Pleasanton
UNIFIED SCHOOL DISTRICT

OPEN ENROLLMENT is September 16 through October 11

2025
Benefit Guide

All Benefit Eligible Employees

Updated 2024

At the Pleasanton Unified School District (the District), we recognize the important role our employees play in providing quality education in our community. The District provides benefits-eligible employees with a competitive and comprehensive benefits package designed to meet your needs and those of your family.

This guide provides an overview of the District's benefits program, including a summary of each type of coverage. Because the selection of your benefits is important, we encourage you to carefully review the information in this guide.

If you have any other questions about your benefits, please contact the vendors, or a Benefit Technician.

Benefit Help

For questions with your benefits, contact your Benefits Specialist.

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Open Enrollment

Open Enrollment will be September 16 - October 11, 2024

Effective Date of Enrollment / Benefit Changes: January 1, 2025

Open Enrollment for 2025 will begin on Monday, September 16 and will remain open until Friday, October 11. Open Enrollment is generally your one time of the year to make changes to your benefits. During Open Enrollment you will be able to:

- Confirm your current coverage
- Enroll or make changes to your medical, dental, vision
- Enroll or make changes to your worksite-voluntary plans through American Fidelity
- Contribute to your Health Care and/or Dependent Care Flexible Spending Account (FSA). You must re-enroll to have this benefit January 1, 2025.

Note: You cannot change coverage, start or stop coverage, or add or drop any family members to or from your coverage during the plan year (outside of open enrollment) unless you have a qualifying event. **See page 4 for more information.**

New for 2025

Doula Benefit for all Pregnant and Postpartum Members. New benefit for all pregnant and postpartum Basic plan members to receive health education, advocacy, physical and emotional non-medical support before, during and after pregnancy, miscarriage, stillbirth, and abortions. Standardized travel and lodging coverage for eligible medically necessary services including, but not limited to abortion services, gender affirming care, complex surgeries, and cancer care that cannot be accessed within 50 miles from the member's residence for all Basic and Medicare plan members, up to $5,000 per occurrence. This includes transportation, lodging, and meals for the member and a companion (both parents/guardians when patient is under 18).

When you select coverage under the medical, dental or vision plans, coverage stays in effect for the entire plan year. (January 1 through December 31.)

Action is not required for all benefit-eligible employees.

1. Not Making Changes?
   If you are not making any changes and/or not re-enrolling in the Flexible Spending Account (FSA), and wish to continue your current health plans, you don't have to take any action.
2. Making Changes?
   If you are making changes or enrolling in the FSA for 2025, you will need to meet with an American Fidelity advisor no later than October 11.
   - You can use **this link** to schedule your open enrollment appointment link. It is also found within the open enrollment online benefit portal provided by your district's health benefits specialist. During your appointment, your advisor will instruct you on how to make your changes.

Eligibility and Changes

Who Is Eligible?

Most benefits coverage begins on the first of the month following the completion of your employment waiting period. In order to determine your benefits eligibility status (active full-time employee, part-time employee, early retiree, retiree age 65+, leaves of absence, or other bargaining unit arrangements) please see eligibility under each of the benefit offerings.

You may enroll yourself and your eligible dependents for medical, dental and/or vision coverage. Your eligible dependents generally include:

- Your legal spouse or domestic partner.*
- Your children until age 26 for medical, dental and vision coverage.
- Any dependent child who is incapable of self-support because of a physical or mental disability that manifested itself while otherwise eligible.

**You may cover domestic partners of the same or opposite sex and their eligible children under the medical and dental plans. Domestic partners are defined by the state. Please contact the Benefits Specialists for additional eligibility information as well as the applicable forms and cost information.*

District will cover medical for management up to $1,021.41 per month. District will cover medical for classified (CSEA) up to $1,021.41 per month (to be prorated for part-time employees). District will cover medical for certificated (APT) up to $1,021.41 per month (proportioned for part- time).

Making Changes to Your Benefit Elections

You may make changes to your insurance benefit choices once a year during the District's annual open enrollment period for changes effective January 1 of each year. All coverage you select is generally effective for a full plan year (January 1 through December 31), unless you have a change in status or terminate employment. Such changes are subject to any bargaining agreements or applicable laws.

Our plan allows certain benefit election changes to occur during the plan year based on the IRS rules regarding permitted changes.

Examples of permitted changes include, but are not limited to:

- Marriage, divorce, legal separation, addition of a domestic partner or termination of a domestic partnership
- Birth, adoption or custody change of a child
- Loss of your or a dependent's coverage under another plan
- Change in employment (either yours or your spouse's) from part-time to full-time or vice versa
- Relocation out of area

If you have a permitted status change, you can make changes to your benefits by contacting the Benefits Specialist within 31 days of the change.

The change to your benefits must be consistent with the change in status. For example, if you have a new baby, you can enroll the child as a dependent under your current health plans, but you may not remove another covered dependent.

Continuation Coverage

In compliance with federal law, the District offers eligible employees and their families the opportunity to elect a temporary extension of health coverage (referred to as COBRA) in certain instances where coverage would otherwise end. The circumstances which permit this special election privilege are called "qualifying events." It is important for you to become familiar with these events so you can exercise your COBRA rights when eligible.

For some qualifying events, it is your (or a family member's) responsibility to inform the Benefits Specialist in writing or by email of these events so your COBRA rights can be initiated. Please refer to your plan descriptions or carrier materials which explain the provisions of COBRA in greater detail. And of course, the Benefits Specialist is always available to answer your questions.

The District also provides coverage in compliance with other federal and state laws, such as the Family Medical Leave Act and conversion privileges (i.e., the ability to convert some benefits to an individual policy when leaving the District).

Eligibility and Changes *(continued)*

Medical Eligibility

All full-time and part-time certificated and management employees who work at least 50% per week are eligible to enroll. All classified employees are eligible to enroll.

The District provides eligible employees with the following medical plans:

- PERS Platinum
  Preferred Provider Organization (PPO) Plan
- PERS Gold
  Preferred Provider Organization (PPO) Plan
- Kaiser Permanente Health Maintenance Organization (HMO) Plan
- Anthem Blue Cross Select
  Health Maintenance Organization (HMO) Plans
- Anthem Blue Cross Traditional
  Health Maintenance Organization (HMO) Plans
- UnitedHealthcare SignatureValue Alliance
- Blue Shield Access + HMO Plan

All of the District's medical plan options are designed to provide you with cost effective, comprehensive coverage. While each plan covers most of the same services, the provider networks, payroll deductions and your out-of-pocket medical expenses vary by plan.

The PERS Platinum and PERS Gold* PPO plans allow you to access covered medical services from any provider you wish. You receive the highest level of coverage when you access services from Anthem Blue Cross PPO providers.

*Gold is a narrowed network of doctors and hospitals.

Enrolling in an HMO?

Be sure to select a Primary Care Physician (PCP) during enrollment if you haven't already done so. If you don't designate your preferred PCP, the plan will assign one to you. To choose a different PCP, call your plan or go online after you receive your ID card and request that your PCP selection be changed.

The Anthem Blue Cross, Kaiser Permanente, UnitedHealthcare and Blue Shield plans require you to use their providers and facilities (except for emergencies). The tables on the following pages provide a comparison of highlights between the plans. For further details, please refer to the carrier plan descriptions or contact the carrier directly.

Anthem Blue Cross (HMO) 855.839.4524 https://www.anthem.com/ca/calpers/	**Kaiser Permanente** 800.464.4000 https://my.kp.org/calpers
PERS Platinum, PERS Gold 800.334.5847 weblink still pending	**Blue Shield (HMO)** 800.334.5847 www.myoptions.blueshieldca.com

UnitedHealthcare

877.359.3714

https://www.whyuhc.com/calpers

OptumRx*

Pharmacy Benefits Administrator

Active Member Services 855.505.8110 • Medicare Member Services 855.505.8106

www.optumrx.com/calpers

HMO vs. PPO Medical Plans

	HMO Health Maintenance Organization	PPO Preferred Provider Organization
Do I need to designate a Primary Care Physician (PCP)?	**YES** With most HMO plans, all of your healthcare services will be coordinated between you and your designated Primary Care Physician (PCP). Your PCP may be part of a medical group that has contracted with the health plan to perform some functions, including treatment authorization and referrals to specialists.	**NO** A PPO plan does not require you to select a PCP. You can receive care from any doctor you choose, however you will save more money by choosing a doctor, specialist or hospital that is within the network.
Is a referral needed?	**YES** As an example, if you have severe allergies and need to see an allergist, you will first schedule a visit with your PCP. Your doctor will then provide you with a referral for an in-network specialist.	**NO** Generally, PPO plans do not require you to get a referral in order to see a specialist.
If I have a doctor or specialist who is out-of-network, will I still be able to see them and have my care covered?	**NO** HMOs don't provide coverage for care from an out-of-network physician, hospital or facility except in the case of a true medical emergency.	**YES** With a PPO, you have the flexibility to visit providers, hospitals and facilities outside of your network. Keep in mind that visiting an out-of-network provider has higher out-of-pocket expenses. Out-of-network providers have not contracted with the health plan; therefore, you will be responsible for paying any applicable member deductibles or copayments, plus any amount in excess of the covered amount.
Will I have to file a claim?	**NO** Since HMOs only allow you to see providers in-network, it's likely you'll never have to file a claim. This is because your insurance company pays the provider directly.	**YES** In some cases with a PPO, you will have to pay a doctor for services directly and then file a claim to get reimbursed. This is most common when you seek a service from an out-of-network provider.
How much will it cost?	**Lower Cost** You can expect to pay less for out-of-pocket medical services. Plans work on a combination of copays and coinsurance to pay for services.	**Higher Cost** Plans work on a combination of deductibles, copays and coinsurance. Out-of-pocket medical costs can also run higher with a PPO plan, especially if utilizing out-of-network providers.

Medical Plans – CalPERS PPO Options

Open Enrollment takes place September 16 through October 11, 2024 for a January 1, 2025 effective date. For a qualifying event, contact the Benefits Department directly. Be sure to review evidence of coverage links provided for any potential last-minute updates.

	PERS Platinum	
Plan Highlights	**In-Network**	**Out-of-Network**
PLAN PROVISIONS		
Lifetime Benefit Maximum	Unlimited	Unlimited
Annual Deductible	Individual: $500 / Family: $1,000	Individual: $500 / Family: $1,000
Annual Out-of-Pocket	Individual: $2,000 / Family: $4,000	N/A
Coinsurance	10%	40%
DOCTOR'S OFFICE		
Office Visits	$20 Copay	40% After Deductible
Specialist Visits	$35 Copay	40% After Deductible
Routine Physical Exam	No Charge	40% After Deductible
Well Baby Care	No Charge	40% After Deductible
Preventive Laboratory and X-Ray	No Charge	40% After Deductible
HOSPITAL SERVICES		
Emergency Room	$50 Deductible (waived if admitted) +10%	$50 Deductible (waived if admitted) +10%
Inpatient	$250 + 10% After Deductible	$250 + 10% After Deductible
Outpatient Surgery	10% After Deductible	40% After Deductible
MENTAL HEALTH SERVICES		
Inpatient Services	$250 + 10% After Deductible	$250 + 10% After Deductible
Outpatient Services	$20 Copay	40% After Deductible
SUBSTANCE ABUSE SERVICES		
Inpatient Services (Pre-authorization Required)	$250 + 10% After Deductible	$250 + 10% After Deductible
Outpatient Services	$20 Copay	40% After Deductible
PRESCRIPTION DRUGS		
Retail	**30-Day Supply**	
Generic	$5 Copay	
Brand Preferred	$20 Copay	
Non-Preferred Brand	$50 Copay	
Mail Order	**90-Day Supply**	
Generic	$10 Copay	
Brand Preferred	$40 Copay	
Non-Preferred Brand	$100 Copay	

Medical Plans – CalPERS PPO Options *(continued)*

	PERS Gold[4]	
Plan Highlights	**In-Network**	**Out-of-Network**
PLAN PROVISIONS		
Lifetime Benefit Maximum	Unlimited	Unlimited
Annual Deductible	Individual: $1,000[1] / Family: $2,000	Individual: $1,000 / Family: $2,000
Annual Out-of-Pocket	Individual: $2,500 / Family: $5,000	N/A
Coinsurance	20%[2]	40%
DOCTOR'S OFFICE		
Office Visits	$10 Copay[3]	40% After Deductible
Specialist Visits	$35 Copay	40% After Deductible
Routine Physical Exam	No Charge	40% After Deductible
Well Baby Care	No Charge	40% After Deductible
Preventive Laboratory and X-Ray	No Charge	40% After Deductible
HOSPITAL SERVICES		
Emergency Room	$50 Deductible (waived if admitted) +20%	$50 Deductible (waived if admitted) +20%
Inpatient	20% After Deductible	40% After Deductible
Outpatient Surgery	20% After Deductible	40% After Deductible
MENTAL HEALTH SERVICES		
Inpatient Services	20% After Deductible	40% After Deductible
Outpatient Services	$10 Copay[3]	40% After Deductible
SUBSTANCE ABUSE SERVICES		
Inpatient Services (Pre-authorization Required)	20% After Deductible	40% After Deductible
Outpatient Services	$10 Copay[3]	40% After Deductible
PRESCRIPTION DRUGS		
Retail	**30-Day Supply**	
Generic	$5 Copay	
Brand Preferred	$20 Copay	
Non-Preferred Brand	$50 Copay	
Mail Order	**90-Day Supply**	
Generic	$10 Copay	
Brand Preferred	$40 Copay	
Non-Preferred Brand	$100 Copay	

[1] Incentives are available to lower the deductible to $500 for Individual and $1,000 for Family, including biometric screening, condition care, flu shot, second opinion, and smoking cessation.

[2] Coinsurance waived for deliveries if enrolled in Future Moms program.

[3] If enrolled with personal doctor / PCP. $35 Copay if not enrolled with personal doctor / PCP.

[4] PERS Gold utilizes the Blue Shield Gold PPO Network, which is a subset of the Blue Shield PPO Network. Approximately 50% of the Blue Shield PPO Network of Physicians participate in the Gold PPO Network. When obtaining physician services through the Gold PPO Network, you will receive the highest level of reimbursement. If you are a PERS Gold member, you should check to see if a physician is participating in the Gold PPO Network before receiving services.

Medical Plans – CalPERS HMO Options

	HMO Options
Plan Highlights	**Kaiser HMO**
PLAN PROVISIONS	
Lifetime Benefit Maximum	Unlimited
Annual Deductible	Individual: $1,500 / Family: $3,000
Annual Out-of-Pocket	Individual: $7,950 / Family: $15,900
Coinsurance	0%
DOCTOR'S OFFICE	
Office Visits	$15 Copay
Specialist Visits	$15 Copay
Routine Physical Exam	No Charge
Well Baby Care	No Charge
Preventive Laboratory and X-Ray	No Charge
HOSPITAL SERVICES	
Emergency Room	$50 Copay (waived if admitted)
Inpatient	No Charge
Outpatient Surgery	$15 Copay Per Procedure
MENTAL HEALTH SERVICES	
Inpatient Services	No Charge
Outpatient Services	$15 Copay
SUBSTANCE ABUSE SERVICES	
Inpatient Services (Pre-authorization Required)	No Charge
Outpatient Services	$15 Copay
OTHER SERVICES	
Chiropractic	$15 per visit (20 visits per calendar year)
Physical, Occupational, and Speech Therapy Services	$15 Copay
Eye Exams for Refraction	No Charge
PRESCRIPTION DRUGS	
Retail	**30-Day Supply**
Generic	$5 Copay
Brand Preferred	$20 Copay
Non-Preferred Brand	$20 Copay
Mail Order	**100-Day Supply**
Generic	$10 Copay
Brand Preferred	$40 Copay
Non-Preferred Brand	$40 Copay

Medical Plans – CalPERS HMO Options *(continued)*

	HMO Options	
Plan Highlights	**Anthem Blue Cross Select HMO[1]**	**Anthem Blue Cross Traditional HMO**
PLAN PROVISIONS		
Lifetime Benefit Maximum	Unlimited	Unlimited
Annual Deductible	None	None
Annual Out-of-Pocket	Individual $1,500 / Family $3,000	Individual $1,500 / Family $3,000
Coinsurance	0%	0%
DOCTOR'S OFFICE		
Office Visits	$15 Copay	$15 Copay
Specialist Visits	$15 Copay	$15 Copay
Routine Physical Exam	No Charge	No Charge
Well Baby Care	No Charge	No Charge
Preventive Laboratory and X-Ray	No Charge	No Charge
HOSPITAL SERVICES		
Emergency Room	$50 Copay (waived if admitted)	$50 Copay (waived if admitted)
Inpatient	No Charge	No Charge
Outpatient Surgery	No Charge	No Charge
MENTAL HEALTH SERVICES		
Inpatient Services	No Charge	No Charge
Outpatient Services	$15 Copay	$15 Copay
SUBSTANCE ABUSE SERVICES		
Inpatient Services (Pre-authorization Required)	No Charge	No Charge
Outpatient Services	$15 Copay	$15 Copay
OTHER SERVICES		
Chiropractic	$15 per visit (20 visits per calendar year)	$15 per visit (20 visits per calendar year)
Physical, Occupational, and Speech Therapy Services	$15 Copay	$15 Copay
Eye Exams for Refraction	No Charge	No Charge
PRESCRIPTION DRUGS		
Retail	**30-Day Supply**	**30-Day Supply**
Generic	$5 Copay	$5 Copay
Brand Preferred	$20 Copay	$20 Copay
Non-Preferred Brand	$50 Copay	$50 Copay
Mail Order	**90-Day Supply**	**90-Day Supply**
Generic	$10 Copay	$10 Copay
Brand Preferred	$40 Copay	$40 Copay
Non-Preferred Brand	$100 Copay	$100 Copay

[1]Select HMO works with a narrowed physician network.

Medical Plans – CalPERS HMO Options *(continued)*

	HMO Options
Plan Highlights	**UnitedHealthcare SignatureValue Alliance**
PLAN PROVISIONS	
Lifetime Benefit Maximum	Unlimited
Annual Deductible	Individual $1,500 / Family $3,000
Annual Out-of-Pocket	Individual $7,950/ Family $15,900
Coinsurance	0%
DOCTOR'S OFFICE	
Office Visits	$15 copay
Specialist Visits	$15 copay
Routine Physical Exam	No Charge
Well Baby Care	No Charge
Preventive Laboratory and X-Ray	No Charge
HOSPITAL SERVICES	
Emergency Room	$50 copay / visit
Inpatient	No Charge
Outpatient Surgery	No Charge
MENTAL HEALTH SERVICES	
Inpatient Services	No Charge
Outpatient Services	No Charge
SUBSTANCE ABUSE SERVICES	
Inpatient Services (Pre-authorization Required)	No Charge
Outpatient Services	No Charge
OTHER SERVICES	
Chiropractic	$15 per visit (20 visits per calendar year)
Physical, Occupational, and Speech Therapy Services	No Charge
Eye Exams for Refraction	No Charge
PRESCRIPTION DRUGS	
Retail	**30-Day Supply**
Generic	$5 Copay
Brand Preferred	$20 Copay
Non-Preferred Brand	$50 Copay
Mail Order	**90-Day Supply**
Generic	$10 Copay
Brand Preferred	$40 Copay
Non-Preferred Brand	$100 Copay

Medical Plans – CalPERS HMO Options *(continued)*

	HMO Option
Plan Highlights	**Blue Shield Access + HMO**
PLAN PROVISIONS	
Lifetime Benefit Maximum	Unlimited
Annual Deductible	$0
Annual Out-of-Pocket	$1,500 / $3,000
Coinsurance	0%
DOCTOR'S OFFICE	
Office Visits	$15
Specialist Visits	$15 / $30
Routine Physical Exam	No Charge
Well Baby Care	No Charge
Preventive Laboratory and X-Ray	No Charge
HOSPITAL SERVICES	
Emergency Room	No Charge
Inpatient	No Charge
Outpatient Surgery	No Charge
MENTAL HEALTH SERVICES	
Inpatient Services	No Charge
Outpatient Services	$15
SUBSTANCE ABUSE SERVICES	
Inpatient Services (Pre-authorization Required)	No Charge
Outpatient Services	$15
PRESCRIPTION DRUGS	
Retail	**30-Day Supply**
Generic	$5
Brand Preferred	$20
Non-Preferred Brand	$50
Mail Order	**90-Day Supply**
Generic	$10
Brand Preferred	$40
Non-Preferred Brand	$100

Dental Benefits

Dental Plan Eligibility

All full-time and part-time certificated, classified, and management employees who work at least 50% or more (4 hours a day) per day are required to enroll. Part-time employees are eligible to receive prorated benefits provided for full-time employees based on percentage of time worked, but not less than 75% level of coverage.

The District provides Pleasanton Unified employees and their eligible dependents the choice of two dental plan options – the DeltaCare USA DHMO Plan and the Delta Dental PPO Plan administered by ACSIG. Both options provide comprehensive dental care coverage including orthodontia for children and adults.

Under the DeltaCare USA DHMO option, you must choose a Primary Care Dentist who will provide, coordinate and authorize all of your dental care. You must use dentists in the DHMO network in order to receive benefits.

Under the Dental PPO plan, you may obtain dental care services from any dentist you wish. However, if you obtain services from a dentist in the Delta Dental PPO network, you will save money on your out-of-pocket expenses, and your benefits will be greater. All participating network dentists agree to provide services at discounted, negotiated fees. If you use non-network dental providers, your charges will be based on the Reasonable and Customary (R&C) rates for your area, as determined by Delta Dental.

For more information or to locate Delta Dental providers, call 866.499.3001 or visit their website at www.deltadentalins. com.

If you transfer or move from one Delta Dental plan to another, you do not receive a new calendar year maximum because you transferred or moved. The maximum amount for benefits paid by Delta Dental in a calendar year under both plans will not exceed the maximum allowed under your current plan.

For example: If Delta Dental paid $500 in benefits while you were enrolled in a previous plan and the maximum amount of your current plan is $1,000, the total amount Delta Dental will pay for your benefits under the current plan is $500.

Dental Benefits *(continued)*

Dental Services	DHMO Delta Care USA	PPO			
	Delta Pays	Delta Dental's Copayment	Your Copayment	Calendar Year Maximum[1]	Waiting Period
Diagnostic and Preventive Services	100%	70%-100%	30-0%	$2,000 for each enrollee if services are provided by a Delta Dental PPO Dentist; $1,500 for each enrollee if services are provided by other dentists	None
Basic Services	Various copays apply; See Summary Plan document for details	70%-100%	30-0%		None
Crowns, Inlays, Onlays, and Cast Restorations	Various copays apply; See Summary Plan document for details	70%-100%	30-0%		None
Prosthodontic Services	Various copays apply; See Summary Plan document for details	50%	50%		None
Dental Accident Services	Provides coverage for dental accidents / injuries up to 100% of the Dentist's usual fees, less any applicable copays, to a maximum of $1,600 per person in any 12-month period	100%	0%	$1,000 calendar year maximum for each enrollee[2]	None
Orthodontics for Adults and Children	Various copays apply; See Summary Plan document for details	50%	50%	$1,000 lifetime maximum for each enrollee	None

[1] In-Network – (using Delta Dental PPO provider) $100 additional annual maximum and claims paid at incentive level of member (exception: prosthodontics 50%).
Out-of-Network – (using Delta Dental Premier provider) claims paid at members incentive level without additional $100 annual maximum (exception: prosthodontics 50%).

[2]This benefit is separate from the other benefits.

Vision Benefits

Vision Plan Eligibility

All full-time and part-time certificated and management employees who work at least 50% (or 4 hours a day), and classified employees that work at least two hours per day, are eligible to enroll.

The District provides Pleasanton Unified employees and their eligible dependents a vision plan through VSP. The district contributes up to $10 towards employee only coverage for CSEA and Management for vision.

VSP allows you to receive vision care services from any provider you wish. When you access vision care from VSP network providers, most eligible services are covered at 100% after a copay. Vision care accessed from out-of-network providers is reimbursed to the patient up to the maximums noted below.

Plan Features	Vision Service Plan (VSP)	
	In-Network	**Out-of-Network**
General Information	When you obtain vision services from VSP providers, you will receive higher coverage.	You may receive vision care from any doctor you wish. If you receive care from non-VSP doctors your coinsurance will be higher.
Vision Exam	Covered at 100% after $10 copay once every 12 months	Covered up to a maximum of $45 once every 12 months
GLASSES		
Frames	Covered at 100% after $25 copay up to the maximum allowance of $225 once every 24 months	Covered to a maximum of $70 once every 24 months
Lenses VSP LightCare Anti- glare coating Impact resistant lenses for children	Covered once every 12 months	Covered once every 12 months to the following maximums: Single Lenses: up to $30 Bifocal Lenses: up to $50 Trifocal Lenses: up to $60 Lenticular Lenses: up to $100
CONTACT LENSES		
Medically Necessary	Covered at 100%	Covered to a maximum of $210
Elective	Covered to a maximum of $130 in lieu of frames and lenses once every 12 months	Covered to a maximum of $105 in lieu of frames and lenses once every 12 months

VSP In-Network Savings

Finding the right eyecare provider for you is important to your eye health and overall wellness. That's why with VSP® Vision Care, you can choose to see any eyecare provider—a VSP doctor, or any other provider, including participating retail providers like Costco® Optical. Even if you don't wear prescription glasses, an annual eye exam is an easy and cost-effective way to take care of your eyes and overall health. With VSP LightCare™, you can use your frame and lens benefit to get non-prescription eyewear from your VSP® network doctor. Sunglasses or blue light filtering glasses may be just what you're looking for. To find VSP providers, visit vsp.com or call 800.877.7195.

EYE EXAM

A fully covered comprehensive WellVision Exam®[1]. The VSP Premier Program includes thousands of private practice doctors and over 700 Visionworks® retail locations nationwide.

EYEWEAR

Visit a VSP network doctor and choose either prescription eyewear coverage, or use your frame and lens allowance toward ready-to-wear:

- non-prescription sunglasses or
- non-prescription blue light filtering glasses

Voluntary Life Insurance and AD&D Rates

Pleasanton Unified offers all eligible management employees Basic Life and Accidental Death & Dismemberment (AD&D) Insurance. You must enroll for these coverages when you become eligible.

In addition, Pleasanton Unified offers all eligible employees working 10 or more hours per week the option to purchase Voluntary Life and Voluntary AD&D Insurance coverage.

You will need to designate a beneficiary for your Life, AD&D and, if applicable, Voluntary Life and Voluntary AD&D Insurance plans when you enroll. You can change your beneficiaries at any time.

Basic Life Insurance (Management only)

If your death occurs while you are covered under this plan, your beneficiary will receive a benefit amount equal to $50,000.

AD&D Insurance (Management only)

If your death is the result of an accident, your beneficiary will receive a benefit amount equal to your Basic Life. If you are seriously injured as the result of an accident (e.g., lose one or both of your limbs, paralysis), this plan will pay a partial benefit to you.

Voluntary Life Insurance (All employees working 10 or more hours)

You also have the option to purchase Voluntary Life Insurance and Voluntary AD&D Insurance through UNUM. You may purchase a benefit amount equal to the following:

- Employee Coverage:
  Up to 5x salary or $500,000
  (which ever is less)
- Spousal Coverage:
  Up to $500,000
- Child Coverage:
  $10,000 per child up to age 26*

*if your child reaches age 26, please contact the benefits specialist to have your plan and premiums adjusted

The cost for this coverage will be deducted from your paycheck.

The cost of Voluntary Life is dependent on your age and the coverage amount you select. The rates are on the following page.

Note: Please contact voluntarybenefits@pleasantonusd.net for Enrollment form and Evidence of Insurability form. Please return both to the Benefits Department: voluntarybenefits@pleasantonusd.net

Naming Your Beneficiary

You may name anyone you wish as your beneficiary. This is the individual who will receive your Life and AD&D benefits(s) in case of your death.

Once you have selected your beneficiary(ies), your designation will remain unchanged until you submit a new beneficiary form. You may change your beneficiary(ies) as often as you wish.

Voluntary Life Insurance and AD&D Rates

UNUM Voluntary Life Insurance Rates per $1,000 of Benefit		
Covered Employee's Age	Employee	Spouse / Domestic Partner
	Monthly	Monthly
< 20	$0.020	$0.020
20-24	$0.020	$0.020
25-29	$0.020	$0.020
30-34	$0.040	$0.040
35-39	$0.060	$0.060
40-44	$0.080	$0.080
45-49	$0.130	$0.130
50-54	$0.210	$0.210
55-59	$0.310	$0.310
60-64	$0.460	$0.460
65-69	0.770	$0.770
70-74	$1.370	$1.370
75-79	$1.370	$1.370
80-84	$1.370	$1.370
85-89	$1.370	$1.370
90-94	$1.370	$1.370
95+	$1.370	$1.370

UNUM Voluntary AD&D Insurance Rate per $1,000 of Benefit		
Covered Employee's Age	Employee	Spouse / Domestic Partner
	Monthly	Monthly
All Ages	$0.020	$0.020

UNUM Voluntary Life Insurance Rate for Children per $2,500 of Benefit	
Up To 25 Years of Age	$0.500

UNUM Voluntary AD&D Insurance Rate for Children per $2,500 of Benefit	
Up To 25 Years of Age	$0.075

Voluntary Plans and Other Benefits

Voluntary Benefits

The District offers employees voluntary benefits underwritten by American Fidelity Assurance Company. You may supplement the coverage provided by the District with Life Insurance, Accident Insurance, Annuities, Cancer Insurance, and Hospital Indemnity. Because you pay for these coverages, you own any policies you purchase, and you can take them with you when you retire or if you should leave the District. For more information, contact American Fidelity Assurance Company at 866.504.0010, extension 0 or click the links below.

American Fidelity Links

- Accident Insurance
- Cancer Insurance
- Critical Illness Insurance
- Dependent Care Accounts
- Disability Income Insurance
- Healthcare Flexible Spending Accounts
- Hospital Indemnity Insurance
- Life Insurance

Commuter Benefit Program

The commuter benefit program will help you save money on your commuting costs and offer the convenience of automated electronic fulfillment. My Commuter Check provides vouchers, debit cards and electronic loading of select Smart Cards for a number of transit authorities through an easy online enrollment and benefit management program.

To find out more, email voluntarybenefits@pleasantonusd.net

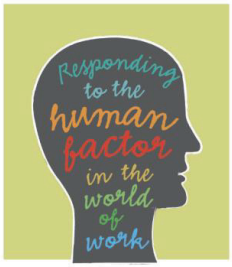
EAP

Counseling visit

The EAP offers 3 free counseling visits per incident, per rolling 12 month for almost any personal issue. Our staff will work with you to find the most appropriate counselor to meeting your needs. This benefit is company-paid.

800.834.3773
www.claremonteap.com

- Marital / Relationship issues
- Parenting / Family issues
- Work concerns
- Depression
- Anxiety
- Stress
- Substance abuse
- Other issues impacting



CLAREMONT EAP

Provided to Employees and Covered Dependents of Pleasanton USD

The Claremont Employee Assistance Program (EAP) helps you resolve personal issues before they become more serious and difficult to manage. You and your eligible family members can receive professional, confidential counseling at no cost. We also provide access to resources that can help you address virtually any personal concern or question.

Who provides the EAP? Claremont is a firm of select professionals who can help you with life's challenges. You will be referred to a conveniently located counselor or resource with expertise in your area of concern.

Who will know? The EAP is a confidential service. Claremont understands the importance of maintaining your privacy. Your involvement with Claremont is afforded the maximum confidentiality permitted under the law.

At what cost? There is no cost to you or your covered dependents for EAP services, however, all services must be pre-authorized by Claremont.

What's the first step? Call 800-834-3773 to discuss your question or issue with an experienced counselor who will refer you to the resources most appropriate for your needs.

Call toll-free, 24 hours a day, seven days a week: 800-834-3773
Or visit us at: www.claremonteap.com

CLAREMONT EAP

Voluntary Plans and Other Benefits

Petcare Voluntary Benefits

With the ASPCA® Pet Health Insurance program, you can choose the care you want when your pet is hurt or sick and take comfort in knowing they have coverage.

Exam Fees, Diagnostics, and Treatments

- Accidents
- Hereditary Conditions
- Dental Disease
- Illnesses
- Behavioral Issues
- Cancer

Customizable Options

Annual Limit - from $3,000 to unlimited.

Reimbursement Percentage - 90%, 80%, or 70% of your covered vet bill.

Deductible - select $100, $250, or $500. You'll only need to satisfy it once per 12-month policy period.

Add Preventive Care Coverage - Get reimbursed scheduled amounts for things that protect your pet from getting sick, like vaccines, dental cleanings, and screenings for a little more per month.

Select Accident-Only Coverage - If you're just looking to have some cushion when your pet gets hurt, you can choose coverage that only includes care for accidents.

Simple to Use

Just pay your vet bill, submit claims, and get reimbursed! You're free to visit any licensed vet, specialist, or emergency clinic you want, and you can choose to receive reimbursement by direct deposit or mail. We work hard to make our customers' user experience as simple and smooth as possible. For you convenience, our online member center is available 24/7 from any device. You can go there to submit and track claims, update your contact and billing information, find resources about our coverage and services, view your policy, and add new pets to your account.

Save with your discount!

Get your customized quote and enroll today! www.aspcapetinsurance.com/PUSD
Priority code: EB22PUSD 1.877.343.5314.

ASPCA Pet Health Insurance Pets and Dependents, Too.

Visit www.aspcapetinsurance.com/PUSD and save with your discount!

Retirement Savings Plans

Pleasanton Unified School District offers employees voluntary retirement plans which include a 403(b) Tax Sheltered Annuity Plan and a 457(b) Deferred Compensation Plan. You can make pre-tax salary deferral contributions. One of the benefits of participating in these plans is the ability to defer from current taxation salary that would otherwise be currently taxable and also defer income taxes on the earnings credited to your account.

The amounts you contribute to the 403(b) Plan have an independent limit from the amounts that you contribute to the 457(b) Plan. You may make pre-tax salary deferral contributions to the 403(b) Plan, the 457(b) Plan only, or you may make pre-tax contributions to both plans simultaneously.

Please note that if you also make contributions, or have contributions made for you, to a 401(a) or 401(k) plan, you are limited to $48,000 for all plans including 403(b), 401(a) and 401(k). To learn more about participating in the 403(b) Plan or the 457(b) Plan, please visit our retirement plans administrator Envoy Plan Services, Inc. at:
www.envoyplanservices.com
or call 800.248.8858.

District Retirement Benefits

- **Certificated** – Please refer to APT contract, Article 12, Page 63.
- **Management** – Please refer to Management Matters 2019.
- **Classified** – Please refer to CSEA contract, Section 8 Page 44. (Early Retirement Incentive) and Exhibit E.

Year	403(b)	457(b)	Total
2025 Basic Limit	$23,000	$23,000	$46,000
Age 50+ Catch-up*	$7,500	$7,500	$15,000
Total	$30,500	$30,500	$61,000

*Participants who are age 50 or older any time during the year qualify to make an additional contribution to their 403(b) and/or 457(b).
** 2025 Limits have not been officially updated by IRS at the time of this publication.

Getting Started

- Logon to www.envoyplanservices.com*
- Click onto Client Center; then Click onto your State, County and Employer.
- You are now on your Employer's home page on the Envoy website.
    - ***403(b) Plan Providers*** – A complete list of Approved Providers currently available in the Plan is listed on the Employer's home page.
    - **Forms Tab** – A Forms tab is at the top of the home page. Clicking on this tab will provide you with Definitions, Enrollment Procedures, Plan Highlights, Salary Reduction Agreement (SRA), Transaction Request Form and Instructions.
      Please download applicable forms and read carefully!
    - **Frequently Asked Questions** – A list of frequently asked questions and the responses to the questions is provided for your reference.
    - **Educational Videos** are provided for your viewing.

1. Enrolling with a 403(b) or 457(b) Provider
    - Locate the provider of your choice from the list on your Employer's home page.
    - Contact information is listed for each approved provider.
    - Contact the provider directly to request enrollment forms and instructions.
    - Work directly with the provider to complete their enrollment process. (Envoy Plan Services will not accept provider enrollment forms).

Retirement Savings Plans

Getting Started *continued*

1. Establish Salary Reduction Agreement (SRA)
    - After you have established your 403(b) account, you will need to submit a completed SRA to begin your payroll deduction contributions.

Paper:

To obtain a paper SRA form logon to the website at: **www.envoyplanservices.com**.

a. Click on Customer Service Center
b. Click on your state
c. Click on your county
d. Click on your employer's section
e. Click on the Forms tab
f. Click on Salary Reduction Agreement
g. Complete the SRA form (it is a fillable PDF file), print it, sign and date and fax it to Envoy's toll free fax number 877.513.2272.

Online:

To submit an online SRA logon to Envoy's website at www.envoyplanservices.com and click on the red Login Button at the top right of the page.

a. Username: enter your Social Security Number (SSN)
b. Password: Your default password will be the last 4 digits of your SSN
c. If this is your initial login, go to the next page for instructions on how to change your password to a more personal and secure one. Otherwise, you will be directed to the Main Menu.
    - The SRA must be received by Envoy no later than the **last business day of the month prior to the month that you want** your first payroll deduction or the date you would like the change(s) to be effective.

Transactions:

Transactions for the Plan include: loans, transfers, rollovers, contract exchanges, and all distributions.

- All transactions must be sent to Envoy for approval prior to submission to your provider for processing.
- To submit a transaction request to Envoy for approval follow the steps below:

Paper:

a. Contact your provider and request their specific paperwork.
b. Go to Envoy's website and obtain the Transaction Request Form and Instructions (located from Envoy's website home page under Forms and Tools)
c. Complete and mail all of the paperwork to Envoy at the address below, or you can fax the paperwork toll free at 877.513.2272.

Online:

a. Logon to Envoy's website at www.envoyplanservices.com and click on the red Login Button at the top right of the page
b. Username: enter your Social Security Number (SSN)
c. Password: Your default password will be the last 4 digits of your SSN
d. If this is your initial login, go to the next page for instructions on how to change your password to a more personal and secure one. Otherwise, you will be directed to the Main Menu.
    - ***Important note:*** *If you have a 403(b) and/or 457(b) plan account with a previous employer, you must establish a new account to enroll in this plan. Your salary deferral contributions in this employer's 403(b) and 457(b) plan cannot be invested in the 403(b) and 457(b) plan of a previous employer.*

Tax Savings Benefits

The District offers employees two flexible spending accounts (FSAs) through American Fidelity Assurance Company – Health Care and Dependent Care – that allow you to use pre-tax dollars to pay for certain health and dependent care expenses. You can participate in one or both of the accounts. Each year, you decide how much to contribute on a pre-tax basis up to the amount allowed by the IRS. The annual amount you elect is deducted from your paycheck in equal amounts each pay period. As you incur eligible expenses during the year, you can request reimbursement with your untaxed money from the appropriate account.

To learn how much you can save by enrolling in one or both of the FSAs, call 800.325.0654 or visit www.afadvantage. com. The website provides you with expense calculators, worksheets and answers to frequently asked questions.

Health Care Spending Account

The Health Care Spending Account allows you to pay for certain health care expenses that are not covered or only partially covered by your health care plans (medical, dental, prescription drug and vision). Examples of eligible expenses include, but are not limited to, copays for office visits and prescription drugs, coinsurance, deductibles, and fees for acupuncture, chiropractic care, laser eye surgery and orthodontia.

Eligible expenses can be incurred by you, or any of your eligible dependents. **The 2025 FSA will begin January 1 and end December 31**.

The Health Care FSA allows a grace period for health care claims, so you have 15.5 months to incur expenses that can be reimbursed. For example: The dollars you set aside for the 2025 plan year can be used to reimburse for eligible expenses incurred between January 1, 2025 (or your 2025 benefits effective date) and March 15, 2026. You will have until March 31, 2026 to submit claims. This only applies to the Health Care FSA, not the Dependent Care FSA. You can contribute up to $3,200 per year.

Dependent Care Spending Account

The Dependent Care Spending Account is designed for people who need dependent care so that they can work. You are eligible to participate if you are single or married. However, if you are married, your spouse must either work, go to school full-time or be unable to care for your eligible dependents due to a disability in order for you to use the Dependent Care Spending Account.

Dependent care can be for your children, spouse or parents. Dependents must live with you and be claimed as a dependent on your federal income tax return. The most you can contribute per year to the Dependent Care Spending Account is $5,000 per IRS household.

Important

Estimate your expenses and make your contribution elections wisely. The balances in your FSA accounts are “use it or lose it’ – what you don’t use each year will be forfeited. You cannot change your election during the plan year unless you have a qualified change in status.

Employee Benefit Rates

The District's Benefits Department has prepared rate sheets reflecting payroll deductions for active full-time and part-time employees.

Active employees pay 100% for all benefit elections. Contributions by active employees for medical and dental coverage, and for flexible spending accounts, are deducted from paychecks on a pre-tax basis before federal income taxes, Social Security, and unemployment taxes are withheld. Similar income tax treatment applies in California when permitted by California law.

2025 Monthly Premium Rates

Medical – CalPERS (Bay Area Region)	Employee Only	Employee + 1	Employee + 2 or More
Anthem Blue Cross Select	$1,256.65	$2,513.30	$3,267.29
Anthem Blue Cross Traditional	$1,500.40	$3,000.80	$3,901.04
Blue Shield Access+	$1,170.17	$2,340.34	$3,042.44
UnitedHealthcare SignatureValue Alliance	$1,184.58	$2,369.16	$3,079.91
Kaiser Permanente	$1,112.90	$2,225.80	$2,893.54
PERS Platinum	$1,476.10	$2,952.20	$3,837.86
****PERS Gold**	$1.013.70	$2,027.40	$2,635.62

*Classified (CSEA) premiums are reduced by up to $1,021.41 per month (prorated for part-time employees). Certificated (APT) premiums are reduced by $1,021.41per month (prorated for part-time employees). Management premiums are reduced by $1,021.41 per month.

Dental – Delta Dental	Employee Only	Employee + 1	Employee + 2 or More
Premier PPO – 100%	$74.72	$121.69	$182.10
Premier PPO – 75%	$56.04	$91.27	$136.58
DeltaCare DHMO	$24.27	$40.02	$59.21

*Classified (CSEA) premiums receive employer contributions up to $75 per month (prorated for part-time employees). Management premiums receive employer contributions up to $25 per month.

Vision – Vision Service Plan (VSP)	Employee Only	Employee + 1	Employee + 2 or More
PPO Plan	$8.54	$17.04	$27.47

*Classified (CSEA) and Management receive employer contributions up to $10 per month towards vision.

New Changes to Medical Plans

Benefit	Changes
Reproductive Health Equity Language	New benefit language providing all persons' access to reproductive health benefits regardless of sex, sexual orientation, or gender identity.
Fertility Care Health Equity Language	New benefit language updating the definition of infertility to provide access to infertility treatment to members regardless of age, sexual orientation, gender identity, or marital status.
Hearing Aids	Hearing aids are covered at 100% in both ears every 36 months when medically necessary to prevent and treat speech and language development delay due to hearing loss.
Match Preferred Provider Organization (PPO) Members with Primary Care Providers	New match to a Primary Care Providers (PCP) for PPO members in a basic plan only and doesn't apply to Medicare. Members will be free to choose a different PCP without affecting the ability to see a specialist anytime. Members with an existing PCP assignment will keep that PCP, unless the member requests a new assignment through their health plan.

***Employer contributions are subject to change depending on the outcome of ongoing negotiations.**

Benefit Contacts

If you have questions or require additional information about your District benefits, you may contact the Benefits Specialist or our benefit partners using the telephone numbers and websites provided below.

Health Care Benefits Contacts			
	Policy Number / Group ID	**Phone**	**Website / Email Address**
Kaiser Permanente	Group 3	800.464.4000	www.kp.org/calpers
CalPers		877.737.7776	website link pending
UnitedHealthcare (HMO)		888.867.5581	www.whyuhc.com/calpers
Blue Shield Access + HMO		800.334.5847	www.myoptions.blueshieldca.com
Delta Dental **PPO Incentive Plan** **DeltaCare USA DHMO**	6505 71691	866.499.3001	www.deltadentalins.com
VSP **Vision Plan**	30026708	800.877.7195	www.vsp.com
Flexible Spending Accounts **American Fidelity Insurance Company**		800.325.0654	www.americanfidelity.com
Life Insurance Plan (Management) **UNUM**	377498	800.421.0344	www.UNUM.com
VOLUNTARY BENEFITS (ALL EMPLOYEES)			
Claremont EAP		800.834.3773	www.claremonteap.com
UNUM Voluntary Life	205904	800.421.0344	www.UNUM.com
American Fidelity Assurance Company **Short-Term Disability, Life Insurance,** **Accident Insurance, Annuities,** **Cancer Insurance, Hospital Indemnity**		866.504.0010, EXT. 0	www.americanfidelity.com
Retirement Plans Envoy Plan **Services 403(b), 457(b), ROTH**		800.248.8888	www.envoyplanservices.com
District's Benefit Specialists **Nancy Bronzini** **Lisa Hansen**			nbronzini@pleasantonusd.net lisahansen@pleasantonusd.net
ADDITIONAL RESOURCES			
C2MB	https://c2mb.ajg.com/pusd/home/		

Health Care Reform

On March 23, 2010, President Obama signed the Patient Protection and Affordable Health Care Act (PPACA), commonly referred to as "health care reform." Changes resulting from health care reform impact the administration of the District's health plans and the Open Enrollment Process.

Following is important information on how these changes may impact you and your dependents. Details for some provisions are yet to be defined; however we are closely monitoring these changes and will strive to keep you informed of any important developments which may affect you and our health plans.

No Higher Out-of-Network Cost-Share for Emergency Room Services

Emergency Room services are covered at the same level regardless of whether the services are obtained in-network or out-of-network and may not be subject to the plan's prior authorization requirements.

Dependent Eligibility

The definition of an eligible dependent child is expanded to include children up to age 26, regardless of student status, residency, marital status or financial dependence. "Children" includes natural children, legally adopted children and stepchildren. Spouses of married children, grandchildren and children eligible for medical coverage through their employer are not eligible as a dependent. This provision applies only to the District's medical plans.

No Annual or Lifetime Dollar Limits on "Essential" Benefits

Health plans may no longer apply annual or lifetime limits on the dollar value of "essential" benefits. The definition of essential benefits may vary by state, so carriers are waiting for further guidance. In the meantime, medical plans may apply limits to the number of services that may be obtained in a year.

The term essential benefits is yet to be defined by the Secretary of Health and Human Services, but will at least include ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services, chronic disease management, and pediatric services, including oral and vision care.

No Cost Sharing for Coverage of Preventive Health Services

Copays and coinsurance are not required for in-network preventive care services; out-of-network preventive care services will continue to be subject to the deductible and coinsurance. Examples of preventive care services include routine physical exams and vaccinations, routine well child exams and immunizations, routine mammograms and routine OB/GYN exams.

The definition of preventive services covered under this provision continues to be updated by the government. For the most current list of covered preventive services, you may refer to www.healthcare.gov/center/regulations/prevention/taskforce.html.

Women's preventive care benefits have been expanded to include coverage without cost-sharing for FDA-approved contraceptive methods, breast feeding support, supplies and counseling, sterilization procedures and patient education and counseling for women with reproductive capacity.

Appeals Process

The medical plan contracts will be amended to conform to the government's required procedures when dealing with employee appeals, including a provision for external review requirements.

Rescission

Rescission (termination of coverage retroactive to the inception date) is allowable when the covered individual commits fraud or an intentional misrepresentation of material fact, as prohibited by the terms of the plan.

W-2 Reporting

Employers are required to include the value of applicable employer-sponsored coverage on each employee's W-2. This reporting is for informational purposes only and will have no impact on your taxable income. Employees' premiums will still be made on a pre-tax basis.

Exchanges

State and federal exchanges are open for business effective January 1, 2014. For more information visit www.coveredca.com.

Annual Notices

Women's Health & Cancer Rights Act

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

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

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

Plan 1: CalPERS PPO Options - PERS Platinum (Individual: 10% coinsurance and $500 deductible; Family: 10% coinsurance and $1,000 deductible)
Plan 2: CalPERS PPO Options - PERS Gold (Individual: 20% coinsurance and $1,000 deductible; Family: 20% coinsurance and $2,000 deductible)
Plan 3: CalPERS HMO Options - Kaiser HMO (Individual: 0% coinsurance and $1,500 deductible; Family: 0% coinsurance and $3,000 deductible)
Plan 4: CalPERS HMO Options - Anthem Blue Cross Select HMO (Individual: 0% coinsurance and none deductible; Family: 0% coinsurance and none deductible)
Plan 5: CalPERS HMO Options - Anthem Blue Cross Traditional HMO (Individual: 0% coinsurance and none deductible; Family: 0% coinsurance and none deductible)
Plan 6: CalPERS HMO Options - UnitedHealthcare SignatureValue Alliance (Individual: 0% coinsurance and $1,500 deductible; Family: 0% coinsurance and $3,000 deductible)
Plan 7: CalPERS HMO Options - Blue Shield Access + HMO (Individual: 0% coinsurance and $0 deductible; Family: 0% coinsurance and $0 deductible)

Newborns' and Mothers' Health Protection Act

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

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

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

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

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance.** If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

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

ALABAMA – Medicaid	ALASKA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid	**CALIFORNIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**FLORIDA – Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268
GEORGIA – Medicaid	**INDIANA – Medicaid**
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162, Press 2	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone: 1-800-457-4584

IOWA – Medicaid and CHIP (Hawki)	KANSAS – Medicaid
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
KENTUCKY – Medicaid	**LOUISIANA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kynect.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid	**MASSACHUSETTS – Medicaid and CHIP**
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid	**MISSOURI – Medicaid**
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
MONTANA – Medicaid	**NEBRASKA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
NEVADA – Medicaid	**NEW HAMPSHIRE – Medicaid**
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 5218
NEW JERSEY – Medicaid and CHIP	**NEW YORK – Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825

OKLAHOMA – Medicaid and CHIP	OREGON – Medicaid and CHIP
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	**RHODE ISLAND – Medicaid and CHIP**
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP)(pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	**SOUTH DAKOTA – Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS – Medicaid	**UTAH – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
VERMONT – Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP	**WYOMING – Medicaid**
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

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

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

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

Paperwork Reduction Act Statement

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

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

OMB Control Number 1210-0137 (expires 1/31/2026)

HIPAA Special Enrollment Rights

Pleasanton Unified School District Health Plan Notice of Your HIPAA Special Enrollment Rights

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

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

Loss of Other Coverage (Excluding Medicaid or a State Children's Health Insurance Program). If you decline enrollment for yourself or for an eligible dependent (including your spouse) while other health insurance or group health plan coverage is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

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

New Dependent by Marriage, Birth, Adoption, or Placement for Adoption. If you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your new dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

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

To request special enrollment or to obtain more information about the plan's special enrollment provisions, contact Shiobhan McCord - Human Resources Coordinator at 925.426.4327 or smccord@pleasantonusd.net.

Important Warning

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

Marketplace Notice

Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: General Information

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

What is the Health Insurance Marketplace?

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

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

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

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

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

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

[1] Indexed annually; see https://www.irs.gov/pub/irs-drop/rp-22-34.pdf for 2023.
[2] An employer-sponsored or other employment-based health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs. For purposes of eligibility for the premium tax credit, to meet the "minimum value standard," the health plan must also provide substantial coverage of both inpatient hospital services and physician services.

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

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

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

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

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

What about Alternatives to Marketplace Health Insurance Coverage?

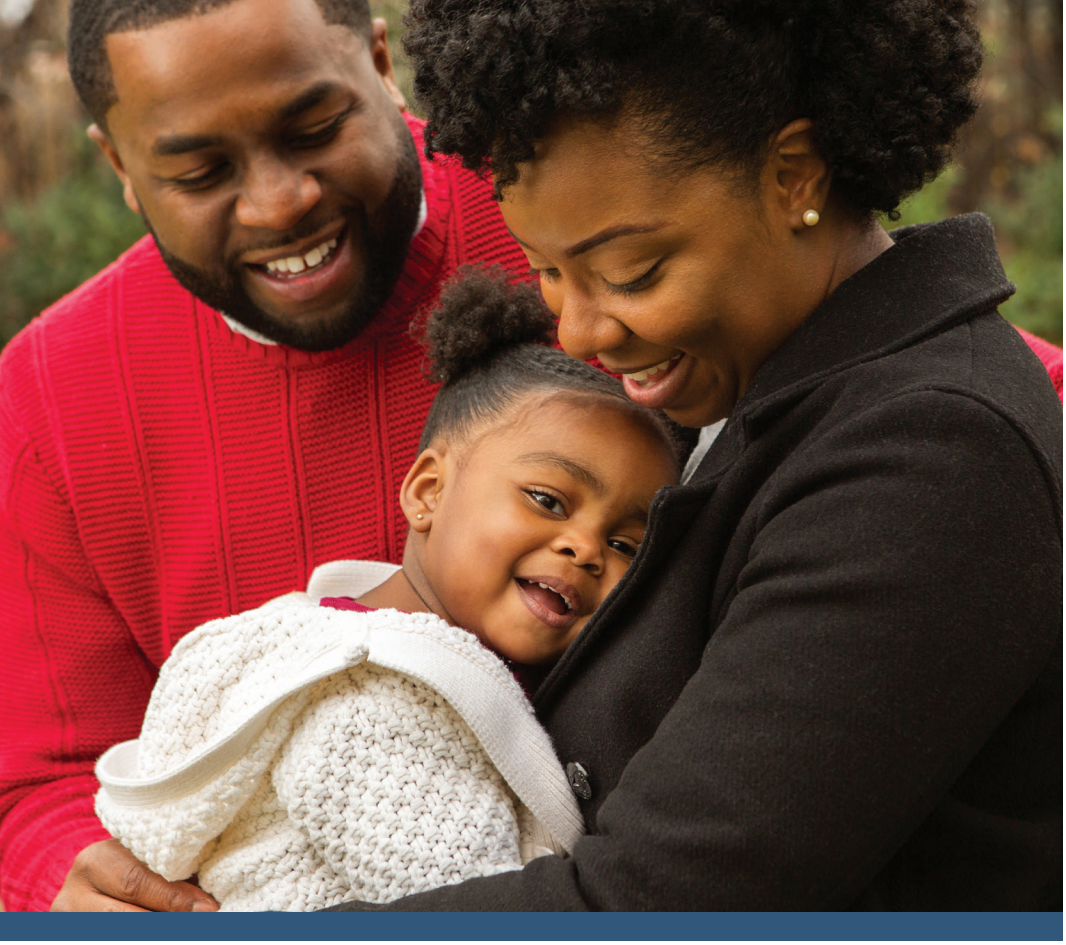
If you or your family are eligible for coverage in an employment-based health plan (such as an employer-sponsored health plan), you or your family may also be eligible for a Special Enrollment Period to enroll in that health plan in certain circumstances, including if you or your dependents were enrolled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

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

How Can I Get More Information?

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

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



This benefit guide prepared by

Gallagher

Insurance | Risk Management | Consulting