Roseville City

SIG Schools INSURANCE GROUP

2017 - 2018

BENEFIT GUIDE

HELPING YOU MAKE INFORMED CHOICES ABOUT YOUR EMPLOYEE BENEFITS

Who To Contact

The quickest way to find answers to your benefits questions is to go directly to the source. This contact list includes web addresses and phone numbers for the administrators of each of our benefit plans. The insurance company can verify benefits and coverage or copayment information. We suggest you contact the insurance company prior to seeking care should you have any questions regarding your benefits.

BENEFIT AND CARRIER	MEMBER SERVICES	WEBSITE
MEDICAL		
Kaiser	800-464-4000	www.kp.org
Western Health Advantage	888-563-2250	www.ChooseWHA.com/SIG
Sutter Health Plus	855-315-5800	www.SutterHealthPlus.org/employer/schools-insurance-group.html
DENTAL		
Delta Dental	866-499-3001	www.DeltaDentalins.com
VISION		
Vision Service Plan	800-877-7195	www.vsp.com
LIFE AND DISABILITY		
The Hartford	Contact your District Benefit Coordinator for more info.	
HEALTH SAVINGS ACCOUNT (HSA)		
Optum Bank	844-326-7967	www.optumbank.com
SCHOOLS INSURANCE GROUP	800-442-4199	www.SchoolsInsuranceGroup.com
Kelley Henry	Ext. 201	KelleyH@SIGAuburn.com
Melissa Gianopulos	Ext. 202	MelissaG@SIGAuburn.com

In this Guide

Individual Mandate: Make Sure You're Covered

As of January 1, 2014, the Affordable Care Act — also known as "healthcare reform" — requires you and your dependents to have health insurance (unless you meet certain exceptions). You can meet this requirement by enrolling in a company sponsored plan, purchasing coverage in the Marketplace Exchange or if you have Medicare or Medi-Cal. If you do not have health insurance, you may pay a tax penalty when you file your taxes at the end of the year.

Schools Insurance Group's medical plan options provide valuable comprehensive coverage that meets the requirements of the healthcare reform law and is intended to be affordable as defined by the law. It is unlikely that you are eligible for financial assistance from the government to help you pay for insurance purchased through the Marketplace because you have access to an employer plan that complies with the affordability standard.

All enrollment and eligibility matters should be directed to the Human Resources Department.

About This Guide

We consider our employee benefits program to be one of our most important investments. Because we recognize the value our employees bring to the organization, we are committed to providing you with a competitive benefits package 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.

Great care has been taken to ensure that this guide is accurate. However, oversights can occur or condensed summaries can be misinterpreted. If there is a difference between this overview and the official plan documents governing the plans, the plan documents will prevail.

Eligibility for Benefits

Please check with your school district for information on your eligibility date. The following family members may be enrolled in the medical, dental and vision programs:

- Your legal spouse
- Your qualified domestic partner (under California law)
- Your children or the children of your qualified domestic partner until age 26 on medical, dental and vision
- Your dependent child who is incapable of self support because of a mental or physical disability

For the purpose of our benefit plans, your children include:

- Natural and adopted children
- Stepchildren
- Any other children you support for whom you are the legal guardian or for whom you are required to provide coverage as the result of a qualified medical child support order

Making Changes to Your Benefits

During Open Enrollment you can change your benefit choices. Open Enrollment is during the months prior to your benefits renewal and changes which are effective July 1st. Your decisions remain in effect for twelve months unless you have a qualifying life event as defined by the IRS. Qualifying events include:

- The addition of a dependent through birth, adoption or marriage
- The loss of other “group” coverage
- The loss of a dependent through divorce or death, or if your child reaches the maximum age limit for coverage
- A change in you or your spouse’s employment status from full-time to part-time or vice versa
- A substantial change in your benefits coverage or a spouse’s coverage
- The addition or separation of a qualified domestic partner
- Change in eligibility for Medicaid or Children’s Health Insurance Program (CHIP) subsidy

Any benefit changes must be consistent with the type of event you experience. If you gain a dependent, you can add them to your benefits but that qualifying event does not allow you to drop another dependent from benefits. For example, if you have a baby, you can add the baby to your medical plan but you could not drop a spouse from the plan.

If you experience a family status change and want to change your benefits, you MUST contact Human Resources **within 30 days of the status change.**

Kaiser Permanente $20E (Chiro & Optical)

Services with the Kaiser HMO plan must be obtained from a participating provider or hospital. Select a doctor at a Kaiser facility near you. The doctor you choose must be a primary care physician (PCP) - Internal Medicine, Family/ General Medicine or Pediatric Medicine. Your PCP will refer you to see a specialist when needed. Most Kaiser locations offer multiple services under one roof. That means you may be able to see your PCP, get an X-ray, visit the lab and fill your prescription all in the same place. The information listed is only a brief summary. For complete details refer to the carrier plan documents. Visit www.kp.org or call (800) 464-4000 to find Kaiser participating providers.

Benefits	In-Network Only
Calendar Year Deductible	None
Calendar Year Out-of-Pocket Maximum	$1,500 Individual $3,000 Family
Office Visits	
Preventive Care	No Charge
Primary Care Physician Office Visits	$20 copay
Specialist Physician Office Visits	$20 copay
Lab & X-Ray	No Charge
Acupuncture (physician referred only)	$20 copay
Chiropractic Care (up to 30 visits per year)	$10 copay
Optical	
Eye Exam	No Charge
Glasses (once every 24 months)	$175 allowance
Hospitalization Services	
Emergency room (copay waived if admitted)	$50 copay
Urgent care visit	$20 copay
Hospital inpatient services	No Charge
Outpatient surgery	$20 copay
Mental Health Services	
Outpatient mental health and substance abuse	$20 copay
Inpatient mental health and substance abuse	No Charge
Prescriptions	**Retail (up to 100 day supply)**
Drug Deductible	None
Most Generic Items	$10 copay
Most Brand Name Items	$25 copay
Specialty Items	20% (not to exceed $150) for up to a 30-day supply

This is a summary of the most frequently asked about benefits. This chart does not explain benefits. Cost Sharing, out-of-pocket maximums, exclusions, or limitations, nor does it list all benefits and Cost Sharing. For a complete explanation, please refer to the EOC (Evidence of Coverage).

Kaiser Permanente HSA Plan

Services with the Kaiser HMO plan must be obtained from a participating provider or hospital. Select a doctor at a Kaiser facility near you. The doctor you choose must be a primary care physician (PCP) - Internal Medicine, Family/ General Medicine or Pediatric Medicine. Your PCP will refer you to see a specialist when needed. Most Kaiser locations offer multiple services under one roof. That means you may be able to see your PCP, get an X-ray, visit the lab and fill your prescription all in the same place. The information listed is only a brief summary. For complete details refer to the carrier plan documents. Visit www.kp.org or call (800) 464-4000 to find Kaiser participating providers.

Benefits	In-Network Only	
Calendar Year Deductible	$2,000 Individual	$4,000 Family
Calendar Year Out-of-Pocket Maximum	$3,000 Individual	$6,000 Family
Office Visits	***AFTER DEDUCTIBLE***	
Preventive Care	No Charge (deductible waived)	
Primary Care Physician Office Visits	$30 copay after deductible	
Specialist Physician Office Visits	$30 copay after deductible	
Lab & X-Ray	$10 per encounter after deductible	
Acupuncture (physician referred only)	$30 copay after deductible	
Chiropractic Care	Not Covered	
Hospitalization Services		
Emergency room (copay waived if admitted)	$100 copay after deductible	
Urgent care visit	$30 copay after deductible	
Hospital inpatient services	$250 per admission after deductible	
Outpatient surgery	$150 per procedure after deductible	
Mental Health Services		
Outpatient mental health and substance abuse	$30 copay after deductible	
Inpatient mental health and substance abuse	$250 per admission after deductible	

Prescriptions	Retail (up to 30 day supply)	Mail Order (up to 100 day supply)
Drug Deductible	Combined with Medical Deductible	
Most Generic Items	$10 copay after combined deductible	2 times retail cost
Most Brand Name Items	$30 copay after combined deductible	
Specialty Items	20% (not to exceed $150) for up to a 30-day supply after deductible	

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Sutter Health Plus $20 Copay

Services with the Sutter Health Plus HMO plan must be obtained from a participating provider or hospital. Select a contracting Physician Group near you. The doctor you choose must be a primary care physician (PCP) - Internal Medicine, Family/General Medicine or Pediatric Medicine. Your PCP will refer you to see a specialist when needed. The information listed is only a brief summary. For complete details refer to the carrier plan documents. Visit www.SutterHealthPlus.org or call (855) 315-5800 to find participating providers.

Benefits	In-Network Only	
Calendar Year Deductible	None	
Calendar Year Out-of-Pocket Maximum	$1,500 Individual	$3,000 Family
Office Visits		
Preventive Care	No Charge	
Primary Care Physician Office Visits	$20 copay	
Specialist Physician Office Visits	$20 copay	
Lab & X-Ray	$20 copay	
Acupuncture/Chiro (up to 20 visits per year combined)	$15 copay	
Hospitalization Services		
Emergency room (copay waived if admitted)	$50 copay	
Urgent care visit	$20 copay	
Hospital inpatient services	No copay	
Outpatient surgery	No copay	
Mental Health Services		
Outpatient mental health and substance abuse	$20 copay	
Inpatient mental health and substance abuse	No copay	
Prescriptions	**Retail 30 day supply**	**Mail order 100 day supply**
Drug Deductible	Combined with Medical	
Generic	$10 copay	$20 copay
Preferred brand	$30 copay	$60 copay
Non-preferred brand	$60 copay	$120 copay
Specialty Drugs (see EOC for details)	20% up to $100/script	

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Sutter Health Plus
Your Health Plan

Sutter Health Plus 1500 HSA

Services with the Sutter Health Plus HMO plan must be obtained from a participating provider or hospital. Select a contracting Physician Group near you. The doctor you choose must be a primary care physician (PCP) - Internal Medicine, Family/General Medicine or Pediatric Medicine. Your PCP will refer you to see a specialist when needed. The information listed is only a brief summary. For complete details refer to the carrier plan documents. Visit www.SutterHealthPlus.org or call (855) 315-5800 to find participating providers.

Benefits	In-Network Only
Calendar Year Deductible	$1,500 Individual / $2,600 Ind. in family / $3,000 Family
Calendar Year Out-of-Pocket Maximum	$3,000 Individual / $3,000 Ind. In family / $6,000 Family
Preventive Care	No Charge (Deductible Waived)
Office Visits	***AFTER DEDUCTIBLE***
Primary Care Physician Office Visits	No copay after deductible
Specialist Physician Office Visits	No copay after deductible
Lab & X-Ray	No copay after deductible
Acupuncture	No copay after deductible
Hospitalization Services	
Emergency room (copay waived if admitted)	No copay after deductible
Urgent care visit	No copay after deductible
Hospital inpatient services	$50 copay after deductible
Outpatient surgery	No copay after deductible
Mental Health Services	
Outpatient mental health and substance abuse	No copay after deductible
Inpatient mental health and substance abuse	$50 copay after deductible

Prescriptions	Retail 30 day supply; Mail order 100 day supply
Drug Deductible	***AFTER COMBINED MEDICAL DEDUCTIBLE***
Generic	No copay after deductible
Preferred brand	No copay after deductible
Non-preferred brand	No copay after deductible
Specialty Drugs (see EOC for details)	No copay after deductible

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Sutter Health Plus
Your Health Plan

Sutter Health Plus 2500 HSA

Services with the Sutter Health Plus HMO plan must be obtained from a participating provider or hospital. Select a contracting Physician Group near you. The doctor you choose must be a primary care physician (PCP) - Internal Medicine, Family/General Medicine or Pediatric Medicine. Your PCP will refer you to see a specialist when needed. The information listed is only a brief summary. For complete details refer to the carrier plan documents. Visit www.SutterHealthPlus.org or call (855) 315-5800 to find participating providers.

Benefits	In-Network Only	
Calendar Year Deductible	$2,500 Individual / $2,600 Ind. in family / $5,000 Family	
Calendar Year Out-of-Pocket Maximum	$4,000 Individual / $4,000 Ind. In family / $8,000 Family	
Preventive Care	No Charge (Deductible Waived)	
Office Visits	***AFTER DEDUCTIBLE***	
Primary Care Physician Office Visits	20% coinsurance	
Specialist Physician Office Visits	20% coinsurance	
Lab & X-Ray	20% coinsurance	
Acupuncture	20% coinsurance	
Hospitalization Services		
Emergency room (copay waived if admitted)	20% coinsurance	
Urgent care visit	20% coinsurance	
Hospital inpatient services	20% coinsurance	
Outpatient surgery	20% coinsurance	
Mental Health Services		
Outpatient mental health and substance abuse	20% coinsurance	
Inpatient mental health and substance abuse	20% coinsurance	
Prescriptions	**Retail 30 day supply**	**Mail order 100 day supply**
Drug Deductible	***AFTER COMBINED MEDICAL DEDUCTIBLE***	
Generic	$10 copay	$20 copay
Preferred brand	$30 copay	$60 copay
Non-preferred brand	$60 copay	$120 copay
Specialty Drugs (see EOC for details)	20% up to $100/script	

This is a summary of the most frequently asked about benefits. This chart does not explain benefits. Cost Sharing, out-of-pocket maximums, exclusions, or limitations, nor does it list all benefits and Cost Sharing. For a complete explanation, please refer to the EOC (Evidence of Coverage).

Sutter Health Plus
Your Health Plan

Western Health Advantage Premier 20

Services with the Western Health Advantage HMO plan must be obtained from a participating provider or hospital. Select a contracting Physician Group near you. The doctor you choose must be a primary care physician (PCP) - Internal Medicine, Family/General Medicine or Pediatric Medicine. Your PCP will refer you to see a specialist when needed. The information listed is only a brief summary. For complete details refer to the carrier plan documents. Visit www.WesternHealth.com or call (888) 563-2250 to find Western Health Advantage participating providers.

Benefits	In-Network Only	
Calendar Year Deductible	None	
Calendar Year Out-of-Pocket Maximum	$1,500 Individual	$2,500 Family
Preventive Care	No Charge	
Office Visits		
Primary Care Physician Office Visits	$20 copay	
Specialist Physician Office Visits	$20 copay	
Lab & X-Ray	No copay	
Acupuncture (up to 20 visits per year)	$15 copay	
Chiropractic Care (up to 20 visits per year)	$15 copay	
Hospitalization Services		
Emergency room (copay waived if admitted)	$100 copay	
Urgent care visit	$35 copay	
Hospital inpatient services	No copay	
Outpatient surgery	$100 copay	
Mental Health Services		
Outpatient mental health and substance abuse	$20 copay	
Inpatient mental health and substance abuse	No copay	

Prescriptions	Retail 30 day supply	Mail order 90 day supply
Drug Deductible	Combined with Medical	
Generic	$10 copay	$25 copay
Preferred brand	$30 copay	$75 copay
Non-preferred brand (includes specialty oral drugs)	$50 copay	$125 copay
Home Self-Injectable Drugs (see EOC for details)	20% up to $100/script	

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Western Health Advantage

Western Health Advantage 1800 HSA

Services with the Western Health Advantage HMO plan must be obtained from a participating provider or hospital. Select a contracting Physician Group near you. The doctor you choose must be a primary care physician (PCP) - Internal Medicine, Family/General Medicine or Pediatric Medicine. Your PCP will refer you to see a specialist when needed. The information listed is only a brief summary. For complete details refer to the carrier plan documents. Visit www.WesternHealth.com or call (888) 563-2250 to find Western Health Advantage participating providers.

Benefits	In-Network Only
Calendar Year Deductible	$1,800 Individual / $2,600 Ind. In Family / $3,600 Family
Calendar Year Out-of-Pocket Maximum	$3,600 Individual / $3,600 Ind. In Family / $7,200 Family
Preventive Care	No Charge (Deductible Waived)
Office Visits	*AFTER DEDUCTIBLE*
Primary Care Physician Office Visits	No copay after deductible
Specialist Physician Office Visits	No copay after deductible
Lab & X-Ray	No copay after deductible
Acupuncture/Chiro (up to 20 visits per year)	No copay after deductible
Hospitalization Services	
Emergency room (copay waived if admitted)	No copay after deductible
Urgent care visit	No copay after deductible
Hospital inpatient services	No copay after deductible
Outpatient surgery	No copay after deductible
Mental Health Services	
Outpatient mental health and substance abuse	No copay after deductible
Inpatient mental health and substance abuse	No copay after deductible
Prescriptions	**Retail 30 day supply; Mail order 90 day supply**
Drug Deductible	Combined with Medical
Generic	No copay after deductible
Preferred brand	$30 copay after deductible
Non-preferred brand (includes specialty oral drugs)	$50 copay after deductible
Home Self-Injectable Drugs (see EOC for details)	No copay after deductible

This is a summary of the most frequently asked about benefits. This chart does not explain benefits. Cost Sharing, out-of-pocket maximums, exclusions, or limitations, nor does it list all benefits and Cost Sharing. For a complete explanation, please refer to the EOC (Evidence of Coverage).

Western Health Advantage

Western Health Advantage 2800/40 HSA

Services with the Western Health Advantage HMO plan must be obtained from a participating provider or hospital. Select a contracting Physician Group near you. The doctor you choose must be a primary care physician (PCP) - Internal Medicine, Family/General Medicine or Pediatric Medicine. Your PCP will refer you to see a specialist when needed. The information listed is only a brief summary. For complete details refer to the carrier plan documents. Visit www.WesternHealth.com or call (888) 563-2250 to find Western Health Advantage participating providers.

Benefits	In-Network Only	
Calendar Year Deductible	$2,800 Individual	$5,600 Family
Calendar Year Out-of-Pocket Maximum	$4,000 Individual	$8,000 Family
Preventive Care	No Charge (Deductible Waived)	
Office Visits	*AFTER DEDUCTIBLE*	
Primary Care Physician Office Visits	$40 copay	
Specialist Physician Office Visits	$40 copay	
Lab & X-Ray	No copay after deductible	
Acupuncture/Chiro (up to 20 visits per year)	No copay after deductible	
Hospitalization Services		
Emergency room (copay waived if admitted)	$100 copay	
Urgent care visit	$50 copay	
Hospital inpatient services	$500 per day	
Outpatient surgery	$250 copay	
Mental Health Services		
Outpatient mental health and substance abuse	$500 per day copay	
Inpatient mental health and substance abuse	$40 copay	

Prescriptions	Retail 30 day supply	Mail order 90 day supply
Drug Deductible	Combined with Medical	
Generic	$10 copay	$25 copay
Preferred brand	$30 copay	$75 copay
Non-preferred brand (includes specialty oral drugs)	$50 copay	$125 copay
Home Self-Injectable Drugs (see EOC for details)	20% up to $100 per script after deductible	

This is a summary of the most frequently asked about benefits. This chart does not explain benefits. Cost Sharing, out-of-pocket maximums, exclusions, or limitations, nor does it list all benefits and Cost Sharing. For a complete explanation, please refer to the EOC (Evidence of Coverage).

Western Health Advantage

Medical Plan Option: Health Savings Account

What's an HSA?

HSA stands for Health Savings Account. It's a special savings account for people who have a high deductible health plan (HDHP). The HSA allows you to save tax-free dollars to pay for IRS-qualified medical expenses the HDHP doesn't cover.

Key Benefits:

- Contributions made to your Health Savings Account are tax advantaged
- Your organization offers payroll deduction to help you deposit money into your HSA with Optum Bank
- You pay a lower premium for your health plan because of its higher deductible
- Your deposits may earn interest and continue to grow over time
- Depending on your account, you may be able to invest a portion of your balance in mutual funds to help save for future health care expenses
- The money in your HSA belongs to you, no matter who deposited it, even if you change jobs or switch health plans.

2016 HSA Limits

The IRS limits how much you can deposit into your HSA each year. The 2017 limits are:

- $3,400 for individual coverage
- $6,750 for family coverage

Are You 55 or Older?

You can deposit an extra $1,000 during the year. This is called a catch-up contribution.

How the medical plan works with the Health Savings Account

Remember, you do not need to pay anything out of your pocket for eligible preventive care as it will be covered at 100% when received in the network.

Your deductible – You pay out of pocket until you reach the deductible.

When you have an eligible expense, such as a doctor visit, the entire cost of the visit will apply to your deductible. You will pay the full cost of your health care expenses until you meet your deductible. You can choose to pay for care from your HSA or you can choose to pay another way (i.e., cash, credit card) and let your HSA grow. It's your money; it's your choice.

Your coverage – Your plan pays a percentage of your expenses.

Once the deductible is paid, your health plan has co-insurance. With co-insurance, the plan shares the cost of expenses with you. The plan will pay a percentage of each eligible expense, and you will pay the rest. For example, if your plan pays 90% of the cost, you will pay 10%. After the deductible, your plan may have a co-payment for certain services, such as prescriptions.

Your out-of-pocket limit – You are protected from major expenses.

An out-of-pocket limit protects you from major expenses. The out-of-pocket limit is the most you will have to pay in the plan year for covered services. The plan will then pay 100% of all remaining covered expenses for the rest of the plan year. Your deductible, co-insurance and co-payments (if they apply) will apply to your out-of-pocket limit.

Please contact your Benefit Coordinator to set up your Health Savings Account.

Delta Dental Plan IIA

With the PPO Plan, you can visit any dentist, but you pay less out-of-pocket when you choose an In-Network PPO dentist. If dental services are expected to exceed $300, we encourage you to obtain a "pre-determination of benefits." Your dentist office can submit this request for you to the carrier prior to receiving services. This will give you an estimate of what your out-of-pocket costs will be in advance of having the procedure performed.

Visit www.deltadentalins.com or call 866-499-3001 to find participating **PPO** providers.

PLAN DESIGN

In this incentive plan, Delta Dental pays 70% of the contract allowance for covered diagnostic, preventive and basic services and 70% of the contract allowance for major services during the first year of eligibility. **The coinsurance percentage will increase by 10% each year (to a maximum of 100%) for each enrollee if that person visits the dentist at least once during the year.** If an enrollee does not use the plan during the calendar year, the percentage remains at the level attained the previous year. If an enrollee becomes ineligible for benefits and later regains eligibility, the percentage will drop back to 70%.

Benefits*	In-Network ** PPO dentists	Out-of-Network** Premier & Non-Delta Dentists
Calendar Year Maximum	**$1,700 per person per calendar year**	**$1,500 per person per calendar year**
Calendar Year Deductible	**None**	
	Plan Pays	**Plan Pays**
Diagnostic & Preventive Exams, cleanings, x-rays	70% - 100%	70% - 100%
Basic Services Fillings, simple tooth extractions, sealants	70% - 100%	70% - 100%
Endodontics (root canals) **Periodontics (gum treatment)** **Oral Surgery**	70% - 100%	70% - 100%
Major Services Crowns, inlays, onlays & cast restorations	70% - 100%	70% - 100%
Prosthodontics Bridges and dentures	50%	50%
Dental Accident	100% (separate $1,000 max per person per calendar year)	100% (separate $1,000 max per person per calendar year)

* Limitations or waiting periods may apply for some benefits; some services may be excluded from your plan. Reimbursement is based on Delta Dental contract allowances and not necessarily each dentist's actual fees.

** Reimbursement is based on PPO contracted fees for PPO dentists, Premier contracted fees for Premier dentists and program allowance for non-Delta Dental dentists.

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Vision Plan 12/12/24 $0 Copayment

Using your VSP Benefit is easy!

1. Register at vsp.com. Once your plan is effective, review your benefit information.
2. Find an eye care provider who's right for you.VSP.com or call 800-877-7195
3. At your appointment, tell them you have VSP. There's no ID card required. If you obtain services from an In-Network provider, there are no claim forms to complete. However, if you obtain services from an Out-of-Network provider, you may need to pay and submit for claims reimbursement according to the schedule below.

New! Costco, Pearle Vision and Vision Works will be added as an In-Network Provider!

Copays	**Exam** **Prescription Glasses** **Contact Lens fitting & evaluation**	**$0** **$0** **Max $60**
Frequency	**Exam** **Lenses or contact lenses** **Frame**	**Once every 12 months** **Once every 12 months** **Once every 24 months**
	In-Network	**Out-of-Network**
Exam	**100% after copay**	**Reimbursed up to $50**
Lenses **Single** **Bifocal** **Trifocal**	 **100% after copay** **100% after copay** **100% after copay**	 **Reimbursed up to $50** **Reimbursed up to $75** **Reimbursed up to $100**
Frame	**$150 allowance + 20% off amount over allowance**	**Reimbursed up to $70**
Contact Lenses ***(in lieu of lens/frame)*** **Elective** **Medically Necessary**	 **$150 allowance for contacts and lens exam (fitting and evaluation) + 15% off contact lens exam** **100% after copay**	 **Reimbursed up to $105** **Reimbursed up to $210**

Extra savings and discounts include: 20-30% off additional glasses and sunglasses, guaranteed pricing on retinal screening, and discounted laser vision correction from available contracted facilities. For more information about these discounts, please visit www.VSP.com or call 800-877-7195.

This is a summary of the most frequently asked about benefits. This chart does not explain benefits, cost sharing, exclusions, or limitations, nor does it list all of the benefits and cost sharing. For a complete explanation, please refer to the EOC (Evidence of Coverage).

Information regarding Section 125 and Imputed Income

About Your Premiums

Any contributions you make for you and your IRS dependents' medical, dental and vision plan coverage is automatically deducted from your paycheck on a pre-tax basis per IRS guidelines under Section 125. This decreases your taxable earnings and can increase your take-home pay.

Your elections remain in effect and can not be changed for twelve months or the remainder of the group plan year, whichever occurs first, unless you have a qualifying life event as defined by the IRS. Qualifying life events are listed on page 5 of the Employee Benefits Guide.

Imputed Income

Because the IRS does not recognize domestic partners or their children (unless they qualify as dependents under Section 152) for tax filing purposes, we are required to "impute" the value of these benefits and report that value as taxable income to the employee. The applicable amount will be added back into your paycheck as taxable income and you will pay taxes on that amount.

GLOSSARY OF KEY TERMS

Coinsurance – The member and insurance company share the cost of covered procedures in a specific ratio (e.g., member pays 20% and the insurance company pays 80%). This is primarily used in medical and dental PPO plans. If the plan has a deductible, coinsurance does not apply until it has been met.

Copayment – A specific dollar amount you pay to the provider or pharmacy when receiving services or prescriptions.

Deductible – The amount you must pay before the insurance company begins paying benefits on your behalf. The deductible is generally waived for preventive visits and services that require a copayment, including prescription drugs.

Explanation of Benefits (EOB) – A notice sent to the covered person after a claim for payment has been processed by the insurance company. The form explains the action taken on the claim. This explanation usually indicates the amount paid, the benefits available, reasons for denying payment or the claims appeal process.

Formulary – A list containing the names of certain prescription drugs that a medical plan covers when dispensed to its members who have drug coverage through a participating pharmacy. You can obtain a list of formulary medications covered under your plan by visiting the carrier websites referenced on the "Who to Contact" page.

HMO – With this type of medical or dental plan, all care - except emergency services - must be coordinated through a Primary Care Physician (PCP) and/or medical group. Failure to coordinate care through a PCP may result in loss of benefit and greatly increase the amount of money that the member will have to pay for care. Each family member can have a different PCP and they can be changed monthly.

Imputed Income – The IRS has ruled that a domestic partner or same-sex spouse is not a legal spouse for tax purposes. Employers are obligated to report and withhold taxes on the value of benefits provided to a domestic partner and the domestic partner's children. The applicable amount is treated as taxable income to the employee and added back into an employee's paycheck as taxable income. Imputed income also applies to the premiums that employers pay on your behalf for life insurance coverage amounts in excess of $50,000 and LTD benefits. This premium is added to your gross income for tax purposes.

In-Network – All medical, dental and vision carriers have a designated network of doctors or dentists. These providers have agreed to discounted fees with the insurance carrier. In turn, you generally pay a lower percentage of the costs, resulting in less out-of-pocket cost.

Mail Order Prescriptions – A benefit that allows you to order certain maintenance drugs at a reduced cost. You receive multiple months' worth of medication by mail.

Non-formulary – A drug or medication not included on the formulary list of the health insurance plan. If covered, these medications have a higher copay or cost to the member.

Out-of-Network – Medical, dental and vision providers who do not agree to accept the negotiated rates offered by insurance companies. A member may pay higher copays and/or deductibles to see an out-of-network provider or have no coverage at all.

Out-of-Pocket Maximum - Generally, the maximum amount of money a member will have to pay each year. The out-of-pocket maximum most often applies to coinsurance. An individual who meets the out-of-pocket maximum may still be responsible for copays.

PCP – Primary Care Physician. A doctor who is your first point of contact and who must coordinate your care and refer you to specialists. Primarily required by medical or dental HMO plans.

Preferred Provider Organization (PPO) – A type of medical or dental plan that gives members the flexibility to see any provider. If a member chooses an in-network provider or hospital, they will typically have to pay less out-of-pocket.

Pre-determination of Benefits – An estimate reflecting the amount of money an insurance company intends to pay on a member's behalf for a particular procedure. This generally applies to medical and dental plans.

Usual Customary and Reasonable (UCR) – The range of usual fees for comparable services charged by professionals in a geographic area. If your provider charges more than the reasonable and customary fee, you may be responsible for paying the difference. This is often referred to as "Balance Billing".

2017-2018 Annual Notices

IMPORTANT
Please be sure to read each of the notices on the following pages. If you have any questions or would like to obtain additional information, please contact Human Resources.

The Newborns' and Mothers' Health Protection Act of 1996

The Newborns' and Mothers' Health Protection Act of 1996 prohibits group and individual health insurance policies from restricting benefits for any hospital length of stay for the mother or newborn child in connection with childbirth; (1) following a normal vaginal delivery to less than 48 hours, and (2) following a cesarean section, to less than 96 hours. Health insurance policies may not require that a provider obtain authorization from the health insurance plan or the issuer for prescribing any such length of stay. Regardless of these standards, an attending health care provider may, in consultation with the mother, discharge the mother or newborn child prior to the expiration of such minimum length of stay.

Further, a health insurer or health maintenance organizations may not:

- deny to the mother or newborn child eligibility, or continued eligibility, to enroll or to renew coverage under the terms of the plan, solely to avoid providing such length of stay coverage
- provide monetary payments or rebates to mothers to encourage such mothers to accept less than the minimum coverage
- provide monetary incentives to an attending medical provider to induce such provider to provide care inconsistent with such length of stay
- require a mother to give birth in a hospital
- restrict benefit for any portion of a period within a hospital length of stay described in this notice.

These benefits are subject to the plan's regular deductible and co-pay. For further details, refer to your Summary Plan Description.

The Women's Health and Cancer Rights Act of 1998

The Women's Health and Cancer Rights Act of 1998 requires your employer to notify you, as a participant or beneficiary of the Health and Welfare Plan, of your rights related to benefits provided through the plan in connection with a mastectomy. You, as a participant or beneficiary, have rights to coverage to be provided in a manner determined in consultation with your attending physician 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
- prosthesis and treatment of physical complications of the mastectomy, including lymph edema.

These benefits are subject to the plan's regular deductible and copay. For further details, refer to your Summary Plan Description.

Important Notice from Schools Insurance Group About Your Prescription Coverage

Medicare Part D

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

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

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. The Carriers have determined that the prescription drug coverage offered by the Kaiser, WHA, and Sutter Health Plan plans are, 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 Group coverage will not be affected. You can keep this coverage if you elect part D.

If you do not decide to join a Medicare drug plan and drop your current Group coverage, be aware that you and your dependents may be able to get this coverage back.

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

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

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

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

For further information please contact human resources (listed below). You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Schools Insurance Group changes. You also may request a copy of this notice at any time.

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

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

For more information about Medicare prescription drug coverage:
• Visit www.medicare.gov
• Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
• Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Date:	July 1, 2017
Name of Entity/Sender:	Schools Insurance Group
Contact--Position/Office:	Melissa Gianopulos, Eligibility Coordinator
Address:	550 High St #201, Auburn, CA 95603
Phone Number:	(530) 823-9582

HIPAA Protecting Your Health Information Privacy Rights

Your employer is committed to the privacy of your health information. The administrators of your Group Health Plan (the "Plan") use strict privacy standards to protect your health information from unauthorized use or disclosure.

The Plan's policies protecting your privacy rights under the law are described in the Plan's Notice of Privacy Practices. You may receive a copy of the Notice of Privacy Practices by contacting the Plan carrier directly.

HIPAA Special Enrollment Rights

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 or your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage). However, you must request enrollment within "31 days" after you or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, this special enrollment opportunity will not be available when other coverage ends unless you provide a written statement now explaining the reason that you are declining coverage for yourself or your dependent(s). Failing to accurately complete and return this form for each person for whom you are declining coverage will eliminate this special enrollment opportunity for the person(s) for whom a statement is not completed, even if other coverage is currently in effect and is later lost. In addition, unless you indicate in the statement that you are declining coverage because other coverage is in effect, you will not have this special enrollment opportunity for the person(s) covered by the statement. (See the paragraph below, however, regarding enrollment in the event of marriage, birth, adoption or placement for adoption.)

If you have a new dependent as result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must enroll within "31 days" after the marriage, birth, adoption, or placement for adoption.

A special enrollment opportunity may be available in the future if you or your dependents lose other coverage. This special enrollment opportunity will not be available when other coverage ends, however, unless you provide a written statement now explaining the reason that you are declining coverage for yourself or your dependent(s). Failing to accurately complete and return this form for each person for whom you are declining coverage will eliminate this special enrollment opportunity for the person(s) for whom a statement is not completed, even if other coverage is currently in effect and is later lost. In addition, unless you indicate in the statement that you are declining coverage because other coverage is in effect, you will not have this special enrollment opportunity for the person(s) covered by the statement. (See the paragraph above, however, regarding enrollment in the event of marriage, birth, adoption or placement for adoption.)

Effective April 1, 2009 special enrollment rights also exist in the following circumstances:

- If you or your dependent experience a loss of eligibility for Medicaid or your State Children's Health Insurance Program (SCHIP) coverage; or
- If you or your dependents become eligible for premium assistance under an option state Medicaid or SCHIP program that would pay the employee's portion of the health insurance premium.

Note: In the two above listed circumstances only, you or your dependents will have sixty (60) days to request special enrollment in the group health plan coverage. An individual must request this special enrollment within sixty (60) days of the loss of coverage described at bullet one, and within sixty (60) days of when eligibility is determined as described in bullet two.

To request special enrollment or obtain additional information, contact Human Resources.

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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2017. Contact your State for more information on eligibility –

ALABAMA – Medicaid	**FLORIDA – Medicaid**
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: http://flmedicaidtplrecovery.com/hipp/ Phone: 1-877-357-3268
ALASKA – Medicaid	**GEORGIA – 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	Website: http://dch.georgia.gov/medicaid - Click on Health Insurance Premium Payment (HIPP) Phone: 404-656-4507
ARKANSAS – Medicaid	**INDIANA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	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
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**IOWA – Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: Colorado.gov/HCPF/Child-Health-Plan-Plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711	Website: http://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp Phone: 1-888-346-9562

KANSAS – Medicaid	NEW HAMPSHIRE – Medicaid
Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512	Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf Phone: 603-271-5218
KENTUCKY – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	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
LOUISIANA – Medicaid	**NEW YORK – Medicaid**
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
MAINE – Medicaid	**NORTH CAROLINA – Medicaid**
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711	Website: https://dma.ncdhhs.gov/ Phone: 919-855-4100
MASSACHUSETTS – Medicaid and CHIP	**NORTH DAKOTA – Medicaid**
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-462-1120	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
MINNESOTA – Medicaid	**OKLAHOMA – Medicaid and CHIP**
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	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
MISSOURI – Medicaid	**OREGON – Medicaid**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
MONTANA – Medicaid	**PENNSYLVANIA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084	Website:http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm Phone: 1-800-692-7462
NEBRASKA – Medicaid	**RHODE ISLAND – Medicaid**
Website: http://dhhs.ne.gov/Children_Family_Services/AccessNebraska/Pages/accessnebraska_index.aspx Phone: 1-855-632-7633	Website: http://www.eohhs.ri.gov/ Phone: 401-462-5300
NEVADA – Medicaid	**SOUTH CAROLINA – Medicaid**
Medicaid Website: https://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900	Website: https://www.scdhhs.gov Phone: 1-888-549-0820

SOUTH DAKOTA - Medicaid	WASHINGTON – Medicaid
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program Phone: 1-800-562-3022 ext. 15473
TEXAS – Medicaid	**WEST VIRGINIA – Medicaid**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: http://www.dhhr.wv.gov/bms/Medicaid%20Expansion/Pages/default.aspx Phone: 1-877-598-5820, HMS Third Party Liability
UTAH – Medicaid and CHIP	**WISCONSIN – Medicaid and CHIP**
Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
VERMONT– Medicaid	**WYOMING – Medicaid**
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531
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	

To see if any other states have added a premium assistance program since January 31, 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

Paperwork Reduction Act Statement

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

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

Patient Protection Disclosure

Kaiser, WHA, and Sutter Health Plus HMO plans generally requires the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. Until you make this designation, the plan will designate one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the Insurance Carrier.

For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from your Insurance Carrier or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact your Insurance Carrier.

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 1-31-2017)

PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

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 coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.[1]

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 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.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact Human Resources.

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

1 An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application. Here is some basic information about health coverage offered by this employer:

1. Employer Name		**2. Employer Identification Number (EIN)**
Roseville City		94-6002477
3. Employer Address		**4. Employer Phone Number**
1050 Main Street		916-771-1600 x 125
5. City	**6. State**	**7. Zip Code**
Roseville	California	95678
8. Who can we contact about employee health coverage at this job?		
Dawn Mercer		
9. Phone Number (if different from above)		**10. Email address**
		dmercer@rcsdk8.org

As your employer, we offer a health plan to:

☐ All employees.

☒ Some employees. Eligible employees are:

Full Time employees working 20 or more hours

With respect to dependents:

☒ We do offer coverage. Eligible Dependents are:

Same and opposite sex Spouse
Same sex Domestic Partner (registered with the State)
Dependent Children up to age 26 for medical coverage

☐ We do not offer coverage.

If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid–year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, HealthCare.gov will guide you through the process. You can visit HealthCare.gov to find out if you can get a tax credit to lower your monthly premiums.