WASHINGTON UNIFIED SCHOOL DISTRICT
WEST SACRAMENTO

2017 EMPLOYEE **BENEFITS GUIDE**

Supporting employees with a commitment to excellence and care

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INTRODUCTION & ELIGIBILITY

Flexible solutions for your benefits needs

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

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

Please contact the Benefits Department at **(916) 375-7604 ext. 7 (ext. 4001 if calling internally)** if you have any questions regarding your employee benefits package.

Thank you.

Who's eligible?

Employees

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

Eligible Dependents

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

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

For more information, contact the Benefits Department at (916) 375 - 7604 ext. 7 (ext. 4001 if calling internally).

WHEN YOU CAN ENROLL

New Hires/Newly Eligible for Benefits

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

Open Enrollment

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

Qualifying Family Status Change

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

*Qualifying status includes:

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

Contact the Benefits Department at (916) 375-7604 ext. 7 (ext. 4001 if calling internally) for a complete explanation of qualifying family status change.

MEDICAL AND VISION PLAN OPTIONS

Eligible Employees and Early Retirees

WUSD employees can choose from three medical plans which each include vision coverage. The medical plans provide comprehensive coverage but are different in how they are designed. *Certificated employees are offered vision coverage through Superior Vision. Classified employees and Retirees receive vision benefits from Kaiser, WHA and Health Net.*

You decide which plan best meets your needs

- **Kaiser Permanente HMO - $20 office visit co-pay plan**
- **Western Health Advantage HMO - $20 office co-pay plan**
- **Western Health Advantage HSA - 1800 Plan *(Updated Plan)***

Kaiser Permanente & Western Health Advantage HMO
If you choose the HMO, you must select a primary care physician who will manage your care and refer you to a specialist when it is needed. Most services are covered at a 100% after you pay a copayment.

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

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

Post-65 Retirees
(Must have Medicare Parts A & B and live within 30 miles of a Health Net HMO medical group or Kaiser Facility.)

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

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

Visit Kaiser:
www.kp.org

Visit Western Health Advantage:
www.westernhealth.com

Visit Superior Vision:
www.superiorvision.com

Visit Health Net:
www.healthnet.com

Refer to carrier plan documents for complete plan descriptions.

KAISER PERMANENTE®

HMO $20

ELIGIBLE EMPLOYEES & EARLY RETIREES

PLAN BENEFITS	WHAT YOU PAY
Lifetime Maximum	Unlimited
Maximum Out of Pocket	$1,500 Individual/$3,000 Family
PREVENTIVE SERVICES	
Routine Physical	No Charge
Well Baby/Immunizations	No Charge
PHYSICIAN/DIAGNOSTIC SERVICES	
Office Visits	$20 Copay
Lab & X-ray & Diagnostic Test	No Charge
Prenatal/Postnatal Office Visits	No Charge
HOSPITAL SERVICES	
Semi-Private Room & Board	$250 Copay
Outpatient Surgery	$100 Copay
Emergency Room (waived if admitted)	$125 Copay
Urgent Care	$20 Copay
OTHER SERVICES	
Ambulance	$100 Copay
Vision Services (Classified employees only)	$175 allowance for each eyewear purchased at a Plan Medical Office
Durable Medical Equipment	No Charge
PRESCRIPTION DRUGS	
Plan Pharmacy Generic/Brand (Up to a 30-day supply)	$10/$30 Copay
Mail-order Generic/Brand (Up to a 100-day supply)	$20/$60 Copay

Western Health Advantage

Advantage 250 MHP

ELIGIBLE EMPLOYEES & EARLY RETIREES

PLAN BENEFITS	WHAT YOU PAY
Lifetime Maximum	Unlimited
Maximum Out of Pocket	$1,500 Individual/$2,500 Family
PREVENTIVE SERVICES	
Routine Physical	No Charge
Well Baby/Immunizations	No Charge
PHYSICIAN/DIAGNOSTIC SERVICES	
Office Visits (including specialists)	$20 Copay
Lab & X-ray & Diagnostic Test	No Charge
Prenatal/Postnatal Office Visits	No Charge
HOSPITAL SERVICES	
Semi-Private Room & Board	$250 Copay
Outpatient Surgery (facility)	$100 Copay
Emergency Room (waived if admitted)	$125 Copay
Urgent Care	$35 Copay
OTHER SERVICES	
Ambulance	No Charge if medically necessary
Vision Services (Classified employees only)	$20 Exam Copay
Durable Medical Equipment	20% Co-pay when medically necessary*
PRESCRIPTION DRUGS	
Plan Pharmacy (Up to a 30-day supply) Generic/Brand/Non-Formulary	$10/$30/$50 Copay
Mail-order (Up to a 90-day supply) Generic/Brand/Non-Formulary	$25/$75/$125 Copay

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

Western Health Advantage

HSA 1800 . PLAN

ELIGIBLE EMPLOYEES

PLAN BENEFITS	WHAT YOU PAY
Lifetime Maximum	Unlimited
Annual Deductible	$1,800 Individual/$3,600 Family *($2,600 max per member)*
Maximum Out of Pocket	$3,600 Individual/$7,200 Family *($3,600 max per member)*
PREVENTIVE SERVICES	
Routine Physical	No Charge (deductible waived)
Well Baby/Immunizations	No Charge (deductible waived)
PHYSICIAN/DIAGNOSTIC SERVICES	
Office Visits	No Charge (after deductible)
Lab & X-ray & Diagnostic Test	No Charge (after deductible)
Prenatal/Postnatal Office Visits	No Charge (deductible waived)
HOSPITAL SERVICES	
Semi-Private Room & Board	No Charge (after deductible)
Outpatient Surgery (facility)	No Charge (after deductible)
Emergency Room (waived if admitted)	No Charge (after deductible)
Urgent Care	No Charge (after deductible)
OTHER SERVICES	
Ambulance	No Charge if medically necessary (after deductible)
Vision Services (Classified employees only)	Exam No Charge (deductible waived)
Durable Medical Equipment	No Charge when medically necessary (after deductible)
PRESCRIPTION DRUGS	
Plan Pharmacy (Up to a 30-day supply) Generic/Brand/Non-Formulary	$0/$30/$50 Copay (after deductible)
Mail-order (Up to a 90-day supply) Generic/Brand/Non-Formulary	$0/$75/$125 Copay (after deductible)

KAISER PERMANENTE®

SENIOR ADVANTAGE HMO $5

POST 65 RETIREES ONLY

PLAN BENEFITS	WHAT YOU PAY
Lifetime Maximum	Unlimited
Maximum Out of Pocket	$1,500 Individual/$3,000 Family
PREVENTIVE SERVICES	
Routine Physical	No Charge
PHYSICIAN/DIAGNOSTIC SERVICES	
Office Visits	$5 Copay
Lab & X-ray & Diagnostic Test	No Charge
HOSPITAL SERVICES	
Semi-Private Room & Board	No Charge
Outpatient Surgery	$5 Copay
Emergency Rooms (waived if admitted with 24 hours)	$20 Copay
Urgent Care	$5 Copay
OTHER SERVICES	
Ambulance	No Charge
Durable Medical Equipment	No Charge
Vision Services	$175 allowance for each eyewear purchased at a Plan Medical Office
PRESCRIPTION DRUGS	
Generic/Brand (Up to a 100-day supply)	$5/$10 Copay

Health Net®
A Better Decision

SENIORITY PLUS

POST 65 RETIREES ONLY

PLAN BENEFITS	WHAT YOU PAY
Lifetime Maximum	Unlimited
Maximum Out of Pocket (individual only)	$3,400
PREVENTIVE SERVICES	
Routine Physical	No Charge
Immunizations	No Charge
PHYSICIAN/DIAGNOSTIC SERVICES	
Office Visits	$5 Copay
Lab & X-ray & Diagnostic Test	No Charge
HOSPITAL SERVICES	
Semi-Private Room & Board	No Charge
Outpatient Surgery	No Charge
Emergency Room (waived if admitted)	$20 Copay
Urgent Care (waived if admitted)	$20 Copay
OTHER SERVICES	
Ambulance	No Charge
Vision Services (Medicare only)	$5 Co-Pay Exam/ No Charge Lenses/ No charge for Frames after each cataract surgery
Durable Medical Equipment	No Charge
PRESCRIPTION DRUGS	
Retail Prescription (Up to a 30-day Supply)	$7/$7 Copay
Retail Prescription (Up to a 90-day Supply)	$21/$21 Copay
Mail Order (Up to a 90-day Supply)	$14/$14 Copay
When Medicare Part D out-of-pocket costs exceed $4,550 you pay higher of:	$2.50 Generic / $6.30 all other drugs or 5% Co-insurance Co-Pay

SUPERIOR VISION

See yourself healthy.

BASE PLAN

CERTIFICATED EMPLOYEES ONLY

VISION PLAN BENEFITS	WHAT IS COVERED	
BENEFITS		
Exam Copay	$0	
Materials Copay	$0	
Contact Lens Fitting	$30	
SERVICES/FREQUENCY		
Exam	12 Months	
Frames	24 Months	
Contact Lens Fitting	12 Months	
Lenses	24 Months	
Contact Lenses	24 Months	
EXAMS	**IN-NETWORK**	**OUT-OF-NETWORK**
Vision Exam (MD) Vision Exam (OD)	Covered in full	Up to $40 Up to $30
LENSES		
Single Bifocal Trifocal Polycarbonate for Dept. Children	Covered in full	Up to: $32 $42 $58 Not Covered
FRAMES		
Frames	$100 retail allowance then 20% off remaining balance	Up to $48
CONTACTS		
Necessary & in lieu of glasses	$100 retail allowance	Up to $80
Disposable Contact Lenses	10% off retail cost	10% off retail cost

Discount Features:

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

SUPERIOR VISION

See yourself healthy.

BUY-UP PLAN

CERTIFICATED EMPLOYEES ONLY

VISION PLAN BENEFITS	WHAT IS COVERED	
BENEFITS		
Exam Copay	$0	
Materials Copay	$0	
Contact Lens Fitting	$30	
SERVICES/FREQUENCY		
Exam	12 Months	
Frames	12 Months	
Contact Lens Fitting	12 Months	
Lenses	12 Months	
Contact Lenses	12 Months	
EXAMS	**IN-NETWORK**	**OUT-OF-NETWORK**
Vision Exam (MD) Vision Exam (OD)	Covered in full	Up to $40 Up to $30
LENSES		
Single Bifocal Trifocal Polycarbonate for Dept. Children	Covered in full	Up to: $32 $42 $58 Not Covered
FRAMES		
Frames	$150 retail allowance then 20% off remaining balance	Up to $72
CONTACTS		
Necessary & in lieu of glasses	$130 retail allowance	Up to $100
Disposable Contact Lenses	10% off retail cost	10% off retail cost

Discount Features:

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

DENTAL PLAN	WHAT IS COVERED	
BENEFITS	**PPO**	**NON-PPO**
Deductible	None	None
Per Calendar Year Maximum	$1,700	$1,500
DIAGNOSTIC & PREVENTIVE SERVICES		
Oral examinations, cleanings, X-rays, examinations of tissue biopsy, fluoride treatment, space maintainers, and specialist consultations	70% - 100%	70% - 100%
BASIC SERVICES		
Oral surgery (extractions), fillings, root canals, periodontic (gum) treatment, tissue removal (biopsy), and sealants	70% - 100%	70% - 100%
MAJOR SERVICES		
Crowns, jackets and other cast restorations	70% - 100%	70% - 100%
Prosthodontic Benefits: Bridges, partial and full Dentures	50%	50%
Dental Accident Benefits: $1,000 Max Per Calendar Year	100%	100%
Orthodontics	Not Covered	Not Covered

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

BASIC LIFE INSURANCE

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

Employee Basic Life Insurance

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

Accidental Death and Dismemberment (AD&D)

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

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

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

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

REMINDER:
Don't forget to update your beneficiary information!

Employee Assistance Program (EAP)

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

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

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

Telephonic and online support services:

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

Counseling Services:

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

Legal Services:

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

Financial Services:

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

Work-Life Services:

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

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

Toll Free Call | 1-855-327-4463

Available 24/7

FLEXIBLE SPENDING ACCOUNT PLAN

WAGEWORKS FLEXIBLE SPENDING ACCOUNTS

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

Health Care

Your health care account may not exceed $2,600 each plan year per household.

Flexible Spending Accounts utilize the "Use it or Lose It" rule, which means all medical services for reimbursement must occur between January 1, 2017 and December 31, 2017.

Dependent Care

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

All Dependent Day Care expenses must be incurred between January 1, 2017 and December 31, 2017.

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

All claims MUST be submitted no later than March 31, 2018 (90 days from the end of plan year) for reimbursement. Any funds left unclaimed on March 31, 2018 will be forfeited. Washington Unified School District has elected to offer a $500 rollover option, which will allow you to roll over up to $500 of unused contributions into the next plan year. Be conservative when making elections.

IMPORTANT NOTICES 2017

Newborns and Mothers Health Protection Act (NMHPA)

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

Women's Health and Cancer Rights Act (WHCRA)

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

Networks/Claims/Appeals

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

WASHINGTON UNIFIED SCHOOL DISTRICT
WEST SACRAMENTO

COBRA Continuation Coverage

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

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

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

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

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

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

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

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

WHEN IS COBRA CONTINUATION COVERAGE AVAILABLE?

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

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

For all other Qualifying Events (e.g. divorce or legal separation of the Employee and spouse or a Dependent child's losing eligibility for coverage as a Dependent child), you must notify the Plan Administrator within 60 days after the Qualifying Event occurs. You must provide this notice to the Benefits Department at (916) 375-7604 ext. 7 (ext. 4001 if calling internally).

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

NOTICE AND ELECTION PROCEDURES

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

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

IMPORTANT NOTICES (continued)

ELECTION AND ELECTION PERIOD

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

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

HOW IS COBRA CONTINUATION COVERAGE PROVIDED?

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

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

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

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

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

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

OTHER OPTION BESIDES COBRA CONTINUATION COVERAGE

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

IF YOU HAVE QUESTIONS

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

KEEP YOUR PLAN INFORMED OF ADDRESS CHANGES

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

EFFECTIVE DATE OF COVERAGE

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

COST OF CONTINUATION COVERAGE

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

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

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

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

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

See the Plan Summary for more information.

Special Enrollment Rights Notice

CHANGES TO YOUR HEALTH PLAN ELECTIONS

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

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

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

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

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

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

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

Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

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

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. **Washington Unified School District has determined that the prescription drug coverage offered by the Washington Unified School District Medical Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.**

WHEN CAN YOU JOIN A MEDICARE DRUG PLAN?

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

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

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

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

If you do decide to join a Medicare drug plan and drop your current Washington Unified School District coverage, be aware that you and your Dependents may not 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 Washington Unified School District and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

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

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

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

FOR MORE INFORMATION ABOUT YOUR OPTIONS UNDER MEDICARE PRESCRIPTION DRUG COVERAGE

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

FOR MORE INFORMATION ABOUT MEDICARE PRESCRIPTION DRUG COVERAGE

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

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

REMEMBER

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

Date:	October 15, 2016
Name of Entity/Sender:	Washington Unified School District
Contact:	Benefits Department
Address:	930 Westacre Road West Sacramento, CA 95691
Phone:	(916) 375-7604 ext. 7 (ext. 4001 if calling internally)

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

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

Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: GENERAL INFORMATION

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

WHAT IS THE HEALTH INSURANCE MARKETPLACE?

The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins November 1, 2016 and ends on January 31, 2017.

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

You may qualify to save money and lower your monthly premium, but only if your employer does not offer you coverage, or offers medical coverage that is not "Affordable" or does not provide "Minimum Value." If the lowest cost plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, then that coverage is not Affordable. Moreover, if the medical coverage offered covers less than 60% of the benefits costs, then the plan does not provide Minimum Value.

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

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

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

In the event you wish to apply for coverage on the Exchange, all the information you need from Human Resources is listed below.

<table>
<tr><td colspan="2">3. Employer name
Washington Unified School District</td><td colspan="2">4. Employer Identification Number (EIN)
68-0343642</td></tr>
<tr><td colspan="2">5. Employer address
930 Westacre Road</td><td colspan="2">6. Employer phone number
(916) 375-7604 ext. 7
(ext. 4001 if calling internally)</td></tr>
<tr><td colspan="2">7. City
West Sacramento</td><td>8. State
CA</td><td>9. ZIP code
95691</td></tr>
<tr><td colspan="4">10. Who can we contact about employee health coverage at this job?
Payroll / Benefits Dept.</td></tr>
</table>

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 July 31, 2016. Contact your State for more information on eligibility –

ALABAMA – Medicaid	FLORIDA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: http://flmedicaidtplrecovery.com/hipp/ Phone: 1-877-357-3268
ALASKA – Medicaid	**GEORGIA – Medicaid**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Website: http://dch.georgia.gov/medicaid - Click on Health Insurance Premium Payment (HIPP) Phone: 404-656-4507
ARKANSAS – Medicaid	**INDIANA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.hip.in.gov Phone: 1-877-438-4479 All other Medicaid Website: http://www.indianamedicaid.com Phone 1-800-403-0864
COLORADO – Medicaid	**IOWA – Medicaid**
Medicaid Website: http://www.colorado.gov/hcpf Medicaid Customer Contact Center: 1-800-221-3943	Website: http://www.dhs.state.ia.us/hipp/ Phone: 1-888-346-9562

KANSAS – Medicaid	NEW HAMPSHIRE – Medicaid
Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512	Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf Phone: 603-271-5218
KENTUCKY – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
LOUISIANA – Medicaid	**NEW YORK – Medicaid**
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447	Website: http://www.nyhealth.gov/health_care/medicaid/ Phone: 1-800-541-2831
MAINE – Medicaid	**NORTH CAROLINA – Medicaid**
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711	Website: http://www.ncdhhs.gov/dma Phone: 919-855-4100
MASSACHUSETTS – Medicaid and CHIP	**NORTH DAKOTA – Medicaid**
Website: http://www.mass.gov/MassHealth Phone: 1-800-462-1120	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
MINNESOTA – Medicaid	**OKLAHOMA – Medicaid and CHIP**
Website: http://mn.gov/dhs/ma/ Phone: 1-800-657-3739	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
MISSOURI – Medicaid	**OREGON – Medicaid**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
MONTANA – Medicaid	**PENNSYLVANIA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084	Website: http://www.dhs.pa.gov/hipp Phone: 1-800-692-7462
NEBRASKA – Medicaid	**RHODE ISLAND – Medicaid**
Website: http://dhhs.ne.gov/Children_Family_Services/AccessNebraska/Pages/accessnebraska_index.aspx Phone: 1-855-632-7633	Website: http://www.eohhs.ri.gov/ Phone: 401-462-5300
NEVADA – Medicaid	**SOUTH CAROLINA – Medicaid**
Medicaid Website: http://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900	Website: http://www.scdhhs.gov Phone: 1-888-549-0820

SOUTH DAKOTA - Medicaid	WASHINGTON – Medicaid
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program Phone: 1-800-562-3022 ext. 15473
TEXAS – Medicaid	**WEST VIRGINIA – Medicaid**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: http://www.dhhr.wv.gov/bms/Medicaid%20Expansion/Pages/default.aspx Phone: 1-877-598-5820, HMS Third Party Liability
UTAH – Medicaid and CHIP	**WISCONSIN – Medicaid and CHIP**
Website: Medicaid: http://health.utah.gov/medicaid CHIP: http://health.utah.gov/chip Phone: 1-877-543-7669	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
VERMONT– Medicaid	**WYOMING – Medicaid**
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531
VIRGINIA – Medicaid and CHIP	
Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm CHIP Phone: 1-855-242-8282	

To see if any other states have added a premium assistance program since July 31, 2016, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/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 10/31/2016)

BENEFIT PLAN CONTACT INFORMATION

Provider	Coverage Type	Policy #	Phone & Website
KAISER PERMANENTE®	**Medical** **HMO / Senior Advantage**	1086	(800) 464-4000 www.kp.org
Western Health Advantage	**Medical** **HMO / HSA**	106876	(888) 563-2250 www.westernhealth.com Provider Search: www.westernhealth.com/search-for-providers
Health Net® A Better Decision	**Seniority Plus**	6210SN 62102S	(800) 631-3366 www.healthnet.com
DELTA DENTAL®	**Dental**	18481	Call Delta Dental: (866) 499-3001 www.deltadentalins.com
SUPERIOR VISION See yourself healthy.	**Vision**	34004	(800) 507-3800 www.superiorvision.com
Lincoln Financial Group®	**Life and AD&D**	10181511	(800) 423-2765 www.lfg.com
Lincoln Financial Group®	**Employee Assistance Program (EAP)**	10181511	(855) 327-4463 www.guidanceresources.com Company code: Lincoln
WageWorks everyone benefits®	**Flexible Spending Account**		(877) 924-3967 www.wageworks.com
Trustmark Voluntary Benefit Solutions® PERSONAL. FLEXIBLE. TRUSTED.	**Voluntary Benefits**		(800) 918-8877 www.trustmarksolutions.com

Benefits Department

Call (916) 375-7604 ext. 7
(ext. 4001 if calling internally)