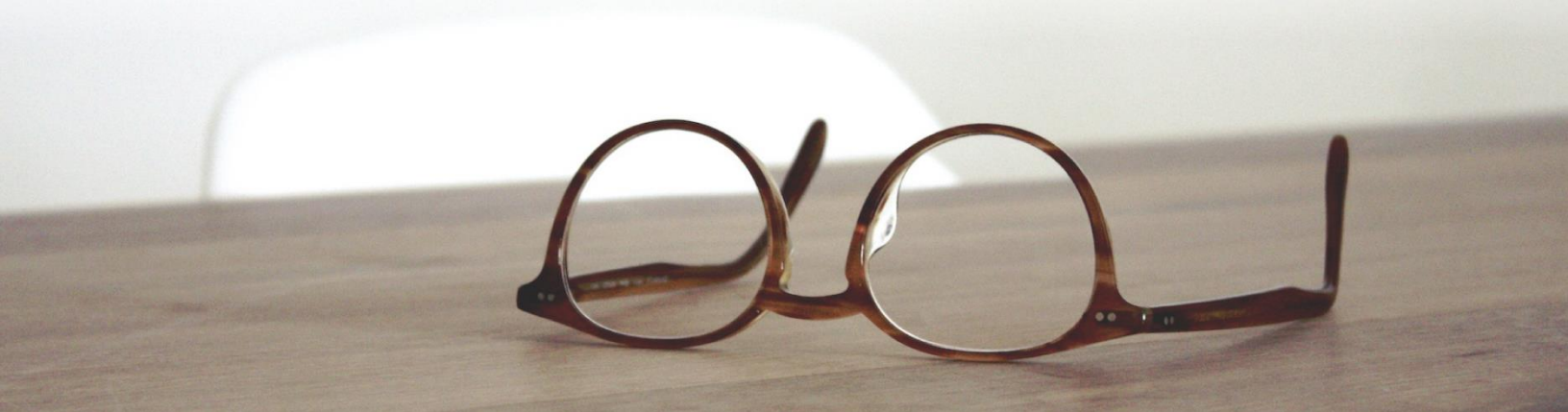
As with a traditional PPO, you may take advantage of the highest level of benefit by receiving services from in-network vision providers and doctors. You would be responsible for a copayment at the time of your service. There is no ID card; just make an appointment with a VSP-Signature doctor and tell them you are a VSP member. However, if you receive services from an out-of-network doctor, you pay all expenses at the time of service and submit a claim for reimbursement up to the VSP-allowed amount.

Any questions pertaining to your vision coverage can be directed to VSP Vision Care by calling 1.800.877.7195 or visiting their website, www.vsp.com.

"I need specific vision care! How much does it cost?"

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

The above information is a summary only. Please refer to your Evidence of Coverage for complete details of Plan benefits, limitations and exclusions.



Hearing Aids

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

The cost of a pair of quality hearing aids usually costs more than $5,000. TruHearing is making hearing aids affordable by providing exclusive savings to all VSP Vision Care members. VSP members can save up to $2,400 on a pair of digital hearing aids. Dependents and even extended family members are eligible for exclusive savings too.

In addition to great pricing, TruHearing provides VSP members with:

- Three visits for an exam, fitting, adjustments and cleanings with a TruHearing-participating licensed hearing aid professional. The provider may charge up to $75 for the exam.
- 45-day money back guarantee
- Three-year manufacturer's warranty for repairs and for one-time loss and damage
- 48 free batteries per hearing aid
- Deep discounts on replacement batteries shipped directly to your home

How Do You Get Started?

1. Call TruHearing at 1.877.372.4040. You and family members MUST mention VSP when you call.
2. TruHearing will answer your questions and schedule a hearing exam with a local, participating provider.
3. The provider will make a recommendation, order the hearing aids through TruHearing, and fit them for you.

Learn more about this VSP Exclusive Member Extra at www.truhearing.com/vsp or call TruHearing at 1.877.372.4040.

The relationship between VSP and TruHearing is that of independent contractors. VSP makes no endorsement, representations or warranties regarding any products or services offered by TruHearing, a third-party vendor. The vendor is solely responsible for the products or services offered by them. If you have any questions regarding the services offered here, you should contact the vendor directly.

Basic Life and AD&D

Protect Your Loved Ones

In the event of your death, Life Insurance will provide your family members or other beneficiaries with financial protection and security.

District-Paid Basic Life and AD&D Coverage

Your District-paid Basic Life and AD&D benefit ceases on your retirement date. However, Hartford offers two options to continue the amount of your Basic Life insurance with an individual policy without your having to provide evidence of good health. Application for either option must be made within 31 days of your retirement. The options are:

1. Convert to a Permanent, level-premium policy, or
2. If you have not reached your Social Security Normal Retirement Age, "port" your insurance to a different Term, increasing-premium insurance policy.

These post-retirement options do not include AD&D insurance. Conversion plan rates and benefits may differ greatly from the group plan. If you are interested in receiving a rate quote and determining your eligibility for this option, please contact the Employee Benefits Department to complete a Notice of Conversion and/or Portability Rights Form on your behalf. The completed form will be returned back to you for submission to Selman & Co which is the administrator selected by Hartford Life. Billing for any coverage that is ported/converted will not be managed by the District.

Premium Waiver Provision: If you are totally disabled (as defined by Hartford) on the day you cease working as a benefit-eligible employee and are under age 70, you may be eligible to continue your Basic Life insurance with no premium payments up to the earlier of your age 70 or the date you are no longer totally disabled. If you think you may be eligible, please contact the Employee Benefits Department to request a premium waiver claim form.

TIP

Are Your Beneficiaries Up to Date?

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

- **You can make your initial beneficiary designation once coverage begins**
- **You can change your beneficiary designation at any time.**
- **To select or change your beneficiary, please visit: https://enroll.thehartfordatwork.com**

You will need to have the following information for each beneficiary you would like to designate:

- ✓ **Name**
- ✓ **Birth Date**
- ✓ **Social Security Number**

Voluntary Life Insurance

For retirees who elected Voluntary Supplemental Life insurance coverage (excludes AD&D coverage) as an active employee for yourself and/or spouse/RDP, you may:

1. Continue that existing coverage by contacting Hartford directly at 1-855-396-7655 after your retirement date but within 60 days of retirement. Billing for monthly premium payments will continue to be handled by the District, or
2. Elect to change to an individual policy with The Harford within 31 days of your retirement and without having to provide evidence of insurability. The options are:
    a. Convert to a Permanent, level-premium policy, or
    b. If you have not reached your Social Security Normal Retirement Age, "port" your insurance to a different Term, increasing-premium policy.

To obtain more information about individual policies, please first contact the Employee Benefits Department for a Notice of Conversion and/or Portability Rights form within 31 days of your retirement date

Please note: If you elect to continue the existing program through the District, benefits reduce in accordance with the following schedule:

AT AGE	BENEFITS REDUCE TO THE FOLLOWING PERCENT OF YOUR UNDER AGE 65 BENEFIT
65	65%
70	50%
75	25%
80	The lesser of $10,000 or your age 75 amount

Premium Waiver Provision: If you are totally disabled (as defined by Hartford) on the day you cease working as a benefit-eligible employee and are under age 60, you may be eligible to continue your life insurance with no premium payments up to the earlier of your age 70 or the date you are no longer totally disabled. If you think you may be eligible, please contact the Employee Benefits Department to request a premium waiver claim form

Please refer to your Certificate of Insurance for complete descriptions of the benefits, limitations, exclusions and further details about your life insurance

Tenthly Premium Rates – Voluntary Life Coverage THROUGH the District

Retiree Age	Tenthly Rates / $10,000		Tenthly Rates / $5,000	
	Retiree (Non-Smoker)	Retiree (Smoker)	Spouse / RDP (Non-Smoker)	Spouse / RDP (Smoker)
Under 40	$0.59	$1.13	$0.28	$0.54
40 – 49	$1.17	$1.94	$0.56	$0.93
50 – 59	$2.90	$5.42	$1.38	$2.58
60 – 64	$5.90	$9.27	$2.81	$4.42
65 – 69	$10.46	$16.00	$4.98	$7.62
70 – 74	$19.39	$26.47	$9.23	$12.61
75 – 79	$25.96	$44.10	$12.36	$21.00
80+	$25.96	$61.21	$12.36	$29.15

Spending Accounts

Flexible Spending Accounts (FSA)

If you contributed to a Health Care FSA as an active employee, you may submit claims for expenses that were incurred during the portion of the plan year up to the end of the month after termination except when termination of employment occurs between June 1 and August 31 of the plan year. In that case, you may continue to submit claims for expenses incurred up to August 31 of the plan year. The plan year is defined as January 1 to December 31. A Health Care FSA is eligible for COBRA continuation through the end of the plan year only if there is a positive balance in the Health Care FSA account at the time of retirement. Continuation of a Health Care FSA under COBRA is not a pre-tax benefit and is subject to a 2% administrative fee. In lieu of COBRA, active employees may continue their coverage after retirement through the end of the current plan year by contacting the District Benefits Department to have the remainder of their annual election deducted from their last paycheck on a pre-tax basis.

FSA Type	Detail
Healthcare FSA	• Can reimburse for eligible healthcare expenses not covered by your medical, dental, and vision insurance. • Maximum contribution for 2024 is $3,050.

Remember to Plan Carefully!

- You cannot change your Health Care FSA contributions during the year unless you experience an applicable Qualified Life Event. In lieu of COBRA, active employees can elect to have the remainder of their annual Health Care FSA election deducted pre-tax from their final paycheck.
- Any amount remaining in your account(s) when contributions cease as an active employee cannot be refunded or carried over to the next year. If you don't use the money in your Health Care FSA, you'll lose it, based on IRS regulations
- You must save all receipts* as proof of the eligibility of the expense is required by the Internal Revenue Code (IRC); even if you use your American Fidelity Benefits Debit Card as payment.

**The internal Revenue Code (IRC) requires proof of the eligible expenses using itemized receipts or other documentation showing the date of service, person for whom service was provided and description of the expense. Depending on the type of expense, documentation may come in the form of third party itemized statements or Explanation of Benefits.*

INDIVIDUALS ENROLLED IN THE UHC CS VEBA ALLIANCE HMO JOURNEY OR THE UHC HARMONY HMO JOURNEY PLAN MAY NOT RECEIVE REIMBURSEMENT FROM BOTH THEIR HEALTH REIMBURSEMENT ACCOUNT AND THEIR HEALTH CARE FSA FOR THE SAME OUT-OF-POCKET HEALTH CARE EXPENSES.

Receiving Reimbursements

If you do not receive automatic reimbursement by using your debit card, you can submit a manual reimbursement request by:

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

You may receive your manual reimbursement by check in the mail or by means of direct deposit into your personal Checking or Savings Account.

Employee Assistance Program (EAP)

(EXCLUDES RETIREES ON MEDICARE PLANS)

There may be times in your life when you need personal help and don't know where to turn. Whatever the problem, you don't need to handle it alone. VEBA has arranged to provide confidential EAP services through Optum Health to retirees under age 65 retirees and their dependents who are covered by a District-sponsored medical plan.

When you call the EAP, you will be connected with a licensed EAP counselor who will help you determine the most appropriate type of assistance to resolve your issue. The EAP provides up to five (5) face-to-face confidential and personal counseling sessions per incident, per 12 months, at no cost through participating providers.

- For authorization or referrals call Optum EAP at 1.888.625.4809 or visit the EAP's website at www.LiveAndWorkWell.com.
- Use Access Code: VEBA

The EAP program can help with life issues through a wide range of services, including face-to-face counseling sessions or a referral to community resources. Here are some examples:

Counseling Services:

- Depression, anxiety and stress
- Workplace conflicts
- Grief and loss
- Relationship problems
- Alcohol and substance abuse/addiction

Dependent Care Referrals:

- Referrals to childcare or elder care providers
- Referrals to home health care providers

Legal and Financial Issues (One free 30-minute legal consultation is provided; subsequent assistance is available with a 25% discount.)

- Wills, trusts and estate planning
- Divorce or custody
- Small claims and personal injury
- Real estate transactions
- Financial planning and debt management
- Planning for retirement

Retirement Savings Plans - IRC 457(B) / 403(B)

After your retirement, you may not make contributions to your Deferred Compensation IRC 457(b) plan or your Tax Sheltered Annuity IRC Section 403(b) plan. In general, your withdrawal options are listed below; however, it is strongly recommended that you discuss your options with a financial advisor at Variable Annuity Life Insurance Company (VALIC) by calling at 619.718.7000 or by going to MyRetirementManager.com.

To check your 457(b) plan and/or the 403(b) plan account balance, view your contributions, change your investments and more, visit MyRetirementManager.com. For login or password assistance please contact the Fiscal Control Department at 1-619-725-7669 or send an email to deferred.comp@sandi.net.

Additional 457(b) and 403(b) Information

Distributions after Retirement: Upon retirement from the District, you are entitled to request a full distribution of your vested account balance. This may be done as a rollover to another 457(b) or 403(b) plan, a 401(k) plan, or to an IRA. You also may request a lump-sum cash payment to yourself. Please be aware of possible taxes and penalties, which may apply to any payment other than a rollover. To avoid tax penalties, IRS determined required minimum withdrawals must commence in the calendar year in which a retiree attains age 72.

Marsh & McLennan Insurance Agency LLC does not serve as advisor, broker-dealer or registered investment advisor for this plan. All of the terms and conditions of your plan are subject to applicable laws, regulations and policies. In case of a conflict between your plan document and this information, the plan documents will always govern.

Directory & Resources

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

Information Regarding		Contact Information
Enrollment & Eligibility		
• SDUSD Benefits Department	619.725.8130	Email: employeebenefits@sandi.net www.sandiegounified.org/departments/benefits
California Schools VEBA		
• VEBA	619.278.0021	www.vebaonline.com
• VEBA Advocacy Program	888.276.0250	www.vebaonline.com/contact
• VEBA Resource Center (VRC)	619.398.4220	www.vebaresourcecenter.com
Medical Coverage & Programs		
Kaiser		
• HMO	800.464.4000	my.kp.org/veba
• Senior Advantage HMO	800.443.0815	my.kp.org/veba
UnitedHealthcare		
• HMO	888.586.6365	www.whyuhc.com/csveba
• Medicare Advantage HMO	800.457.8506	www.UHCRetiree.com
• UMR NexusACO Select Plus PPO	800.826.9781	www.umr.com
• Medicare Advantage PPO	877.211.6550	www.UHCRetiree.com
• Express Scripts RX – Under Age 65 Plans	800.918.8011	www.express-scripts.com
• Optum Rx for UHC Medicare Plans	888.279.1828	www.optumrx.com
• Carrum Health – Under Age 65 Plans	888.855.7806	
TelaDoc Medical	800.835.2362	www.teladoc.com/medical-experts
Optum Health Chiropractic/Acupuncture – Under Age 65 Plans	800.428.6337	www.MyOptumPhysicalHealthofCA.com
HealthInvest HRA - UHC Alliance/Harmony Journey	844.342.5505	www.HealthInvestHRA.com
Dental Coverage		
Delta Dental		
• PPO	866.499.3001	www.deltadentalins.com
DeltaCare		
• HMO	800.422.4234	www.deltadentalins.com
Western Dental		
• HMO	800.992.3366	www.westerndental.com
Vision Coverage		
Vision Service Plan		
• VSP Vision Care	800.877.7195	www.vsp.com
Life Insurance Plans		
The Hartford		
• Basic Life & Supplemental Life	855.396.7655	www.enroll.thehartfordatwork.com/enroll/login.aspx
Flexible Spending Accounts		
American Fidelity	800.662.1113	www.americanfidelity.com Email: flex@americanfidelity.com
Deferred Compensation 457(b) Plans / Tax Sheltered Annuity 403(b) Plans		
VALIC Office	619.718.7000	MyRetirementManager.com
Employee Assistance Plan		
OptumHealth	888.625.4809	www.liveandworkwell.com access code: VEBA

Plan Guidelines and Evidence of Coverage

The benefit summaries listed on the following pages are brief summaries only. They do not fully describe the benefits coverage for your health and welfare plans. For details on the benefits coverage, please refer to the plan's Evidence of Coverage. The Evidence of Coverage or Summary Plan Description is the binding document between the elected health plan and the member.

A health plan physician must determine that the services and supplies are medically necessary to prevent, diagnose, or treat the members' medical condition. These services and supplies must be provided, prescribed, authorized, or directed by the health plan's network physician unless the member enrolls in the PPO plan where the member can use a non-network physician.

The HMO member must receive the services and supplies at a health plan facility or skilled nursing facility inside the service area except where specifically noted to the contrary in the Evidence of Coverage.

For details on the benefit and claims review and adjudication procedures for each plan, please refer to the plan's Evidence of Coverage. If there are any discrepancies between benefits included in this summary and the Evidence of Coverage or Summary Plan Description, the Evidence of Coverage or Summary Plan Description will prevail.

Informing You of Health Care Reform – The Affordable Care Act (ACA)

You can obtain health insurance through our benefits program or purchase coverage elsewhere, such as a State Health Insurance Exchange.

For more information regarding Health Care Reform, please contact the District's Employee Benefits Department or visit www.cciio.cms.gov. You can also visit www.coveredca.com to review information specific to the Covered California State Health Insurance Exchange.

As part of ACA, "full-time" employees, as defined by ACA will receive an IRS Form 1095-C from the District. This form provides information about whether the District offered such employees medical benefits plans that met ACA "Affordability" and "Minimum Value" requirements in the prior calendar year. The form also identifies the months that eligible employees were enrolled in a medical benefits plan in the prior calendar year. Covered dependents will not be reflected on this Form.

In addition, employees, retirees and COBRA beneficiaries who were covered under a District-sponsored medical plan in the prior calendar year will receive an IRS Form 1095-B from their medical benefits provider, i.e., Kaiser or UnitedHealthcare. The form also will identify the months in the prior calendar year that eligible employees, retirees COBRA beneficiaries and their family members were enrolled in a medical benefits plan.

The above identified individuals should receive the forms by January 31 of the subsequent calendar year and can be used by individuals for the completion of their federal tax filings and to prove enrollment in medical benefits in the event an individual is audited by the IRS.

San Diego Unified School District's Health and Welfare Benefits Annual Notice Packet

For the 2024 Plan Year

Dear Valued Retiree,

Enclosed is a packet of notices and disclosures that pertain to your employer-sponsored health and welfare plans, as required by federal law.

Enclosures:

- ☐ Medicare Part D Creditable Coverage Notice
- ☐ HIPAA Special Enrollment Rights Notice
- ☐ HIPAA Notice of Privacy Practices
- ☐ Children's Health Insurance Program (CHIP) Notice
- ☐ Women's Health and Cancer Rights Act (WHCRA) Notice
- ☐ Newborns' Mothers Health Protection Act (NMHPA) Notice
- ☐ General Notice of COBRA Continuation Rights

Should you have any questions regarding the content of the notices, please contact The District's Employee Benefits Department at 619-725-8130 or by email at employeebenefits@sandi.net

Medicare Part D
Creditable Coverage Notice

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

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

1. **Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.**
2. **San Diego Unified School District has determined that the prescription drug coverage offered by the San Diego Unified School District 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 while enrolled in San Diego Unified School District coverage as an active employee, please note that your San Diego Unified School District coverage will be the primary payer for your prescription drug benefits and Medicare will pay secondary. As a result, the value of your Medicare prescription drug benefits may be significantly reduced. Medicare

will usually pay primary for your prescription drug benefits if you participate in San Diego Unified School District coverage as a former employee.

You may also choose to drop your San Diego Unified School District coverage. If you do decide to join a Medicare drug plan and drop your current San Diego Unified School District coverage, be aware that you and your dependents may not be able to get this coverage back.

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

You should also know that if you drop or lose your current coverage with San Diego Unified School District and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage…

Contact the person listed below for further information or California Schools VEBA at 619.278.0021. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through San Diego Unified School District changes. You also may request a copy of this notice at any time.

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

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

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- 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).

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

HIPAA Special Enrollment Rights Notice

If you are declining enrollment in San Diego Unified School District group health coverage for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if 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 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Finally, you and/or your dependents may have special enrollment rights if coverage is lost under Medicaid or a State health insurance ("CHIP") program, or when you and/or your dependents gain eligibility for state premium assistance. You have 60 days from the occurrence of one of these events to notify the company and enroll in the plan.

HIPAA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

San Diego Unified School District sponsors certain group health plan(s) (collectively, the "Plan" or "We") to provide benefits to our employees, their dependents and other participants. We provide this coverage through various relationships with third parties that establish networks of providers, coordinate your care, and process claims for reimbursement for the services that you receive. This Notice of Privacy Practices (the "Notice") describes the legal obligations of San Diego Unified School District, the Plan and your legal rights regarding your protected health information held by the Plan under HIPAA. Among other things, this Notice describes how your protected health information may be used or disclosed to carry out treatment, payment, or health care operations, or for any other purposes that are permitted or required by law.

We are required to provide this Notice to you pursuant to HIPAA. The HIPAA Privacy Rule protects only certain medical information known as "protected health information." Generally, protected health information is individually identifiable health information, including demographic information, collected from you or created or received by a health care provider, a health care clearinghouse, a health plan, or your employer on behalf of a group health plan, which relates to:

(1) your past, present or future physical or mental health or condition;
(2) the provision of health care to you; or
(3) the past, present or future payment for the provision of health care to you.

Note: If you are covered by one or more fully-insured group health plans offered by San Diego Unified School District, you will receive a separate notice regarding the availability of a notice of privacy practices applicable to that coverage and how to obtain a copy of the notice directly from the insurance carrier.

Contact Information

If you have any questions about this Notice or about our privacy practices, please contact the San Diego Unified School District HIPAA Privacy Officer or employeebenefits@sandi.net

San Diego Unified School District Attention:
HIPAA Privacy Officer
CA Schools VEBA
Attn: Plan Privacy Officer
1843 Hotel Circle South
San Diego, CA 92108
619.278.0021

Effective Date

This Notice as revised is effective January 1, 2024.

Our Responsibilities

We are required by law to:

- maintain the privacy of your protected health information;
- provide you with certain rights with respect to your protected health information;
- provide you with a copy of this Notice of our legal duties and privacy practices with respect to your protected health information; and
- follow the terms of the Notice that is currently in effect.

We reserve the right to change the terms of this Notice and to make new provisions regarding your protected health information that we maintain, as allowed or required by law. If we make any material change to this Notice, we will provide you with a copy of our revised Notice of Privacy Practices. You may also obtain a copy of the latest revised Notice by contacting our Privacy Officer at the contact information provided above or on our intranet at www.sandiegounified.org/departments/benefits. Except as provided within this Notice, we may not disclose your protected health information without your prior authorization.

How We May Use and Disclose Your Protected Health Information

Under the law, we may use or disclose your protected health information under certain circumstances without your permission. The following categories describe the different ways that we may use and disclose your protected health information. For each category of uses or disclosures we will explain what we mean and present some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose protected health information will fall within one of the categories.

For Treatment

We may use or disclose your protected health information to facilitate medical treatment or services by providers. We may disclose medical information about you to providers, including doctors, nurses, technicians, medical students, or other hospital personnel who are involved in taking care of you. For example, we might disclose information about your prior prescriptions to a pharmacist to determine if a pending prescription is inappropriate or dangerous for you to use.

For Payment

We may use or disclose your protected health information to determine your eligibility for Plan benefits, to facilitate payment for the treatment and services you receive from health care providers, to determine benefit responsibility under the Plan, or to coordinate Plan coverage. For example, we may tell your health care provider about your medical history to determine whether a particular treatment is experimental, investigational, or medically necessary, or to determine whether the Plan will cover the treatment. We may also share your protected health information with a utilization review or precertification service provider. Likewise, we may share your protected health information with another entity to assist with the adjudication or subrogation of health claims or to another health plan to coordinate benefit payments.

For Health Care Operations

We may use and disclose your protected health information for other Plan operations. These uses and disclosures are necessary to run the Plan. For example, we may use medical information in connection with conducting quality assessment and improvement activities; underwriting, premium rating, and other activities relating to Plan coverage; submitting claims for stop-loss (or excess-loss) coverage; conducting or arranging for medical review, legal services, audit services, and fraud & abuse detection programs; business planning and development such as cost management; and business management and general Plan administrative activities. The Plan is prohibited from using or disclosing protected health information that is genetic information about an individual for underwriting purposes.

To Business Associates
We may contract with individuals or entities known as Business Associates to perform various functions on our behalf or to provide certain types of services. In order to perform these functions or to provide these services, Business Associates will receive, create, maintain, use and/or disclose your protected health information, but only after they agree in writing with us to implement appropriate safeguards regarding your protected health information. For example, we may disclose your protected health information to a Business Associate to administer claims or to provide support services, such as utilization management, pharmacy benefit management or subrogation, but only after the Business Associate enters into a Business Associate Agreement with us.

As Required by Law
We will disclose your protected health information when required to do so by federal, state or local law. For example, we may disclose your protected health information when required by national security laws or public health disclosure laws.

To Avert a Serious Threat to Health or Safety
We may use and disclose your protected health information when necessary to prevent a serious threat to your health and safety, or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat. For example, we may disclose your protected health information in a proceeding regarding the licensure of a physician.

To Plan Sponsors
For the purpose of administering the Plan, we may disclose to certain employees of the Employer protected health information. However, those employees will only use or disclose that information as necessary to perform Plan administration functions or as otherwise required by HIPAA, unless you have authorized further disclosures. Your protected health information cannot be used for employment purposes without your specific authorization.

Special Situations

In addition to the above, the following categories describe other possible ways that we may use and disclose your protected health information. For each category of uses or disclosures, we will explain what we mean and present some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

Organ and Tissue Donation
If you are an organ donor, we may release your protected health information to organizations that handle organ procurement or organ, eye, or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

Military and Veterans
If you are a member of the armed forces, we may release your protected health information as required by military command authorities. We may also release protected health information about foreign military personnel to the appropriate foreign military authority.

Workers' Compensation
We may release your protected health information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks
We may disclose your protected health information for public health actions. These actions generally include the following:

- to prevent or control disease, injury, or disability;
- to report births and deaths;
- to report child abuse or neglect;
- to report reactions to medications or problems with products;
- to notify people of recalls of products they may be using;
- to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
- to notify the appropriate government authority if we believe that a patient has been the victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree, or when required or authorized by law.

Health Oversight Activities
We may disclose your protected health information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes
If you are involved in a lawsuit or a dispute, we may disclose your protected health information in response to a court or administrative order. We may also disclose your protected health information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement
We may disclose your protected health information if asked to do so by a law enforcement official—

- in response to a court order, subpoena, warrant, summons or similar process;
- to identify or locate a suspect, fugitive, material witness, or missing person;
- about the victim of a crime if, under certain limited circumstances, we are unable to obtain the victim's agreement;
- about a death that we believe may be the result of criminal conduct;
- about criminal conduct; and
- in emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Directors
We may release protected health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about patients to funeral directors as necessary to carry out their duties.

National Security and Intelligence Activities
We may release your protected health information to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

Inmates
If you are an inmate of a correctional institution or are in the custody of a law enforcement official, we may disclose your protected health information to the correctional institution or law enforcement official if necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

Research

We may disclose your protected health information to researchers when:

(1) the individual identifiers have been removed; or
(2) when an institutional review board or privacy board has (a) reviewed the research proposal; and (b) established protocols to ensure the privacy of the requested information, and approves the research.

Required Disclosures

The following is a description of disclosures of your protected health information we are required to make.

Government Audits
We are required to disclose your protected health information to the Secretary of the United States Department of Health and Human Services when the Secretary is investigating or determining our compliance with the HIPAA privacy rule.

Disclosures to You
When you request, we are required to disclose to you the portion of your protected health information that contains medical records, billing records, and any other records used to make decisions regarding your health care benefits. We are also required, when requested, to provide you with an accounting of most disclosures of your protected health information if the disclosure was for reasons other than for payment, treatment, or health care operations, and if the protected health information was not disclosed pursuant to your individual authorization.

Notification of a Breach.
We are required to notify you in the event that we (or one of our Business Associates) discover a breach of your unsecured protected health information, as defined by HIPAA.

Other Disclosures

Personal Representatives
We will disclose your protected health information to individuals authorized by you, or to an individual designated as your personal representative, attorney-in-fact, etc., so long as you provide us with a written notice/authorization and any supporting documents (i.e., power of attorney). Note: Under the HIPAA privacy rule, we do not have to disclose information to a personal representative if we have a reasonable belief that:

(1) you have been, or may be, subjected to domestic violence, abuse or neglect by such person;
(2) treating such person as your personal representative could endanger you; or
(3) in the exercise or professional judgment, it is not in your best interest to treat the person as your personal representative.

Spouses and Other Family Members
With only limited exceptions, we will send all mail to the employee. This includes mail relating to the employee's spouse and other family members who are covered under the Plan, and includes mail with information on the use of Plan benefits by the employee's spouse and other family members and information on the denial of any Plan benefits to the employee's spouse and other family members. If a person covered under the Plan has requested Restrictions or Confidential Communications (see below under "Your Rights"), and if we have agreed to the request, we will send mail as provided by the request for Restrictions or Confidential Communications.

Authorizations

Other uses or disclosures of your protected health information not described above, including the use and disclosure of psychotherapy notes and the use or disclosure of protected health information for fundraising or marketing purposes, will not be made without your written authorization. You may revoke written authorization at any time, so long as your revocation is in writing. Once we receive your written revocation, it will only be effective for future uses and disclosures. It will not be effective for any information that may have been used or disclosed in reliance upon the written authorization and prior to receiving your written revocation. You may elect to opt out of receiving fundraising communications from us at any time.

Your Rights

You have the following rights with respect to your protected health information:

Right to Inspect and Copy
You have the right to inspect and copy certain protected health information that may be used to make decisions about your health care benefits. To inspect and copy your protected health information, submit your request in writing to the Privacy Officer at the address provided above under Contact Information. If you request a copy of the information, we may charge a reasonable fee for the costs of copying, mailing, or other supplies associated with your request. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to your medical information, you may have a right to request that the denial be reviewed and you will be provided with details on how to do so.

Right to Amend
If you feel that the protected health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the Plan. To request an amendment, your request must be made in writing and submitted to the Privacy Officer at the address provided above under Contact Information. In addition, you must provide a reason that supports your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- is not part of the medical information kept by or for the Plan;
- was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- is not part of the information that you would be permitted to inspect and copy; or
- is already accurate and complete.

If we deny your request, you have the right to file a statement of disagreement with us and any future disclosures of the disputed information will include your statement.

Right to an Accounting of Disclosures
You have the right to request an “accounting” of certain disclosures of your protected health information. The accounting will not include (1) disclosures for purposes of treatment, payment, or health care operations; (2) disclosures made to you; (3) disclosures made pursuant to your authorization; (4) disclosures made to friends or family in your presence or because of an emergency; (5) disclosures for national security purposes; and (6) disclosures incidental to otherwise permissible disclosures.

To request this list or accounting of disclosures, you must submit your request in writing to the Privacy Officer at the address provided above under Contact Information. Your request must state a time period of no longer than six years (three years for electronic health records) or the period San Diego Unified School District has been subject to the HIPAA Privacy rules, if shorter.

Your request should indicate in what form you want the list (for example, paper or electronic). We will attempt to provide the accounting in the format you requested or in another mutually agreeable format if the requested format is not reasonably feasible. The first list you request within a 12-month period will be provided free of charge. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions
You have the right to request a restriction or limitation on your protected health information that we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on your protected health information that we disclose to someone who is involved in your care or the payment for your care, such as a family member or friend. For example, you could ask that we not use or disclose information about a surgery that you had.

We are not required to agree to your request. However, if we do agree to the request, we will honor the restriction until you revoke it or we notify you. To request restrictions, you must make your request in writing to the Privacy Officer at the address provided above under Contact Information. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure, or both; and (3) to whom you want the limits to apply—for example, disclosures to your spouse.

Right to Request Confidential Communications
You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. To request confidential communications, you must make your request in writing to the Privacy Officer at the address provided above under Contact Information. We will not ask you the reason for your request. Your request must specify how or where you wish to be contacted. We will accommodate all reasonable requests if you clearly provide information that the disclosure of all or part of your protected information could endanger you.

Right to a Paper Copy of This Notice
You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. To obtain a paper copy of this notice, telephone or write the Privacy Officer as provided above under Contact Information.

For more information, please see Your Rights Under HIPAA**.**

Complaints
If you believe that your privacy rights have been violated, you may file a complaint with the Plan or with the Office for Civil Rights of the United States Department of Health and Human Services. You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.

To file a complaint with the Plan, telephone write the Privacy Officer as provided above under Contact Information. You will not be penalized, or in any other way retaliated against, for filing a complaint with the Office of Civil Rights or with us. You should keep a copy of any notices you send to the Plan Administrator or the Privacy Officer for your records.

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 July 31, 2022. Contact your State for more information on eligibility –

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

GEORGIA – Medicaid

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

INDIANA – Medicaid

Healthy Indiana Plan for low-income adults 19-64

Website: http://www.in.gov/fssa/hip/

Phone: 1-877-438-4479

All other Medicaid

Website: https://www.in.gov/medicaid/

Phone 1-800-457-4584

IOWA – Medicaid and CHIP (Hawki)

Medicaid Website: https://dhs.iowa.gov/ime/members
Medicaid Phone: 1-800-338-8366

Hawki Website: http://dhs.iowa.gov/Hawki

Hawki Phone: 1-800-257-8563

HIPP Website:
https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp

HIPP Phone: 1-888-346-9562

KANSAS – Medicaid

Website: https://www.kancare.ks.gov/

Phone: 1-800-792-4884

KENTUCKY – Medicaid

Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website:
https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx

Phone: 1-855-459-6328

Email: KIHIPP.PROGRAM@ky.gov

KCHIP Website:
https://kidshealth.ky.gov/Pages/index.aspx

Phone: 1-877-524-4718

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

LOUISIANA – Medicaid

Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp

Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)

MAINE – Medicaid

Enrollment Website:
https://www.maine.gov/dhhs/ofi/applications-forms
Phone: 1-800-442-6003 TTY: Maine relay 711
Private Health Insurance Premium Webpage:
https://www.maine.gov/dhhs/ofi/applications-forms
Phone: -800-977-6740 TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP

Website: https://www.mass.gov/masshealth/pa
Phone: 1-800-862-4840
TTY: (617) 886-8102

MINNESOTA – Medicaid

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

Phone: 1-800-657-3739

MISSOURI – Medicaid

Website:

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

MONTANA – Medicaid

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

NEBRASKA – Medicaid

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

NEVADA – Medicaid

Medicaid Website: http://dhcfp.nv.gov

Medicaid Phone: 1-800-992-0900

NEW HAMPSHIRE – Medicaid

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

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

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

Women's Health Cancer Rights Act (WHCRA) Notice

Do you know that your Plan, as required by the Women's Health and Cancer Rights Act of 1998 (WHCRA), provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema?

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. If you would like more information on WHCRA benefits, contact your plan administrator at employeebenefits@sandi.net.

Newborns' and Mothers' Health Protection Act (NMHPA) Notice

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 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 the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Model General Notice of COBRA Continuation Coverage Rights

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

Introduction

You're getting this notice because you recently gained coverage under a group health plan (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 the San Diego Unified School District 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:

- **San Diego Unified School District Employee Benefits Department**
- **4100 Normal St., Room 1150A**
- **San Diego, CA 92103**

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/agencies/ebsa**. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit **www.HealthCare.gov**.

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

Plan contact information

VEBA – San Diego Unified School District
Eugene Brucker Education Center
San Diego Unified School District Employee Benefits Department
4100 Normal Street, Room 1150A
San Diego, CA 92103

[1] https://www.medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b/part-a-part-b-sign-up-periods.

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Prepared by: Marsh & McLennan Insurance Agency LLC
www.MarshMMA.com | CA Insurance Lic: 0H18131