Employee Benefits Guide 2018

WASHINGTON UNIFIED SCHOOL DISTRICT
WEST SACRAMENTO

Employee Benefits Guide 2018

If you (and/or your dependents) have Medicare or you will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please see page 23 for more details.

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Introduction and Eligibility

Flexible Solutions For Your Benefits Needs

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

This guide has been prepared to assist you in making informed decisions regarding your employee benefits. We urge you to read this guide carefully and keep it as a reference. If you are well informed you will be better able to make the benefit choices that best meet your needs.

Please contact the Benefits Department at 916.375.7604 Ext. 7 (Ext. 4001 if calling internally) if you have any questions regarding your employee benefits package.

Thank you.

Who's Eligible?

Employees

Please contact the Washington Unified School District Benefits Department to inquire about eligibility guidelines.

Eligible Dependents

Your eligible dependents include your legally married spouse, domestic partner, and children (including stepchildren and adopted children) up to age 26. Age limits may apply to dependents enrolled as full-time students.

Coverage may be available for a mentally or physically disabled child who is age 26 or older. Requirements for such coverage and documentation of disability depend on the insurance carrier.

For more information, contact the
Benefits Department at 916.375.7604 Ext. 7 (Ext. 4001 if calling internally)

When You Can Enroll

New Hires/Newly Eligible for Benefits

When you are first hired or become eligible for benefits, you have 30 days to enroll for benefits. If you do not enroll within that time period you will not be eligible for benefits until the next Open Enrollment, unless you have a **Change in Status**.

Open Enrollment

During Open Enrollment you will have the opportunity to make changes to your benefit elections. You must enroll by the Open Enrollment deadline for your benefits to be effective January 1st . Except for a **Change in Status**, you will not be able to change your elections until the next year's Open Enrollment.

Change in Status

If you have a Change in Status, you may be able to change your benefits before the next Open Enrollment. You must notify the Benefits Department within 30 days of the change.* If you meet the deadline, changes will be effective on the event date.

*Change in Status events include:

- Change in marital status
- Change in dependents
- Change in benefits eligibility for you, your spouse or dependent
- Change in employment for you, your spouse or dependent
- Change in work schedule for you or your spouse
- Gaining other coverage through your spouse
- Loss of other coverage for your dependent
- Change in residence causing loss of coverage
- Federal and state family medical leave, if qualified
- Medicare or Medicaid entitlement for you, your spouse or dependent
- Qualified Medical Child Support Order (QMCSO)

Contact the Benefits Department at 916.375.7604 Ext. 7 (Ext. 4001 if calling internally) for a complete explanation of qualifying family status change.

Medical

Eligible Employees and Early Retirees

WUSD employees can choose from various medical plans. The medical plans provide comprehensive coverage but are different in how they are designed. Certificated employees are offered vision coverage through Superior Vision and effective 1/1/18, Classified employees will also have vision coverage available through Superior Vision. Medicare eligible Retirees receive vision benefits from Kaiser and Health Net.

You decide which plan best meets your needs

- Certificated:
  - Kaiser Permanente HMO - $20 office visit co-pay plan
  - Kaiser Permanente HMO HSA - HDHP #9835 plan
  - Blue Shield of California Trio HMO - $20 office co-pay plan
  - Blue Shield of California Access+ HMO - $20 office co-pay plan
- Classified:
  - Kaiser Permanente HMO - $20 office visit co-pay plan
  - Western Health Advantage HMO - $20 office co-pay plan
  - Western Health Advantage HMO HSA - 1800/0 plan

When enrolling in an HMO, you must select a primary care physician who will manage your care and refer you to a specialist when it is needed. Most services are covered at 100% after you pay a copayment.

Health Saving Account

Your HSA-compatible plan is a high deductible health plan (HDHP) that enables you, as a consumer, to manage your individual or family health care expenditures. This highly-rated plan provides you and your family medical services at lower premiums. Your HSA is the financial component (the account that holds your funds) providing a tax-free way to save and pay for qualified medical expenses. The combined strength of your HSA-compatible plan and the funds in your HSA provides you peace of mind about your current and future health care needs. This plan has been updated to include member maximums within family coverage. Please refer to pages 5 & 9 for the summary of benefits.

Superior Vision Plan

All eligible employees have two Superior Vision plans from which to choose. There is a base plan and buy-up plan option, and both offer comprehensive coverage through the Superior Vision National Network of providers. Superior Vision also offers a number of non-covered services at a discount.

Post-65 Retirees

(Must have Medicare Parts A & B and live within 30 miles of a Health Net HMO medical group or Kaiser Facility.)

You have the choice to select one plan from the following:

- Kaiser Permanente HMO Senior Advantage (California Only)
- Health Net HMO Seniority Plus (California Only)

Visit Kaiser Permanente:
www.kp.org

Visit Blue Shield of California:
www.blueshieldca.com

Visit Western Health Advantage:
www.westernhealth.com

Visit Superior Vision:
www.superiorvision.com

Visit Health Net:
www.healthnet.com

Medical (continued)

Eligible Employees & Early Retirees

Plan Benefits	Kaiser Permanente HMO Traditional All Employees & Early Retirees
Lifetime Maximum	Unlimited
Maximum Out of Pocket	$1,500 Individual/$3,000 Family
Preventive Services	
• Routine Physical	No Charge
• Well Baby/Immunizations	No Charge
Physician/Diagnostic Services	
• Office Visits	$20 Copay
• Lab & X-ray & Diagnostic Test	No Charge
• Prenatal/Postnatal Office Visits	No Charge
Hospital Services	
• Semi-Private Room & Board	$250 Copay
• Outpatient Surgery	$100 Copay
• Emergency Room (waived if admitted)	$125 Copay
• Urgent Care	$20 Copay
Other Services	
• Ambulance	$100 Copay
• Durable Medical Equipment	No Charge
Prescription Drugs	
• Plan Pharmacy (Up to a 30-day supply)	
– Generic	$10 Copay
– Brand	$30 Copay
• Mail-order (Up to a 100-day supply)	
– Generic	$20 Copay
– Brand	$60 Copay

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Medical (continued)

Plan Benefits	Kaiser Permanente HMO HDHP w/ HSA Certificated Actives & Early Retirees Only
General Plan Information	
• Annual Deductible/Individual	$1,800 per calendar year
• Annual Deductible/Family	$2,700 (Each member in a family of two or more members) $3,600 (Entire family of two or more members) per cal year
• Coinsurance	100% after cal year deductible
• Office Visit/Exam	100% after cal year deductible
• Outpatient Specialist Visit	100% after cal year deductible
• Annual Out-of-Pocket Limit/Individual	$3,600 per cal year
• Annual Out-of-Pocket Limit/Family	$3,600 (Each member in a family of two or more members) $7,200 (Entire family of two or more members) per cal year
• Deductible Included in Out-of-Pocket Limits	Yes
• Lifetime Plan Maximum	Unlimited
• Primary Care Physician Election Required	Yes
Outpatient Services	
Preventive Services	
• Well-Child Care	100% (deductible does not apply)
• Immunizations	100% (deductible does not apply)
• Well Woman Exams	100% (deductible does not apply)
• Mammograms	100% (deductible does not apply)
• Adult Periodic Exams with Preventive Tests	100% (deductible does not apply)
• Diagnostic X-Ray and Lab Tests	100% after cal year deductible
Maternity Care	
• Pregnancy and Maternity Care (Pre-Natal Care)	100% (deductible does not apply)
Inpatient Hospital Services	
• Inpatient Hospitalization	100% after cal year deductible
• Pre-Authorization of Services Required	Yes
• Semi-Private Room & Board; Including Services and Supplies	100% after cal year deductible
Surgical Services	
• Outpatient Facility Charge	100% after cal year deductible
Emergency Services	
• Emergency Room	100% after cal year deductible
Ambulance	
• Air	100% after cal year deductible
• Ground	100% after cal year deductible
Urgent Care	
• Urgent Care Facility	100% after cal year deductible
Mental Health Benefits	
• Inpatient Care	100% after cal year deductible
• Outpatient Care	100% after cal year deductible

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Medical (continued)

Plan Benefits	Kaiser Permanente HMO HDHP w/ HSA Certificated Actives & Early Retirees Only
Substance Abuse	
Inpatient Care	
• Inpatient Hospitalization	100% after cal year deductible
• Inpatient Detoxification Services	100% after cal year deductible
Outpatient Care	
• Outpatient Services	100% after cal year deductible
Prescription Drug Benefits	
• Prescription Drug Deductible	Subject to plan deductible
• Prescription Drug Annual Out-of-Pocket Limit/Individual	Will accrue to annual OOP Max
• Prescription Drug Annual Out-of-Pocket Limit/Family	Will accrue to annual OOP Max
• Generic	$10 copay after cal year deductible
• Preferred Specialty	$30 copay after cal year deductible
• Brand (Formulary/Preferred)	$30 copay after cal year deductible
• Brand (Non-Formulary/Non-preferred)	$30 copay after cal year deductible
• Number of Days Supply	30 days
Mail Order	
• Brand (Formulary/Preferred)	$60 copay after cal year deductible
• Brand (Non-Formulary/Non-preferred)	$60 copay after cal year deductible
• Number of Days Supply for Mail Order	100 days
Other Services and Supplies	
• Durable Medical Equipment & Prosthetic Devices	100% after cal year deductible
• Home Health Care	100% after cal year deductible
• Skilled Nursing or Extended Care Facility	100% after cal year deductible
• Hospice Care	100% after cal year deductible
• Chiropractic Services	Not covered
• Acupuncture	Must be referred
Hearing	
• Screening	100% after cal year deductible
• Aid(s)	Not covered
Infertility	
• Diagnosis	See Plan Certificate
• Treatment	See Plan Certificate
Outpatient Rehabilitative Therapy Services	
• Physical	100% after cal year deductible
• Occupational	100% after cal year deductible
• Speech	100% after cal year deductible

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Medical (continued)

Plan Benefits	Blue Shield of California HMO Trio / Access+ Certificated Actives & Early Retirees Only
General Plan Information	
• Annual Deductible/Individual	$0
• Annual Deductible/Family	$0
• Coinsurance	100%
• Office Visit/Exam	$20 copay
• Outpatient Specialist Visit	$20 copay with medical group referral; $30 copay for Trio+ / Access+ specialist self-refer
• Annual Out-of-Pocket Limit/Individual	$1,500
• Annual Out-of-Pocket Limit/Family	$3,000
• Deductible Included in Out-of-Pocket Limits	N/A
• Lifetime Plan Maximum	Unlimited
• Primary Care Physician Election Required	Yes
Outpatient Services	
Preventive Services	
• Well-Child Care	100%
• Immunizations	100%
• Well Woman Exams	100%
• Mammograms	100%
• Adult Periodic Exams with Preventive Tests	100%
• Diagnostic X-Ray and Lab Tests	100%
Maternity Care	
• Pregnancy and Maternity Care (Pre-Natal Care)	100%
Inpatient Hospital Services	
• Inpatient Hospitalization	$250 copay per admit
• Pre-Authorization of Services Required	Yes
• Semi-Private Room & Board; Including Services and Supplies	$250 copay per admit
Surgical Services	
• Outpatient Facility Charge	$100 copay/ procedure at a surgical facility; $150 copay/ procedure outpatient dept of a hospital
Emergency Services	
• Emergency Room	$100 copay waived if admitted
Ambulance	
• Air	$100 copay
• Ground	$100 copay
Urgent Care	
• Urgent Care Facility	$20 copay
Mental Health Benefits	
• Inpatient Care	$250 per admit
• Outpatient Care	$20 copay

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Medical (continued)

Plan Benefits	Blue Shield of California HMO Trio / Access+ Certificated Actives & Early Retirees Only
Substance Abuse	
Inpatient Care	
• Inpatient Hospitalization	$250 copay per admit
• Inpatient Detoxification Services	$250 copay per admit
Outpatient Care	
• Outpatient Services	$20 copay
Prescription Drug Benefits	
• Prescription Drug Deductible	N/A
• Prescription Drug Annual Out-of-Pocket Limit/Individual	Will accrue to annual OOP Max
• Prescription Drug Annual Out-of-Pocket Limit/Family	Will accrue to annual OOP Max
• Generic / Tier 1	$10 copay
• Specialty / Tier 4	20% coinsurance up to $200 per Rx
• Brand (Formulary / Preferred) Tier 2	$30 copay
• Brand (Non-Formulary / Non-Preferred) Tier 3	$50 copay Requires Pre Auth by BSC for medical necessity
• Number of Days Supply	30 days
Mail Order	
• Generic / Tier 1	$20 copay
• Specialty / Tier 4	20% coinsurance up to $400 per Rx
• Brand (Formulary / Preferred) Tier 2	$60 copay
• Brand (Non-Formulary / Non-Preferred) Tier 3	$100 copay Requires Pre Auth by BSC for medical necessity
• Number of Days Supply for Mail Order	90 days
Other Services and Supplies	
• Durable Medical Equipment & Prosthetic Devices	20% copay
• Home Health Care	$20 copay Limit of 100 visits per cal year
• Skilled Nursing or Extended Care Facility	$100 copay per day Limit of 100 days per benefit period
• Hospice Care	100%
• Chiropractic Services	$10 copay Limit of 30 visits per cal year combined with acupuncture
• Acupuncture	$10 copay Limit of 30 visits per cal year combined with chiropractic
Hearing	
• Screening	$100%
• Aid(s)	Not covered
Infertility	
• Diagnosis	Included See Plan Certificate for limitations
• Treatment	Included See Plan Certificate for limitations
Outpatient Rehabilitative Therapy Services	
• Physical	$20 copay
• Occupational	$20 copay
• Speech	$20 copay

Note: The UC Davis primary care provider network is not included in the Trio plan

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Medical (continued)

Plan Benefits	Western Health Advantage HMO 250 MHP Classified Actives & Early Retirees Only
Lifetime Maximum	Unlimited
Annual Deductible	None
Maximum Out of Pocket	$1,500 Individual/$2,500 Family
Preventive Services	
• Routine Physical	No Charge
• Well Baby/Immunizations	No Charge
Physician/Diagnostic Services	
• Office Visits (including specialists)	$20 Copay
• Lab & X-ray & Diagnostic Test	No Charge
• Prenatal/Postnatal Office Visits	No Charge
Hospital Services	
• Semi-Private Room & Board	$250 Copay
• Outpatient Surgery (facility)	$100 Copay
• Emergency Room (waived if admitted)	$125 Copay
• Urgent Care	$35 Copay
Other Services	
• Ambulance	No Charge
• Durable Medical Equipment	20% Copay
Prescription Drugs	
• Plan Pharmacy (Up to a 30-day supply)	
– Generic	$10 Copay
– Preferred Specialty	20% not to exceed $100 per Rx
– Brand	$30 Copay
– Non-Formulary	$50 Copay
• Mail-order (Up to a 90-day supply)	
– Generic	$25 Copay
– Brand	$75 Copay
– Non-Formulary	$125 Copay

* Copayments do not contribute to the out-of-pocket maximum (unless required for the management or treatment diabetes or pediatric asthma supplies and equipment). Percentage copayment amounts are based on WHA's contracted rate.

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Medical (continued)

Plan Benefits	Western Health Advantage HMO HSA 1800/0 Classified Actives & Early Retirees Only
General Plan Information	
• Annual Deductible/Individual	$1,800 per cal year
• Annual Deductible/Family	$2,700 (Each member of a family of two or more members) $3,600 (Entire family of two or more members) per cal year
• Coinsurance	100% after cal year deductible
• Office Visit/Exam	100% after cal year deductible
• Outpatient Specialist Visit	100% after cal year deductible
• Annual Out-of-Pocket Limit/Individual	$3,600 per cal year
• Annual Out-of-Pocket Limit/Family	$3,600 (Each member of a family of two or more members) $7,200 (Entire family of two or more members) per cal year
• Deductible Included in Out-of-Pocket Limits	Yes
• Lifetime Plan Maximum	Unlimited
• Primary Care Physician Election Required	Yes
Outpatient Services	
Preventive Services	
• Well-Child Care	100% (deductible doesn't apply)
• Immunizations	100% (deductible doesn't apply)
• Well Woman Exams	100% (deductible doesn't apply)
• Mammograms	100% (deductible doesn't apply)
• Adult Periodic Exams with Preventive Tests	100% (deductible doesn't apply)
• Diagnostic X-Ray and Lab Tests	100% after cal year deductible
Maternity Care	
• Pregnancy and Maternity Care (Pre-Natal Care)	100% (deductible doesn't apply)
Inpatient Hospital Services	
• Inpatient Hospitalization	100% after cal year deductible
• Pre-Authorization of Services Required	Yes
• Semi-Private Room & Board; Including Services and Supplies	100% after cal year deductible
Surgical Services	
• Outpatient Facility Charge	100% after cal year deductible
Emergency Services	
• Emergency Room	100% after cal year deductible
Ambulance	
• Air	100% after cal year deductible
• Ground	100% after cal year deductible
Urgent Care	
• Urgent Care Facility	100% after cal year deductible
Mental Health Benefits	
• Inpatient Care	100% after cal year deductible
• Outpatient Care	100% after cal year deductible
Substance Abuse	
Inpatient Care	
• Inpatient Hospitalization	100% after cal year deductible
• Inpatient Detoxification Services	100% after cal year deductible

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Medical (continued)

Plan Benefits	Western Health Advantage HMO HSA 1800/0 Classified Actives and Early Retirees Only
Outpatient Care	
• Outpatient Services	100% after cal year deductible
Prescription Drug Benefits	
• Prescription Drug Deductible	Subject to plan deductible
• Prescription Drug Annual Out-of-Pocket Limit/Individual	Will accrue to annual OOP Maximum
• Prescription Drug Annual Out-of-Pocket Limit/Family	Will accrue to annual OOP Maximum
• Generic	100% after cal year deductible
• Preferred Specialty	100% after cal year deductible
• Brand (Formulary/Preferred)	$30 copay after cal year deductible
• Brand (Non-Formulary/Non-preferred)	$50 copay after cal year deductible
• Number of Days Supply	30 days
Mail Order	
• Generic	100% after cal year deductible
• Brand (Formulary/Preferred)	$75 copay after cal year deductible
• Brand (Non-Formulary/Non-preferred)	$125 copay after cal year deductible
• Number of Days Supply for Mail Order	90 days
Other Services and Supplies	
• Durable Medical Equipment & Prosthetic Devices	100% after cal year deductible
• Home Health Care	100% after cal year deductible; Limit of 100 visits per cal year
• Skilled Nursing or Extended Care Facility	100% after cal year deductible; Limit of 100 visits per cal year
• Hospice Care	100% after cal year deductible
• Chiropractic Services	$15 copay; 20 visits per cal year
• Acupuncture	$15 copay; 20 visits per cal year
Hearing	
• Screening	100% after cal year deductible
• Aid(s)	Not covered
Infertility	
• Diagnosis	See Plan Certificate
• Treatment	See Plan Certificate
Outpatient Rehabilitative Therapy Services	
• Physical	100% after cal year deductible
• Occupational	100% after cal year deductible
• Speech	100% after cal year deductible

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Medical (continued)

Post 65 Retirees Only

Plan Benefits	Kaiser Permanente Senior Advantage HMO Post 65 Retirees Only
Lifetime Maximum	Unlimited
Maximum Out of Pocket	$1,500 Individual/$3,000 Family
Preventive Services	
• Routine Physical	No Charge
Physician/Diagnostic Services	
• Office Visits	$5 Copay
• Lab & X-ray & Diagnostic Test	No Charge
Hospital Services	
• Semi-Private Room & Board	No Charge
• Outpatient Surgery	$5 Copay
• Emergency Rooms (waived if admitted)	$20 Copay
• Urgent Care	$5 Copay
Other Services	
• Ambulance	No Charge
• Durable Medical Equipment	No Charge
Vision Services	$175 allowance for eyeglasses or contacts every 24 months
Prescription Drugs	
• Generic (Up to a 100-day supply)	$5 Copay
• Brand (Up to a 100-day supply)	$10 Copay

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Medical (continued)

Post 65 Retirees Only

Plan Benefits	HealthNet Seniority Plus HMO Post 65 Retirees Only
Lifetime Maximum	Unlimited
Maximum Out of Pocket (individual only)	$3,400
Preventive Services	
• Routine Physical	No Charge
• Immunizations	No Charge
Physician/Diagnostic Services	
• Office Visits	$5 Copay
• Lab & X-ray & Diagnostic Test	No Charge
Hospital Services	
• Semi-Private Room & Board	No Charge
• Outpatient Surgery	No Charge
• Emergency Room (waived if admitted)	$20 Copay
• Urgent Care (waived if admitted)	$20 Copay
Other Services	
• Ambulance	No Charge
• Vision Services (Medicare only)	$5 Co-Pay Exam/ Eyeware at no charge; Limited to one pair of eyeglasses or contacts after each cataract surgery
• Durable Medical Equipment	No Charge
Prescription Drugs	
• Retail Prescription (Up to a 30-day Supply)	$7/$7 Copay
• Mail Order (Up to a 90-day Supply)	$14/$14 Copay

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Dental

Delta Dental pays 70% for Diagnostic, Preventive, Basic, Crowns, Inlays, Onlays, and Cast Restoration benefits during the first calendar year of your eligibility. The coinsurance increases 10% each year you visit a dentist until you reach 100%. If you do not visit the dentist and the plan is not used, the coinsurance will not increase. The coinsurance will drop back to 70% if you lose eligibility and then become eligible again.

Benefits	Delta Dental	
	In-Network	Out-of-Network
Deductible	None	None
Per Calendar Year Maximum	$1,700	$1,500
Diagnostic & Preventive Services		
• Oral examinations, cleanings, X-rays, examinations of tissue biopsy, fluoride treatment, space maintainers, and specialist consultations	70% - 100%	70% - 100%
Basic Services		
• Oral surgery (extractions), fillings, root canals, periodontic (gum) treatment, tissue removal (biopsy), and sealants	70% - 100%	70% - 100%
Major Services		
• Crowns, jackets and other cast restorations	70% - 100%	70% - 100%
• Prosthodontic Benefits: Bridges, partial and full Dentures	50%	50%
• Dental Accident Benefits: $1,000 Max Per Calendar Year	100%	100%
Orthodontics	Not Covered	Not Covered

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Vision

Benefits	Superior Vision Base Plan	
	In-Network	Out-of-Network
Exam Copay	$0	
Materials Copay	$0	
Contact Lens Fitting	$30	
Services/Frequency		
Exam	12 Months	
Frames	24 Months	
Contact Lens Fitting	12 Months	
Lenses	24 Months	
Contact Lenses	24 Months	
Exams		
• Vision Exam (MD)	Covered in full	Up to $40
• Vision Exam (OD)	Covered in full	Up to $30
Lenses		
• Single	Covered in full	Up to $32
• Bifocal	Covered in full	Up to $42
• Trifocal	Covered in full	Up to $58
• Polycarbonate for Dept. Children	Covered in full	Not Covered
Frames		
• Frames	$100 retail allowance then 20% off remaining balance	Up to $48
Contacts		
• Necessary & in lieu of glasses	$100 retail allowance	Up to $80
• Disposable Contact Lenses	10% off retail cost	10% off retail cost

Discount Features:

Superior Vision has a nationwide network of refractive surgeons and leading LASIK networks who offer members a discount. These discounts range from 15%-50%.

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Vision (continued)

Benefits	Superior Vision Buy-Up Plan	
	In-Network	Out-of-Network
Exam Copay	$0	
Materials Copay	$0	
Contact Lens Fitting	$30	
Services/Frequency		
Exam	12 Months	
Frames	12 Months	
Contact Lens Fitting	12 Months	
Lenses	12 Months	
Contact Lenses	12 Months	
Exams		
• Vision Exam (MD)	Covered in full	Up to $40
• Vision Exam (OD)	Covered in full	Up to $30
Lenses		
• Single	Covered in full	Up to $32
• Bifocal	Covered in full	Up to $42
• Trifocal	Covered in full	Up to $58
• Polycarbonate for Dept. Children	Covered in full	Not Covered
Frames		
• Frames	$150 retail allowance then 20% off remaining balance	Up to $72
Contacts		
• Necessary & in lieu of glasses	$130 retail allowance	Up to $100
• Disposable Contact Lenses	10% off retail cost	10% off retail cost

Discount Features:

Superior Vision has a nationwide network of refractive surgeons and leading LASIK networks who offer members a discount. These discounts range from 15%-50%.

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Basic Life & AD&D

Lincoln Financial Group

As an eligible employee with WUSD you are provided employer paid Life and Accidental Death & Dismemberment (AD&D) insurance. All eligible employees are automatically enrolled in Life/AD&D plans.

Employee Basic Life Insurance

- Benefit amount of $10,000
- Guaranteed Issue amount $10,000
- 100% paid by WUSD

Accidental Death and Dismemberment (AD&D)

- Benefit amount of $10,000
- Guaranteed Issue amount $10,000
- 100% paid by WUSD

Voluntary Life and AD&D Insurance

- Benefit available to employees, spouses and dependent child(ren)
- Rates & Benefits vary based off coverage elected
- 100% paid by employee

In addition to death benefit, AD&D coverage provides specified benefits for a covered accidental bodily injury that directly causes dismemberment.

In the event of death that occurs from a covered accident—both Life and AD&D benefits would be payable.

Please refer to the Lincoln Financial Group Life Insurance documents for complete plan descriptions.

REMINDER:

Don't forget to update your beneficiary information!

The information described on this page is only intended to be a summary of benefits. It does not describe or include all benefit provisions, limitations, exclusions, or qualifications for coverage. Please review plan documents for full details. If there are any conflicts with information provided on this page, the plan documents will prevail.

Employee Assistance Program

Lincoln Financial Group

All benefit eligible employees with WUSD are provided with an employer paid Employee Assistance Plan (EAP) through Lincoln. All eligible employees are automatically enrolled in this coverage.

Life is full of challenges and sometimes balancing it is difficult. The EAP is there when you need it. Lincoln offers the appropriate assistance for a wide range of issues and provides referrals to professional counselors or services that can help you resolve emotional health, family and work issues. Everything is kept completely confidential.

All members of your household can utilize the benefits of this program.

Telephonic and online support services:

- Toll-free access 24/7 to a master's level intake, providing access and triage
  - Counseling, legal, financial, work-life and/or convenience services
  - Crisis intervention support
- Access to password protected interactive online websites
  - Includes information on a wide range of topics, helpful tools, assessments, and the ability to confidentially email issues to a Ask a Guidance Consultant

Counseling Services:

- Six face-to-face sessions per person, per issue/year
- Local, in-person EAP assessment, referral, and counseling
- Community resource referrals to supplement EAP counseling, such as support meetings and sliding scale resources
- Matching employees with a network provider based on individual preference

Legal Services:

- Unlimited telephonic support for information from an attorney and unlimited referrals
- One free 30-minute consultation with a network attorney over the phone or in person
- Discount of 25% off of published fees when in-person representation is necessary

Financial Services:

- Unlimited telephonic support by a financial expert for budgeting and other common financial issues
- Unlimited referrals to a network of financial experts

Work-Life Services:

- Unlimited telephonic support for customized research
- Tailored educational materials
- Referrals for childcare, adoption, and eldercare; additional referrals available for personal convenience, education, and pet care
  - Resource and information research available on a wide range of topics

Online Member Services | www.guidanceresources.com | Company code: Lincoln

Toll Free Call | 1-855-327-4463

Available 24/7

Flexible Spending Accounts (FSA)

Navia Benefit Solutions FSA

All eligible full-time employees have the option of participating in our Navia Flexible Spending Accounts for medical and dependent care reimbursement. Flexible spending accounts, under Section 125 of the Internal Revenue Service, allow employees to set aside pre-tax dollars to pay for out-of-pocket, eligible health care and dependent care expenses, as well as your contributions for dependent medical, dental, and vision premiums.

Health Care

Your health care account may not exceed $2,650 each plan year per household.

Flexible Spending Accounts utilize the "Use it or Lose It" rule, which means all medical services for reimbursement must occur between January 1, 2018 and December 31, 2018.

Limited Health Care

This health care account is available to employees that have a high deductible health plan with a health savings account.

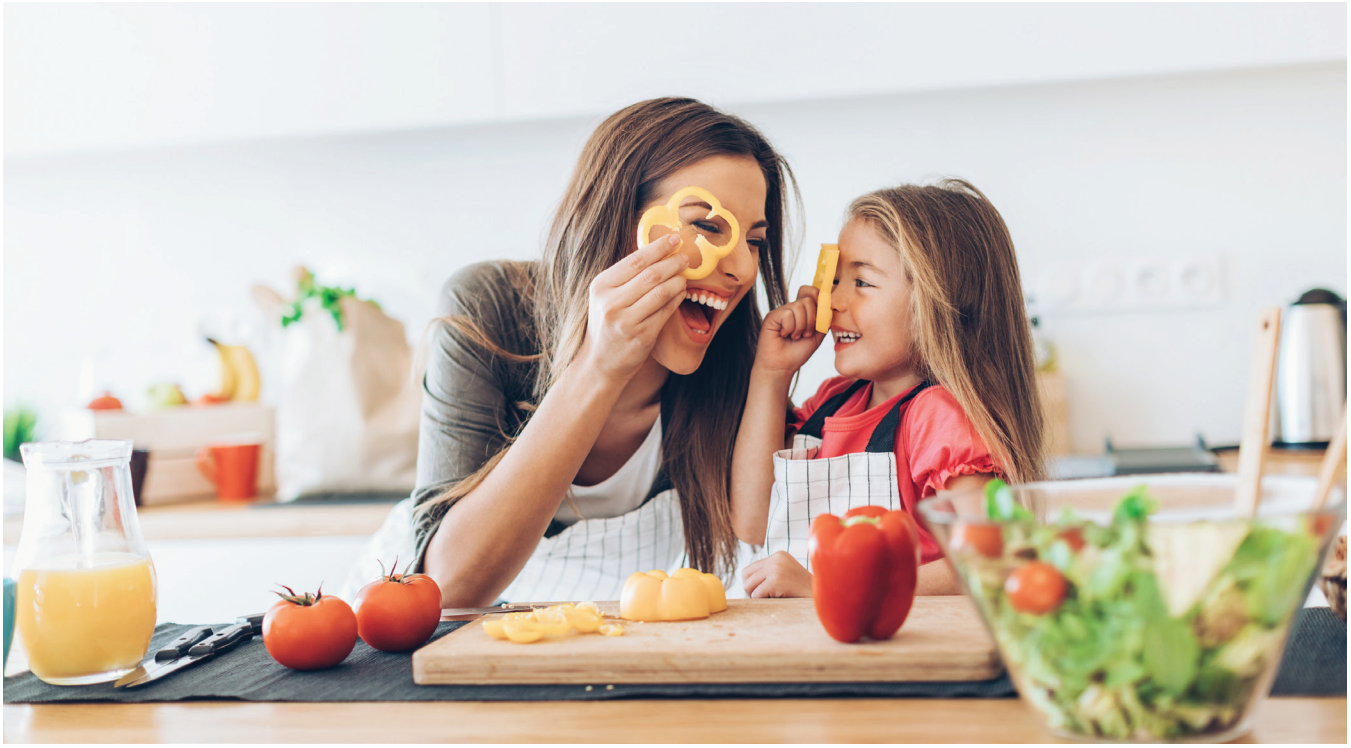
Dependent Care

Your dependent care account may not exceed $5,000 each calendar year per household ($2,500 if married and filing separately).

All Dependent Day Care expenses must be incurred between January 1, 2018 and December 31, 2018.

"Use-It-or-Lose-It" Rule

All claims MUST be submitted no later than March 31, 2019 (90 days from the end of plan year) for reimbursement. Any funds left unclaimed on March 31, 2019 will be forfeited. Washington Unified School District has elected to offer a $500 rollover option, which will allow you to roll over up to $500 of unused contributions into the next plan year. Be conservative when making elections.



Important Notices

Newborns and Mothers Health Protection Act (NMHPA)

A health plan which provides benefits for pregnancy delivery generally may not restrict benefits for a covered pregnancy Hospital stay (for delivery) for a mother and her newborn to less than 48 hours following a vaginal delivery or 96 hours following a Cesarean section. Also, any utilization review requirements for Inpatient Hospital admissions will not apply for this minimum length of stay and early discharge is only permitted if the attending health care provider, in consultation with the mother, decides an earlier discharge is appropriate.

Women's Health and Cancer Rights Act (WHCRA)

Do you know that your plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema. For more information, you should review the Summary Plan Description or call your Plan Administrator at (916) 375-7604 ext. 7 (ext. 4001 if calling internally) for more information.

Networks/Claims/Appeals

The major medical plans described in this booklet have provider networks with Kaiser Permanente, Western Health Advantage, and Blue Shield. The listing of provider networks will be available to you automatically and free of charge. You have a right to appeal denials of claims, and a right to a response within a reasonable amount of time. Claims that are not submitted within a reasonable time may be denied, Please review your summary plan description for more detail.

COBRA Continuation Coverage

This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it. When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

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

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

WHAT IS COBRA CONTINUATION COVERAGE?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "Qualifying Event." Specific Qualifying Events are listed later in this notice. After a Qualifying Event, COBRA continuation coverage must be offered to each person who is a "Qualified Beneficiary." You, your spouse, and your Dependent children could become Qualified Beneficiaries if coverage under the Plan is lost because of the Qualifying Event. Under the Plan, Qualified Beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you're an Employee, you'll become a Qualified Beneficiary if you lose coverage under the Plan because of the following Qualifying Events:

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

If you're the spouse of an Employee, you'll become a Qualified Beneficiary if you lose your coverage under the Plan because of the following Qualifying Events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or

Important Notices (continued)

- You become divorced or legally separated from your spouse.

Your Dependent children will become Qualified Beneficiaries if they lose coverage under the Plan because of the following Qualifying Events:

- **The parent-Employee dies;**
- **The parent-Employee's employment ends for any reason other than his or her gross misconduct;**
- **The parent-Employee becomes entitled to Medicare benefits (Part A, Part B, or both);**
- **The parents become divorced or legally separated; or**
- **The child stops being eligible for coverage under the Plan as a "dependent child."**

WHEN IS COBRA CONTINUATION COVERAGE AVAILABLE?

The Plan will offer COBRA continuation coverage to Qualified Beneficiaries only after the Plan Administrator has been notified that a Qualifying Event has occurred. The Employer must notify the Plan Administrator of the following Qualifying Events:

- The end of employment or reduction of hours of employment;
- Death of the Employee; or
- The Employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other Qualifying Events (e.g. divorce or legal separation of the Employee and spouse or a Dependent child's losing eligibility for coverage as a Dependent child), you must notify the Plan Administrator within 60 days after the Qualifying Event occurs. You must provide this notice to Washington Unified School District.

Life insurance, accidental death and dismemberment benefits and weekly income or long-term disability benefits (if part of the Employer's Plan) are not eligible for continuation under COBRA.

NOTICE AND ELECTION PROCEDURES

Each type of notice or election to be provided by a Covered Employee or a Qualified Beneficiary under this COBRA Continuation Coverage Section must be in writing, must be signed and dated, and must be furnished by U.S. mail, registered or certified, postage prepaid and properly addressed to the Plan Administrator.

Each notice must include all of the following items: the Covered Employee's full name, address, phone number and Social Security number; the full name, address, phone number and Social Security number of each affected Dependent, as well as the Dependent's relationship to the Covered Employee; a description of the Qualifying Event or disability determination that has occurred; the date the Qualifying Event or disability determination occurred on; a copy of the Social Security Administration's written disability determination, if applicable; and the name of this Plan. The Plan Administrator may establish specific forms that must be used to provide a notice or election.

ELECTION AND ELECTION PERIOD

COBRA continuation coverage may be elected during the period beginning on the date Plan coverage would otherwise terminate due to a Qualifying Event and ending on the later of the following: (1) 60 days after coverage ends due to a Qualifying Event, or (2) 60 days after the notice of the COBRA continuation coverage rights is provided to the Qualified Beneficiary.

If, during the election period, a Qualified Beneficiary waives COBRA continuation coverage rights, the waiver can be revoked at any time before the end of the election period. Revocation of the waiver will be an election of COBRA continuation coverage. However, if a waiver is revoked, coverage need not be provided retroactively (that is, from the date of the loss of coverage until the waiver is revoked). Waivers and revocations of waivers are considered to be made on the date they are sent to the Employer or Plan Administrator.

HOW IS COBRA CONTINUATION COVERAGE PROVIDED?

Once the Plan Administrator receives notice that a Qualifying Event has occurred, COBRA continuation coverage will be offered to each of the Qualified Beneficiaries. Each Qualified Beneficiary will have an independent right to elect COBRA continuation coverage. Covered Employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation on behalf of their children.

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

Important Notices (continued)

DISABILITY EXTENSION OF THE 18-MONTH PERIOD OF COBRA CONTINUATION COVERAGE

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

SECOND QUALIFYING EVENT EXTENSION OF 18-MONTH PERIOD OF COBRA CONTINUATION COVERAGE

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

OTHER OPTION BESIDES COBRA CONTINUATION COVERAGE

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

IF YOU HAVE QUESTIONS

For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Address and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

KEEP YOUR PLAN INFORMED OF ADDRESS CHANGES

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

EFFECTIVE DATE OF COVERAGE

COBRA continuation coverage, if elected within the period allowed for such election, is effective retroactively to the date coverage would otherwise have terminated due to the Qualifying Event, and the Qualified Beneficiary will be charged for coverage in this retroactive period.

COST OF CONTINUATION COVERAGE

The cost of COBRA continuation coverage will not exceed 102% of the Plan's full cost of coverage during the same period for similarly situated non-COBRA Beneficiaries to whom a Qualifying Event has not occurred. The "full cost" includes any part of the cost which is paid by the Employer for non-COBRA Beneficiaries.

The initial payment must be made within 45 days after the date of the COBRA election by the Qualified Beneficiary. Payment must cover the period of coverage from the date of the COBRA election retroactive to the date of loss of coverage due to the Qualifying Event (or date a COBRA waiver was revoked, if applicable). The first and subsequent payments must be submitted and made payable to the Plan Administrator or COBRA Administrator. Payments for successive periods of coverage are due on the first of each month thereafter, with a 30-day grace period allowed for payment. Where an Employee organization or any other entity that provides Plan benefits on behalf of the Plan Administrator permits a billing grace period later than the 30 days stated above, such period shall apply in lieu of the 30 days. Payment is considered to be made on the date it is sent to the Plan or Plan Administrator.

The Plan will allow the payment for COBRA continuation coverage to be made in monthly installments but the Plan can also allow for payment at other intervals. The Plan is not obligated to send monthly premium notices.

The Plan will notify the Qualified Beneficiary in writing, of any termination of COBRA coverage based on the criteria stated in this subsection that occurs prior to the end of the Qualified Beneficiary's applicable maximum coverage period. Notice will be given within 30 days of the Plan's decision to terminate.

Important Notices (continued)

Such notice shall include the reason that continuation coverage has terminated earlier than the end of the maximum coverage period for such Qualifying Event and the date of termination of continuation coverage.

See the Summary Plan Description for more information.

Special Enrollment Rights Notice

CHANGES TO YOUR HEALTH PLAN ELECTIONS

Once you make your benefits elections, they cannot be changed until the next Open Enrollment. Open Enrollment is held once a year.

If you are declining enrollment for yourself or your Dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your Dependents in this plan if there is a loss of other coverage. However, you must request enrollment no later than 30 days after that other coverage ends.

If you declined coverage while Medicaid or CHIP is in effect, you may be able to enroll yourself and / or your Dependents in this plan if you or your Dependents lose eligibility for that other coverage. However, you must request enrollment no later than 60 days after Medicaid or CHIP coverage ends.

If you or your Dependents become eligible for Medicaid or CHIP premium assistance, you may be able to enroll yourself and / or your Dependents into this plan. However, you must request enrollment no later than 60 days after the determination for eligibility for such assistance.

If you have a change in family status such as a new Dependent resulting from marriage, birth, adoption or placement for adoption, divorce (including legal separation and annulment), death or Qualified Medical Child Support Order, you may be able to enroll yourself and / or your Dependents. However, you must request enrollment no later than 30 days after the marriage, birth, adoption or placement for adoption or divorce (including legal separation and annulment).

Medicare Part D – Important Notice About Your Prescription Drug Coverage and Medicare

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

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

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

WHEN CAN YOU JOIN A MEDICARE DRUG PLAN?

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

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

WHAT HAPPENS TO YOUR CURRENT COVERAGE IF YOU DECIDE TO JOIN A MEDICARE DRUG PLAN?

If you decide to join a Medicare drug plan, your current Washington Unified School District coverage will not be affected.

If you do decide to join a Medicare drug plan and drop your current Washington Unified School District coverage, be aware that you and your Dependents will be able to get this coverage back.

Important Notices (continued)

WHEN WILL YOU PAY A HIGHER PREMIUM (PENALTY) TO JOIN A MEDICARE DRUG PLAN?

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

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

FOR MORE INFORMATION ABOUT THIS NOTICE OR YOUR CURRENT PRESCRIPTION DRUG COVERAGE

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

FOR MORE INFORMATION ABOUT YOUR OPTIONS UNDER MEDICARE PRESCRIPTION DRUG COVERAGE

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

FOR MORE INFORMATION ABOUT MEDICARE PRESCRIPTION DRUG COVERAGE

- Visit medicare.gov.
- Call your State Health Insurance Assistance Program (see your copy of the Medicare & You handbook for their telephone number) for personalized help.
- Call 800.MEDICARE (800.633.4227). TTY users should call 877.486.2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 800.772.1213 (TTY 800.325.0778).

REMEMBER

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

Date:	October 6, 2017
Name of Entity / Sender:	Washington Unified School District
Contact:	Benefits Department
Address:	930 Westacre Road West Sacramento, CA 95691
Phone:	(916) 375-7604 ext. 7 (ext. 4001 if calling internally)

Availability of Health Insurance Portability and Accountability Act (HIPAA) Notice of Privacy Practices

Washington Unified School District Group Health Plan (Plan) maintains a Notice of Privacy Practices that provides information to individuals whose protected health information (PHI) will be used or maintained by the Plan. If you would like a copy of the Plan's Notice of Privacy Practices, please contact the Benefits Department at (916) 375-7604 ext. 7 (ext. 4001 if calling internally).

Important Notices (continued)

Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: GENERAL INFORMATION

This notice provides you with information about Washington Unified School District in the event you wish to apply for coverage on the Health Insurance Marketplace. All the information you need from Human Resources is listed in this notice. If you wish to have someone assist you in the application process or have questions about subsidies that you may be eligible to receive, you can contact KeenanDirect at 855.653.3626 or at KeenanDirect.com, or contact the Health Insurance Marketplace directly at HealthCare.gov.

WHAT IS THE HEALTH INSURANCE MARKETPLACE?

The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through Covered California begins November 1, 2017 and ends on January 31, 2018.

CAN I SAVE MONEY ON MY HEALTH INSURANCE PREMIUMS IN THE MARKETPLACE?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer you coverage, or offers medical coverage that is not "Affordable" or does not provide "Minimum Value." If the lowest cost plan from your employer that would cover you (and not any other members of your family) is more than 9.69% (for 2017) and 9.56% (for 2018) of your household income for the year, then that coverage is not Affordable. Moreover, if the medical coverage offered covers less than 60% of the benefits costs, then the plan does not provide Minimum Value.

DOES EMPLOYER HEALTH COVERAGE AFFECT ELIGIBILITY FOR PREMIUM SAVINGS THROUGH THE MARKETPLACE?

Yes. If you have an offer of medical coverage from your employer that is both Affordable and provides Minimum Value, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's medical plan.

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

PART B: EXCHANGE APPLICATION INFORMATION

In the event you wish to apply for coverage on the Exchange, all the information you need from Human Resources is listed below. If you wish to have someone assist you in the application process or have questions about subsidies that you may be eligible to receive, you can contact KeenanDirect at 855.653.3626 or at KeenanDirect.com.

3. Employer name Washington Unified School District	**4. Employer Identification Number (EIN)** 68-0343642	
5. Employer address 930 Westacre Road	**6. Employer phone number** (916) 375-7604 ext. 7 (ext. 4001 if calling internally)	
7. City West Sacramento	**8. State** CA	**9. ZIP code** 95691
10. Who can we contact about employee health coverage at this job? Benefits Department		
11. Phone number (if different from above)	**12. Email address** jgeminder@wusd.k12.us	

Important Notices (continued)

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 August 10, 2017. Contact your State for more information on eligibility.

ALABAMA – Medicaid
Website: http://myalhipp.com/
Phone: 1-855-692-5447

ALASKA – Medicaid
The AK Health Insurance Premium Payment Program
Website: http://myakhipp.com/
Phone: 1-866-251-4861
Email: CustomerService@MyAKHIPP.com
Medicaid Eligibility:
http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx

ARKANSAS – Medicaid
Website: http://myarhipp.com/
Phone: 1-855-MyARHIPP (855-692-7447)

COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
Health First Colorado Website:
https://www.healthfirstcolorado.com/
Health First Colorado Member Contact Center:
1-800-221-3943/ State Relay 711
CHP+: https://colorado.gov/HCPF/Child-Health-Plan-Plus
CHP+ Customer Service:
1-800-359-1991/ State Relay 711

FLORIDA – Medicaid
Website: http://flmedicaidtplrecovery.com/hipp/
Phone: 1-877-357-3268

GEORGIA – Medicaid
Website: http://dch.georgia.gov/medicaid
Click on Health Insurance Premium Payment (HIPP)
Phone: 404-656-4507

INDIANA – Medicaid
Healthy Indiana Plan for low-income adults 19-64
Website: http://www.in.gov/fssa/hip/
Phone: 1-877-438-4479
All other Medicaid
Website: http://www.indianamedicaid.com
Phone 1-800-403-0864

IOWA – Medicaid
Website:
http://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp
Phone: 1-888-346-9562

KANSAS – Medicaid
Website: http://www.kdheks.gov/hcf/
Phone: 1-785-296-3512

KENTUCKY – Medicaid
Website: http://chfs.ky.gov/dms/default.htm
Phone: 1-800-635-2570

LOUISIANA – Medicaid
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331
Phone: 1-888-695-2447

MAINE – Medicaid
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html
Phone: 1-800-442-6003
TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP
Website:
http://www.mass.gov/eohhs/gov/departments/masshealth/
Phone: 1-800-862-4840

MINNESOTA – Medicaid
Website: http://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/medical-assistance.jsp
Phone: 1-800-657-3739

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

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

Important Notices (continued)

NEBRASKA – Medicaid
Website: http://www.ACCESSNebraska.ne.gov
Phone: (855) 632-7633
Lincoln: (402) 473-7000
Omaha: (402) 595-1178

NEVADA – Medicaid
Medicaid Website: https://dwss.nv.gov/
Medicaid Phone: 1-800-992-0900

NEW HAMPSHIRE – Medicaid
Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf
Phone: 603-271-5218

NEW JERSEY – Medicaid and CHIP
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

NEW YORK – Medicaid
Website: https://www.health.ny.gov/health_care/medicaid/
Phone: 1-800-541-2831

NORTH CAROLINA – Medicaid
Website: https://dma.ncdhhs.gov/
Phone: 919-855-4100

NORTH DAKOTA – Medicaid
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/
Phone: 1-844-854-4825

OKLAHOMA – Medicaid and CHIP
Website: http://www.insureoklahoma.org
Phone: 1-888-365-3742

OREGON – Medicaid
Website: http://healthcare.oregon.gov/Pages/index.aspx
http://www.oregonhealthcare.gov/index-es.html
Phone: 1-800-699-9075

PENNSYLVANIA – Medicaid
Website:
http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm
Phone: 1-800-692-7462

RHODE ISLAND – Medicaid
Website: http://www.eohhs.ri.gov/
Phone: 855-697-4347

SOUTH CAROLINA – Medicaid
Website: https://www.scdhhs.gov
Phone: 1-888-549-0820

SOUTH DAKOTA - Medicaid
Website: http://dss.sd.gov
Phone: 1-888-828-0059

TEXAS – Medicaid
Website: http://gethipptexas.com/
Phone: 1-800-440-0493

UTAH – Medicaid and CHIP
Medicaid Website: https://medicaid.utah.gov/
CHIP Website: http://health.utah.gov/chip
Phone: 1-877-543-7669

VERMONT– Medicaid
Website: http://www.greenmountaincare.org/
Phone: 1-800-250-8427

VIRGINIA – Medicaid and CHIP
Medicaid Website:
http://www.coverva.org/programs_premium_assistance.cfm
Medicaid Phone: 1-800-432-5924
CHIP Website:
http://www.coverva.org/programs_premium_assistance.cfm
CHIP Phone: 1-855-242-8282

WASHINGTON – Medicaid
Website: http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program
Phone: 1-800-562-3022 ext. 15473

WEST VIRGINIA – Medicaid
Website: http://mywvhipp.com/
Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)

WISCONSIN – Medicaid and CHIP
Website:
https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf
Phone: 1-800-362-3002

WYOMING – Medicaid
Website: https://wyequalitycare.acs-inc.com/
Phone: 307-777-7531

To see if any other states have added a premium assistance program since August 10, 2017, 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

Contact Information

Below is a listing of the telephone numbers you can call with questions about the plans available to you. You can also use the web site (if available) to access information from providers for the various plans.

Plan	Plan Number	Phone Number	Web Site
Medical			
• Kaiser Permanente HMO (All Employees)	1086	800.464.4000	www.kp.org
• Kaiser Permanente HDHP (Certificated Only)	1086	800.390.3507	www.kp.org
• Blue Shield of California HMO Access+ (Certificated Only)	W0065256	888.256.1915	www.blueshieldca.com/networktriohmo
• Blue Shield of California HMO Trio (Certificated Only)	W0065256	855.829.3566	www.blueshieldca.com
• Western Health Advantage HMO / HSA (Classified Only)	106876	888.563.2250	www.westernhealth.com **Provider Search:** www.westernhealth.com/search-for-providers
• HealthNet Seniority Plus	6210SN 62102S	800.631.3366	www.healthnet.com
Dental			
• Delta Dental	18481	866.499.3001	www.deltadentalins.com
Vision			
• Superior Vision	34004	800.507.3800	www.superiorvision.com
Employee Assistance Program (EAP)			
• Lincoln Financial Group	10181511	855.327.4463	www.guidanceresources.com **Company Code:** Lincoln
Basic Life / AD&D, Voluntary Term Life			
• Lincoln Financial Group	10181511	800.423.2765	www.lfg.com
Flexible Spending Accounts (FSA)			
• Navia Benefit Solutions		866.535.9227	www.NaviaBenefits.com
Other Voluntary Insurance Products			
• Colonial Life		702.463.2600	http://www.buildingblocksforbusiness.com

Benefits Department

Call 916.375.7604 Ext. 7 (Ext. 4001 if calling internally)

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