PLEASANTON
UNIFIED SCHOOL DISTRICT

Employee Benefits Guide 2020

OPEN ENROLLMENT
is September 9 through October 4

All Benefit Eligible Employees

Updated August, 2019

Table of Contents

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 Accounts Specialist.

? Benefit Help

For questions with your benefits, contact your Benefits Specialist.

smccord@pleasantonusd.net

NOTE: On the following pages you will find highlights-only comparison charts of the health coverages offered by Pleasanton Unified School District. They do not include all of the terms, coverages, exclusions, limitations, and conditions of the actual contract language. If there is a difference between the plan comparisons and the summary of benefits, certificate of Insurance or contracts, the carriers materials will prevail.

Open Enrollment 3

Eligibility & Changes 5
- Who Is Eligible
- Making Changes To Your Benefit Elections
- Continuation Coverage

Medical Benefits 6
- Medical Eligibility
- HMO vs. PPO
- Medical Plans

Dental Benefits 13
- Dental Plan Eligibility
- Dental Services

Vision Benefits 15
- Vision Plan Eligibility
- Vision Services

Life and AD&D Insurance 16
- Basic Life Insurance
- AD&D Insurance
- Voluntary Life Insurance

Voluntary Plans and Other Benefits 17
- Long Term Care Insurance
- Voluntary Benefits
- Commuter Benefits

Retirement Savings Plans 20

Tax Savings Benefits 21
- Health Care Spending Account
- Dependent Care Spending Account

Benefit Contacts 22

Employee Benefit Rates 23

Health Care Reform 24

Summary of Required Notices 26

Open Enrollment

Open Enrollment will be September 9 – October 4

Effective Date of Enrollment/Benefit Changes: January 1, 2020

Open Enrollment for 2020 will begin on Monday, September 9 and will remain open until Friday, October 4. 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, 2020.**

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 5 for more information.

Action May Be Required!

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 2020, you will need to meet with an American Fidelity advisor no later than October 4.

- Set an appointment with an advisor. Here's how:
  - Arrange an appointment at your site with your site secretary. During your appointment, your advisor will instruct you on how to make your changes.

Eligibility & 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.*

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 & 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 Care Preferred Provider Organization (PPO) Plan
- PERS Choice Preferred Provider Organization (PPO) Plan
- PERS Select Preferred Provider Organization (PPO) Plan
- Kaiser Permanente Health Maintenance Organization (HMO) Plan
- Anthem Blue Cross Health Maintenance Organization (HMO) Plan
- Health Net SmartCare Health Maintenance Organization (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 Care, PERS Choice, and PERS Select* 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.

*Select 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, and Health Net 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://www13.anthem.com/cp/web/calpers/benefits	**Kaiser Permanente** (800) 464-4000 https://my.kp.org/calpers
PERS Care, PERS Select, and PERS Choice (877) 737-7776 https://www13.anthem.com/cp/web/calpers/benefits	
Health Net (888) 926-4921 https://healthnet.com/calpers	
OptumRx* Pharmacy Benefits Administrator Active Member Services (855) 505-8110 • Medicare Member Services (855) 505-8106 www.optumrx.com/calpers	

* **NOTE**: Contact OptumRx for questions about pharmacy/prescriptions for all plans except Kaiser. For questions about pharmacy benefits for Kaiser, call the Customer Service number for the plan listed above.

HMO vs. PPO

	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 co-payments, 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 co-pays and co-insurance 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 9 through October 4, 2019 for a January 1, 2020 effective date.
For a qualifying event, contact the Benefits Department directly.

	PERS Care		PERS Choice	
Plan Highlights	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Plan Provisions				
Lifetime Benefit Maximum	Unlimited	Unlimited	Unlimited	Unlimited
Annual Deductible	Individual: $500; Family: $1,000	Individual: $500; Family: $1,000	Individual: $500; Family: $1,000	Individual: $500; Family: $1,000
Annual Out-of-Pocket Maximum	Individual: $2,000; Family: $4,000	N/A	Individual: $3,000; Family: $6,000	N/A
Coinsurance	10%	40%	20%	40%
Doctor's Office				
Office Visits	$20 Copay	40% After Deductible	$20 Copay	40% After Deductible
Specialist Visits	$35 Copay	40% After Deductible	$35 Copay	40% After Deductible
Routine Physical Exam	No Charge	40% After Deductible	No Charge	40% After Deductible
Well Baby Care	No Charge	40% After Deductible	No Charge	40% After Deductible
Preventive Laboratory & X-Ray	No Charge	40% After Deductible	No Charge	40% After Deductible
Hospital Services				
Emergency Room	$50 Deductible (waived if admitted) +10%	$50 Deductible (waived if admitted) +10%	$50 Deductible (waived if admitted) +20%	$50 Deductible (waived if admitted) +20%
Inpatient	$250 + 10% After Deductible	$250 + 40% After Deductible	20% After Deductible	40% After Deductible
Outpatient Surgery	10% After Deductible	40% After Deductible	20% After Deductible	40% After Deductible
Mental Health Services				
Inpatient Services	$250 + 10% After Deductible	$250 + 40% After Deductible	20% After Deductible	40% After Deductible
Outpatient Services	$20 Copay	40% After Deductible	$20 Copay	40% After Deductible
Substance Abuse Services				
Inpatient Services (Pre-authorization Required)	$250 + 10% After Deductible	$250 + 40% After Deductible	20% After Deductible	40% After Deductible
Outpatient Services	$20 Copay	40% After Deductible	$20 Copay	40% After Deductible
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	

Medical Plans – CalPERS PPO Options

(continued)

	PERS Select[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 Maximum	Individual: $3,000; Family: $6,000	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 & 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 Select utilizes the Anthem Blue Cross Select PPO Network, which is a subset of the Anthem Blue Cross Prudent Buyer PPO Network. Approximately 50% of the Anthem Blue Cross Prudent Buyer PPO Network of physicians participate in the Select PPO Network. When obtaining physician services through the Select PPO Network, you will receive the highest level of reimbursement. If you are a PERS Select member, you should check to see if a physician is participating in the Select PPO Network before receiving services.

Medical Plans – CalPERS HMO Options

	HMO Options
Plan Highlights	**Kaiser HMO**
Plan Provisions	
Lifetime Benefit Maximum	Unlimited
Annual Deductible	None
Annual Out-of-Pocket Maximum	Individual $1,500; Family $3,000
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 & 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 Maximum	Individual $1,500; Family $3,000	Individual $1,500; Family $3,000
Coinsurance	0%	0%
Doctor's Office		
Office Visits	$15 Copay	$15 Copay
Specialit Visits	$15 Copay	$15 Copay
Routine Physical Exam	No Charge	No Charge
Well Baby Care	No Charge	No Charge
Preventive Laboratory & 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)

Plan Highlights	Health Net SmartCare
Plan Provisions	
Lifetime Benefit Maximum	Unlimited
Annual Deductible	None
Annual Out-of-Pocket Maximum	Individual $1,500; Family $3,000
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 & X-Ray	No Charge
Hospital Services	
Emergency Room	$50 Copay (waived if admitted)
Inpatient	No Charge
Outpatient Surgery	No Charge
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	$50 Copay
Mail Order	**90-Day Supply**
Generic	$10 Copay
Brand Preferred	$40 Copay
Non Preferred Brand	$100 Copay

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.

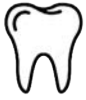
Under the DeltaCare USA DHMO option, you must choose a Primary Care Dentist who will provide, coordinate and authorize all of your dental care. You must use dentists in the DHMO network in order to receive benefits.

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%	$1,600 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.

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 $130 once every 24 months	Covered to a maximum of $70 once every 24 months
Lenses	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. To find VSP providers, visit **vsp.com** or call **(800) 877-7195**. The chart below shows *an average savings of $350.16 annually* for eye care products and services purchased in-network.

	Eye Exam	Frame	Bifocal Lenses	Progressives	Anti-reflective Coating	Employee-only Annual Contribution	**TOTAL**
Without VSP Coverage	$140	$130	$139	$138	$106	N/A	$653.00
With VSP Coverage	$10 Copay	$25 Copay		$105	$69	$93.84	**$302.84**

Comparison based on national averages for comprehensive eye exams and most commonly purchased brands.

Voluntary Life Insurance and AD&D Rates

Pleasanton Unified offers all eligible management employees Basic Life and Accidental Death and 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

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 see **Enrollment form** and **Evidence of Insurability form** attached at the end of this guidebook for your use. 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 Monthly	Spouse/Domestic Partner 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 Monthly	Spouse/Domestic Partner 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

Long Term Care Insurance

All Management employees are offered Voluntary Long Term Care coverage through UNUM Life Insurance Company of America (a subsidiary of UNUM). Long Term Care coverage is not only available to employees, but it is also available to spouses, parents and grandparents.

UNUM's Voluntary Long Term Care Insurance gives financial help in case you need care in a long term care facility, at home or another similar place.

The Long Term Care Plan covers:

- $1,000 Monthly maximum for care in a facility (up to 2 years)
- $500 Monthly maximum for in-home care (up to 4 years)
- $24,000 Lifetime maximum
- The cost of the plan is deducted from your paycheck

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, Hospital Indemnity and/or Long Term Care. 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**.

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**.

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 60.

Management – Please refer to Management Matters 2014, Page 16.

Classified – Please refer to CSEA contract, Section 8 (Early Retirement Incentive) and Exhibit E.

Year*	403(b)	457(b)	Total
2019 Basic Limit	$19,000	$19,000	$38,000
Age 50+ Catch-up	$6,000	$6,000	$12,000
Total	$25,000	$25,000	$50,000

* *Watch for 2020 updates at **www.envoyplanservices.com***

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).

continued ...

Getting Started *continued*

2. 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) and457(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 2020 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 2020 plan year can be used to reimburse for eligible expenses incurred between January 1, 2020 (or your 2020 benefits effective date) and March 15, 2021. You will have until March 31, 2021 to submit claims. This only applies to the Health Care FSA, not the Dependent Care FSA. You can contribute up to $2,700 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.

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	www.anthem.com/ca/calpers
Health Net		(888) 926-4921	www.healthnet.com/calpers
Delta Dental			
PPO Incentive Plan	6505	(866) 499-3001	www.deltadentalins.com
DeltaCare USA DHMO	71691		
VSP			
Vision Plan	30026708	(800) 877-7195	www.vsp.com
Flexible Spending Accounts			
American Fidelity Insurance Company		(800) 325-0654	www.afadvantage.com
Life Insurance Plan (Management)			
UNUM	377498	(800) 421-0344	www.UNUM.com
Voluntary Benefits (All Employees)			
UNUM Voluntary Life	205904	(800) 421-0344	www.UNUM.com
UNUM Voluntary Long Term Care	223054	(800) 227-4165	
Legal Shield		(925) 367-3221	LLBass@LegalShieldAssociate.com www.legalshieldbayarea.com
American Fidelity Assurance Company *Short Term Disability, Life Insurance, Accident Insurance, Annuities, Cancer Insurance, Hospital Indemnity*		(866) 504-0010, EXT. 0	www.afadvantage.com
Retirement Plans			
Envoy Plan Services 403(b), 457(b)		(800) 248-8888	www.envoyplanservices.com
District's Benefit Specialists			Email:
Nancy Bronzini		(925) 426-4327	nbronzini@pleasantonusd.net
Shiobhan McCord		(925) 462-5500 x 4136	smccord@pleasantonusd.net
Additional Resources			
BenefitHub	https://pusd.benefithub.com/		

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.

2020 Monthly Employee Premiums[1]			
CalPERS BASIC Rates			
	PERS Choice	**PERS Care**	**PERS Select**
Single	$ 861.18	$1,133.14	$ 520.29
Two Party	$1,722.36	$2,266.28	$1,040.58
Family	$2,239.07	$2,946.16	$1,352.75
	Kaiser HMO	**Health Net Plan**	
Single	$ 768.49	$1,000.52	—
Two Party	$1,536.98	$2,001.04	
Family	$1,998.07	$2,601.35	
	Anthem Blue Cross Select HMO	**Anthem Blue Cross Traditional HMO**	
Single	$ 868.98	$1,184.84	—
Two Party	$1,737.96	$2,369.68	
Family	$2,259.35	$3,080.58	
Delta Care USA			
Single	$23.79		
Two Party	$39.24		
Family	$58.05		
Delta Dental Premier Plan			
	100% Plan	**75% Plan**	
Single	$ 73.00	$ 54.75	
Two Party	$118.89	$ 89.17	
Family	$177.90	$133.43	
VSP Vision (Optional All Employees)			
Single	$ 9.87		
Two Party	$19.71		
Family	$31.77		

[1] For certificated and management only employee cost, subtract $136.00 from premiums listed above.

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.

continued ...

Health Care Reform *(continued)*

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**.

Additional Information

Your Payment Responsibility – Non-PPO Providers

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

Notice of Special Enrollment Rights

If you are declining enrollment for yourself or any of your dependents 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). However, you must request enrollment within 30 days after other coverage ends. 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.

We urge you to notify us as soon as possible, including before the effective date of the event. To request special enrollment or obtain more information, contact the Human Resources Department.

Notice Regarding the Newborns' 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 the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). If you would like more information, please visit **www.dol.gov/EBSA**.

Notice of Women's Health and Cancer Rights Act (WHCRA)

Our medical plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including all states of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema.

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).

continued ...

Additional Information *(continued)*

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 this plan. Please review the plan option you elected to determine the actual deductible and coinsurance provisions. Contact the Human Resources Department for more information.

HIPAA Special Enrollment Notice

Our records show that you are eligible to participate in the District's 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 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 the Human Resources Department.

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Additional Information *(continued)*

Important Warning

If you decline enrollment for yourself or for an eligible dependent, you must complete the "Form for Employee 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. Further, anyone whom you enroll during annual open enrollment will be treated as a "late enrollee" (unless that person happens to be entitled to special enrollment during the annual open enrollment period).

Summary of Benefits and Coverage

As an employee, the health benefits available to you represent a significant component of your compensation package. They also provide important protection for you and your family in the case of illness or injury. Choosing a health coverage option is an important decision. To help you make an informed choice, your plan makes available a Summary of Benefits and Coverage (SBC), which summarizes important information about any health coverage option in a standard format, to help you compare across plans.

The SBCs are available from Employee Benefits at **https://pusd.benefithub.com** or **calpers.ca.gov**.

Continuation Of Coverage Rights

Your group health plan may contain certain options to continue your and or your dependent's health benefits following termination of coverage. These continuation options may include federal COBRA rights, conversion rights, and/or state mandated continuation rights. Commencing January 1st, 2014, State and Federal Marketplace exchanges can also provide medical coverage with no health questions plus you may be eligible to qualify for a subsidy to make the coverage affordable to you. Additionally, your group life insurance certificates or booklets may also include and describe certain continuation options that may be available to you. Please examine your options carefully before declining this coverage. You should be aware that companies selling individual health insurance typically require a review of your medical history that could result in a higher premium or you could be denied coverage entirely.

continued ...

Additional Information *(continued)*

Notice of Availability of Privacy Practices

The District provides health care benefits and related benefits to its eligible employees and their eligible dependents. By so doing, it creates, receives, uses, and maintains health information about plan participants which is protected by federal law (protected health information or PHI). The Health Insurance Portability and Accountability Act (HIPAA) requires health plan(s) to provide plan participants and others with a notice of the plan's privacy practices with regard to the health information it creates and maintains in the course of providing benefits (Notice of Privacy Practices). This Notice of Privacy Practices describes the ways the plan uses and discloses PHI. To obtain a copy of the plan's Notice of Privacy Practices, you should contact the member services department for your health coverage. Their contact information is located on your ID card.

This is also generally available on their respective websites.

For More Information About Your Rights

More information about your rights can be found in your summary plan description, insurance certificates or booklets, as well as any required notices that are sent to you separately regarding these rights. If you would like more information about any of these notices, please contact the Benefits Department. You can review plan documents at the District Offices, or online at **https//.pusd.benefithub.com.**

Employee Benefits Guide
2020