2023

BENEFIT GUIDE

JULY 1, 2023 THROUGH JUNE 30, 2024

Schools Insurance Group

Roseville City School District

BENEFITS **OVERVIEW**

IN THIS GUIDE

We are proud to offer a comprehensive benefits package to eligible employees. The complete benefits package is briefly summarized in this booklet. Documents from the carriers will give you more detailed information about each of these programs.

You may have a cost share for some benefits and other benefits may be provided at no cost to you. In addition, you may have access to voluntary benefits with reasonable group rates that you can purchase through payroll deductions.

Eligibility for Benefits:

Please check with your Benefits Coordinator for information on your eligibility date.

Eligible dependents are your spouse or domestic partner, children under age 26 and disabled dependents of any age.

Making Changes to your Benefits:

Elections made now will remain until the next open enrollment unless you or your family members experience a qualifying event. If you experience a qualifying event, you must contact HR within 30 days. 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 change in your employment
- 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

CONTACT INFORMATION

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	ADMINISTRATOR	PHONE	WEBSITE/EMAIL
Medical	Kaiser Permanente	800.464.4000	www.kp.org
	Sutter Health Plus	855.315.5800	www.SutterHealthPlus.org
	Western Health Advantage	888.563.2250	www.ChooseWHA.com/SIG
Dental	Delta Dental	866.499.3001	www.DeltaDentalins.com
Vision	VSP	800.877.7195	www.vsp.com
Health Savings Account	Optum Bank	844.326.7967	www.optumbank.com
Life and AD&D, Disability	The Hartford	Contact your District Benefit Coordinator for more information	
Employee Assistance Program	ComPsych	844.582.2327	www.guidanceresources.com
Schools Insurance Group	Melissa Gianopulos Kelley Henry	530.823.9582 ext 202 530.823.9582 ext 201	melissag@sigauburn.com kelleyh@sigauburn.com

Kaiser Permanente $25E (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.

Plan Design	In-Network Only	
Calendar Year Deductible	None	
Calendar Year Out-of-Pocket Maximum	$1,500 Individual / $3,000 Family	
Preventive Services		
Routine Preventive Care / Physical Examinations	No Charge	
Well-Child Visits	No Charge	
Prenatal Care Visits and First Postpartum Visit	No Charge	
Office Visits		
Primary Care Visits / Specialty Care Visits	$25 copay / $50 copay	
Telemedicine	No Charge	
Lab & X-Ray	No Charge	
Chiropractic (up to 30 visits per year)	$10 copay	
Acupuncture Benefits (physician referred only)	$25 copay	
Optical		
Eye Exam	No Charge	
Glasses (once every 24 months)	$175 allowance	
Hospitalization Services		
Emergency Room (copay waived if admitted)	$100	
Urgent care visit	$25 copay	
Hospital inpatient services	$250 copay per admission	
Outpatient Surgery	$100 copay per admission	
Mental Health Services		
Outpatient mental health & substance abuse	$25 copay	
Inpatient mental health & substance abuse	$250 copay per admission	
Prescription (Rx) Drug Services	**Retail 30 day Supply**	**Mail Order 100 Day Supply**
Most Generic Items	$10 copay	$20 copay
Calendar Year Rx Deductible *(does not apply to generics)*	$100 Individual / $200 Family	
Most Brand Items	$25 copay after Rx deductible	$50 copay after Rx deductible
Specialty Items	20% (not to exceed $150) for up to a 30-day supply after Rx 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).

Kaiser Permanente $2000 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.

Plan Design	**In-Network Only**
Calendar Year Deductible	$2,000 Individual / $3,000 Ind. In fam. / $4,000 Family
Calendar Year Out-of-Pocket Maximum	$3,000 Individual / $6,000 Family
Preventive Services	
Routine Preventive Care / Physical Examinations	No Charge (deductible waived)
Well-Child Visits	No Charge (deductible waived)
Prenatal Care Visits and First Postpartum Visit	No Charge (deductible waived)
Office Visits	***AFTER DEDUCTIBLE***
Primary Care Visits / Specialty Care Visits	$30 copay after deductible
Telemedicine	No charge after deductible
Lab & X-Ray	$10 per encounter after deductible
Chiropractic	Not Covered
Acupuncture Benefits (physician referred only)	$30 copay after deductible
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 & substance abuse	$30 copay after deductible
Inpatient mental health & substance abuse	$250 per admission after deductible
Prescription Drug Services	**Retail (up to 30 days)**
Most Generic Items	$10 copay after combined deductible
Most Brand Items	$30 copay after combined deductible
Specialty Items	20% (not to exceed $150) per Rx after combined deductible
Mail Order (up to 100 day supply)	2 times retail cost

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 $3000 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.

Plan Design	In-Network Only
Calendar Year Deductible	$3,000 Individual / $3,000 Ind. In fam. / $6,000 Family
Calendar Year Out-of-Pocket Maximum	$5,250 Individual / $5,250 Ind. In fam. / $10,500 Family
Preventive Services	
Routine Preventive Care / Physical Examinations	No Charge (deductible waived)
Well-Child Visits	No Charge (deductible waived)
Prenatal Care Visits and First Postpartum Visit	No Charge (deductible waived)
Office Visits	***AFTER DEDUCTIBLE***
Primary Care Visits	$30 copay per visit after deductible
Specialty Care Visits	$50 copay per visit after deductible
Telemedicine	No charge after deductible
Lab & X-Ray	$10 copay per encounter after deductible
Hospitalization Services	
Emergency Room (copay waived if admitted)	30% after deductible
Urgent care visit	$30 copay per visit after deductible
Hospital inpatient services	30% after deductible
Outpatient surgery	30% after deductible
Mental Health Services	
Outpatient mental health & substance abuse	Individual: $30 copay per visit after deductible; Group: $15 copay per visit after deductible & $5 copay per visit after deductible
Inpatient mental health & substance abuse	30% after deductible
Prescription Drug Services	**Retail (up to 30 days)**
Most Generic Items	$15 copay after deductible
Most Brand Items	$30 copay after deductible
Specialty Items	20% (not to exceed $250) per Rx after deductible
Mail Order (up to 100 day supply)	2 times retail cost

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).

Pharmacy made easier

Save time with convenient new features

Get most medications delivered to your door

Delivery within 3 to 5 days at no extra cost – or choose same-day or next-day delivery for an additional fee.*

Opt in for reminders and updates

We'll let you know when it's time for a refill – and when your order is out for delivery or ready for pickup.

Enjoy convenient pickup options

Pick up new prescriptions on the same day at no extra cost. Plus, use your phone to pay for prescriptions quickly and safely.

Get started now

at **kp.org/pharmacy** or on the Kaiser Permanente app.

*Some exclusions apply. For more information, contact the pharmacy. Same-day and next-day prescription delivery services may be available for an additional fee. These services are not covered under your health plan benefits and may be limited to specific prescription drugs, pharmacies, and delivery addresses. Order cutoff times and delivery days may vary by pharmacy location. Kaiser Permanente is not responsible for delivery delays by mail carriers. Kaiser Permanente may discontinue same-day and next-day prescription delivery services at any time without notice and other restrictions may apply. Medi-Cal and Medicaid beneficiaries should ask your local pharmacy for more information.

KAISER PERMANENTE®

613667269 March 2021

Mental health and addiction care services

Caring for the whole you

At Kaiser Permanente, mental health care goes hand in hand with all the care we provide.

Primary care

As a member, you can talk to your primary care doctor about any mental health issues, anytime. They'll also do mental health and substance use screenings and help you with next steps if you need support.

Specialty care

If you're already getting care through a specialty or emergency department, your care team can connect you to the right resources. No referral is needed to make an appointment with a mental health care professional.

Many ways to get care

Whether you need help with depression, stress, or addiction issues, you can connect with a mental health professional when and where it works for you.

In person

24/7 advice by phone

Phone appointment[1]

Email

Video visit[1]

E-visit

No matter how you reach out, you'll get support from a care team that can view your medical history and connect you to the right care.

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Learn more at **kp.org/mentalhealth**

KAISER PERMANENTE®

(continued from front)

Connect to care that's right for you

Everyone's mental health and wellness journey is different. We're here to help you connect to the right kind of care based on your unique needs and goals.

Common conditions

We provide assessment and treatment for common conditions, including but not limited to anxiety and stress, addiction, depression, personality and eating disorders, sleep problems, and more.

Learn more at **kp.org/mentalhealth/conditions**

Support and resources

You can count on us to help support you with a wide range of treatment options including inpatient and outpatient services, recovery and social support, classes, webinars, and more.[2]

Learn more at **kp.org/mentalhealth/resources**

Connected care

Your entire Kaiser Permanente care team is connected to each other, and to you, through your electronic health record. So, it's easy for our doctors to consult with one another about your care. Our team includes many health professionals to support you:

- Addiction medicine specialists
- Behavioral medicine specialists
- Case managers
- Licensed clinical social workers
- Licensed marriage and family therapists
- Psychiatrists
- Psychologists
- Primary and specialty care doctors

Self-care and wellness resources at your fingertips

As a member, you'll have access to many tools including self-care apps at no cost, wellness coaching, and classes.[2] These apps can help you with stress, sleep, depression, and more.[3]

Ease your mind with **Calm,** the #1 app for meditation, relaxation, and sleep.

Try personalized programs from **myStrength** to help manage depression, stress, anxiety, and more.[4]

1. When appropriate and available. **2.** Some classes may require a fee. **3.** The services are not covered under your health plan benefits and are not subject to the terms set forth in your *Evidence of Coverage* or other plan documents. These services may be discontinued at any time without notice. **4.** myStrength® is a trademark of Livongo Health, Inc., a wholly owned subsidiary of Teladoc Health, Inc.

Kaiser Permanente health plans around the country: Kaiser Foundation Health Plan, Inc., in Northern and Southern California and Hawaii • Kaiser Foundation Health Plan of Colorado • Kaiser Foundation Health Plan of Georgia, Inc., Nine Piedmont Center, 3495 Piedmont Road NE, Atlanta, GA 30305, 404-364-7000 • Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc., in Maryland, Virginia, and Washington, D.C., 2101 E. Jefferson St., Rockville, MD 20852 • Kaiser Foundation Health Plan of the Northwest, 500 NE Multnomah St., Suite 100, Portland, OR 97232 • Kaiser Foundation Health Plan of Washington or Kaiser Foundation Health Plan of Washington Options, Inc., 1300 SW 27th St., Renton, WA 98057

Learn more at **kp.org/mentalhealth**

KAISER PERMANENTE®

742474726 September 2021

MENTAL HEALTH AND WELLNESS

Get the emotional support you need — whenever you need it.

Text with a coach using the Ginger app

We're working with Ginger to help you cope with some of life's most common challenges – from stress and low mood to issues with work, relationships, and sleep. Ginger's skilled emotional support coaches are accessible 24/7, so you can get the guidance you need when you need it most. Kaiser Permanente members can use Ginger at no cost, no referral needed.[1,2,3,4]

What can you do with Ginger?

- Text with your coach on the Ginger app now or schedule a time to connect later.
- Discuss goals, share challenges, and create an action plan with your coach.
- Get personalized, interactive skill-building tools from your coach and a library of more than 200 activities on the app.
- View recaps from each texting session and track your progress.
- Work with your coach to adjust your action plan if needed to better help you reach your goals.

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1. The Ginger app and coaching services described above are not covered under your health plan benefits, are not a Medicare-covered benefit, and are not subject to the terms set forth in your *Evidence of Coverage* or other plan documents. These services may be discontinued at any time without notice. The app and coaching services are not available to any members under 18 years old. **2.** The app and coaching services are neither offered nor guaranteed under contract with the FEHB Program, but are made available to enrollees and family members, 18 and older, who become members of Kaiser Permanente. **3.** The app and coaching services are not available to Medi-Cal members. **4.** Kaiser Permanente members can text with a coach using the Ginger app for 90 days per year. After the 90 days, members can continue to access the other services available on the Ginger app for the remainder of the year at no cost.

Download Ginger now at **kp.org/coachingapps/ncal**

KAISER PERMANENTE®

919569352 September 2022

Sutter Health Plus $25 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.

Plan Design	In-Network Only	
Calendar Year Deductible	None	
Calendar Year Out-of-Pocket Maximum	$1,500 Individual / $3,000 Family	
Preventive Services		
Routine Preventive Care / Physical Examinations	No Charge	
Well-Child Visits	No Charge	
Prenatal Care Visits and First Postpartum Visit	No Charge	
Office Visits		
Primary Care Visits	$25 copay	
Specialty Care Visits	$50 copay	
Lab & X-Ray	$20 copay	
MRI, CT, PET Scans	$50 copay	
Acupuncture Benefits & Chiropractic *(up to 20 visits per year combined)*	$15 copay	
Hospitalization Services		
Emergency Room (copay waived if admitted)	$100 copay	
Urgent care visit	$25 copay	
Hospital inpatient services	$250 copay per admission	
Outpatient surgery	$100 copay	
Mental Health Services		
Outpatient mental health & substance abuse	$25 copay	
Inpatient mental health & substance abuse	$250 copay per admission	
Prescription (Rx) Drug Services	**Retail 30 day supply**	**Mail order 100 day supply**
Generic Items	$10 copay	$20 copay
Calendar Year Rx Deductible *(does not apply to generics)*	$100 Individual / $200 Family	
Preferred Brand Items	$30 copay after Rx deductible	$60 copay after Rx deductible
Non-Preferred Brand Items	$60 copay after Rx deductible	$120 copay after Rx deductible
Specialty Items	20% (not to exceed $100) for up to a 30-day supply after Rx 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).

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.

Plan Design	In-Network Only
Calendar Year Deductible	$1,500 Individual / $3,000 Ind. in family / $3,000 Family
Calendar Year Out-of-Pocket Maximum	$3,000 Individual / $3,000 Ind. in family / $6,000 Family
Preventive Services	
Routine Preventive Care / Physical Examinations	No Charge (deductible waived)
Well-Child Visits	No Charge (deductible waived)
Prenatal Care Visits and First Postpartum Visit	No Charge (deductible waived)
Office Visits	***AFTER DEDUCTIBLE***
Primary Care Visits / Specialty Care Visits	No charge after deductible
Lab & X-Ray	No charge after deductible
Acupuncture Benefits (physician referred only)	No charge after deductible
Hospitalization Services	
Emergency Room (copay waived if admitted)	No charge after deductible
Urgent care visit	No charge after deductible
Hospital inpatient services	$50 copay after deductible
Outpatient surgery	No charge after deductible
Mental Health Services	
Outpatient mental health & substance abuse	No charge after deductible
Inpatient mental health & substance abuse	$50 copay after deductible
Prescription Drug Services	**Retail (up to 30 days) or Mail Order (up to 100 days)**
	AFTER MEDICAL DEDUCTIBLE
Generic Items	No charge after deductible
Preferred brand Items	No charge after deductible
Non-Preferred brand Items	No charge after deductible
Specialty Drugs (see EOC for details)	No charge 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).

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.

Plan Design	In-Network Only	
Calendar Year Deductible	$2,500 Individual / $3,000 Ind. in family / $5,000 Family	
Calendar Year Out-of-Pocket Maximum	$4,000 Individual / $4,000 Ind. in family / $8,000 Family	
Preventive Services		
Routine Preventive Care / Physical Examinations	No Charge (deductible waived)	
Well-Child Visits	No Charge (deductible waived)	
Prenatal Care Visits and First Postpartum Visit	No Charge (deductible waived)	
Office Visits	***AFTER DEDUCTIBLE***	
Primary Care Visits / Specialty Care Visits	20% coinsurance after deductible	
Lab & X-Ray	20% coinsurance after deductible	
Acupuncture Benefits	20% coinsurance after deductible	
Hospitalization Services		
Emergency Room (copay waived if admitted)	20% coinsurance after deductible	
Urgent care visit	20% coinsurance after deductible	
Hospital inpatient services	20% coinsurance after deductible	
Outpatient surgery	20% coinsurance after deductible	
Mental Health Services		
Outpatient mental health & substance abuse	20% coinsurance after deductible	
Inpatient mental health & substance abuse	20% coinsurance after deductible	
Prescription Drug Services	**Retail 30 day supply**	**Mail order 100 day supply**
	AFTER MEDICAL DEDUCTIBLE	
Generic Items	$10 copay	$20 copay
Preferred brand Items	$30 copay	$60 copay
Non-Preferred brand Items	$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).

Pharmacy Benefits

Managing Your Prescriptions

Sutter Health Plus partners with CVS Caremark® for prescription drug benefits, including retail, mail order and specialty prescriptions.

Retail Pharmacy

Pick up your prescription drugs at most independent pharmacies and chains where you may already shop—CVS Pharmacy, Raley's, Bel Air, Safeway and Walgreens, to name a few.

Mail Order Pharmacy

Sign up for mail order pharmacy service through CVS Caremark Mail Service Pharmacy and receive:

- Up to a 100-day supply, as your benefit plan allows, of your maintenance prescription drugs for the cost of two retail copays
- Free standard shipping of your prescription drugs

Specialty Pharmacy

Specialty drugs are purchased through CVS Specialty®. These drugs are mailed to your home at no cost.

CVS Caremark Guest Website

View sample pharmacy cost sharing for some of our most popular benefit plan designs through the guest website, as well as:

- Find a Pharmacy
- Check Drug Costs
- Sutter Health Plus Formulary
- Mail Order Pharmacy Information

Visit *sutterhealthplus.org/pharmacy*

Sutter Health Plus
Your Health Plan

Transferring Your Prescriptions

If you are new to Sutter Health Plus and you or your covered dependents currently pick up prescription drugs from a pharmacy outside the CVS Caremark network, follow these steps to transfer your prescriptions.

Before Your Effective Date

Check to see if you have refills left on your active prescriptions:

- If you have refills available, fill them through your current health plan before your effective date to ensure you have an adequate supply on hand until you establish care with your new Sutter Health Plus provider
- If you do not have refills available, contact your current prescribing provider as soon as possible; refill your prescription through your current pharmacy before your effective date

Request a written prescription for your new pharmacy to fill on or after your new health plan effective date.

Check the Sutter Health Plus Formulary to see if your prescription drug requires a prior authorization; if so you will need to know about the Medication Continuity of Care process described in your *Evidence of Coverage and Disclosure Form*.

After Your Effective Date

If you have refills available, take your prescription bottle to a CVS Caremark network pharmacy for up to a 30-day supply. The CVS Caremark network pharmacy will work with your current pharmacy to transfer your prescription.

If you have a written prescription from a provider, take it to a network pharmacy for up to a 30-day supply.

If you take a prescription on a regular basis, consider using mail order fulfillment through CVS Caremark Mail Service Pharmacy. You may obtain up to a 100-day supply, as your benefit plan allows, of your maintenance prescription drugs for the cost of a two-month retail supply.

If you take specialty medications, you must fill your prescription through CVS Specialty.

For more information about your pharmacy benefits, including retail, mail order and specialty drugs, please contact CVS Caremark Customer Service at 1-844-740-0635 or visit *sutterhealthplus.org/pharmacy*.

Your Mental Health and Substance Use Disorder Benefits

At **Sutter Health Plus** we believe caring for your mental health is just as important as your physical health. As a member, your coverage includes benefits for mental health and substance use disorder services through U.S. Behavioral Health Plan, California (USBHPC). USBHPC providers can offer support, information and resources to help address issues affecting your personal life, work and well-being, including assistance with:

- Stress or anxiety
- Feeling down or depressed
- Substance use concerns
- Prescription drug questions, and more

Sutter Health Plus
Your Health Plan

Online Resources

USBHPC's Live and Work Well website at ***liveandworkwell.com*** is designed to give you quick, confidential, 24/7 access to the resources available, including:

- **Personal Life:** for caregiving, parenting, military and veterans, relationships, and well-being
- **Mind & Body:** for mental and physical health, recovery and resiliency, and substance use disorder and addiction
- **Crisis Support:** for abuse, addiction, disasters, finance, hospitalization, housing, suicide prevention, and helping a loved one with a mental health crisis
- **Find a Resource:** locate providers and facilities, for in-person and virtual appointments
- **Benefits & Claims:** view claim status and learn about your behavioral health coverage and benefits

Sanvello Mobile App

You have premium access to Sanvello—an app offering help for stress, anxiety and depression—anytime, anywhere. Completely confidential, the Sanvello app is available at no extra cost as part of the behavioral health benefits through USBHPC, a subsidiary of Optum.

Download from your preferred app store:

Download on the App Store

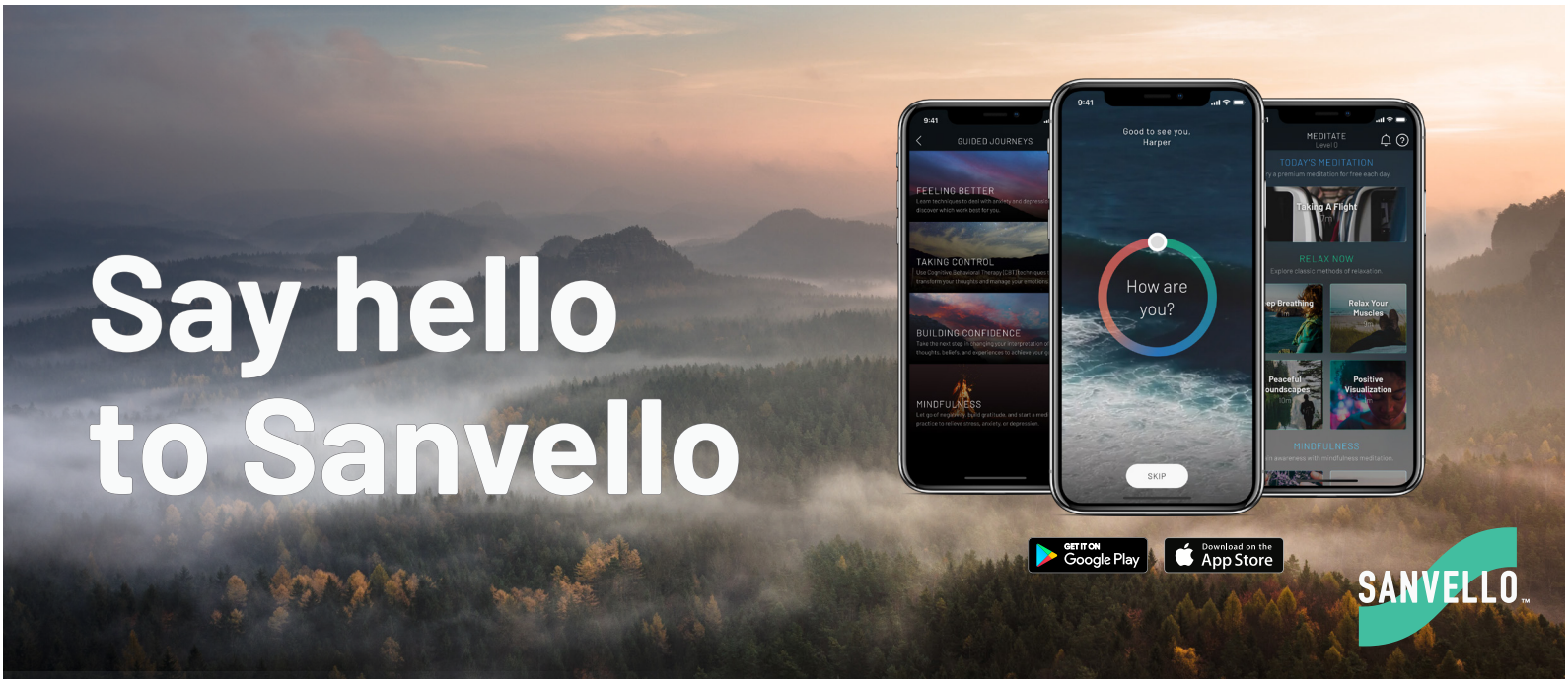
GET IT ON Google Play

Virtual Care

Access to care with your convenience in mind. You can meet with providers online through private and secure video conferencing in real time. USBHPC providers can evaluate and treat general mental health conditions, such as depression and anxiety. They can also provide therapy and prescribe drugs, when appropriate. Treatment is provided by psychiatrists and therapists who are part of USBHPC's behavioral health network. As with in-person office visits, members may self-refer to a participating USBHPC provider for virtual office visits.

To find a participating behavioral health provider, call USBHPC at 1-855-202-0984 or access USBHPC's Live and Work Well website at ***liveandworkwell.com.***

All services are confidential. Your providers will not share your personal information with anyone else without your written permission. All records, including medical information, referrals and evaluations, are kept strictly confidential in accordance with federal and state laws.



On-demand help with stress, anxiety and depression.

Sanvello is an app that offers clinical techniques to help dial down the symptoms of stress, anxiety and depression — anytime. Connect with powerful tools that are there for you right as symptoms come up. Stay engaged each day for benefits you can feel. Escape to Sanvello whenever you need to, track your progress and stay until you feel better.

The Sanvello app is available to you at no extra cost as part of your Sutter Health Plus behavioral health care benefits through USBHPC, a subsidiary of Optum.

More information on **Sanvello.com**

Daily mood tracking

Answer simple questions each day to capture your current mood, identify patterns and self-assess your progress.

Coping tools

Reach for just the right tool to relax, be in the moment or manage stressful situations, like test-taking, public speaking or morning dread.

Guided journeys

Designed by experts for a range of needs, journeys use clinical techniques to help you feel more in control and build long-term life skills.

Personalized progress

Through weekly check-ins, Sanvello creates a roadmap for improvement. Track where you are, set goals and make strides week by week.

Community support

Connect with one of the largest peer communities in the field and share advice, stories and insights — anonymously, anytime.

Get the Sanvello app on **liveandworkwell.com**. To browse as a guest, use access code: **Sutter**. Or get the app on Google Play or iTunes using your medical insurance ID for free access to the premium version. Questions? Email **info@sanvello.com**.

OPTUM®

Sutter Health Plus
Your Health Plan

The Sanvello mobile application should not be used for urgent care needs. If you are experiencing a crisis or need emergency care, call 911 or go to the nearest emergency room. The information contained in the Sanvello mobile application is for educational purposes only; it is not intended to diagnose problems or provide treatment and should not be used as a substitute for your provider's care. The Sanvello mobile application is available at no out-of-pocket cost to you through your health plan membership. Participation in the program is voluntary and subject to the terms of use contained in the application.

Western Health Advantage Premier 25

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	$25 copay	
Specialist Physician Office Visits	$50 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	$250 copay per admission	
Outpatient surgery	$100 copay	
Mental Health Services		
Outpatient mental health and substance abuse	$25 copay	
Inpatient mental health and substance abuse	$250 copay per admission	
Prescription (Rx) Drug Services	**Retail 30 day supply**	**Mail Order 90 Day Supply**
Preferred Generic Items	$10 copay	$25 copay
Calendar Year Rx Deductible *(does not apply to generics)*	$100 Individual / $200 Family	
Preferred Brand Items	$30 copay after Rx deductible	$75 copay after Rx deductible
Non-Preferred Brand Items	$50 copay after Rx deductible	$125 copay after Rx 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 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 / $3,000 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	*AFTER COMBINED MEDICAL DEDUCTIBLE*	
Tier 1	None	None
Tier 2	$30 copay	$75 copay
Tier 3	$50 copay	$125 copay

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 / $3,000 Ind. In Family / $5,600 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	$40 copay after deductible	
Specialist Physician Office Visits	$40 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)	$100 copay after deductible	
Urgent care visit	$50 copay after deductible	
Hospital inpatient services	$500 per day copay after deductible	
Outpatient surgery	$250 copay after deductible	
Mental Health Services		
Outpatient mental health and substance abuse	$500 per day copay after deductible	
Inpatient mental health and substance abuse	$40 copay after deductible	
Prescriptions	**Retail 30 day supply**	**Mail order 90 day supply**
Drug Deductible	*AFTER COMBINED MEDICAL DEDUCTIBLE*	
Generic	$10 copay	$25 copay
Preferred brand	$30 copay	$75 copay
Non-preferred brand (includes specialty oral drugs)	$50 copay	$125 copay

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

PRESCRIPTION BENEFITS

Filling Prescriptions with OptumRx

Pick up at a local pharmacy: You can fill most prescription medications at any retail pharmacy. Get the most savings by going to one of thousands of retail pharmacies in OptumRx's network, which includes large national chains and many local pharmacies. See pharmacy websites for drive-thru pick-up options.

Options for the medications you take regularly: Save time and money by obtaining a 90-day supply through OptumRx's mail-order pharmacy program or by using Select90 at Walgreens or CVS Pharmacy.

More on mail order: Refill your prescription online or by phone and get it delivered straight to your home. There is no charge for standard shipping. To get started, ask your doctor to send an electronic prescription to OptumRx, register at optumrx.com, download the OptumRx App, or call 844.568.4150.

Specialty medications: To ensure you get started on your medications in a timely manner, you are able to pick up two initial fills at local retail pharmacies, with some exceptions (a drug may be limited by the FDA and/or the manufacturer to a specific specialty pharmacy, for example). All other fills will be limited to WHA's exclusive specialty pharmacy network.

Optum Specialty Pharmacy: If you have a prescription for a specialty medication with Optum Specialty Pharmacy, you will be automatically enrolled into OptumRx's clinical management program. All specialty medications are shipped at no cost to your doctor's office or your home, depending on who administers the medication. Optum's patient care coordinators and pharmacists are highly trained to understand your special therapy needs. You have 24-hour-a-day access to registered pharmacists who review lab results and check for side effects or drug interactions. To get started call 855.427.4682 or visit specialty.optumrx.com.

OptumRx Digital Services

> **OptumRx App/OptumRx.com**
Find a network pharmacy, check medication coverage, track home delivery orders, renew or refill your prescriptions and more—and do it whenever you need to, day or night. Search OptumRx app in the App store or Google Play.

> **Automatic Refills**
You can enroll any qualifying medications in the automatic refill program. OptumRx will automatically fill and send your medications right to your home. They'll notify you when your medications are ready to ship.

> **Medication Reminders**
Never miss a dose with the My Medication Reminders™ tool. You can set your own customized notification schedules to receive text message reminders from OptumRx.

LEARN MORE ABOUT PRESCRIPTION BENEFITS | Visit **mywha.org/RX** or call **888.563.2250** for assistance

advantage you

Getting the help you need for mental health and substance use disorders

One in five Americans struggles with some form of mental health concern. If you or a loved one is living with depression, anxiety, a substance use disorder, trauma, or another mental health condition, help is available through your WHA plan.

Whether you need short-term emotional support or treatment for a chronic mental health condition, your benefits include digital support tools and resources, customized treatment plans, and an extensive network of thousands of mental health providers (both virtual and in-person), to ensure prompt access to care and support.

WHA's mental/behavioral health partner is Optum, and their approach to whole-person health care helps meet individuals where they are and helps WHA members access the knowledge, tools, and services needed to achieve and maintain overall well-being.

Optum offers a full spectrum of mental health and substance use disorder services, along with tools and resources to support you and your family, without a referral from a primary care physician (PCP). Members can access a broad group of qualified mental health professionals—with a network of over 5,500 in-person providers and over 3,000 virtual providers—so you can get care nearby.

Optum's Live and Work Well behavioral health member portal provides a resource for members to screen their symptoms, get triaged to the most suitable care, and search mental health professionals seamlessly. By consolidating mental health services from Optum with retail pharmacy services through OptumRx, and existing Optum Disease Management programs, WHA members can benefit from integrated services.

Medication-assisted treatment is available as one of the services, including 26 mental health and 29 substance use disorder inpatient facilities, as well as Specialty Case Management for Substance Use Disorder, Child & Adolescent Care, Eating Disorders, Geriatric, Specialized Mental Illness, and ABA therapy.

In a crisis, call or text #988 for the National Suicide Prevention Lifeline. It's free and available 24/7 providing confidential support for anyone in distress. You'll be connected to trained counselors who will listen, provide support, and connect you to resources. TTY Users: Use your preferred relay service or dial 711 then 988.

visit • mywha.org/bh
access your mental health benefits

call • Optum 800.765.6820
see what programs and services are available
(if a MyCare Medicare member, use **855.857.9748**)

search • mywha.org/directory
find a behavioral health provider

western health

HEALTH SAVINGS ACCOUNT

A Health Savings Account (HSA) is a tax-favored account used in conjunction with your HSA compatible medical plan. You can save on premiums, taxes and future expenses. You can also invest your funds for even greater earning potential. HSAs also promote positive changes in spending behavior by giving you a more active role in your healthcare.

Premium Costs: HSA compatible health plans generally have lower premiums than traditional plans, which could save significant dollars each year. To maximize your savings and fund your HSA, consider using the money saved by enrolling in the less expensive HDHP plan.

Tax Savings: HSAs allow you to contribute funds on a pre-tax or tax deductible basis, which you may use to pay for eligible medical expenses. Any interest you earn on the monies is also non-taxable.

Investment Options: HSA dollars can be invested for increased earning potential. There are various investment options. Your invested funds can be withdrawn to pay for medical expenses, if needed.

Type of Coverage	2023 IRS Limits for Contribution
Employee Only Plan	$3,850
Family Plan	$7,750

MAXIMUM CONTRIBUTIONS

The IRS sets the maximum contribution limits for the Health Saving Accounts.

CATCH-UP CONTRIBUTIONS

Individuals age 55 and over can make catch-up contributions of $1,000.

Some Examples of Eligible Expenses:

- Acupuncture
- Doctor's fees
- Dental treatments
- Dermatologist
- Hospital bills
- Lab fees
- Psychiatrist, Psychologist
- Vision Care
- Weight loss programs (for a specific disease diagnosed by physician)
- Menstrual care products
- Certain over-the-counter medications

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 2 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.

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.		

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).

VSP 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.

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).

Contact Us... Anytime, Anywhere

No-cost, confidential solutions to life's challenges.

Confidential Emotional Support

Our highly trained clinicians will listen to your concerns and help you or your family members with any issues, including:

- Anxiety, depression, stress
- Grief, loss and life adjustments
- Relationship/marital conflicts

Work-Life Solutions

Our specialists provide qualified referrals and resources for just about anything on your to-do list, such as:

- Finding child and elder care
- Hiring movers or home repair contractors
- Planning events, locating pet care

Legal Guidance

Talk to our attorneys for practical assistance with your most pressing legal issues, including:

- Divorce, adoption, family law, wills, trusts and more

Need representation? Get a free 30-minute consultation and a 25% reduction in fees.

Financial Resources

Our financial experts can assist with a wide range of issues. Talk to us about:

- Retirement planning, taxes
- Relocation, mortgages, insurance
- Budgeting, debt, bankruptcy and more

Online Support

GuidanceResources® Online is your 24/7 link to vital information, tools and support. Log on for:

- Articles, podcasts, videos, slideshows
- On-demand trainings
- "Ask the Expert" personal responses to your questions

Your ComPsych® GuidanceResources® program offers someone to talk to and resources to consult whenever and wherever you need them.

Call: 844.582.2327
TTY: 800.697.0353

Your toll-free number gives you direct, 24/7 access to a GuidanceConsultant℠, who will answer your questions and, if needed, refer you to a counselor or other resources.

Online: guidanceresources.com
App: GuidanceResources® Now
Web ID: SIGEAP

Log on today to connect directly with a GuidanceConsultant about your issue or to consult articles, podcasts, videos and other helpful tools.

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Meet your on-demand video wellbeing app!

All SIG employees and families can enjoy unlimited, anytime/anywhere access to Grokker.

Grokker is designed to delight and inspire, regardless of your skill level, abilities, and goals. With over 4,000 on-demand wellbeing videos and a consumer-centric user experience, Grokker makes it fun and easy to move more, eat better, improve your sleep, support your emotional health, and manage financial stress.

Exercise | Mental Health | Sleep | Nutrition | Financial well-being

Stunning 4K video. Grokker's patented HD video programs are fully contextual and personalized, taking into account your physical health, mental/emotional health, and social connectedness to deliver content that's a perfect fit.

4000+ videos. 100+ programs.

Clear instruction, achievable results. From activity duration to recommended schedules, Grokker's programs provide users with a start-to-finish plan to achieve their health and wellbeing goals. All you have to do is enter when you want to start and how long you want the program to last. Grokker does the rest, automatically adding the chosen program to your calendar and sending reminders with direct links to that day's episode.

Community support. Engage with coworkers and over 130 global Grokker Experts in the community for seamless support and motivation.

Create your free account: grokker.com/sigwellness






Don't Let Short-Term Decisions Derail Your Long-Term Financial Goals – Let Us Help

SIGWellness

Everyone wants to be financially secure and have the resources they need to live life on their own terms. Like most Americans, you know it's important to take the right steps to be financially secure to protect what matters most to you. The trick is finding the time and know-how to plan for it, and perhaps more important, finding someone you can trust to point you in the right direction.

You can do it. We can help put you on the right path.

Would you be able to cover a $1,000 emergency right now?

59% of Americans don't have enough savings to cover a $1,000 emergency.[1]

If you or your spouse lost your job, how long would your savings last?

41% of individuals describe themselves as feeling financially secure.[1]

Prudential can help you plan for a brighter future

Prudential offers easy-to-understand financial education seminars that addresses important financial issues for every stage of your life.

Hosted by Prudential financial professionals, these seminars are a great way to focus on the financial topics that matter most to you.

Coming Soon

Watch for upcoming seminars that will provide valuable information to help you reach your financial goals.

Reach out to your district Wellness Champ for upcoming seminars or **www.schoolsinsurancegroup.com** under the events section.

Prudential

1046999-00001-00

Experience a clear path to financial planning

People think Prudential's Financial Wellness Education is valuable…[2]

- **96%** would recommend the program to a co-worker or a friend.[3]
- **96%** said the speaker was easy to understand.
- **94%** said the information was valuable.

…And inspirational…

- **97%** plan to maximize their employee benefits.
- **98%** will create a budget.
- **98%** plan to create or update a will.

Do you know how much money you'll need to cover basic expenses when you retire?

The median retirement savings in the US was just $65,000 in 2019.[4]

AARP estimates that you need about 80% of pre-retirement income to retire.[5]

A Convenient Way to Achieve Financial Wellness

Visit **www.prudential.com/SIG** to access articles, tools, and videos on topics such as budgeting, debt management, life insurance, estate planning strategies, college funding, and saving for retirement

This digital portal also includes a web tool that provides individuals support with **student loan debt** and an option to refinance. The student loan assistance tool can be located on the tools page of the digital portal.

Solution to reduce debt and financial stress

If you're struggling with debt and credit issues, you don't have to do it alone – you can take advantage of a free credit counseling & debt management session from GreenPath.

Based on your unique situation, you will receive recommendations for how to get out of debt, along with a personalized action plan. This may include entering into a debt management plan, which carries a monthly service fee, where GreenPath works with you to repay your debt in full.

Call 877-444-5606 to schedule a free debt consultation today.

Planning and Guidance

Prudential's financial professionals are available to meet with you one-on-one to answer questions related to your overall financial wellness and help you understand what you need to accomplish in order to meet your goals. These meetings are 30 minutes in length and complimentary.

[1] Bankrate January 2020 Financial Security Index Survey. https://www.bankrate.com/banking/savings/financial-security-january-2020/

[2] Results based on feedback provided by 55,168 participants from January 2015 through October 2020.

[3] Positive ratings of "very satisfied" or "extremely satisfied."

[4] The 2019 Survey of Consumer Finances. https://www.federalreserve.gov/econres/scfindex.htm

[5] AARP - https://www.aarp.org/retirement/planning-for-retirement/info-2020/how-much-money-do-you-need-to-retire.html

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”.

PATIENT PROTECTIONS DISCLOSURE

The Schools Insurance Group Health Plan 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, Kaiser Permanente / Sutter Health Plus / Western Health Advantage designates one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact Kaiser Permanente at 800.464.4000 or www.kp.org / Sutter Health Plus at 855.315.5800 or www.SutterHealthPlus.org / Western Health Advantage at 888.563.2250 or www.ChooseWHA.com/SIG.

For children, you may designate a pediatrician as the primary care provider.
You do not need prior authorization from Kaiser Permanente / Sutter Health Plus / Western Health Advantage 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 Kaiser Permanente at 800.464.4000 or www.kp.org / Sutter Health Plus at 855.315.5800 or www.SutterHealthPlus.org / Western Health Advantage at 888.563.2250 or www.ChooseWHA.com/SIG.

WOMEN'S HEALTH & CANCER RIGHTS ACT

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

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

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

Plan 1: Kaiser Permanente $25E (Chiro & Optical) (Individual: 0% coinsurance and $0 deductible; Family: 0% coinsurance and $0 deductible)

Plan 2: Kaiser Permanente $2000 HSA Plan (Individual: 0% coinsurance and $2,000 deductible; Per Family Member: 0% coinsurance and $3,000 deductible; Family: 0% coinsurance and $4,000 deductible)

Plan 3: Kaiser Permanente $3000 HSA Plan (Individual: 30% coinsurance and $3,000 deductible; Per Family Member: 30% coinsurance and $3,000 deductible; Family: 30% coinsurance and $6,000 deductible)

Plan 4: Sutter Health Plus $25 Copay (Individual: 0% coinsurance and $0 deductible; Family: 0% coinsurance and $0 deductible)

Plan 5: Sutter Health Plus 1500 HSA (Individual: 0% coinsurance and $1,500 deductible; Per Family Member: 0% coinsurance and $3,000 deductible; Family: 0% coinsurance and $3,000 deductible)

Plan 6: Sutter Health Plus 2500 HSA (Individual: 20% coinsurance and $2,500 deductible; Per Family Member: 20% coinsurance and $3,000 deductible; Family: 20% coinsurance and $5,000 deductible)

Plan 7: Western Health Advantage Premier 25 (Individual: 0% coinsurance and $0 deductible; Family: 0% coinsurance and $0 deductible)

Plan 8: Western Health Advantage 1800 HSA (Individual: 0% coinsurance and $1,800 deductible; Per Family Member: 0% coinsurance and $3,000 deductible; Family: 0% coinsurance and $3,600 deductible)

Plan 9: Western Health Advantage 2800/40 HSA (Individual: 0% coinsurance and $2,800 deductible; Per Family Member: 0% coinsurance and $3,000 deductible; Family: 0% coinsurance and $5,600 deductible)

If you would like more information on WHCRA benefits, please call your Plan Administrator at 530.823.9582 ext 202 or melissag@sigauburn.com.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

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

PREMIUM ASSISTANCE UNDER MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2023. Contact your State for more information on eligibility –

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

IOWA Medicaid and CHIP (Hawki)	KANSAS Medicaid
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-766-9012
KENTUCKY Medicaid	**LOUISIANA Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov	Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE Medicaid	**MASSACHUSETTS Medicaid and CHIP**
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: (617) 886-8102
MINNESOTA Medicaid	**MISSOURI Medicaid**
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
MONTANA Medicaid	**NEBRASKA Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
NEVADA Medicaid	**NEW HAMPSHIRE Medicaid**
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 5218
NEW JERSEY Medicaid and CHIP	**NEW YORK Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA Medicaid	**NORTH DAKOTA Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825

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

To see if any other states have added a premium assistance program since January 31, 2023, or for more information on special enrollment rights, contact either:

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

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

Paperwork Reduction Act Statement

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

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

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

HIPAA NOTICE OF PRIVACY PRACTICES REMINDER

Protecting Your Health Information Privacy Rights
Schools Insurance Group is committed to the privacy of your health information. The administrators of the Schools Insurance 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 and your 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 Melissa Gianopulos - Eligibility Coordinator at 530.823.9582 ext 202 or melissag@sigauburn.com.

HIPAA SPECIAL ENROLLMENT RIGHTS

Schools Insurance Group Health Plan Notice of Your HIPAA Special Enrollment Rights

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

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

Loss of Other Coverage (Excluding Medicaid or a State Children's Health Insurance Program). If you decline enrollment for yourself or for an eligible dependent (including your spouse) while other health insurance or group health plan coverage is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 31 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

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

New Dependent by Marriage, Birth, Adoption, or Placement for Adoption. If you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your new dependents. However, you must request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

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

To request special enrollment or to obtain more information about the plan's special enrollment provisions, contact Melissa Gianopulos - Eligibility Coordinator at 530.823.9582 ext 202 or melissag@sigauburn.com.

Important Warning

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

NOTICE OF CREDITABLE COVERAGE

Important Notice from Schools Insurance Group

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 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. **Schools Insurance Group has determined that the prescription drug coverage offered by the 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 Schools Insurance Group coverage will not be affected. You can keep this coverage if you elect part D.

If you do decide to join a Medicare drug plan and drop your current Schools Insurance 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…

Contact the person listed below for further information. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through 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).

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:	**July 01, 2023**
Name of Entity/Sender:	**Schools Insurance Group**
Contact—Position/Office:	**Melissa Gianopulos - Eligibility Coordinator**
Office Address:	**550 High Street, Suite 201** **Auburn, California 95603** **United States**
Phone Number:	**530.823.9582 ext 202**

COBRA GENERAL NOTICE

Model General Notice of COBRA Continuation Coverage Rights
(For use by single-employer group health plans)

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

Introduction

You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

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

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

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

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

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

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

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

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

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to Schools Insurance Group, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

When is COBRA continuation coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee;
- Commencement of a proceeding in bankruptcy with respect to the employer; or
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to: Melissa Gianopulos.

How is COBRA continuation coverage provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

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

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage

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

Second qualifying event extension of 18-month period of continuation coverage

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

Are there other coverage options besides COBRA Continuation Coverage?

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

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period[1] to sign up for Medicare Part A or B, beginning on the earlier of

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit https://www.medicare.gov/medicare-and-you.

If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit **www.healthcare.gov**.

Keep your Plan informed of address changes

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

Plan contact information

Schools Insurance Group
Melissa Gianopulos - Eligibility Coordinator
550 High Street, Suite 201
Auburn, California 95603
United States
530.823.9582 ext 202

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

MARKETPLACE NOTICE

New Health Insurance Marketplace Coverage Options and Your Health Coverage

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.[2]

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 Erin Eason.

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.

[2] 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.

3. Employer name Roseville City	4. Employer Identification Number (EIN) 94-6002477	
5. Employer address 1050 Main Street	6. Employer phone number 916.771.1600 x50126	
7. City Roseville	8. State California	9. ZIP code 95678
10. Who can we contact about employee health coverage at this job? Erin Eason		
11. Phone number (if different from above)	12. Email address eeason@rcsdk8.org	

Here is some basic information about health coverage offered by this employer:

• As your employer, we offer a health plan to:

☐ All employees. Eligible employees are:

☒ 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. Here's the employer information you'll enter when you visit HealthCare.gov to find out if you can get a tax credit to lower your monthly premiums.

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This document is an outline of the coverage provided under your employer's benefit plans based on information provided by your company. It does not include all the terms, coverage, exclusions, limitations, and conditions contained in the official Plan Document, applicable insurance policies and contracts (collectively, the "plan documents"). The plan documents themselves must be read for those details. The intent of this document is to provide you with general information about your employer's benefit plans. It does not necessarily address all the specific issues which may be applicable to you. It should not be construed as, nor is it intended to provide, legal advice. To the extent that any of the information contained in this document is inconsistent with the plan documents, the provisions set forth in the plan documents will govern in all cases. If you wish to review the plan documents or you have questions regarding specific issues or plan provisions, you should contact your Human Resources/Benefits Department.

This benefit summary prepared by

Gallagher

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