EMPLOYEE

BENEFITS GUIDE

OCTOBER 1, 2024 — SEPTEMBER 30, 2025

Welcome to ABC Unified School District!

This guide provides a summary of your benefit options and is designed to help you make choices and enroll for coverage. If you would like more information about any of the benefits described here, please contact Fringe Benefits.

CONTENTS

IMPORTANT INFORMATION

THE AFFORDABLE CARE ACT AND YOU

The Affordable Care Act (ACA)'s penalty for not having health coverage (known as the individual mandate) has been eliminated. However, if you are a taxpayer in California, Massachusetts, New Jersey, Rhode Island, Vermont, or the District of Columbia, you will be required to have health coverage (unless you qualify for an exemption) or pay the penalty for the upcoming tax year – these states have an individual mandate requirement.

You may consider these options below to satisfy this requirement:

- Enroll in a medical plan offered by ABCUSD or another group medical plan meeting the requirements for minimum essential coverage;
- Purchase coverage through a health insurance marketplace;
- Enroll in coverage through a government-sponsored program if eligible.

If you choose to purchase coverage through the marketplace, because ABCUSD's medical plans are considered affordable and meet minimum value under the Affordable Care Act, you may not be eligible for a subsidy, and you may not see lower premiums or out-of-pocket costs through the marketplace. In addition, employer contributions to your medical benefits will be lost, and your portion of medical premiums will no longer be paid via payroll deductions on a pre-tax basis.

FOR MORE INFORMATION

Go to **www.healthcare.gov**

ANNUAL NOTICES

ERISA and various other state and federal laws require that employers provide disclosure and annual notices to their plan participants. ABC Unified School District has posted all federally required annual notices on our Online Benefits Enrollment system for you to download and read at your convenience.

The following is a brief summary of the annual notices:

- Medicare Part D Notice of Creditable Coverage: Plans are required to provide each covered participant and dependent a Certificate of Creditable Coverage to qualify for enrollment in Medicare Part D prescription drug coverage when qualified without a penalty.
- Women's Health and Cancer Rights Act (WHCRA): The Women's Health and Cancer Rights Act (WHCRA) contains important protections for breast cancer patients who choose breast reconstruction with a mastectomy.
- Newborns' and Mothers' Health Protection Act: The Newborns' and Mothers' Health Protection Act of 1996 (NMHPA) affects the amount of time a mother and her newborn child are covered for a hospital stay following childbirth.
- Special Enrollment Rights: Plan participants are entitled to certain special enrollment rights outside of the District's open enrollment period. This notice provides information on special enrollment periods for loss of prior coverage or the addition of a new dependent.
- Medicaid & Children's Health Insurance Program: Some states offer premium assistance programs for those who are eligible for health coverage from their employers, but are unable to afford the premiums. This notice provides information on how to determine if your state offers a premium assistance program.
- HIPAA Notice of Privacy Practices: This notice is intended to inform employees of the privacy practices followed by your District's group health plan.

ONLINE DOCUMENTS

You can have view access to your benefits information whenever you want, from home or any place where you have internet access, by visiting our Online Benefits Enrollment System. You'll find documents posted such as the Summary of Benefits and Coverage (SBC), annual notices, carrier benefit summaries, evidence of coverage booklets, claim forms, and much more. See page 6 of this Employee Benefits Guide for more information.

ENROLLMENT INFORMATION

Who May Enroll

If you are a full-time or permanent part-time certificated employee working 18 hours or more per week, or a full-time or permanent part-time classified employee working 20 hours or more per week, you and your eligible dependents may participate in ABC Unified School District's benefits program.

Your eligible dependents include:

- Legally married spouse
- Children under the age of 26, regardless of student or marital status
- Dependent children of any age if they are incapable of self-support due to mental or physical handicap (physician certification is required every 2 years)
- Registered domestic partner as defined by the State of California (domestic partner registration & affidavit required)

When You Can Enroll

As an eligible District employee, you may enroll at the following times:

- As a new hire, you may enroll in benefits on the first day of the month following your date of hire if you are hired between the 1st and the 15th of the month. If you were hired between the 16th and the end of the month you will be eligible for benefits on the first day of the 2nd month
- Each year, during open enrollment
- Within 30 days of a qualifying event as defined by the IRS (see Changes To Enrollment below)
- You may enroll in Voluntary Life and AD&D insurance during Open Enrollment or as a new hire, subject to proof of good health and carrier approval

If you are a new hire enrolling for the first time, please complete your enrollment form indicating your benefit elections and return it to the Fringe Benefits office. If you have any questions, please call Fringe Benefits at (562) 926-5566 ext. 21245 for assistance.

New Hire Employees may have restrictions regarding Medical Plan choice. Please check with the Fringe Benefits Department for further information.

Paying For Your Coverage

The Dental, Vision, Basic Life/AD&D and Employee Assistance Program benefits are provided at no cost to you and are paid entirely by ABC Unified School District. Depending on your medical plan selection and your assigned full time equivalent percentages, you and the District may share in the cost of the Medical plan you elect. Any Voluntary Life/AD&D or Supplemental Benefits you elect will be paid by you at discounted group rates. Your Medical contributions are deducted before taxes are withheld which saves you tax dollars. Paying for benefits before-tax means that your share of the costs are deducted before taxes are determined, resulting in more take-home pay for you. As a result, the IRS requires that your elections remain in effect for the entire year. You cannot drop or change coverage unless you experience a qualifying event.

Changes To Enrollment

Our benefit plans are effective October 1st through September 30th of each year. There is an annual open enrollment period each year, during which you can make new benefit elections for the following October 1st effective date. Once you make your benefit elections, you cannot change them during the year unless you experience a qualifying event as defined by the IRS.

Examples include, but are not limited to the following:

- Marriage, divorce, legal separation or annulment
- Birth or adoption of a child
- A qualified medical child support order
- Death of a spouse or child
- A change in your dependent's eligibility status
- Loss of coverage from another health plan
- Change in your residence or workplace (if your benefit options change)
- Loss of coverage through Medicaid or Children's Health Insurance Program (CHIP)
- Becoming eligible for a state's premium assistance program under Medicaid or CHIP

Coverage for a new dependent is not automatic. If you experience a qualifying event, you have 30 days to update your coverage. Please submit the appropriate documentation to the Fringe Benefits office. Dependent documentation includes certified copies of birth certificates and/or marriage certificates and social security cards.

AMERICAN FIDELITY ASSISTANCE

During open enrollment, American Fidelity Representatives are available (by appointment at (800) 365-9180)to re-enroll or provide information on the Flexible Spending Account or provide information on the variety of voluntary products available. If you are a new employee enrolling during the plan year, contact Fringe Benefits at (562) 926-5566 ext. 21248 or ext. 21245 with any questions.

RESOURCES AND CONTACTS

Below is a list of insurance carrier contacts should you require assistance with your benefit questions following open enrollment. If you are unable to resolve your issues or questions with the insurance carriers, please contact Fringe Benefits.

Blue Shield	
Medical	
Trio ACO HMO Member Services	(855) 829-3566
Local Access+ HMO, Access+ HMO and PPO Member Services	(888) 256-1915
Carrier Website	**www.blueshieldca.com**
Carrier Customized Interactive Video	http://choose.blueshieldca.com/abcusd
Kaiser Permanente	
Medical	
Member Services	(800) 464-4000
Carrier Website	**www.kaiserpermanente.org**
MetLife	
DHMO Dental	
Member Services	(800) 880-1800
Carrier Website	**www.metdental.com**
Delta Dental	
PPO Dental	
Member Services	(866) 499-3001
Carrier Website	**www.deltadentalins.com**
EyeMed	
Vision	
Member Services	(800) 877-6372
Carrier Website	**www.eyemed.com**
The Hartford	
Life/AD&D / Voluntary Life	
Member Services	(888) 563-1124
Carrier Website	**www.The Hartford.com**
American Fidelity	
Flexible Spending Accounts | Supplemental Benefits	
Member Services	(800) 365-9180
Carrier Website	**www.americanfidelity.com**
Pacific Educators	
Supplemental Benefits	
Member Services	(800) 722-3365
Carrier Website	**www.peinsurance.com**

MEDICAL INSURANCE

Options 1-3

Blue Shield | HMO Medical Plan

With the Blue Shield Health Maintenance Organization (HMO) plan, you must choose a primary care physician (PCP) or medical group within the network. All of your care must be directed through your PCP or medical group. Any specialty care you need will be coordinated through your PCP and will generally require a referral or authorization. You will receive benefits only if you use the doctors, clinics and hospitals that belong to the medical group in which you are enrolled, except in the case of an emergency.

Option 1 — Trio ACO HMO

- An Accountable Care Organization (ACO) serves as the provider network for an HMO Plan with an Accountable Care Organization (ACO).
- Limited HMO network where Blue Shield CA and their best medical groups form Accountable Care Organizations (ACO) designed to lower costs and improve the patient experience. A Primary Care Physician (PCP) is required. With Trio ACO, members will experience lower office visit copays and lower prescriptions copays than with the Access+ and Local Access+ plans.

Option 2 — Local Access+ HMO

- A narrow HMO network with less doctor and medical group options but at a lower price point. A Primary Care Physician (PCP) is required. Same benefits as Access+ HMO.
- Members must live and/or work in the Local Access+ HMO plan Service Area in order to enroll in a Local Access+ HMO Plan.

Option 3 — Access+ HMO

- Full HMO network with the most doctor and medical group options but at a higher price point. A Primary Care Physician (PCP) is required. Same benefits as Local Access+.
- Choosing a Primary Care Physician is one of the keys to using an HMO Plan. Access covered services through a network directed by your Personal Physician. Coverage is available only when using an HMO provider. May be a good choice for those seeking comprehensive benefits with predictable out-of-pocket costs.

Options 4-5

Blue Shield | PPO Medical Plan

The Blue Shield Preferred Provider Organization (PPO) plan allows you to direct your own care. You are not limited to the physicians within the network and you may self-refer to specialists. If you receive care from a physician who is a member of the network, a greater percentage of the entire cost will be paid by the insurance plan. You may also obtain services using a non-network provider; however, you will be responsible for the difference between the covered amount and the actual charges and you may be responsible for filing claims.

Option 4 — Full PPO

- A Primary Care Physician (PCP) is not required.
- A PPO plan allows members to receive covered services from any physician and hospital within the plan's network, and outside of the network for a higher share of cost. Out-of-pocket expense may be higher than an HMO plan. Can control costs better by using network providers.
- Blue Shield PPO Plan may be a good choice for those who prefer greater flexibility and freedom with how they seek care. Can also use national providers through the BlueCard Network.

Kaiser Permanente | HMO Medical Plan

Option 5 — Full HMO

With the Kaiser Permanente Health Maintenance Organization (HMO) plan, services must be obtained at a Kaiser Permanente facility, except in the case of emergency. All of your care must be directed through your selected doctor, but you can choose and change your doctor at any time, for any reason. Kaiser Permanente integrates all elements of healthcare such as physicians, medical centers, pharmacy, and administration in one convenient facility. In addition, Kaiser Permanente offers online tools so you can email your doctor's office, make appointments, refill prescriptions, and more.

FINDING A MEDICAL PROVIDER

- **Option 1** - Blue Shield TRIO ACO HMO: Go to **www.blueshieldca.com** or call (855) 829-3566. Refer to the "Trio HMO (ACO HMO Provider Network" when prompted.
- **Option 2** - Blue Shield Local Access+ HMO: Go to **www.blueshieldca.com** or call (888) 256-1915. Refer to the "Select HMO (Local Access+ HMO Provider Network" when prompted.
- **Option 3** - Blue Shield Access+ HMO: Go to **www.blueshieldca.com** or call (888) 256-1915. Refer to the "Full HMO" network when prompted.
- **Option 4** - Blue Shield PPO: Go to **www.blueshieldca.com** or call (888) 256-1915. Refer to the "Full PPO" network when prompted.
- **Option 5** - Kaiser Permanente HMO: Go to **www.kaiserpermanente.org** or call (800) 464-4000.

BENEFITS

MEDICAL INSURANCE

Employee Cost	$	$$	$$$
	Option 1	Option 2	Option 3
Plan Name	Blue Shield Trio ACO HMO	Blue Shield Local Access+ HMO	Blue Shield Access+ HMO
Network Name	Trio ACO HMO (ACO HMO Network)	Local Access+ HMO (Narrow HMO Network)	Access+ HMO (Full HMO Network)
Network Size	🧍	🧍🧍	🧍🧍🧍
Health Benefits			
Lifetime Maximum	Unlimited	Unlimited	Unlimited
Deductible (Annual) - Individual - Family	 $0 $0	 $0 $0	 $0 $0
Co-Insurance (Plan Pays)	100%	100%	100%
Office Visit Copay - Primary Care Physician - Specialist Office Visit - Access+ Self-refer Specialist Visit	 $0 Copay $0 Copay $10 Copay	 $10 Copay $10 Copay $20 Copay	 $10 Copay $10 Copay $20 Copay
Out-of-Pocket Maximum - Individual - Family	 $1,500 $3,000	 $1,500 $3,000	 $1,500 $3,000
Hospitalization - Inpatient Services - Outpatient Services	 No Charge No Charge	 No Charge No Charge	 No Charge No Charge
Emergency Services	$50 Copay	$50 Copay	$50 Copay
Urgent Care	$0 Copay	$10 Copay	$10 Copay
Preventive Care	No Charge	No Charge	No Charge
Chiropractic	$10 Copay Max 30 Visits/Year	$10 Copay Max 30 visits/year	$10 Copay Max 30 Visits/Year
Pharmacy Benefits			
Pharmacy Deductible	$0	$0	$0
Retail Pharmacy - Generic Formulary - Brand Name Formulary - Non-Formulary - Supply Limit	 $3 Copay $20 Copay $40 Copay 30 Days	 $10 Copay $25 Copay $40 Copay 30 Days	 $10 Copay $25 Copay $40 Copay 30 Days
Specialty (30 Day Supply Limit)	20% Max $200 Copay	20% Max $250 Copay	20% Max $250 Copay
Mail Order Pharmacy - Generic Formulary - Brand Name Formulary - Non-Formulary - Supply Limit	 $6 Copay $40 Copay $80 Copay 90 Days	 $20 Copay $50 Copay $80 Copay 90 Days	 $20 Copay $50 Copay $80 Copay 90 Days

BENEFITS

MEDICAL INSURANCE

Employee Cost	$$$$		$
	Option 4		Option 5
Plan Name	Blue Shield PPO		Kaiser Permanente HMO
Network Name	Full PPO	Non- Network	Kaiser Permanente
Network Size	!!!!	N/A	!
Health Benefits			
Lifetime Maximum	Unlimited		Unlimited
Deductible (Annual) - Individual - Family	 $500 $1,500	 $1,500 $4,500	 $0 $0
Co-Insurance (Plan Pays)	80%	60%	100%
Office Visit Copay - Primary Care Physician - Specialist Office Visit - Access+ Self-refer Specialist Visit	 $20 Copay $25 Copay N/A	 Deductible, 40% Deductible, 40% N/A	 $5 Copay $5 Copay N/A
Out-of-Pocket Maximum - Individual - Family	 $3,000 $6,000	 $5,000 $10,000	 $1,500 $3,000
Hospitalization - Inpatient Services - Outpatient Services - Ambulatory Surgery Center - Hospital: Outpatient Surgery	 Deductible, 20% Deductible, 10% Deductible, 25%	 Deductible, 40%* Deductible, 40%* Deductible, 40%*	 No Charge $5 Copay
Emergency Services	$150 Copay, 20%	$150 Copay, 20%	$50 Copay
Urgent Care	$20 Copay	Deductible, 40%	$5 Copay
Preventive Care	No Charge	Not Covered	No Charge
Chiropractic	Deductible, $20 Copay Max 20 Visits/Year	Deductible, 40%	$5 Copay Max 20 Visits/Year
Pharmacy Benefits			
Pharmacy Deductible	$0	$0	$0
Retail Pharmacy - Generic Formulary - Brand Name Formulary - Non-Formulary - Supply Limit	 $10 Copay $20 Copay $35 Copay 30 Days	 25% + $10 Copay 25% + $20 Copay 25% + $35 Copay 30 Days	 $7 Copay $7 Copay $7 Copay up to 100 Days
Specialty (30 Day Supply Limit)	30% Max $250 Copay	30% Max $250 Copay + 25%	$7 Copay
Mail Order Pharmacy - Generic Formulary - Brand Name Formulary - Non-Formulary - Supply Limit	 $20 Copay $40 Copay $70 Copay 90 Days	 Not Covered Not Covered Not Covered N/A	 $7 Copay $7 Copay $7 Copay 100 Days

*Limits apply. See plan summary for details.

MEDICAL INSURANCE

Summary of Benefits and Coverage (SBC)

Health insurance issuers and group health plans are required to provide you with an easy-to-understand summary about your health plan's benefits and coverage, referred to as a Summary of Benefits and Coverage (SBC). This guide is designed to help you understand the medical plan options offered to you by ABC Unified School District. Please refer to the SBC and carrier contracts provided by Kaiser Permanente or Blue Shield for additional plan details.

Tips for Using Your Medical Benefits

1. **Ask questions when in doubt.**
If you are having a procedure or planning an upcoming procedure, make sure you know how the procedure will be covered and what your out-of-pocket cost will be, if any.

2. **Use urgent care centers versus hospital emergency rooms whenever possible.**
Frequently, patients seek the services of the hospital emergency department for ailments or injuries that could be treated more economically, and just as effectively, at an urgent care center. It is not always easy to determine when you should choose urgent care over the hospital emergency department. The following lists offer some guidance, but are not necessarily all-inclusive.

Examples of URGENT CARE situations	Examples of EMERGENCY situations
Any illness or injury that would prompt you to see your primary care physician including but not limited to: • Accidents and falls • Sprains • Back problems • Breathing difficulties • Abdominal pain • Minor bleeding/cuts • High fever • Vomiting, diarrhea or dehydration • Severe sore throat or cough • Mild to moderate asthma	Any accident or illness that may lead to loss of life or limb, serious medical complication or permanent disability including but not limited to: • Chest pain*, Major head injuries • Seizures, Shock, No pulse • Unconscious or catatonic state • Sudden dizziness, loss of coordination or balance • Severe abdominal pain, Spinal cord or back injury • Severe or uncontrollable bleeding • Broken bones or compound fractures • Severe difficulty breathing or shortness of breath • Ingestion of poisons or obstructive objects • Severe burns, animal, snake or human bites

**If you believe you may be experiencing a heart attack, call 911 immediately! Do not drive yourself to the emergency room!*

3. **Use generic and over the counter drugs when available.**
The best way to save on prescriptions is to use generic or over the counter medications as opposed to brand name drugs. When you use generic medications, you will pay the lowest copay. Generic drug companies do not have to develop a medication from scratch, so the costs are significantly less to bring the drug to the market. Once a generic medication is approved, several companies can produce and sell the drug. This competition helps lower prices. In addition, many generic drugs are well-established medications that do not require expensive advertising. Generic drugs must use the same active ingredients as the brand name version of the drug. A generic drug must also meet the same quality and safety standards.

4. **Use the mail-order prescription drug benefit for maintenance medications.**
The mail order pharmacy is a fast, easy and convenient way to save time and money on your maintenance medications. You can order additional supplies of medication at a discount. See carrier provisions for details.

MEDICAL INSURANCE

Tips for Using Your Medical Benefits

5 **Utilize your free preventive care benefits to stay healthy.**
In order to receive the full value of your plan, schedule your preventive care exams! Our medical plans cover these exams 100% when you use in-network providers. Preventive exams can help identify any potential health problems early on. Not all preventive care is recommended for everyone, so talk with your doctor to decide which services are right for you and your family. Preventive care services include, but are not limited to the services listed below.

Females
- Pap tests
- Mammograms
- Annual physicals
- Flu shots
- FDA-approved contraception
- Immunizations
- Colonoscopy
- Blood pressure checks
- Cholesterol (total and HDL)
- Diabetes mellitus: baseline for high-risk individuals

Males
- Colonoscopy
- Prostate cancer screening
- Annual physicals
- Flu shots
- Immunizations
- Blood pressure checks
- Cholesterol (total and HDL)
- Diabetes mellitus: baseline for high-risk individuals

Children
- Well-baby care
- Annual physicals
- Flu shots
- Immunizations
- Medical/family history and physical exam
- Blood pressure checks
- Vision screening

Glossary of Terms

- Deductible: The amount of out-of-pocket expenses that you must pay for before any expenses are payable by the plan.
- Copay: The flat dollar amount a covered individual is required to pay for certain services (could be before or after meeting any applicable deductible).
- Coinsurance: A cost sharing agreement between the insurance company and the insured where payment responsibility is shared for all claims covered by the policy, usually expressed as a percentage.
- Out-of-Pocket Maximum: The annual maximum amount of money you will pay in addition to copays and deductibles.
- In-Network: Providers or facilities who have agreed to discounted fees with insurance carriers to participate within their provider networks.
- Non-Network: A provider with whom an insurance carrier does not have a contract to provide healthcare services. A member may pay higher copays, coinsurance and/or deductibles to see a non-network provider or have no coverage at all.

BLUE SHIELD CUSTOM VIDEO FOR YOU!

Looking for a smarter, easier way to learn about your Blue Shield of California health plan options? View your custom video at **http://choose.blueshieldca.com/abcusd**

EDUCATIONAL VIDEO

Benefits terminology can get confusing. Click here to watch a quick video to learn the basics of how our medical plans work.

Deductibles, Copays, Coinsurance, and Out-of-Pocket Maximums
http://video.burnhambenefits.com/terms/

DENTAL INSURANCE

Options 1

MetLife | DHMO Dental Plan

With the Dental Health Maintenance Organization (DHMO) plan through MetLife, you are required to select a general dentist to provide your dental care. You will contact your general dentist for all of your dental needs, such as routine check□ups and emergency situations. If specialty care is needed, your general dentist will provide the necessary referral. For covered procedures, you'll pay the pre□set copay or coinsurance fee described in your DHMO plan booklet. Please keep a copy of your booklet to refer to when utilizing your dental care. This will show the applicable copays that apply to all of the dental services that are covered under this plan.

Option 2

Delta Dental | PPO Dental Plan

With the Delta Dental Preferred Provider Organization (PPO) dental plan, you may visit a PPO dentist and benefit from the negotiated rate or visit a non□network dentist. When you utilize a PPO dentist, your out-of-pocket expenses will be less. You may also obtain services using a non-network dentist; however, you will be responsible for the difference between the covered amount and the actual charges and you may be responsible for filing claims.

	Option 1	Option 2	
Plan Name	**MetLife DHMO**	**Delta Dental PPO**	
Network Name	**SafeGuard Network**	**Delta Dental PPO Dentists**	**Non-Delta Dental PPO Dentists****
Dental Benefits			
Calendar Year Maximum	Unlimited	$1,700	$1,500
Deductible (Annual) - Individual - Family	 $0 $0	 $0 $0	 $0 $0
Diagnostic / Preventive (Plan Pays) - Exams, X-Rays, Cleanings	100% for Most Services	100%	100% of Delta Dentist's Allowed Fee
Basic Services (Plan Pays) - Fillings, Composites/Sealants, Oral Surgery, Endodontics, Periodontics	See Copay Schedule	100%	100% of Delta Dentist's Allowed Fee
Major Services (Plan Pays) - Crowns, Inlays/Onlays, Cast Restorations	See Copay Schedule	80%	80% of Delta Dentist's Allowed Fee
Prosthodontics - Bridges, Dentures, Implants	See Copay Schedule	50%	50% of Delta Dentist's Allowed Fee
Orthodontia (Adults / Children)	$1,000 Copay	50% with $1,000 Lifetime Maximum	
Dental Accident Benefits	N/A	100% Separate $1,000 Annual Maximum per Person	

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

FINDING A DENTAL PROVIDER

- **Option 1** - MetLife DHMO: Go to **www.metdental.com** or call (800) 880-1800.
  Refer to the "*Dental HMO/Managed Care network*" then select ABC Unified School District under Plan name dropdown.
- **Option 2** - Delta Dental: Go to **www.deltadentalins.com** or call (866) 499-3001.
  Refer to the "Delta Dental PPO" network when prompted.

DENTAL INSURANCE

Tips for Using Your Dental Benefits

1. **Refer to your Evidence of Coverage for limitations on the PPO plan.**
Some examples of limitations on services are the number of cleanings and oral exams covered in a calendar year as well as time limitations on fill and crown replacements. Note: Delta dentists are paid on a different fee base than non-Delta dentists. This may result in higher out-of-pocket costs to you when you visit a non-Delta dentist.

2. **Take advantage of preventive services offered by the plan.**
The least expensive way to maintain good oral health is to go to your dentist at least twice each year for an exam and cleaning. Regular dentist visits can help prevent serious health problems such as oral diseases and cancers, and going to the dentist is more affordable in the long run for those who are insured and take advantage of every service.

   Both the DHMO and the PPO plans cover most preventive services at no charge to you. As an added bonus, the annual deductible is waived for preventive services on the PPO dental plan.

3. **Use contracted dental providers.**
With the DHMO plan, you must visit your selected network dentist for treatment. If you visit another dentist, even if that dentist participates in the network, your visit won't be covered. Under the PPO plan, you have the flexibility to visit any licensed dentist in the network, however, contracted network providers have a rate agreement with the insurance company for services rendered. If you use a non-network provider, your out-of-pocket expenses will be higher and you may be subject to balance billing.

   Delta endodontists, oral surgeons, and periodontists are not PPO dentists, but you receive in-network benefits when visiting one of these specialists.

4. **Ask for a predetermination of benefits.**
We strongly recommend you ask your dentist for a predetermination if total charges are expected to exceed $300. Predetermination enables you and your dentist to know in advance what the payment will be for any service that may be in question.

5. **Know your plan's limits.**
The PPO dental plan includes an $1,700 calendar year maximum benefit for network providers and a $1,500 calendar year maximum benefit for non-network providers for each member of your family. A calendar year maximum benefit is the total maximum amount the plan will pay per year for dental benefits. This amount renews at the beginning of each calendar year. If you do not use this amount, it doesn't roll-over and you'll lose it.

   In addition to the calendar year maximum, the DHMO plan limits the number of cleanings to twice per year and the PPO plan limits the number of cleanings to three times per year. Other limitations may apply. If you are unsure, ask your dentist to verify with you.

6. **Schedule your procedures to make the most of your dental coverage.**
As part of dental planning, you should consult with your dentist and, if possible, delay non-urgent procedures that would push your out-of-pocket costs over your plan's calendar year maximum benefit. If possible, plan your procedures in such a way that your annual maximum renews itself in between stages.

7. **Discuss alternative procedures when necessary.**
By letting your dentist know that cost is an issue, he or she may be able to suggest alternative treatments that are less expensive but just as effective.

VISION INSURANCE

EyeMed Vision | PPO Vision Plan

The EyeMed Vision plan provides professional vision care and high quality lenses and frames through a broad network of optical specialists. You will receive richer benefits if you utilize a network provider. If you utilize a non-network provider, you will be responsible to pay all charges at the time of your appointment and will be required to file an itemized claim with EyeMed Vision.

Plan Name	EyeMed Vision PPO	
Network Name	**Insight Network**	**Non-Network**
Vision Benefits		
Exam Services (Every 12 Months) - PLUS Provider - Exam	 100% 100%	 $40 Reimbursement $40 Reimbursement
Lenses* (Every 24 Months) - Single Vision - Bifocal - Trifocal - Progressive—Standard - Progressive—Premier Tier 1-4	 100% 100% 100% 100% $85-$175 copay	 $30 Reimbursement $50 Reimbursement $70 Reimbursement $50 Reimbursement $50 Reimbursement
Frames (Every 24 Months) - Retail - PLUS Provider	 $150 Allowance $200 Allowance	 $105 Reimbursement $105 Reimbursement
Contact Lenses* (Every 24 Months)	In Lieu of Frames and Lenses	
- Cosmetic / Elective - Medically Necessary	$105 Allowance 100%	$74 Reimbursement $300 Reimbursement

Note
The EyeMed Vision network includes access to independent ophthalmologists and optometrists, as well as Costco, LensCrafters, Pearle Vision, Sam's Club, Sears Optical, Target Optical and Walmart retail stores.

Note: *Costco, Sam's Club and Wal-Mart are all considered in-network wholesale participating providers. Because of that, the retail frame allowance is converted to a wholesale equivalent at the store at the time of purchase. It is not an adjustment. Please understand this is not a lesser benefit. By utilizing any one of these locations it is allowing the wholesale house to buy frames at a fraction of the cost and pass that savings on to the member who would be paying much more elsewhere.*

FINDING A VISION PROVIDER

- Go to **www.eyemed.com** or call (800) 877-6372.
  Refer to the "*Insight*" network when prompted.

Tips for Using Your Vision Benefits

1. **Understand your benefits.**
   Our Vision insurance plan covers preventive care services such as eye exams and vision tests, eyeglass lenses, eyeglass frames and contact lenses. For some services, you'll be provided an allowance. For instance, frames are covered in-network with a $150 allowance, and if the frames you want cost more than that, you'll have to pay the additional cost yourself.

2. **Get your eyes checked each year.**
   Eye exams can detect hidden medical problems, even those with perfect vision shouldn't skip them. As you age, you'll need more frequent vision exams.

3. **Make sure your optometrist accepts your insurance and is in-network.**
   It's important to understand the difference between vision care providers who are "in-network" and those who only "accept" your coverage but are not in-network. Out-of-network providers may be willing to submit claims to your vision insurer on your behalf but you may end up with higher out-of-pocket costs.

LIFE AND AD&D INSURANCE

The Hartford | Basic Life and AD&D Insurance

Life insurance protects your family or other beneficiaries in the event of your death while you are still actively employed with the District. ABC Unified School District pays for coverage, offered through The Hartford, in the amount of $50,000. If your death is due to a covered accident or injury, your beneficiary will receive an additional amount through Accidental Death and Dismemberment (AD&D) coverage.

Coverage amounts will reduce according to the following age reduction schedule:

- **Age 65** — Insurance amount reduces to **65%** of original amount
- **Age 70** — Insurance amount reduces to **50%** of original amount

The Hartford | Voluntary Life and AD&D Insurance

In addition to the District provided Basic Life and AD&D benefits, you may elect to purchase additional Term Life and AD&D insurance at discounted group rates provided by The Hartford. You pay for this coverage with after-tax dollars through convenient payroll deductions.

Employee
You may purchase voluntary life and AD&D coverage for yourself in increments of $10,000 up to a maximum benefit of $250,000 not to exceed 5 times your annual earnings, whichever is less.
Spouse
If you buy coverage for yourself, you may also purchase voluntary life and AD&D coverage for your eligible spouse. Benefits for your spouse are available in increments of $5,000 to a maximum benefit of $25,00, not exceed 100% of your employee election. **NOTE: Spouse cost is calculated by using the employee's age.**
Child(ren)
If you buy coverage for yourself, you may also purchase voluntary life and AD&D coverage for your eligible dependent child(ren) in the amount of $5,000. Maximum benefit amount - live birth to age 26: Flat $5,000

Guaranteed issue is a pre-approved amount of coverage that does not require you to provide proof of good health, and is available to you during your *initial eligibility period (upon hire or newly eligible) and during the annual enrollment period.* Initial and annual enrollment must be completed no later than 30 days before the effective date of coverage.

Guaranteed issue is available in the following amounts:

- Employee: up to $250,000
- Spouse: up to $25,000
- Child(ren): Entire benefit amount of $5,000

Coverage amounts will reduce according to the following age reduction schedule:

- **Age 65** — Insurance amount reduces to **65%** of original amount
- **Age 70** — Insurance amount reduces to **50%** of original amount

If you are no longer in your initial eligibility period or if you previously waived coverage, you may enroll in Voluntary Life and AD&D during the next open enrollment period as long as you provide proof of good health. To provide proof of good health, you will be asked to complete a health questionnaire and are subject to insurance carrier approval. The Hartford may approve or decline coverage based on a review of your health history.

If you initially elected a minimum Voluntary Life and AD&D benefit of $10,000, you will have the opportunity during the annual enrollment period to elect additional coverage to a maximum benefit of $250,000, not to exceed 5 times your annual earnings.

Beneficiary designations may be updated at any time for Basic Life/AD&D and Voluntary Life.

SUPPLEMENTAL BENEFITS

You may purchase individual policies from American Fidelity including Disability Income Insurance, Cancer Protection, Accident Insurance, and Supplemental Life Insurance. Your premiums are paid through payroll deductions on a after-tax basis. American Fidelity policies offer direct-to-the-policyholder cash payouts to help cover what other insurance doesn't. All of the American Fidelity individual policies are portable, which means that you can keep them should you change jobs or retire, with no increase in premiums.

American Fidelity | Disability Income Insurance

Disability Income Insurance helps protect your income. When you are unable to work due to a covered Injury or Sickness, your disability benefit will be paid up to the benefit period for which premium has been paid. Your disability benefit can help pay for necessities.

American Fidelity | Cancer Protection

A cancer diagnosis can be expensive. Benefit payments from American Fidelity's Limited Benefit Cancer Insurance Plan can be used however you'd like, including house payments, utilities, and meals/lodging expenses.

American Fidelity | Accident Insurance

Accidents can happen any time. Limited Benefit Accident Only Insurance can help protect you and your family if a covered accident occurs. Benefit payments are paid directly to you, regardless of other coverage you may have.

American Fidelity | Supplemental Life Insurance

American Fidelity has several life insurance options that you can take with you after employment.

TO LEARN MORE
Go to **www.americanfidelity.com** or call (800) 365-9180

SUPPLEMENTAL BENEFIT PROVIDERS

In addition to the American Fidelity Supplemental Benefits, we offer plans through the carriers listed below.

Pacific Educators — (800) 722-3365

Disability Plans

- Sick Leave
- Maternity Benefits

Life Insurance Plans

- Level Term
- Universal Life
- Whole Life

Cancer Insurance

FLEXIBLE SPENDING ACCOUNTS

You can set aside money in Flexible Spending Accounts (FSA) before taxes are deducted to pay for certain health and dependent care expenses, lowering your taxable income and increasing your take home pay. Only expenses for services incurred during the plan year are eligible for reimbursement from your accounts. Please remember that if you are using your debit card, you must save your receipts, just in case American Fidelity needs a copy for verification. Also, all receipts should be itemized to reflect what product or service was purchased. Credit card receipts are not sufficient per IRS guidelines.

American Fidelity | Health Care Spending Account (HCSA)

This plan is used to pay for expenses not covered under your health plans, such as deductibles, coinsurance, copays and expenses that exceed plan limits. Employees may defer up to $3,200 pre-tax per year.

American Fidelity | Dependent Care Assistance Plan (DCAP)

This plan is used to pay for eligible expenses you incur for child care, or for the care of a disabled dependent, while you work. Employees may defer up to $5,000 pre-tax per year.

FSAs offer sizable tax advantages. The trade-off is that these accounts are subject to strict IRS regulations, including the use-it-or-lose-it rule. According to this rule, you must forfeit any money left in your account(s) after your expenses for the year have been reimbursed. The IRS does not allow the return of unused account balances at the end of the plan year, and remaining balances cannot be carried forward to a future plan year. If you are unable to estimate your health care and dependent care expenses accurately, it is better to be conservative and underestimate rather than overestimate your expenses.

Example	Without the Health Care FSA	With the Health Care FSA
Gross Annual Pay	$45,000	$45,000
Pre-Tax Health Care FSA	Not Elected	$1,200
Taxable Gross Income	**$45,000**	**$43,800**
Payroll Taxes (at 30%)	$13,500	$13,140
Health Care Cost	$1,200	$0
Net Pay	$30,300	$30,660
Annual Net Pay Increase	**$0**	**$360**

Important Note About the FSA

It is important to note that your FSA elections will expire each year on September 30th. If you plan to participate in the FSA for the upcoming plan year, you are required to enroll or re-enroll.

To Enroll or Re-Enroll

Contact American Fidelity today to schedule an appointment to enroll or re-enroll at (800) 365-9180.

EDUCATIONAL VIDEO

Click **here** to watch a quick video to learn the basics of how Flexible Spending Accounts work.

Flexible Spending Accounts
http://video.burnhambenefits.com/fsa/

RETIREMENT PLANNING

It is recommended that you review your benefit choices a year prior to your retirement to make any necessary adjustments at the Annual Heath Benefits Open Enrollment.

Early Retiree Benefits

To be eligible for the Early Retiree Benefits, Your eligible dependents include:

- You must have reached 55, but must be less than age 65
- You must have rendered ten (10) or more years of permanent service to the District. (Check with the Fringe Benefits department to verify eligibility)

Early Retiree Benefits provides "medical only" insurance coverage for a maximum of 7 years or until you turn 65 whichever comes first. The level of benefit shall be no greater than that which was held in the year immediately preceding early retirement.

If you receive CASH in Lieu of Medical Benefits when you retire, then that is the benefit you will receive in lieu of Medical Coverage. For example, Joe Smith retires at 55 and is receiving Cash in Lieu of medical benefits of $200 a month. Joe will receive $200 a month for 10 months, $2,000 a year, for the next seven (7) years or until he reaches age 65. In Joe's case, he will reach the 7 year mark prior to turning age 65.

Over Age 65 Retiree Benefits

Employees reaching the age of 65 and planning to retire, or those early retirees that will be losing district paid benefits upon turning the age of 65, have the opportunity to enroll in the group Kaiser Senior Advantage program on a direct bill basis. For additional information, please pick up an enrollment packet in the Fringe Benefits Department.

Dependent Coverage and Status

If you are an early retiree and your spouse is 65 or older, your spouse must enroll in the district group Kaiser Senior Advantage Plan if your spouse is enrolled in Medicare Part B. The premium rates for these plans are set based on your spouse's Medicare eligibility, which will determine the amount of out of pocket deduction. NOTE: Spouses over 65 must enroll in Medicare A and B.

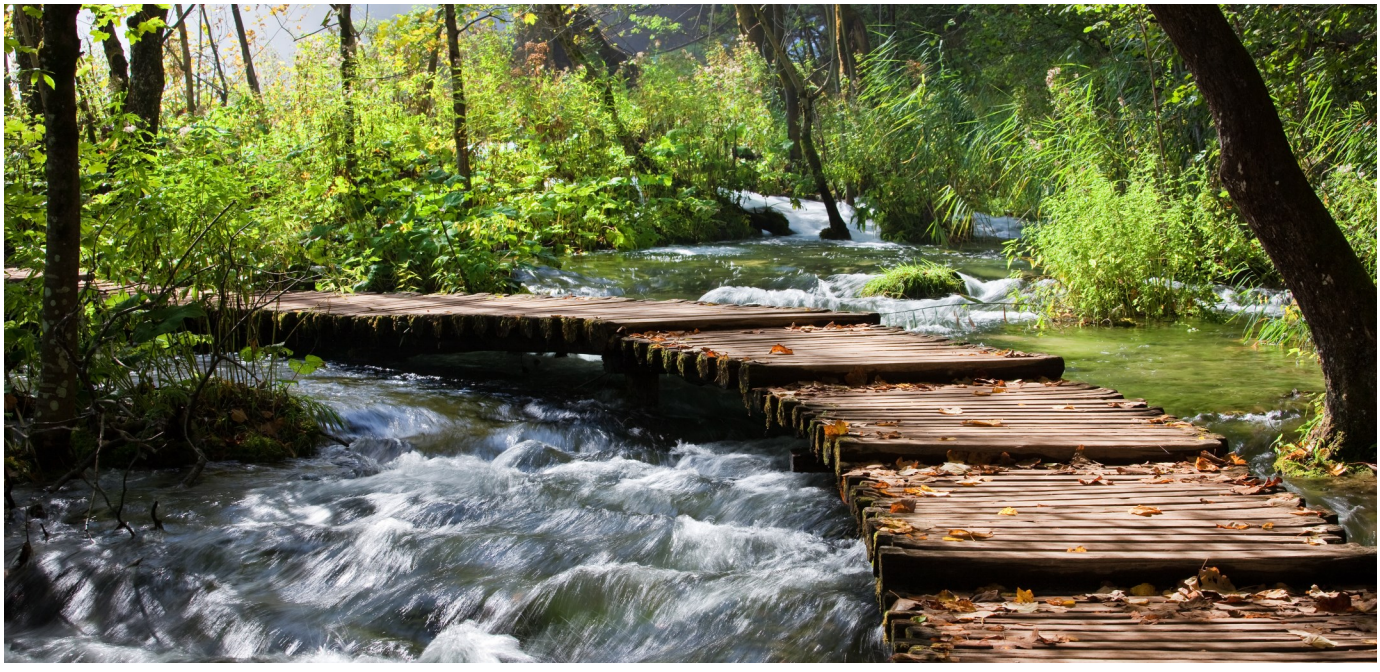
Dental and Vision Benefits

Early Retiree Benefits do not provide coverage for Dental and Vision benefits.

For Dental and Vision benefits, you will receive a COBRA Notification letter informing you of your eligibility to purchase Vision and Dental benefits. COBRA is a one-time offer for you and your dependent(s) to continue the same coverage for 18 months. Information regarding the COBRA program and current premium rates are available in the Fringe Benefits Office.

FOR MORE INFORMATION
Please visit the Fringe Benefits Department.

**Please note—the IRS requires the District to issue a W-2 to all retirees who receive early retiree health benefits or cash in lieu. The amount of the taxable income relating to the early retiree health benefits would equal to the amount of cash in lieu offered to retirees. You can expect to receive a W-2 from ABC Unified School District in January, 2025 for any benefits received in 2024.*



EMPLOYEE CONTRIBUTIONS

This chart compares the **tenthly** contributions for our Employee Benefit plans. Your pre-tax cost for coverage will vary depending on the option and level of coverage you choose. All benefit eligible employees may be eligible to receive cash in lieu of medical benefits. Please refer to the "Waiving Medical Form" for options and details.

Medical	Employee Contribution	District Contribution
Option 1	**Blue Shield | Trio ACO HMO**	
Employee Only Two-Party Family	$0.00 $0.00 $0.00	$931.41 $1,862.80 $2,635.89
Option 2	**Blue Shield | Local Access+ HMO**	
Employee Only Two-Party Family	$0.00 $0.00 $755.55	$1,238.41 $2,476.81 $2,749.12
Option 3	**Blue Shield | Access+ HMO**	
Employee Only Two-Party Family	$379.52 $759.08 $1,829.66	$1,238.41 $2,476.81 $2,749.12
Option 4	**Blue Shield | PPO**	
Employee Only Two-Party Family	$2,587.47 $5,554.32 $8,728.38	$1,238.41 $2,476.81 $2,749.12
Option 5	**Kaiser Permanente | HMO**	
Employee Only Two-Party Family	$0.00 $0.00 $0.00	$971.42 $1,942.84 $2,749.12

Dental	Employee Contribution	District Contribution
Option 1	**MetLife | DHMO**	
	$0.00	$42.14
Option 2	**Delta Dental | PPO**	
	$0.00	$156.13

Vision	Employee Contribution	District Contribution
Option	**EyeMed Vision**	
	$0.00	$15.40

Basic Life & AD&D	Employee Contribution	District Contribution
	The Hartford Basic Life and AD&D	
	$0.00	$7.20

All benefit eligible employees may be eligible to receive cash in lieu of medical benefits. Please refer to the "Waiving Medical Form" for options and details. For employees who are less than 100%, please contact Fringe Benefits

The following benefits are provided to you at no charge and are paid by ABC Unified School District:

- Basic Life/AD&D
- Employee Assistance Program

The following benefits are available to you at discounted group rates. Should you elect these benefits, you will pay 100% of the cost:

- Voluntary Life/AD&D
- Supplemental Benefits (Disability Income Insurance, Cancer Protection, Accident Insurance, Supplemental Life Insurance)

Important Notice from ABC Unified School District 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 ABC Unified School District under the Kaiser & Blue Shield HMO & PPO plans and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this Notice. There are two important things you need to know about your current coverage and Medicare's prescription drug coverage: Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium. ABC Unified School District has determined that the prescription drug coverage offered under the above plan option(s), 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 through 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 Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current coverage with ABC Unified School District will not be affected. If you decide to join a Medicare drug plan and drop your current medical plan coverage, be aware that you and your dependents will be able to get this coverage back (for example, at the next annual open enrollment period or upon incurrence of a special enrollment event).

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 ABC 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 Your Medicare Prescription Drug Coverage Options

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll receive 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; or
- Call (800) MEDICARE or (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 more information about this extra help, visit Social Security on the web at **www.socialsecurity.gov**, or you may 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).

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

Contact the person listed within this document 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 ABC Unified School District changes. You also may request a copy of this notice at any time.

WOMEN'S HEALTH & CANCER RIGHTS ACT (WHCRA)

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 states 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 medical plan.

To obtain more information on WHCR benefits, please call or email the person listed on this document.

NEWBORN AND MOTHER'S 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 the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

To obtain more information, please call or email the person listed on this document.

SPECIAL ENROLLMENT RIGHTS

If you are declining enrollment for yourself or your dependent (s) (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents if you or your dependent(s) lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days or any longer period that applies under the Plan after your or your dependents' other coverage ends (or if the employer stops contributing toward your or your dependents' other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days or any longer period that applies under the Plan after the birth, adoption, or placement for adoption.

To obtain more information, please call or email the person listed on this document.

MEDICAID & CHILDREN'S HEALTH INSURANCE PROGRAM

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 are a California resident, please contact the California Department of Health Care Services to see if you may be eligible for premium assistance:
Website: Health Insurance Premium Payment (HIPP) Program
http://dhcs.ca.gov/hipp
Phone: 916-445-8322
Email: hipp@dhcs.ca.gov

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	
Website	**www.dol.gov/agencies/ebsa**
Phone	(866) 444-EBSA (3272)

U.S. Department of Health and Human Services—Center for Medicare & Medicaid Services	
Website	**www.cms.hhs.gov**
Phone	(877) 267-2323 Menu Option 4, Ext. 61565

HIPAA NOTICE OF PRIVACY PRACTICES

Your Information | Your Rights | Our Responsibilities

Health Care Flexible Spending Account Benefits

This Notice describes how medical information about you that we receive from your health care flexible spending account may be used and disclosed and how you can get access to this information. Please review it carefully.

Contact the person listed in this document for further information.

Your Rights

You have the right to:

- Get a copy of your health and claims records
- Correct your health and claims records
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

***See page 24** for more information on these rights and how to exercise them*

Your Choices

You have some choices in the way that we use and share information as we:

- Tell your family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Market our services and sell your information

***See page 25** for more information on these choices and how to exercise them*

Our Uses and Disclosures

We may use and share your information as we:

- Help manage the health care treatment you receive
- Run our organization
- Bill for your health services
- Administer your health plan
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

***See pages 25 and 26** for more information on these uses and disclosures*

HIPAA NOTICE OF PRIVACY PRACTICES

Your Rights	When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.
Get a copy of your health and claims records	• You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this. • We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
Ask us to correct health and claims records	• You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this. • We may say "no" to your request, but we'll tell you why in writing within 60 days.
Request confidential communications	• You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. • We will consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not.
Ask us to limit what we use or share	• You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care. • If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with you health insurer. We will say "yes" unless a law requires us to share that information.
Get a list of those with whom we've shared information	• You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. • We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
Get a copy of this privacy notice	• You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
Choose someone to act for you	• If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. • We will make sure the person has this authority and can act for you before we take any action.
File a complaint if you feel your rights are violated	• You can complain if you feel we have violated your rights by contacting us using the information at the end of this Notice of Privacy Practices. • You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling (877) 696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/** • We will not retaliate against you for filing a complaint.

HIPAA NOTICE OF PRIVACY PRACTICES

Your Choices

For certain health information, you can tell us your choices about what we share.
If you have a clear preference for how we share your information in the situations described on in this document, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in payment for your care.
- Share information in a disaster relief situation.

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information

Our Uses and Disclosures

How do we typically use or share your health information?
We typically use or share your health information in the following ways.

Help manage the health care treatment you receive	• We can use your health information and share it with professionals who are treating you.	**Example:** A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.
Run our organization	• We can use and disclose your information to run our organization and contact you when necessary. • We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long term care plans.	**Example:** We use health information about you to develop better services for you.
Pay for your health services	• We can use and disclose your health information as we pay for your health services.	**Example:** We share information about you with your dental plan to coordinate payment for your dental work.
Administer your plan	• We may disclose your health information to your health plan sponsor for plan administration.	**Example:** Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.

NOTICE OF PRIVACY PRACTICES (CONT'D.)

Our Uses and Disclosures (continued)

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html**

Help with public health and safety issues	• We can share health information about you for certain situations such as: preventing disease, helping with product recalls, reporting adverse reactions to medications, reporting suspected abuse, neglect, or domestic violence, preventing or reducing a serious threat to anyone's health or safety.
Do research	• We can use or share your information for health research.
Comply with the law	• We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
Respond to organ and tissue donation requests and work with a medical examiner or funeral director	• We can share health information about you with organ procurement organizations. • We can share health information with a coroner, medical examiner, or funeral director when an individual dies.
Address workers' compensation, law enforcement, and other government requests	We can use or share health information about you: • For workers' compensation claims. • For law enforcement purposes or with a law enforcement official. • With health oversight agencies for activities authorized by law. • For special government functions such as military, national security, and presidential protective services.
Respond to lawsuits and legal actions	• We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information, visit: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html**

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site, and we will mail a copy to you.

Effective Date of Notice

This Notice is current as of 10/01/2024

To obtain more information regarding any of the information listed in this packet, or if you have any questions, please contact:

ABC Unified School District

Natalie Breidenthal, *Supervisor of Payroll & Fringe Benefits*
(562) 926-5566 ext. 21300
Natalie.breidenthal@abcusd.us
16700 Norwalk Blvd | Cerritos, CA 90703
Plan Effective Date: 10/1/2024

NOTES

NOTES

2211 Michelson Drive, Suite 1200 | Irvine, California 92612
Telephone: (949) 833-2983 | Fax: (949) 833-9549

Learn more at **www.burnhambenefits.com**

This Employee Benefits Guide provides an overview of some of your benefit plan choices. It is for informational purposes only. It is not intended to be an agreement for continued employment. Neither is it a legal plan document. If there is a disagreement between this guide and the plan documents, the plan documents will govern.

In addition, the plans described in this guide are subject to change without notice. Continuation of any benefit plan or coverage is at the District's discretion and in accordance with federal and state laws. If you need additional information or have any questions about the benefit program, please contact the Human Resources Department.

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