La Habra City School District

2023 – 2024 PLAN YEAR BENEFITS

CERTIFICATED, CLASSIFIED, MANAGEMENT AND CONFIDENTIAL ACTIVE EMPLOYEES BENEFIT BROCHURE

CONTENTS

Medicare Part D Notice:

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a federal law gives you more choices about your prescription drug coverage. Please see Annual Notice on pages 41 - 42 for more details.

GETTING STARTED

Whether you're enrolling in benefits for the first time, nearing retirement, or somewhere in between, the La Habra School District supports you with benefit programs and resources to help you thrive today and prepare for tomorrow.

This guide provides an overview of your healthcare coverage, life, disability, retirement benefits, and more.

You'll find tips to help you understand your medical coverage, save time and money on healthcare, reduce taxes, and balance your work and home life. Review the coverage and tools available to you to make the most of your benefits package.

This guide is an overview and does not provide a complete description of all benefit provisions. For more detailed information, please refer to your summary plan descriptions (SPDs).

A list of plan contacts is included on page 35 of this guide.

The Benefits in this Summary are effective 10/01/2023 through 09/30/2024

OPEN ENROLLMENT: July 10 – August 18, 2023

What's New: Highlights of 2023 - 2024

Inflation is affecting every corner of the economy, from the gas we put in our cars to the food we purchase at the grocery store. Purchasing healthcare is no exception to these rising costs and medical premium rates are increasing by 8% this year. The Districts participation in SISC (Self Insured Schools of California) helps us to control this cost, with almost every dollar collected in premium used to pay directly for healthcare services, with a 5 year renewal history average of 4.7%, well below the California average of 9%.

La Habra CSD is committed to providing you comprehensive benefits with multiple plan design options to best meet your budget. There is a low, medium and high option for Kaiser, a low and high Anthem HMO option and a low and high Anthem PPO option. This choice can help you determine the plan that best fits with the needs of your family.

Important!

The District will have a positive Open Enrollment this year. This means your 2022-2023 benefits will roll over to the 2023-2024 benefit year, except for the Healthcare Flexible Spending Account (FSA) and Dependent Care FSA. It is recommended that all employees review their benefits. Remember that you must re-enroll in the Flexible Spending Accounts if you wish to participate in the 2023-2024 plan year.

Enrollment will be conducted virtually and in-person from July 10 – August 18.

A welcome back event will take place at the La Habra High School Amphitheater on August 8th. American Fidelity will be on-site to assist with in-person enrollments.

For those adding a New Dependent, you must meet with an American Fidelity representative. See below for the link to schedule an appointment.

If you need assistance or have questions, you may make an appointment and meet with an American Fidelity representative. To meet with an American Fidelity Representative, click the link below to schedule an appointment:

https://enroll.americanfidelity.com/44BF95BA

Dental

- Introducing the Delta Dental SmileWay program. SISC members with certain health conditions (i.e. cancer, diabetes, heart disease, and more) will also have access to additional teeth and gum cleanings.

Vision

- Effective 1/1/24, SISC VSP members will be able to access the full $150 frame allowance when purchasing frames at Walmart, Sam's Club, or Costco.

SISC Value Added Programs

- NEW! Eden Health virtual primary care for SISC PPO members. This new smart phone app helps encourage members to stay in touch and establish a relationship with a primary care provider.
- Effective 1/1/24, Hinge Health and Vida will no longer be available to SISC HSA members.
- Effective 10/1/23, MDLIve visits will have a $10 copay. HSA members will continue to pay the full costs of the visit until the deductible is met.

WHO'S ELIGIBLE FOR BENEFITS?

Employees

All Certificated, Administrators, Management, Confidential, and full-time Classified employees are eligible to participate in the La Habra City School District sponsored group benefit plans. Those Certificated bargaining unit/Certificated Management employees who work less than full time shall receive a prorated district contribution for fringe benefits in the same ratio as their part time employment bears to full time employment.

Coverage for all Certificated, Administrators, Management, Confidential, and full-time Classified employees will be effective on the first of the month following your date of hire. Open Enrollment changes will be effective October 1, 2023.

Eligible Dependents

- Legally married spouse (including same-sex spouse).
- Natural, adopted, or stepchildren up to age 26.
- Children over age 26 who are disabled and dependent on you for support.
- Children named in a Qualified Medical Child Support Order (QMCSO) as defined by federal law.
- Please refer to the Summary Plan Descriptions for details on how benefits eligibility is determined.

When You Can Enroll

Open Enrollment for current employees is generally held in August. Open Enrollment is the one time each year that employees can make changes to their benefit elections without a qualifying life event. If you miss the enrollment deadline, you'll need to wait until the next open enrollment (the one time each year that you can make changes to your benefits for any reason).

LIFE HAPPENS

A change in your life may allow you to update your benefit choices. Watch the video for a quick take on your options.

Changing Your Benefits

Outside of Open Enrollment, you may be able to add or remove dependents or change benefit options if you have a big change in your life and submit your change within 30 days. Eligible events include:

- Change in legal marital status.
- Change in number of dependents or dependent eligibility status.
- Change in employment status that affects eligibility for you, your spouse, or dependent child(ren).
- Change in residence that affects access to network providers.
- Change in your health coverage or your spouse's coverage due to your spouse's employment.
- Change in an individual's eligibility for Medicare or Medicaid.
- A court order requiring coverage for your child.
- A "special enrollment" event under the Health Insurance Portability and Accountability Act (HIPAA), including a new dependent by marriage, birth or adoption, or loss of coverage under another health insurance plan.
- An event allowed under the Children's Health Insurance Program (CHIP) Reauthorization Act (you have 60 days to request enrollment due to events allowed under CHIP).

ENROLLING FOR BENEFITS

La Habra City School District Benefits Enrollment

How to Login

1. To access the online enrollment site, go to **www.afenroll.com/enroll**. **Note: This link will only be accessible during open enrollment, July 10, 2023 to August 18th, 2023.**

2. At the login screen, you will enter the site using the following information:

- **Type in your user ID:** Your Social Security Number (SSN)
- **Type in your PIN:** The last four digits of your SSN and last two of your birth year. (For example, for SSN 123-45-6789 and birth year 1974, you would type in 678974).

3. Click the 'Log On' button.

For New Hires or if you prefer to make a virtual appointment with an American Fidelity Representative, please click the link below:
https://enroll.americanfidelity.com/44BF95BA

Note: If you will be adding a new dependent to medical, dental, or vision benefits for the 2023-2024 plan year, then you must meet with an AF representative to provide appropriate documentation.

Changing Your PIN

You will be asked to change your PIN and complete the security questions, after your initial login to the system. Enter a new PIN and confirm it on the next line. You may choose any combination of letters and numbers. Entering your PIN is the equivalent of your digital signature. Before you can complete your PIN change, you must select a security question, answer it, and provide your email address. This will allow you to reset your PIN if you forget it. Click the 'Save New PIN' button.

Helpful Tips

- **Log Out:** If you leave the site in the middle of the process, click the 'Log Out' button to save your selections.
- **Print Confirmation:** Be sure to print your confirmation. Once you confirm your enrollment, you may click on the confirmation link at the bottom of the 'Sign/Submit Complete' to print your confirmation statement.
- **Re-Enter/Make Changes:** You may re-enter the enrollment site (including to 'View Only' your original selections) to make changes at any time during your enrollment period. Please note: Before you exit the system, you must re-confirm with your PIN or your enrollment will not be valid.
- **Opting Out:** If you choose not to select benefits, you must enter each product module and make that choice.
- **Required:** Social Security Numbers and Dates of Birth are required for all employees and their dependents.
- **Adding Dependent:** If you are adding a dependent as a beneficiary, their Social Security Number is required.
- **Signature:** You will use your PIN to confirm applications and your enrollment confirmation.

To view a step-by-step video on how to enroll using AFenroll, please visit:
americanfidelity.com/howtoenroll.

If you have questions or need help at any time please contact:

Danelle Bautista
Phone: (562) 690-2321
Email: dbautista@lahabraschools.org

Denise Orozco
Phone: (562) 690-2398
Email: dorozco@lahabraschools.org

American Fidelity
Phone: (800) 365-9180 ext. 0
Email: AFES-WildomarBranch@americanfidelty.com

MEDICAL

OUR PLANS

- Kaiser HMO $20
- Kaiser HMO $30
- Kaiser Deductible HMO 500
- Anthem PPO J
- Anthem HDHP Plan A
- Anthem HMO 20/40/250
- Anthem HMO 30/40/500

HMO, PPO, HDHP… WHAT?

Not all medical plans work the same way. Click on the below icons to watch these videos to understand how each type of plan works.

All About Medical Plans

Insurance Lingo

WORDS TO KNOW

Can you beat the Health Lingo game? Learn the words that will help you understand how your plan works.

- **DEDUCTIBLE:** The amount of healthcare costs you have to pay for with your own money before your plan will start to pay anything.
- **OUT-OF-POCKET MAXIMUM:** Protects you from big medical bills. Once costs "out of your own pocket" reach this amount, the plan pays 100% of most eligible expenses for the rest of the plan year.
- **COINSURANCE:** After the deductible (if applicable), you and the plan share the cost. For example, if the plan pays 80%, your coinsurance share of the cost is 20%. You are billed for your coinsurance after your visit.
- **COPAY:** A set fee you pay instead of coinsurance for some healthcare services, for example, a doctor's office visit. You pay the copay at the time you receive care.
- **IN-NETWORK / OUT-OF-NETWORK:** In-network services will always be the lowest cost option. Out-of-network services will cost more or may not be covered. Check your plan's website to find doctors, hospitals, labs, and pharmacies that belong to the network.

Medical HMO Plans

KAISER PERMANENTE® Anthem®

You always pay the deductible and copayment ($).

	Kaiser HMO Deductible $500	Kaiser HMO $20	Kaiser HMO $30	Anthem HMO $20/40/250	Anthem HMO $30/40/500
	In-network only				
Annual deductible	$500 Individual $1,000 Family	$0 $0	$0 $0	$0 $0	$0 $0
Annual out-of-pocket maximum	$3,000 Individual $6,000 Family	$1,500 Individual $3,000 Family	$1,500 Individual $3,000 Family	$2,000 Individual $4,000 Family	$2,500 Individual $5,000 Family
Primary provider office visit	$20 copay	$20 copay	$30 copay	$20 copay	$30 copay
Specialist office visit	$20 copay	$20 copay	$30 copay	$40 copay	$40 copay
Chiropractic care	$10 copay (up to 30 visits per year, combined with Acupuncture)	$10 copay (up to 30 visits per year, combined with Acupuncture)	$10 copay (up to 30 visits per year, combined with Acupuncture)	$20 copay (combined outpatient rehab limit: up to 60 days per year)	$30 copay (combined outpatient rehab limit: up to 60 days per year)
Preventive care	No Charge	No Charge	No Charge	No Charge	No Charge
Diagnostic lab and X-ray	Complex imaging: You pays 10% up to $50 per procedure Other Labs: $10 copay per procedure	No Charge	No Charge	Complex imaging: $100 copay per test. All others no charge.	Complex imaging: $100 copay per test. All others no charge.
Urgent care	$20 copay	$20 copay	$30 copay	$20 copay (copay waived if admitted)	$30 copay (copay waived if admitted)
Emergency room	Plan pays 90% after deductible	$100 copay (copay waived if admitted)	$100 copay (copay waived if admitted)	$100 copay (copay waived if admitted)	$150 copay (copay waived if admitted)
Hospitalization	Plan pays 90% after deductible	No Charge	No Charge	$250 per admission copay	$500 per day copay (1st 3 days per admission) Thereafter plan pays 100%
Outpatient surgery	Plan pays 90% after deductible	$20 copay per procedure	$30 copay per procedure	$125 copay per procedure	$250 copay per procedure

Medical PPO Plans

Anthem

You always pay the deductible and copayment ($).

	Anthem PPO Plan J		Anthem HDHP/HSA Plan A	
	In-network	Out-of-network	In-network	Out-of-network
Annual deductible	$750 per individual; $1,500 family		$1,500 Individual; $2,800 Member; $3,000 Family limit	
Annual out-of-pocket maximum	$3,000 individual; $6,000 family	Unlimited; Unlimited	$3,000 per individual; $6,000 family limit	
Primary provider office visit	$30 copay	Plan pays up to allowable amount after deductible	Plan pays 90% after deductible	Plan pays up to allowable amount after deductible
Specialist office visit	$30 copay	Plan pays up to allowable amount after deductible	Plan pays 90% after deductible	Plan pays up to allowable amount after deductible
Chiropractic care	Plan pays 80% after deductible	Not covered	Plan pays 90% after deductible	Not Covered
Preventive care	No Charge	Not covered	No Charge	Not Covered
Diagnostic lab and X-ray	Plan pays 80% after deductible	Complex imaging: Plan pays up to allowable amount after deductible (up to $800 per procedure); All other: not covered	Plan pays 90% after deductible	Complex imaging: Plan pays up to allowable amount after deductible (up to $800 per procedure); All other: not covered
Urgent care	$30 copay	Plan pays up to allowable amount after deductible	Plan pays 90% after deductible	Plan pays up to allowable amount after deductible
Emergency room	$100 copay then Plan pays 80% after deductible (copay waived if admitted)	$100 copay then Plan pays 80% after deductible (copay waived if admitted)	$100 copay then Plan pays 90% after deductible (copay waived if admitted)	$100 copay then Plan pays 90% after deductible (copay waived if admitted)
Hospitalization	Plan pays 80% after deductible	Plan pays up to allowable amount after deductible (up to $600 per day)	Plan pays 90% after deductible	Plan pays up to allowable amount after deductible (up to $600 per day)
Outpatient surgery	Plan pays 80% after deductible	Plan pays up to allowable amount after deductible (ASC: up to $350 per day)	Plan pays 90% after deductible	ASC: Plan pays up to allowable amount after deductible (up to $350 per day); Hospital: Plan pays 50% after deductible

Prescription

	Kaiser HMO Deductible $500	Kaiser HMO $20	Kaiser HMO $30	Anthem HMO $20/40/250	Anthem HMO $30/40/500
	In Network Only				
Annual Deductible	N/A			$200 Individual $500 Family	$200 Individual $500 Family
Annual out-of-pocket maximum	Prescriptions subject to medical out-of-pocket maximums			$2,500 Individual $3,500 Family	$2,500 Individual $3,500 Family
Generic	**Pharmacy:** $10 copay Costco: Not available **Mail order:** $20 copay Costco: Not available	**Pharmacy:** $10 copay Costco: Not available **Mail order:** $10 copay Costco: Not available	**Pharmacy:** $10 copay Costco: Not available **Mail order:** $10 copay Costco: Not available	**Pharmacy:** $10 copay Costco: No Charge **Mail order:** No Charge Costco: No Charge	**Pharmacy:** $10 copay Costco: No Charge **Mail order:** No Charge Costco: No Charge
Preferred brand	**Pharmacy:** $30 copay Costco: Not available **Mail order:** $60 copay Costco: Not available	**Pharmacy:** $20 copay Costco: Not available **Mail order:** $20 copay Costco: Not available	**Pharmacy:** $30 copay Costco: Not available **Mail order:** $30 copay Costco: Not available	**Pharmacy:** $35 copay Costco: $35 copay **Mail order:** $90 copay Costco: $90 copay	**Pharmacy:** $35 copay Costco: $35 copay **Mail order:** $90 copay Costco: $90 copay
Number of days' supply	**Pharmacy:** 1 to 100 days **Mail order:** 1 to 100 days	**Pharmacy:** 1 to 100 days **Mail order:** 1 to 100 days	**Pharmacy:** 1 to 100 days **Mail order:** 1 to 100 days	**Pharmacy:** 30 days **Mail order:** 90 days	**Pharmacy:** 30 days **Mail order:** 90 days

Prescription, Continued

	Anthem PPO Plan J		Anthem HDHP/HSA Plan A	
	In-network	Out-of-network	In-network	Out-of-network
Annual Out-of-Pocket Maximum	$2,500 Individual $3,500 Family		$3,000 Individual $6,000 Family	
Generic	**Pharmacy:** $9 copay Costco: No Charge **Mail order:** No Charge Costco: No Charge	Member must pay the entire cost up front and apply for reimbursement	**Pharmacy:** $9 copay Costco: No Charge **Mail order:** No Charge Costco: No Charge	Member must pay the entire cost up front and apply for reimbursement
Preferred brand	**Pharmacy:** $35 copay Costco: $35 copay **Mail order:** $90 copay Costco: $90 copay	Member must pay the entire cost up front and apply for reimbursement	**Pharmacy:** $35 copay Costco: $35 copay **Mail order:** $90 copay Costco: $90 copay	Member must pay the entire cost up front and apply for reimbursement
Number of days' supply	**Pharmacy:** 30 days; **Mail order:** 90 days		**Pharmacy:** 30 days; **Mail order:** 90 days	

FINDING CARE WITH ANTHEM

Choose with confidence

You can start using **Find Care** by downloading the Sydney Health app to your mobile device or logging in to **anthem.com/ca/sisc** Select **Find Care** and the Find Care tool will guide you through the steps.

We're ready to help you

The Find Care tool empowers you to take control of your healthcare by helping you connect with high quality care options. If you have questions, you can reach us using the interactive chat feature on the Sydney Health app or through the Message Center on **anthem.com/ca/sisc** .

Download Sydney Health today to find a provider that's right for you

Use your smartphone camera to scan this QR code.

The Find Care tool helps you search for doctors/dentists and compare costs

Choosing a provider you trust is important — and choosing one in your plan's network can help keep your costs down. Finding high-quality, cost-effective care is simple when you use the Find Care tool on the Sydney Health mobile app or **anthem.com/ca/sisc.**

Note: When you enroll in the HMO plan for the first time, you will need to choose a primary care doctor for you and your enrolled dependents. If you're already an Anthem HMO member, you don't need to change or select a new primary care doctor.

If you don't select a primary care doctor at the time of enrollment, Anthem will automatically assign a primary care doctor to you and your enrolled family members. You can change your primary care doctor by calling Member Services at the number on the back of your ID card.

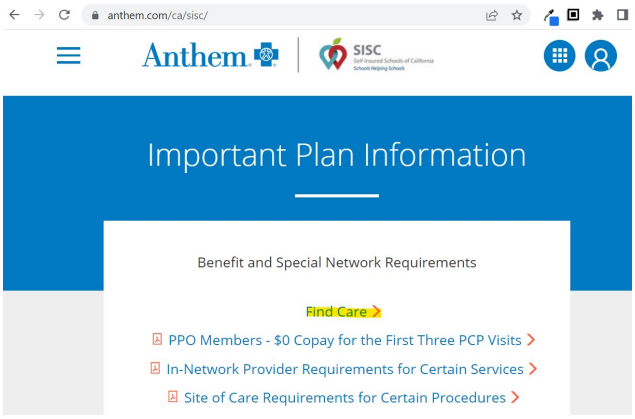
How to make sure you're using doctors in your plan's network:

1. Log in at **anthem.com/ca/sisc** or use our mobile app on a smartphone. Pick the Find Care tool to search for doctors and facilities.
2. Remind your doctor and other health care professionals to refer you to doctors in your plan's network only. At the hospital, it's important to ask if all the facility-based professionals (such as radiologists, anesthesiologists and pathologists) are part of your plan's network.
3. Call the Member Services number on your ID card to check if certain providers are part of your plan's network.

HOW TO FIND ANTHEM NETWORK PROVIDER

It's easy to find a provider online:

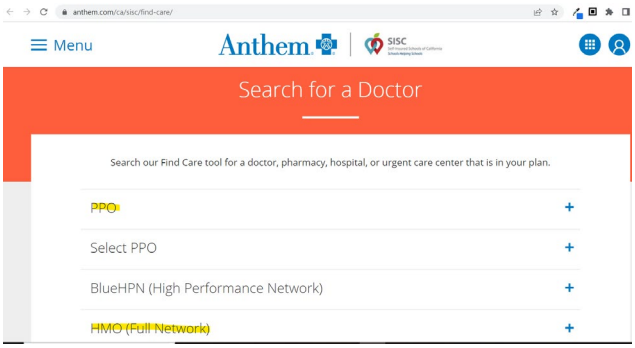
1. Go to **anthem.com/ca/sisc**.
2. Scroll down to "Important Plan Information" and select "Find Care".
3. Choose the network you are enrolled in: HMO Full Network or PPO and click the link.
4. You will then be directed to the Anthem website where you can search by specific provider type or location.

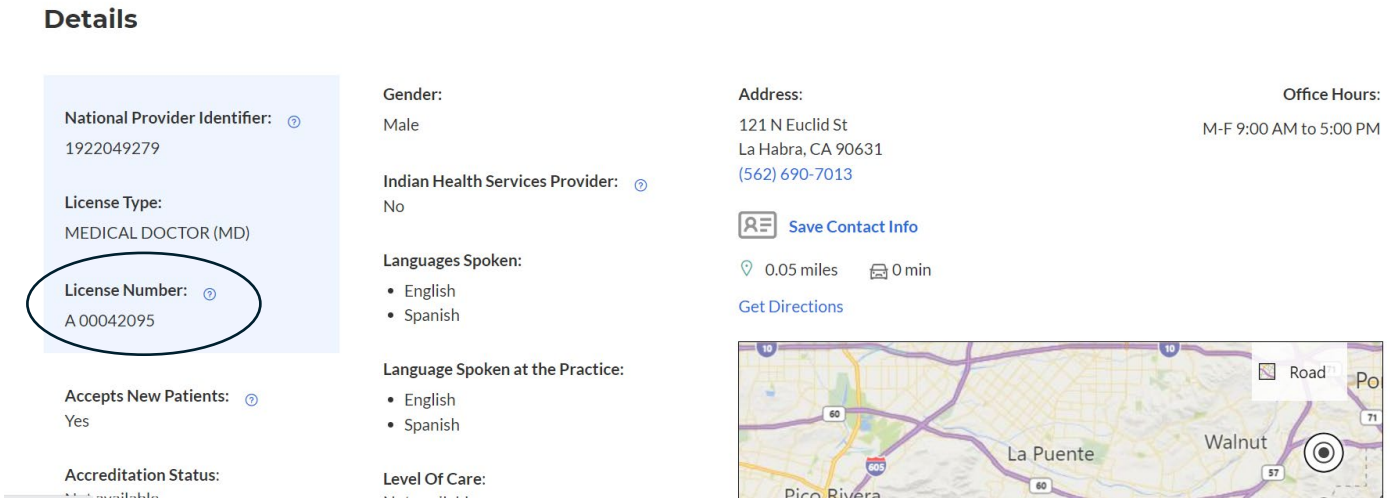


Note: If you're looking for a primary care doctor, select the check boxes that say Accepting New Patients and Able to serve as Primary Care Physician (PCP).

To find your doctor's provider and medical group/IPA number (needed when you enroll in the HMO plan for the first time), select the doctor's name and look for their license number.

That is the number that will go on your enrollment form.





Remember: Choosing a PCP is only required for those who choose an Anthem HMO plan. If you do not choose a PCP at the time of Open Enrollment, Anthem will automictically assign one to you. If you wish to change your PCP, you may contact Anthem's customer service line on the back of your ID card to request a change. Anthem will mail new cards with the PCP change.

HEALTH SAVINGS ACCOUNT (HSA)

Click to play video

ARE YOU ELIGIBLE?

The HSA is not for everyone. You're eligible only if you are:

1. Enrolled in the La Habra City School District qualified Anthem High Deductible Health Plan/HSA Plan A medical plan.
2. Not enrolled in other non-HDHP medical coverage, including Medicare, Medicaid, or Tricare.
3. Not a tax dependent.
4. Not enrolled in a healthcare Flexible Spending Account (FSA), unless it's a "limited purpose" FSA for dental and vision expenses.
5. Not active in the military.
6. A U.S resident.

Find out more

- Eligible Expenses
- Ineligible Expenses

A personal savings account for healthcare

A Health Saving Account is a tax-advantaged personal savings or investment account that you can use to pay for qualified health expenses. Additionally, your entire election amount is available to you at the beginning of your plan year. This benefit is administered by American Fidelity.

How it works

- An HSA is an employee-owned bank account that can be used to help pay for qualified medical expenses such as office visits, hospital stays and prescription drugs.
- You elect the contribution amount to your HSA each pay period, up to the IRS maximum before taxes are withheld. You may change the deduction amounts at the beginning of each calendar quarter. The Employee contribution are subject to CA state taxes.
- If you and your spouse are both enrolled in a HDHP and contribute into an HSA, your combined HSA contribution cannot be more than the 2024 IRS maximum, even if your spouse does not work for the La Habra CSD.
- You can contribute up to the 2024 limit set by the IRS:
  Individual: $4,150 per year.
  Family: $8,300 per year.
  Annual Catch-up for those age 55 and older: An additional $1,000 per year
- You can use your HSA debit card to pay for eligible expenses like office visits, lab tests, prescriptions, dental and vision care, and even some drugstore items.

Four reasons to love an HSA

1. **Tax-free.** No federal tax on contributions, or state tax in most states. Withdrawals are also tax-free as long as they're for eligible healthcare expenses.
2. **No "use it or lose it."** Your balance rolls over from year to year. You own the account and can continue to use it even if you change medical plans or leave the company.
3. **Use it now or later.** Use your HSA for healthcare expenses you have today or save it to use in the future.
4. **Boosts retirement savings.** After you retire, you can use your HSA for healthcare expenses tax-free, or for regular living expenses, taxable but no penalties.

For more information, contact American Fidelity at 800.365.9180 or visit www.americanfidelity.com/support/hsa/

HEALTHCARE FLEXIBLE SPENDING ACCOUNT (FSA)

Click to play video

IMPORTANT CONSIDERATIONS

- Expenses must be incurred between **10/1/2023** and **9/30/24** and submitted for reimbursement by **12/31/24**.
- **Healthcare FSA:** You can keep (rollover) up to $610 of unused money for use in the next plan year. Unused amounts above $610 will be lost, so it is very important that you plan carefully before making your election.
- **Dependent Care FSA:** Unused amounts will be lost at the end of the plan year, so it is very important that you plan carefully before making your election.
- Elections cannot be changed during the plan year.
- FSA funds can be used for you, your spouse, and your tax dependents only.
- You cannot obtain reimbursement for eligible expenses for a domestic partner or their children, unless they qualify as your tax dependents (Important: questions about the tax status of your dependents should be addressed with your tax advisor).
- Keep your receipts. In most cases, you'll need to provide proof that your expenses were considered eligible for IRS purposes.

REMEMBER!

You must re-enroll in this program each year if you wish to participate in an FSA for that year. It is NOT automatic.

Set Aside Healthcare Dollars For The Coming Year

A healthcare FSA allows you to set aside tax-free money to pay for healthcare expenses you expect to have over the coming year. The money can be used for eligible healthcare and dependent daycare expenses that you and your family expect to have over the next year. The main benefit of using an FSA is that you reduce your taxable income, which means you have more money to spend. The catch is that you have to use the money in your account by our plan year's end. Otherwise, that money is lost, so plan carefully. You must re-enroll in this program each year. American Fidelity administers this program.

Healthcare FSA Account

This plan allows you to pay for eligible out-of-pocket healthcare expenses with pre-tax dollars. Eligible expenses include medical, dental, or vision costs including plan deductibles, copays, coinsurance amounts, and other non-covered healthcare costs for you and your tax dependents. You may access your entire annual election from the first day of the plan year and you can set aside up to **$3,050** this year.

Dependent Care FSA Account

This plan allows you to pay for eligible out-of-pocket dependent care expenses with pre-tax dollars. Eligible expenses may include daycare centers, in- home childcare, and before or after school care for your dependent children under age 13. Other individuals may qualify if they are considered your tax dependent and are incapable of self-care. It is important to note that you can access money only after it is placed into your Dependent Care FSA account. All caregivers must have a tax ID or Social Security number. This information must be included on your federal tax return. If you use the dependent care reimbursement account, the IRS will not allow you to claim a dependent care credit for reimbursed expenses. Consult your tax advisor to determine whether you should enroll in this plan. You can set aside up to **$5,000** per household for eligible dependent care expenses for the year.

Limited Purpose FSA Account

This account is only for members enrolled in the HDHP plan with an HSA account. IRS rules allows you to have an HSA and a Limited Purpose Account, but not a Healthcare FSA. You can only use this account for dental and vision expenses. You may set aside **$3,050** this year.

COMPARING HSA VS. FSA

Choosing a health savings plan can be difficult. Here's a breakdown to understand what the differences are between a HSA and Healthcare FSA.

HSA	FSA
Eligibility Requirements	
Must have a qualified HDHP and no other disqualified health plan	No specific eligibility requirements
Availability of Funds	
Funds are available as contributions are made	The full election amount is available up front at the beginning of the plan year
Changing Contribution Amounts	
May change at any point during the year, subject to plan provisions	May be adjusted at Open Enrollment or with a qualifying change in employment or family status
Rollover	
Any unused balance always rolls over to the next plan year	FSAs are "use it or lose it" and you forfeit any unused balance at the end of the plan year
Connection of Employer	
It's your account. You can take with you wherever you go	Generally, you will lose your FSA with a change in employment
Effect on Taxes	
Contributions may be taken out of your paycheck pre-tax. Growth and distributions for qualified expenses are tax free	Contributions are taken out of your paycheck pre-tax. Distributions are tax free for qualified expenses

Watch the HSA Vs FSA Video!

Click to play video

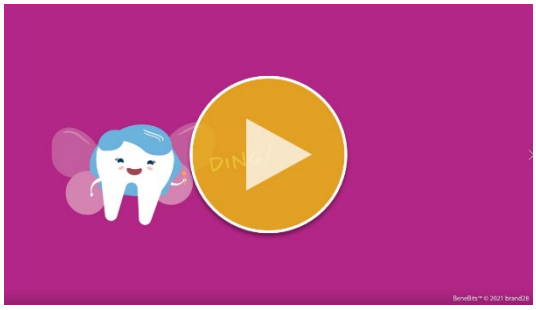
DENTAL

OUR PLANS

Delta Dental PPO Plan

Delta Dental DHMO Dental Plan

Click to play video



Important for the DHMO Plan! In order to enroll in the Delta Dental DHMO Dental plan, enrollees MUST input a provider number. To find an HMO in-network provider please see page 17.

Why Sign Up For Dental Coverage?

It's important to go to the dentist regularly. Brushing and flossing are great, but regular exams catch dental issues early before they become more expensive and difficult to treat.

That's where dental insurance comes in. Dental insurance makes it easier and less expensive to get the care you need to maintain good oral health.

Dental insurance covers three types of treatments:

- **Preventive** care includes exams, cleanings and x-rays
- **Basic** care focuses on repair and restoration with services such as fillings, root canals, and gum disease treatment
- **Major** care goes further than basic and includes bridges, crowns and dentures
- **Orthodontia** treatment to properly align teeth within the mouth.

DELTA DENTAL

	Delta Dental PPO Plan		DHMO Dental Plan
	In-Network	Out-Of-Network	In-Network
Calendar Year Deductible	$0 $0	$0 $0	$0 $0
Annual Plan Maximum	$2,200 per member*	$2,000 per member (combined with in-network)	Unlimited
Waiting Period	None	None	None
Diagnostic and Preventive	Plan pays 70% - 100%	Plan pays 70% - 100% UCR	$0-$45 copay then plan pays 100% (varies by service, see contract for fee schedule)
Basic Services **Fillings**	Plan pays 70% - 100%	Plan pays 70% - 100% UCR	$0-$240 copay then plan pays 100% (varies by service, see contract for fee schedule)
Root Canals	Plan pays 70% - 100%	Plan pays 70% - 100% UCR	$0-$280 copay then plan pays 100% (varies by service, see contract for fee schedule)
Periodontics	Plan pays 70% - 100%	Plan pays 70% - 100% UCR	$0-$280 copay then plan pays 100% (varies by service, see contract for fee schedule)
Major Services	Prosthodontics: Plan pays 50% Crowns, inlays, onlays & cast restorations: plan pays 70%-100%	Prosthodontics: Plan pays 50% Crowns, inlays, onlays & cast restorations: plan pays 70%-100%	$0-$240 copay then plan pays 100% (varies by service, see contract for fee schedule)
Orthodontic Services			
Orthodontia	Plan pays 50%	Plan pays 50% UCR	$1,700 Child and $1,900 Adult Lifetime maximums
Lifetime Maximum	$1,000 per member	$1,000 per member	Unlimited
Dependent Children	Covered	Covered	Covered to age 19
Full-time Students	Covered	Covered	Covered

* This amount includes the additional $200 for using a PPO dentist. The plan provides an additional $200 toward the calendar year maximum when you visit a PPO dentist. Look for this information for the dentist of your choice on the Delta find a provider website to take advantage of this additional amount: (Other network affiliations: Delta Dental PPO).

HOW TO FIND A DELTA DENTAL PROVIDER

1. Visit https://www1.deltadentalins.com/individuals/find-a-dentist.html

2. Input your location by entering your address, city or ZIP code

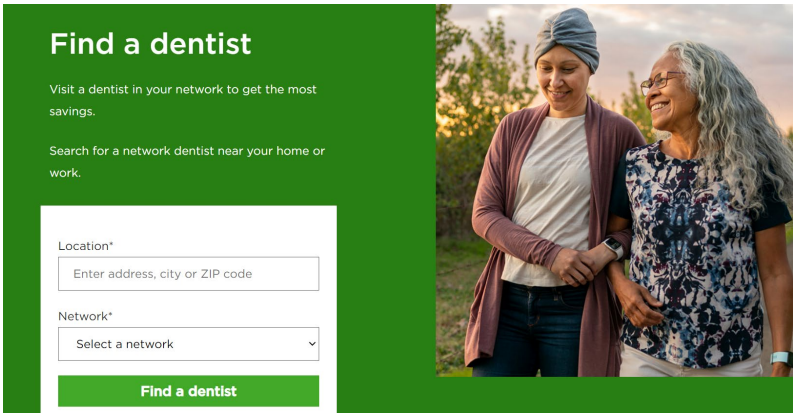
3. Select your network:

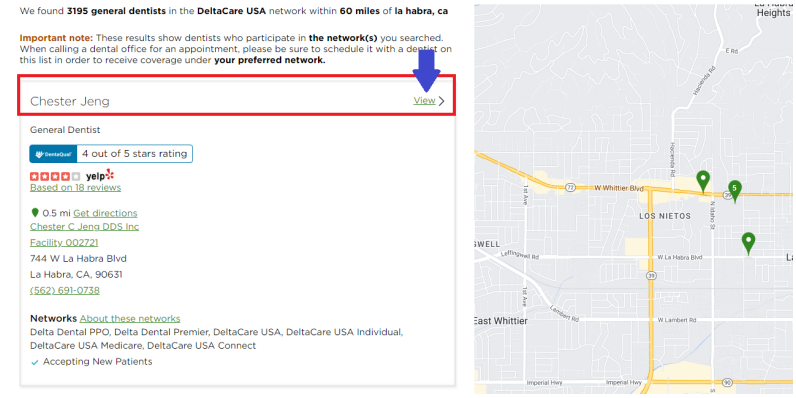
   - **PPO members select “Delta Dental PPO”**
   - **DHMO members select “DeltaCare USA”**

4. Click on Find a dentist

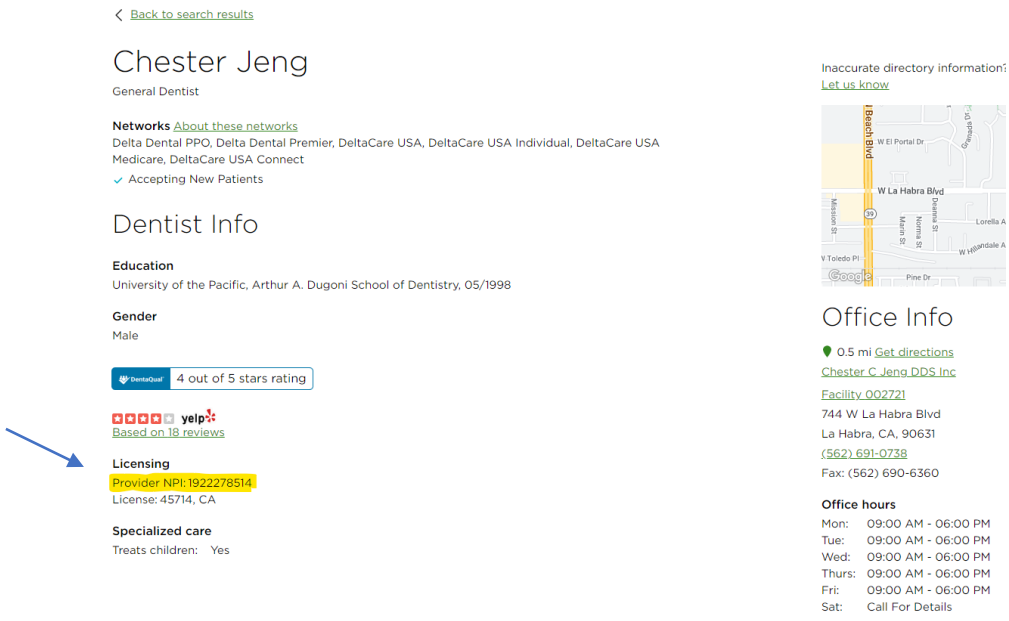
5. You can refine your search by clicking on Refine Search or use the Search box.

6. You can view more information on a provider by clicking on the “view” icon next to the provider’s name.





Important Note: DHMO members will need the Provider NPI # when enrolling in the DHMO plan. After clicking “view” for your preferred provider, you can find this # under “licensing”. See the following below photo:



DELTA DENTAL VIRTUAL RESOURCES

Toothpic:

Toothpic is a photo-based teledentristry app for PPO plan members that offers virtual dental screenings from a Delta Dental dentist. Answer a few questions about your oral health and take photos of your mouth from your smartphone and receive a personalized dental report in under 24 hours. Visit **https://deltadental.toothpic.com/** to register.

Virtual Consult:

Delta Dental is also offering a new virtual dentistry tool – Virtual Consult. Virtual Consult connects Delta Dental members and dentists for real-time video appointments. Visit **https://deltadentalvirtualconsult.com/landing.htm** for more information and to learn how to download and use Virtual Consult.

Virtual Consult is great if you:
• Are experiencing an urgent dental issue.
• Don't have a regular dentist.
• Can't take time of work or have difficulty visiting the dentist's office.
• Aren't feeling well or visiting the dentist's office isn't recommended.

Grin! E-Magazine:

Sign up to receive the Grin! E-magazine, which is filled with informative articles, fun facts, and tasty recipes. Go to **www.deltadental.com/grinmag/us/en/ddpa.html** to sign up or for more information.

Amplifon Hearing Health Care

With your Delta Dental plan, you also have access to discounts on hearing aids through Amplifon. Amplifon is a leader in hearing health care and will act as your personal concierge. They'll guide you through every step, from using your discounts o finding the right products and care to match your hearing needs.

With Amplifon you'll get:

- Access to the best hearing aid prices of up to 62% average savings off retail pricing.
- Choice of top hearing Aid Brands
- Thousands of hearing care providers
- One year of free follow-up care, two years of free batteries, and a three-year product warranty on all purchases.

To get started you can call Amplifon at 800.778.1429 or visit **www.amplifonusa.com/lp/deltadentalins**.

QualSight LASIK

Think you'd never be able to afford LASIK eye surgery? Now it may be within reach. Why? Because Delta Dental has selected QualSight to offer you access to discounts on LASIK services. Through QualSight, you can save 40-50% off the national average price of Traditional LASIK along with big savings on Custom and Custom Bladeless LASIK procedures!

To start taking advantage of these savings, you can call QualSight care at 855.248.2020 or visit **www.qualsight.com/-delta-dental**.

New! Delta Dental SmileWay Program

Get support for chronic conditions with Delta Dental's new SmileWay Program

Delta Dental PPO members also have additional dental coverage to support your overall health.

Chronic conditions and the medications used to treat them can impact your oral health. If you or a covered family member has been diagnosed with a chronic medical condition like diabetes, cancer or rheumatoid arthritis, you may benefit from additional teeth and gum cleanings.

Take advantage of expanded coverage to help safeguard your oral health. To qualify, you or a covered family member must be diagnosed with any of the following:

- Amyotrophic lateral sclerosis (ALS)
- Cancer
- Chronic kidney disease
- Diabetes
- Heart disease
- HIV/AIDS
- Huntington's disease
- Joint replacement
- Lupus
- Opioid misuse & addiction
- Parkinson's disease
- Rheumatoid arthritis
- Sjogren's syndrome
- Stroke

*This coverage is subject to any applicable maximums and deductibles under the terms and conditions outlined in your plan's Evidence of Coverage. Please review your plan booklet for specific details about your coverage.

SmileWay Wellness Benefit

100% Coverage	One periodontal scaling and root planning procedure per quadrant per calendar or contract year*
Four of the following (any combination) per calendar or contract year	
100% coverage	Prophylaxis (teeth cleaning)
	Periodontal maintenance
	Scaling in presence or moderate or severe gingival inflammation

Learn more or to opt in by visiting www1.deltadentalins.com/smileway or by calling Customer Service at (888) 335-8227, Monday through Friday.

VISION

OUR PLANS

VSP Vision Plan

Click to play video

Why Sign Up For VSP Vision Coverage?

Vision coverage helps with the cost of eyeglasses or contacts. But even if you don't need vision correction, an annual eye exam checks the health of your eyes and can even detect more serious health issues such as diabetes, high blood pressure, high cholesterol, and thyroid disease.

You'll even find discounts on services like LASIK ,discounts glasses and on contact lenses, and money off on hearing aids and other related services. Visit www.vsp.com/offers/special-offers to check out these extra savings.

Using Your VSP Benefit Is Easy

- Find a VSP doctor who's right for you at www.vsp.com.
- Review your plan coverage before your appointment.
- At your appointment, tell them you have VSP. **There's no ID card necessary** but you can print one by logging in to your account on www.vsp.com.

VISION

Your vision checkup is fully covered after your Exam copay. After any materials copay, the plan covers frames, lenses, and contacts as described below.

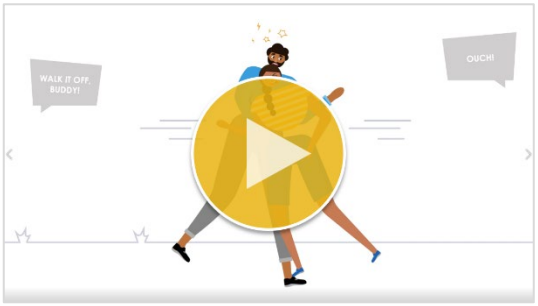
VSP Vision Plan

	In-Network	Out-Of-Network
Examination		
Benefit	$20 copay (combined with glasses)	Up to $35 Allowance
Frequency	1 x every 12 months	In-network limitations apply
Materials	$0 after examination copay	See Schedule below
Eyeglass Lenses		
Single Vision	Plan pays 100%	Up to $25 Allowance Up
Lens Bifocal	Plan pays 100%	to $40 Allowance Up to
Lens Trifocal	Plan pays 100%	$50 Allowance
Lens Frequency	1 x every 12 months	In-network limitations apply
Frames	Combined with exam copay	
Benefit	Up to $150 allowance (20% off amount over allowance)	Up to $30 Allowance
Frequency	1 x every 24 months	In-network limitations apply
Contacts		
(Elective)		
Benefit	Up to $150 allowance (copay waived; instead of eyeglasses)	Up to $90 allowance (copay waived; instead of eyeglasses)
Frequency	1 x every 12 months	1 x every 12 months

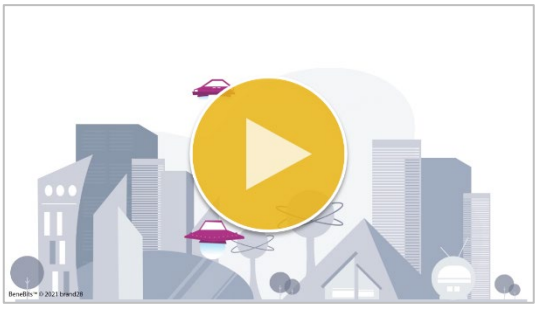
***Contact lenses are in lieu of spectacle lenses and frame. If you choose contacts, you will be eligible for a frame 24 months from the date the contact lenses were obtained.**

SISC Programs & Mental Health Resources

Click to play video



Urgent Care vs ER



Virtual Healthcare

Maximize Your Healthcare

Knowing how to best use your healthcare coverage can help you improve your health and reduce your expenses. In this section you'll find tips on:

- Finding the right care at the right cost
- Saving money on prescription drugs with **Costco & Navitus**

Health Enhancing Programs

In addition to medical coverage, we provide these programs and services to help you access care when and how you need it and address special health concerns:

- **Eden Health - NEW!**
- **Learn to Live**
- **Maven**
- **Employee Assistance Program (EAP)**
- **Kaiser's Telemedicine**
- **Kaiser's Calm App and myStrength**
- **Telehealth – MDLive , Anthem's LiveHealth Online, & Vida Health**
- **Hinge Health**
- **Carrum Health Program**
- **Contigo Health**
- **Condition Management**

KNOW WHERE TO GO

Where you get medical care can have a significant impact on the cost. Here's a quick guide to help you know where to go, based on your condition, budget, and time.

Type	Appropriate for	Examples	Access	Cost
Nurseline 	Quick answers from a trained nurse	• Identifying symptoms • Decide if immediate care is needed • Home treatment options and advice	24/7	**$0**
Online visit 	Many non-emergency health conditions	• Cold, flu, allergies • Headache, migraine • Skin conditions, rashes • Minor injuries • Mental health concerns	24/7	**$**
Office visit 	Routine medical care and overall health management	• Preventive care • Illnesses, injuries • Managing existing conditions	Office Hours	**$$**
Urgent care, walk-in clinic 	Non-life-threatening conditions requiring prompt attention	• Stitches • Sprains • Animal bites • Ear-nose-throat infections	Office Hours, or up to 24/7	**$$$**
Emergency room 	Life-threatening conditions requiring immediate medical expertise	• Suspected heart attack or stroke • Major bone breaks • Excessive bleeding • Severe pain • Difficulty breathing	24/7	**$$$$$**

PRESCRIPTIONS BREAKING YOUR BUDGET?

THE FORMULARY DRUG TIERS DETERMINE YOUR COST

$	Generic Drug
$$	Brand Name Drug
$$$	Specialty Drug

Understanding the formulary can save you money

If your doctor prescribes medicine, especially for an ongoing condition, don't forget to check your health plan's drug formulary. It's a powerful tool that can help you make informed decisions about your medication options and identify the lowest cost selection.

What is a formulary?

A drug formulary is a list of prescription drugs covered by your medical plan. Most prescription drug formularies separate the medications they cover into four or five drug categories, or "tiers." These groupings range from least expensive to most expensive cost to you. "Preferred" drugs generally cost you less than "non-preferred" drugs.

Get the most from your coverage with Costco & Navitus

Take advantage of these SISC Value Added Benefits to help you save on prescription costs!

Navitus: Specialty Medications

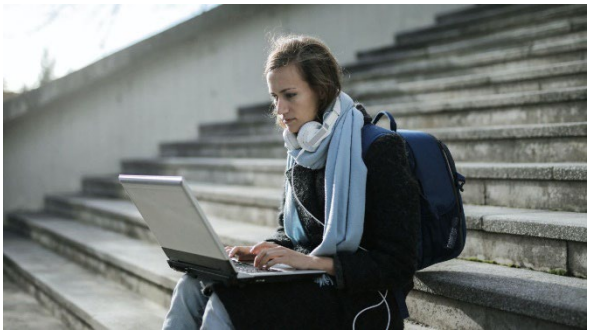
Specialty medications are high-cost injectable, infused, oral, or inhaled medications that generally require special handling and may be subject to special rules such as quantity limits, prior authorization and/or step therapy. These medications have become a vital part of the treatment for chronic illnesses and complex diseases such as multiple sclerosis, rheumatoid arthritis and cancer. Some medications may involve special delivery and instructions that not all pharmacies can easily provide. These medications require personalized coordination between the member, the prescriber and pharmacy. Navitus Specialty helps patients stay on track with treatment while offering the highest standard of compassionate care through personalized support, free delivery and refill reminders. Most medications classified as Specialty can be found on the SISC Drug List located on Navitus' secure member website Navi-Gate for Members at www.navitus.com. Not available to Medicare members.

Costco Generic Prescriptions

$0 co-pay for generic prescriptions. Costco membership is NOT required. 30 or 90-day supplies of most generics. Some narcotic pain and cough medications are not included in the Costco Free Generic or 90-day supply programs. This program is available to all Anthem PPO and HMO plans. Find a Costco location by calling (800) 774-2678 (press 1) or visit **www.costco.com**.

Click to play video

KAISER MENTAL HEALTH RESOURCES



Everyone needs support for total health – mind, body, and spirit. Digital tools can help you navigate life's challenges, make small changes that improve sleep, mood, and more, or simply support an overall sense of well-being.

KAISER PERMANENTE TELEMEDICINE

Kaiser Permanente members have access to remote healthcare. For primary care, specialty care, and mental health services, KP members can connect with their care team from the comfort and safety of their homes.

Kaiser members can assess telehealth by signing in to **kp.org**.

KAISER CALM MEDITATION AND MINDFULNESS APP

All SISC Kaiser Permanente Members have **free access** to the highly acclaimed Calm meditation and mindfulness smart phone application.

Adult members can get the Calm app at no cost. Practice mindfulness with Calm can help you build resilience and support your overall emotional health and wellness. Anyone can benefit from Calm, and the app offers something for everyone:

- ✓ A new 10-minute daily calm meditation every day
- ✓ Guided meditations covering anxiety, stress, gratitude, and more
- ✓ Sleep stories (soothing bedtime tales for grown ups)
- ✓ Music or focus, relaxation, and sleep
- ✓ Calm Masterclasses taught by world-renowned experts and celebrities

KP members can get access to Calm at **kp.org/selfcareapps**.

MYSTRENGTH APP

myStrength® is a personalized program that includes interactive activities, in-the-moment coping tools, inspirational resources, and community support. You can track preferences and goals, current emotional states, and ongoing life events to improve your awareness and change behaviors.

This program can help with depression, anxiety, sleep, stress, substance abuse, and even chronic pain. To get started or to learn more, go to **kp.org/selfcareapps/scal** to access myStrength.

FOR IN-PERSON MENTAL HEALTH AND SUBSTANCE USE SERVICES

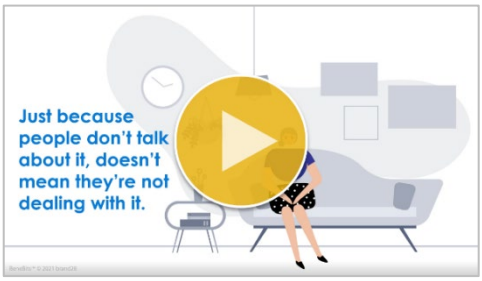
If you need to set up or find a participating therapist and psychiatrist, use the SoCal Kaiser Permanente Location finder at **https://healthy.kaiserpermanente.org/southern-california/health-wellness/mental-health** or call member services at (**833) 574-2273** (TTY 711).

All support is confidential.
Our providers will never share your information with your employer.

SISC MENTAL HEALTH RESOURCES

These are challenging times, and we understand that you or people close to you may also be faced with additional work and family stresses. Feelings of isolation, depression or despair should never be taken lightly. This is a reminder that our medical plans include coverage for mental health care. And through our telemedicine provider, you can connect to a mental health provider within minutes, from any location, at any time.

Click to play video



EMPLOYEE ASSISTANCE PROGRAM – available to all SISC members (Kaiser & Anthem).

There are times when everyone needs a little help or advice. The confidential Employee Assistance Program (EAP) through Anthem can help you with things like stress, anxiety, depression, chemical dependency, relationship issues, legal issues, parenting questions, financial counseling, and dependent care resources.

If you need counseling, you get up to 6 visits with a licensed professional and best of all, it's free.

Help is available 24/7, 365 days a year by telephone at (**800) 999-7222**.

Other resources are available online at www.anthemEAP.com; Company Code SISC.

The program is available to your family and household members.

ANTHEM LIVEHEALTH ONLINE – available to all SISC members via Anthem EAP

See a psychologist or therapist right at home. Your Anthem EAP also includes **free** online therapy visits with LiveHealth Online.

Counselors on LiveHealth Online can help you with:

- Stress
- Anxiety
- Depression
- Relationship issues
- Family issues
- Grief
- Panic attacks

Call Anthem EAP at (**800) 999-7222** to get a coupon code to get started.

MDLIVE – TELEHEALTH – available to all members on the Anthem and PPO and HMO plans.

MDLive offers 24/7/365 on-demand access to a national network of board-certified doctors, behavioral health professionals and pediatricians that can diagnose, recommend treatment and prescribe medications. For $10 copay, you, can access medical care from the comfort of your home without having to go to a doctor's office.

To register or to learn more go to www.mdlive.com/sisc or call (**800) 657-6169**.

VIDA HEALTH - available to Anthem PPO and HMO members at no cost.

Get one-on-one health coaching, therapy, digital programs and other tools and resources via online or mobile access. This program helps you prevent, manage or reverse conditions such as pre-diabetes, diabetes, hypertension, obesity, depression, anxiety, etc. To learn more, go to www.vida.com/SISC or call (**855) 442-5885.**

LEARN TO LIVE

An Emotional Well-being resource that offers help when you need it.

Change your mind. Change your life with Learn to Live. A program available at no cost to you through your Anthem EAP benefit. **Anthem EAP is available to all SISC members (Kaiser & Anthem).**

Your emotional health is an important part of your overall health. With Emotional Well-being Resources, administered by Learn to Live, you can receive support to help you live your happiest, healthiest life.

Built on the proven principals of Cognitive Behavioral Therapy (CBT), our digital tools are available anywhere and anytime. They can help you identity thoughts and behavior patterns that affect your emotional well-being and work through them. You'll learn effective ways to manage stress, depression, anxiety, substance use and sleep issues.

A Wealth of Resources at your fingertips:

- **Personalized, one-on-one coaching** – team up with an experienced coach who can provide support and encouragement by email, text, or phone.
- **Build a Support Team –** add friends or family members as "Teammates". They can help you stay motivated and accountable while you work through the programs.
- **Practice mindfulness on the go –** receive weekly text messages filled with positivity, quick tips, and exercises to improve your mood.
- **Live and on-demand webinars –** Learn how to Improve mental well-being with useful tips and advice from experts.

To access Learn to Live, visit AnthemEAP.com and enter your company code to log in: **SISC**.

You can also reach out the Anthem EAP program at **(800) 999-7222** to learn more.

learntolive

Anthem EAP

SISC
Self-Insured Schools of California
Schools Helping Schools

OTHER SISC ADDED VALUE SERVICES

Take advantage of these no cost benefits to help you get and stay healthy

ENHANCED CANCER BENEFIT
Oncology Center of Excellence Program

Anthem PPO members can consult experts who can help you navigate the complex world of cancer treatment. Services include assistance in receiving an accurate initial diagnosis and developing a comprehensive care plan. Also covers care coordination services with a home provider, transportation benefits and more. To learn more, go to sisc.hdplus.com or call (**877) 220-3556**.

CONDITION MANAGEMENT

Condition management is a confidential, voluntary program designed to help people with specific conditions stay as healthy as possible for as long as possible. Health management nurses work over the telephone with PPO plan participants who are living with one of the following conditions:

- Diabetes
- Coronary artery disease (CAD)

Please visit the Health Smarts web page at www.sischealth.com for additional information.

HINGE HEALTH

Anthem PPO members have access to Hinge Health at no cost to you. Hinge Health is a pioneering digital therapy program that helps users conquer chronic back or joint pain, without drugs or surgery. Best of all, it can be done at home - no need to schedule PT appointments.

The program includes:

- **Unlimited 1-on-1 Coaching:** To motivate and help users meet their goals
- **Convenient Exercise Therapy:** Personalized to each user, and in the convenience of their home
- **Education:** To help understand treatment options and how to manage pain

Click on the demo video to learn how it works: Back Demo Video. To learn more or apply visit: www.hingehealth.com/healthyschools or call (**855) 902-2777**.

CARRUM HEALTH PROGRAM

Anthem PPO members can receive inpatient surgical procedures with no cost sharing (deductible applies for HSA members) at Scripps Hospital in San Diego.

Covered procedures:

- Total hip replacement
- Total knee replacement
- Cervical spinal fusion
- Lumbar spinal fusion
- Anterior/Posterior Spinal Fusion
- Discectomy/Spinal Decompression

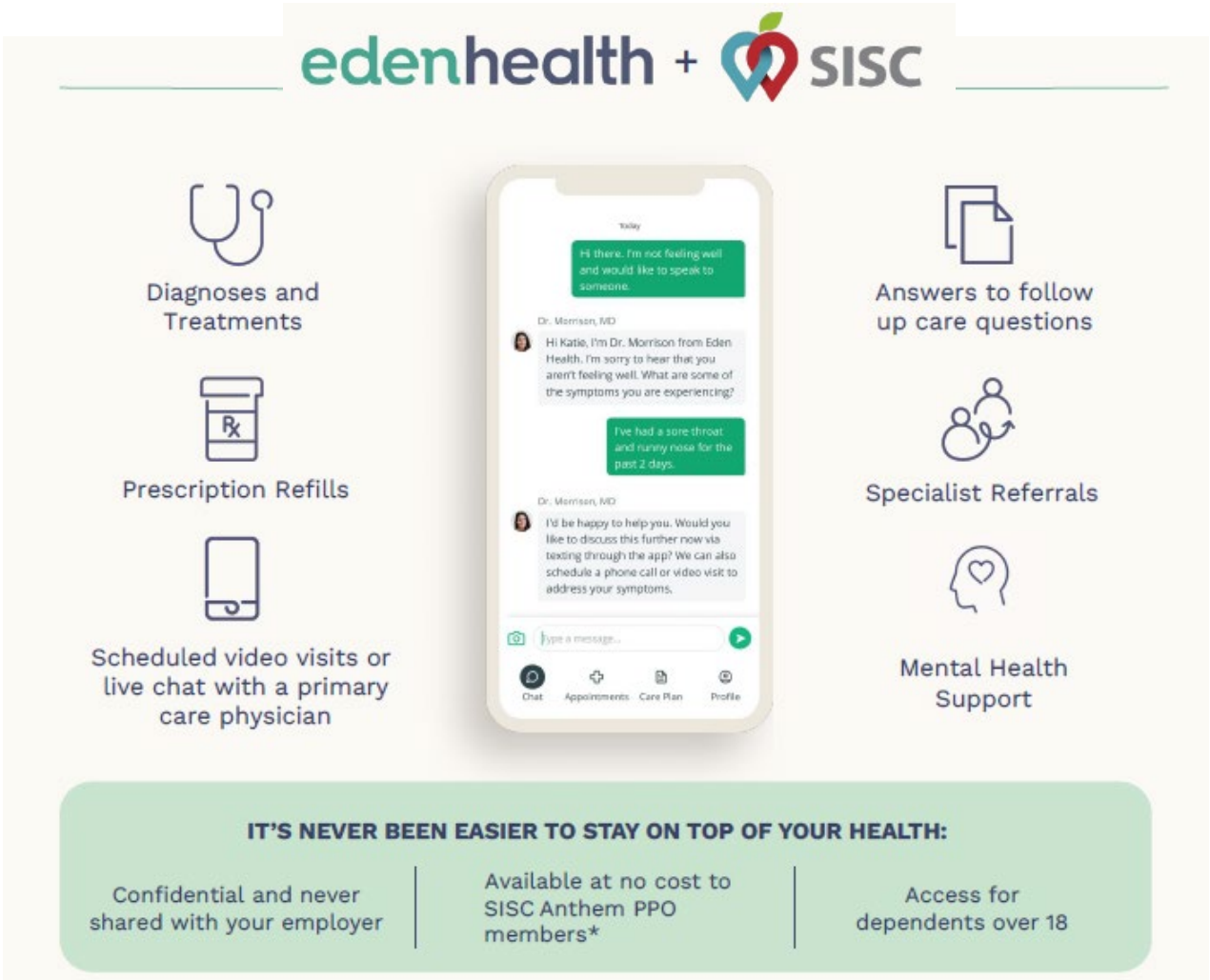
For videos and resources, visit www.carrumhealth.com/sisc.

New! Eden Health Virtual Primary Care for SISC PPO Members

Effective 4/1/23, SISC is pleased to expand primary care access to SISC Anthem PPO members* through a new smart phone application, Eden Health.

Need a Primary Care Doctor? Just Ask Eden.

Get connected to an entire health care team with Eden Health, a 24/7 access care to a primary care provider. With Eden Health you can get access to not only primary care, but also mental health support, and answers to follow-up care questions through one app. The answer to most of your health questions is now simple: “Just Ask Eden”.



Scan the QR code to download the Eden Health App and register for your free Eden Health membership.

*Eden Health is only available to District members on the Anthem PPO plan. Anthem HMO and HDHP-HSA and Kaiser members are not eligible.

MAVEN

Free On-Demand Care for Your Parenthood Journey

SISC is providing PPO members with free access to Maven Virtual Care for pregnancy and postpartum support. Use Maven for 24/7 access to doctors, specialists, coaches, and trustworthy content tailored to your experience.

To activate your membership: download the Maven Clinic app or visit mavenclinic.com/join/SISC.

You can also scan the QR Code!

What is Maven?

Maven offers 24/7 virtual access to one-on-one maternity and postpartum support. Eligible SISC PPO members are matched with a Care Advocate who connects them to trustworthy maternity and postpartum content.

How do I use Maven?

Download and log into the Maven Clinic app to access maternity and postpartum doctors, specialists, coaches, mental health experts, and so much more.

Get the Following Support at Every State of your Journey:

Pregnancy

- ✓Midwives, OB-GYNs, Doulas
- ✓Birth Planning
- ✓Prenatal Nutritionists
- ✓Mental Health Specialists
- ✓Loss Support

Postpartum

- ✓Infant Care Advice
- ✓Pediatricians
- ✓Lactation Counseling
- ✓Infant Sleep Coach

Return to Work

- ✓ Emotional support
- ✓ Back-to-Work Support
- ✓ Career Coaching

VOLUNTARY PLANS

You're Unique—And So Are Your Benefit Needs

Voluntary benefits are optional coverages that help you customize your benefits package to your individual needs. The La Habra City School District offers several voluntary Insurance policies to help. You pay the entire cost for these plans, but rates may be more affordable than individual coverage. And you get the added convenience of paying through payroll deduction.

BENEFITS AVAILABLE VIA 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 benefits can help pay for necessities until you are able to return to work.
- **Life Insurance:** Did you know your group life policy may not be portable? American Fidelity has several life insurance options that you can take with you after employment. Take steps to help protect your loved ones and secure a life insurance policy today.
- **Cancer Insurance:** 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.
- **Accident Only 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.

THE STANDARD (For California members only)

The California Teachers Association (CTA), has partnered with The Standard to provide Disability and Life Insurance plans specifically designed for education professionals. For more information call, 800.522.0406 Monday-Friday from 7am to 6pm. The plan offers a number of great features:

- Access to the CTA Advisory Panel on Endorsed Services
- Coverage for disabilities occurring on or off the job
- Coverage for extra duty pay such as coaching and tutoring
- Provisions to allow for continuation of coverage during temporary layoffs and labor disputes
- Special enrollment opportunities
- Convenient payroll deduction

403(b) and 457(b) Plans

SCHOOLSFIRST
Plan Administration, LLC

La Habra City School District sponsors voluntary retirement plans that include a 403(b) and a 457(b) plan. Participation in these plans is voluntary through SchoolsFirst Federal Credit Union. SchoolsFirst Plan Administration, LLC is the third party administrator of your 403(b) retirement plan. The information below highlights the options that are available to help you save for retirement by participating in a 403(b) and/or a 457(b) plan. These plans are designed to assist you in building and growing your savings for retirement by complimenting your pension income at retirement.

What is a 403(b)/457(b) plan?

The IRS created retirement savings plans for various groups to encourage retirement savings by offering tax benefits. They developed the 403(b) for non-profit organizations and the 457(b) for state employees. School employees have the unique opportunity in contributing to one or both plans. Contributions to these plans are made directly from your paycheck before taxes are taken out – reducing your tax bill while saving for retirement.

What if I already have a 403(b)/457(b) plan?

You always have the opportunity to increase your contributions to the 403(b) and/or 457(b) plan any time during the year, contact a representative and they will be happy to assist you.

How much may I contribute?

You may contribute up to $22,500 in 2023 to each plan, in addition to qualifying for additional catch-up limits. If you are over the age of 50, you can add an additional $6,500 in catch up limits.

Get Started

If you would like to start contributions to a 403(b) and/or a 457(b) plan, you must first establish an account with an approved investment provider. If you are already working with a financial advisor or agent, please feel free to continue to do so. If you do not have a financial advisor or agent, SchoolsFirst Federal Credit Union is here to help!

Their goal, as your District's third-party administrator, is to provide you with the very best personal service. If you have questions regarding the administration of your retirement plans, please call 800.462.8328 or email **retirement@schoolsfirstfcu.org**.

If you would like to schedule an appointment to meet with an advisor, please contact Brian Burnett at 800.462.8328, x 4116.

PLAN CONTACTS

Plan Type	Provider	Phone Number	Website
Medical	Anthem	(800) 825-5541	www.anthem.com/ca/sisc
Medical – Rx	Anthem	(866) 333 – 2757	www.navitus.com
Medical	Kaiser	(800) 464-4000	www.kp.org
Dental HMO	Delta Dental	(800) 422 – 4234	www.deltadentalins.com
Dental PPO	Delta Dental	(866) 499 – 3001	www.deltadentalins.com
Vision	VSP	(800) 877 – 7195	www.vsp.com
EAP	Anthem	(800) 999 – 7222	www.anthemEAP.com
FSA	American Fidelity	(800) 365 - 9180	www.americanfidelity.com
	Pamela Weaver	(800) 365 – 9180 Ext. 329	Pamela.weaver@americanfidelity.com
	Steve Douglass	(800) 365 – 9180 Ext. 382	Steve.douglass@americanfidelity.com
Voluntary Retirement Plans 403(b) and 457(b)	SchoolsFirst	(800) 462 – 8328 Ext. 4737	www.schoolsdfirstfcu.com

COST OF COVERAGE

In general, you pay for health coverage before federal, state, and social security taxes are withheld, so you pay less in taxes. If you have questions on your cost of coverage, please contact Danelle Bautista at (562) 690-2321.

MEDICAL

	Employee Only	Employee + Dependent	Employee + Family
Kaiser HMO $20 Plan			
Tenthly Premium Cost to District	$799.20	$1,657.20	$2,289.60
Tenthly Premium Cost to Employee	$185.20	$360.20	$435.60
Kaiser HMO $30 Plan			
Tenthly Premium Cost to District	$784.80	$1,628.40	$2,248.80
Tenthly Premium Cost to Employee	$170.80	$331.40	$394.80
Kaiser HMO Deductible $500 Plan			
Tenthly Premium Cost to District	$759.60	$1,576.80	$2,178.00
Tenthly Premium Cost to Employee	$145.60	$279.80	$324.00
Anthem HMO $20/40/250			
Tenthly Premium Cost to District	$872.40	$1,831.20	$2,541.60
Tenthly Premium Cost to Employee	$258.40	$534.20	$687.60
Anthem HMO $30/40/500			
Tenthly Premium Cost to District	$832.80	$1,743.60	$2,418.00
Tenthly Premium Cost to Employee	$218.80	$446.60	$564.00
Anthem PPO Plan J			
Tenthly Premium Cost to District	$907.20	$1,894.80	$2,625.60
Tenthly Premium Cost to Employee	$293.20	$597.80	$771.60
Anthem HDHP/HSA Plan A			
Tenthly Premium Cost to District	$793.20	$1,644.00	$2,274.00
Tenthly Premium Cost to Employee	$179.20	$347.00	$420.00

DENTAL & VISION

	Employee Only	Employee + Dependent	Employee + Family
Delta Dental DHMO			
Tenthly Premium Cost to District	$26.09	$26.09	$26.09
Tenthly Premium Cost to Employee	$0	$0	$0
Delta Dental DPPO			
Tenthly Premium Cost to District	$63.36	$130.80	$189.12
Tenthly Premium Cost to Employee	$0	$0	$53.12
VSP Vision			
Tenthly Premium Cost to District	$8.52	$17.04	$25.56
Tenthly Premium Cost to Employee	$0	$0	$0

BASIC LIFE AND AD&D

	Tenthly Premium Cost to District	Tenthly Premium Cost to Employee
MetLife		
EE Only <65 $50K	$6.60	$0.00
EE Only >65 $32.5K	$4.30	$0.00
EE Only 70+ $25K	$3.30	$0.00
MetLife AD&D		
EE Only <65 $50K	$1.14	$0.00
EE Only >65 $32.5K	$0.74	$0.00
EE Only 70+ $25K	$0.58	$0.00

WAIVING BENEFITS (WABE)

	Tenthly Premium Cost to District	Tenthly Premium Cost to Employee
Waive		
Employee Only	$640.80	$0.00

GLOSSARY

-A-

AD&D Insurance
An insurance plan that pays a benefit to you or your beneficiary if you suffer from loss of a limb, speech, sight, or hearing, or if you have a fatal accident.

Allowed Amount
The maximum amount your plan will pay for a covered healthcare service.

Ambulatory Surgery Center (ASC)
A healthcare facility that specializes in same-day surgical procedures such as cataracts, colonoscopies, upper GI endoscopy, orthopedic surgery, and more.

Annual Limit
A cap on the benefits your plan will pay in a year. Limits may be placed on particular services such as prescriptions or hospitalizations. Annual limits may be placed on the dollar amount of covered services or on the number of visits that will be covered for a particular service.
After an annual limit is reached, you must pay all associated health care costs for the rest of the plan year.

-B-

Balance Billing
In-network providers are not allowed to bill you for more than the plan's allowable charge, but out-of-network providers are. This is called balance billing. For example, if the provider's fee is $100 but the plan's allowable charge is only $70, an out-of-network provider may bill YOU for the $30 difference (the balance).

Note: The "No Surprises Act" provides protections against surprise billing for emergency services, air ambulance services, and certain services provided by a non-participating provider at a participating facility. For these services, the member's cost are generally limited to what the charge would have been if received in-network, leaving any balance to be settled between the insurer and the out-of-network provider. Consult your health plan documents for details.

Beneficiary
The person (or persons) that you name to be paid a benefit should you die. Beneficiaries are requested for life, AD&D, and retirement plans. You must name your beneficiary in advance.

Brand Name Drug
A drug sold under its trademarked name. For example, Lipitor is the brand name of a common cholesterol medicine.

-C-

COBRA
A federal law that may allow you to temporarily continue healthcare coverage after your employment ends, based on certain qualifying events. If you elect COBRA (Consolidated Omnibus Budget Reconciliation Act) coverage, you pay 100% of the premiums, including any share your employer used to pay, plus a small administrative fee.

Claim
A request for payment that you or your health care provider submits to your healthcare plan after you receive services that may be covered.

Coinsurance
Your share of the cost of a healthcare visit or service. Coinsurance is expressed as a percentage and always adds up to 100%. For example, if the plan pays 70%, your coinsurance responsibility is 30% of the cost. If your plan has a deductible, you pay 100% of the cost until you meet your deductible amount.

Copayment
A flat fee you pay for some healthcare services, for example, a doctor's office visit. You pay the copayment (sometimes called a copay) at the time you receive care. In most cases, copays do not count toward the deductible.

-D-

Deductible
The amount of healthcare expenses you have to pay for with your own money before your health plan will pay. The deductible does not apply to preventive care and certain other services.

Family coverage may have an ***aggregate*** or ***embedded*** deductible. Aggregate means your family must meet the entire family deductible before any individual expenses are covered. Embedded means the plan begins to make payments for an individual member as soon as they reach their individual deductible.

Dental Basic Services
Services such as fillings, routine extractions and some oral surgery procedures.

Dental Diagnostic & Preventive Generally includes routine cleanings, oral exams, x-rays, and fluoride treatments.
Most plans limit preventive exams and cleanings to two times a year.

Dental Major Services
Complex or restorative dental work such as crowns, bridges, dentures, inlays and onlays.

Dependent Care Flexible Spending Account (FSA)
An arrangement through your employer that lets you pay for eligible child and elder care expenses with tax-free dollars. Eligible expenses include day care, before and after-school programs, preschool, and summer day camp for children under age 13. Also included is care for a spouse or other dependent who lives with you and is physically incapable of self-care.

-E-

Eligible Expense
A service or product that is covered by your plan. Your plan will not cover any of the cost if the expense is not eligible.

Excluded Service
A service that your health plan doesn't pay for or cover.

-F-

Formulary
A list of prescription drugs covered by your medical plan or prescription drug plan. Also called a drug list.

-G-

Generic Drug
A drug that has the same active ingredients as a brand name drug but is sold under a different name. For example, Atorvastatin is the generic name for medicines with the same formula as Lipitor.

Grandfathered
A medical plan that is exempt from certain provisions of the Affordable Care Act (ACA).

-H-

Health Reimbursement Account (HRA) An account funded by an employer that reimburses employees, tax-free, for qualified medical expenses up to a maximum amount per year. Sometimes called Health Reimbursement Arrangements.

Healthcare Flexible Spending Account (FSA)
A health account through your employer that lets you pay for many out-of-pocket medical expenses with tax-free dollars. Eligible expenses include insurance copayments and deductibles, qualified prescription drugs, insulin, and medical devices, and some over-the-counter items.

GLOSSARY

High Deductible Health Plan (HDHP)
A medical plan with a higher deductible than a traditional insurance plan. The monthly premium is usually lower, but you pay more health care costs (the deductible) before the insurance company starts to pay its share. A high deductible plan (HDHP) may make you eligible for a health savings account (HSA) that allows you to pay for certain medical expenses with money free from federal taxes.

-I-

In-Network
In-network providers and services contract with your healthcare plan and will usually be the lowest cost option. Check your plan's website to find doctors, hospitals, labs, and pharmacies. Out-of-network services will cost more or may not be covered.

-L-

Life Insurance
An insurance plan that pays your beneficiary a lump sum if you die.

Long Term Disability Insurance
Insurance that replaces a portion of your income if you are unable to work due to a debilitating illness, serious injury, or mental disorder. Long term disability generally starts after a 90-day waiting period.

-M-

Mail Order
A feature of a medical or prescription drug plan where medicines you take routinely can be delivered by mail in a 90-day supply.

-O-

Open Enrollment
The time of year when you can change the benefit plans you are enrolled in and the dependents you cover. Open enrollment is held one time each year. Outside of open enrollment, you can only make changes if you have certain events in your life, like getting married or adding a new baby or child in the family.

Out-of-Network
Out-of-network providers (doctors, hospitals, labs, etc.) cost you more because they are not contracted with your plan and are not obligated to limit their maximum fees. Some plans, such as HMOs and EPOs, do not cover out-of- network services at all.

Out-of-Pocket Cost
A healthcare expense you are responsible for paying with your own money, whether from your bank account, credit card, or from a health account such as an HSA, FSA or HRA.

Out-of-Pocket Maximum
Protects you from big medical bills. Once costs "out of your own pocket" reach this amount, the plan pays 100% of most remaining eligible expenses for the rest of the plan year.

Family coverage may have an *aggregate* or *embedded* maximum. Aggregate means your family must meet the entire family out-of-pocket maximum before the plan pays 100% for any member. Embedded means the plan will cover 100% for an individual member as soon as they reach their individual maximum.

Outpatient Care
Care from a hospital that doesn't require you to stay overnight.

-P-

Participating Pharmacy
A pharmacy that contracts with your medical or drug plan and will usually result in the lowest cost for prescription medications.

Plan Year
A 12-month period of benefits coverage. The 12-month period may or may not be the same as the calendar year.

Preferred Drug
Each health plan has a preferred drug list that includes prescription medicines based on an evaluation of effectiveness and cost. Another name for this list is a "formulary." The plan may charge more for non-preferred drugs or for brand name drugs that have generic versions. Drugs that are not on the preferred drug list may not be covered.

Preventive Care Services
Routine healthcare visits that may include screenings, tests, check-ups, immunizations, and patient counseling to prevent illnesses, disease, or other health problems. Many preventive care services are fully covered. Check with your health plan in advance if you have questions about whether a preventive service is covered.

Primary Care Provider (PCP)
The main doctor you consult for healthcare issues. Some medical plans require members to name a specific doctor as their PCP and require care and referrals to be directed or approved by that provider.

-S-

Short Term Disability Insurance
Insurance that replaces a portion of your income if you are temporarily unable to work due to surgery and recovery time, a prolonged illness or injury, or pregnancy issues and childbirth recovery.

-T-

Telehealth / Telemedicine / Teladoc
A virtual visit to a doctor using video chat on a computer, tablet or smartphone. Telehealth visits can be used for many common, non-serious illnesses and injuries and are available 24/7. Many health plans and medical groups provide telehealth services at no cost or for much less than an office visit.

-U-

UCR (Usual, Customary, and Reasonable)
The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service. The UCR amount sometimes is used to determine the allowed amount.

Urgent Care
Care for an illness, injury or condition serious enough that care is needed right away, but not so severe it requires emergency room care. Treatment at an urgent care center generally costs much less than an emergency room visit.

-V-

Vaccinations
Treatment to prevent common illnesses such as flu, pneumonia, measles, polio, meningitis, shingles, and other diseases. Also called immunizations.

Voluntary Benefit
An optional benefit plan offered by your employer for which you pay the entire premium, usually through payroll deduction.

IMPORTANT PLAN INFORMATION

PLAN DOCUMENTS

As an employee, the health benefits provided by La Habra City School District represent a significant component of your compensation package. They also provide important protection for you and your family in the case of illness or injury. Each year, the District must provide you with several federal notices and plan documents. Paper copies of these documents and notices are available upon request.

SUMMARY PLAN DESCRIPTION

The Summary Plan Description (SPD) is a legal document which describes the benefit provided under the plan as well as plan rights and obligations and beneficiaries. The following SPD plan descriptions are available:

- Kaiser HMO $500
- Kaiser HMO $20
- Kaiser HMO $30
- Anthem HMO $20/40/250
- Anthem HMO $30/40/$500
- Anthem PPO J
- Anthem High Deductible PPO Plan A

SUMMARY OF BENEFITS AND COVERAGE

The Summary of Benefits and Coverage (SBC) is a document that is required by the Affordable Care Act (ACA) that present the benefit plan features in a standardized format. The following SBCs are available:

- Kaiser HMO $500
- Kaiser HMO $20
- Kaiser HMO $30
- Anthem HMO $20/40/250
- Anthem HMO $30/40/$500
- Anthem PPO J
- Anthem High Deductible PPO Plan A

Statement of Material Modifications

This enrollment guide constitutes a Summary of Material Modifications (SMM) to the La Habra City School District SISC Anthem and Kaiser plans. It is meant to supplement and/or replace certain information in the SPD, so retain it for future reference along with your SPD. Please share these materials with your covered family members.

COBRA CONTINUATION COVERAGE

You and/or your dependents may have the right to continue coverage after you lose eligibility under the terms of our health plan. Upon enrollment, you and your dependents receive a COBRA Initial Notice that outlines the circumstances under which continued coverage is available and your obligations to notify the plan when you or your dependents experience a qualifying event. Please review this notice carefully to make sure you understand your rights and obligations.

MEDICARE PART D NOTICE OF CREDITABLE COVERAGE

Important Notice from La Habra City 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 La Habra City 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. La Habra City School District has determined that the prescription drug coverage offered by the following plans (Kaiser HMO Deductible $500, Kaiser HMO $20, Anthem HMO $20/40/250, Anthem HMO $30/40/500, Anthem PPO Plan J, and Anthem HDHP/HSA Plan A) are, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and are therefore considered Creditable Coverage.

Because your existing coverage is considered 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.

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 La Habra City 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 credible 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 (penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

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 La Habra City School District coverage could be affected. See below for more information about what happens to your current coverage if you join a Medicare drug plan.

Since the existing prescription drug coverage under La Habra City School District is creditable (e.g., as good as Medicare coverage), you can retain your existing prescription drug coverage and choose not to enroll in a Part D plan; or you can enroll in a Part D plan as a supplement to, or in lieu of, your existing prescription drug coverage.

If you do decide to join a Medicare drug plan and drop your coverage through La Habra City School District, be aware that you and your dependents may not be able to get this coverage back.

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

Contact your plan at the number listed below. **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 La Habra City 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'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit **medicare.gov**
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help.
- Call 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 socialsecurity.gov, or call them at (800) 772-1213 (TTY (800) 325-0778).

Date:	10/01/2023
Name of Entity:	La Habra City School District
Contact:	Personnel Office
Address:	500 North Walnut St., La Habra, CA 90631-3769
Phone:	(562) 690-2305

WOMEN'S HEALTH AND CANCER RIGHTS ACT

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

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. If you would like more information on WHCRA benefits, call your plan administrator.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

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

HIPAA NOTICE OF SPECIAL ENROLLMENT RIGHTS

If you decline enrollment in La Habra City School District's health plan for you or your dependents (including your spouse) because of other health insurance or group health plan coverage, you or your dependents may be able to enroll in La Habra City School District's health plan without waiting for the next open enrollment period if you:

- Lose other health insurance or group health plan coverage. You must request enrollment within 30 days after the loss of other coverage.
- Gain a new dependent as a result of marriage, birth, adoption, or placement for adoption. You must request health plan enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.
- Lose Medicaid or Children's Health Insurance Program (CHIP) coverage because you are no longer eligible. You must request medical plan enrollment within 60 days after the loss of such coverage.

If you request a change due to a special enrollment event within the 30 day timeframe, coverage will be effective the date of birth, adoption or placement for adoption. For all other events, coverage will be effective the first of the month following your request for enrollment. In addition, you may enroll in La Habra City School District's health plan if you become eligible for a state premium assistance program under Medicaid or CHIP. You must request enrollment within 60 days after you gain eligibility for medical plan coverage.

If you request this change, coverage will be effective the first of the month following your request for enrollment. Specific restrictions may apply, depending on federal and state law.

Note: If your dependent becomes eligible for a special enrollment right, you may add the dependent to your current coverage or change to another health plan.

AVAILABILITY OF PRIVACY PRACTICES NOTICE

The District maintains the HIPAA Notice of Privacy Practices for describing how health information about you may be used and disclosed. You may obtain a copy of the Notice of Privacy Practices by contacting the plan administrator.

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

CALIFORNIA - Medicaid	Website: http://dhcs.ca.gov/hipp Phone: 1-916-445-8322

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

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

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

PAPERWORK REDUCTION ACT STATEMENT

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

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

OMB Control Number 1210-0137 (expires 12/31/2023)

NOTICE OF CHOICE PROVIDERS

HMO plans generally require the designation of a primary care provider. You have the right to designate any primary care provider who participates in their network and who is available to accept you or your family members. Until you make this designation, our carrier will make one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the insurance carrier directly.

MODEL GENERAL NOTICE OF COBRA CONTINUATION COVERAGE RIGHTS

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

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

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

What is COBRA continuation coverage?
COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage [choose and enter appropriate information: must pay or aren't required to pay] for COBRA continuation coverage. If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

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

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

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

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

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

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

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

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

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 30 days after the qualifying event occurs. You must provide this notice to: Personnel Office at (562) 690-2305

How is COBRA continuation coverage provided?
Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children. COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage. There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

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

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

Are there other coverage options besides COBRA Continuation Coverage?
Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, 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 concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

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

Plan contact information:
Date: October 2023
Name of Entity: La Habra City School District Contact: Personnel Office
Address: 500 N. Walnut St., La Habra CA 90631 Phone: (562) 690-2305

NONDISCRIMINATION AND ACCESSIBILITY REQUIREMENTS NOTICE

La Habra City School District complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. La Habra City School District does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

La Habra City School District:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact The Personnel Office.

If you believe that La Habra City School District has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: La Habra City School District Personnel Office, 500 N. Walnut St., La Habra CA 9063, and (562) 690-2305

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, La Habra City School District Personnel Office is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW Room
509F, HHH Building Washington, D.C.
20201
1-800-368-1019, 800-537-7697 (TDD)

Compliant forms are available at **https://www.hhs.gov/ocr/office/file**.

DETERMINING ELIGIBILITY

The information below explains in detail how your eligibility for healthcare coverage is determined, in accordance with the rules of the Affordable Care Act (ACA).

Look-Back Measurement Method

Under the ACA, employers are required to report specific benefits information to IRS on “full-time” employees as defined by the ACA. A “full-time” employee is generally an employee who works on average 130 hours per month. ACA full-time status can affect or determine major medical benefits eligibility but is not a guarantee of benefits eligibility. La Habra City School District uses the look-back measurement method to determine group health plan eligibility.

New employees hired to work full-time. If you are hired as a new full-time employee (work on average 130 or more hours a month), you and your dependents are generally eligible for group health plan coverage as of first of the month following 30 days of employment.

New employees hired to work a part-time, variable hour or seasonal schedule. If you are hired into a part-time position, a position where your hours vary and La Habra City School District is unable to determine — as of your date of hire — whether you will be a full-time employee, or you are hired as a seasonal employee who will work for six (6) consecutive months or less (regardless of monthly hours worked), you will be placed in an initial measurement period (IMP) of 12 Months. Your IMP will begin on 1st of the month following Date of Hire. If, during your IMP, you average 130 or more hours a month, you will become full-time and, if otherwise eligible for benefits, you will be offered coverage October 1. Your full-time status will remain in effect during an associated stability period that will last 12 Months. If your employment is terminated during that stability period, and you were enrolled in benefits, you will be offered coverage under COBRA.

Ongoing employees. An ongoing employee is an individual who has been employed for an entire standard measurement period. A standard measurement period is the 12 Months period during which La Habra City School District counts employee hours to determine which employees work full-time. Those employees who average 130 or more hours a month over the standard measurement period will be deemed full time and, if otherwise eligible for benefits, offered coverage as of the first day of the stability period associated with the standard measurement period. Full-time status will be in effect during an associated stability period for 12 Months. If your employment is terminated during a stability period, and you were enrolled in benefits, you will be offered continued coverage under COBRA.

La Habra City School District uses the standard measurement period and associated stability period annual cycle set forth below:

Measurement Period: Time to determine if you work 130+ hours per month on average – used to establish if you are "full-time" or "part-time" for medical eligibility	August 1 to August 1
Stability Period: Time during which you will be considered "full-time" or "part-time" for medical plan eligibility - based on hours worked during preceding Measurement Period	October 1 to October 1

DEPENDENT ELIGIBILITY DOCUMENTATION

For each dependent you are covering under the District's Health and Welfare Plans (medical, dental, vision, and life), you must provide appropriate documentation. The documentation requirements are noted below. You must also return the required Eligibility Verification Affidavit form along with your documentation for each dependent you are covering within 30 days of the event.

Dependent Type	Required Documentation	Resources to Obtain Documentation
Dependent Spouse (same or opposite gender)	Add: Marriage Certificate, or tax return Remove: Divorce Decree	• County office that issued original birth certificate
Registered Domestic Partner	Add: State of California, County or City issued Declaration/Certificate of Domestic partnership Remove: Termination of Domestic Partnership	• Government Site
Dependent child by birth	Birth Certificate (must include parents name), and/or copies of any court orders, divorce decrees or other legal documents relating to custody or health coverage or tax return	• County office that issued original birth certificate • Hospital in which child was born • U.S. Department of State (for children born outside of the U.S) • Social Security Administration
Dependent child by adoption	Final Adoption Papers and/or copies of any court orders, divorce decrees or other legal documents relating to custody or health coverage	• State agency that issued final adoption papers • Adoption agency that issued placement papers • Social Security Administration
Dependent stepchild(ren)	Marriage Certificate and Birth Certificate (must include parents name), and/or copies of any court orders, divorce decrees or other legal documents relating to custody, health coverage or income tax exemptions	• County office that issued original birth certificate • Hospital in which child was born • U.S. Department of State (for children born outside of the U.S) • Social Security Administration
Dependent child Legal Guardianship	Birth Certificate (must include parents name), and copies of any court orders or other legal documents relating to custody or health coverage	• County office that issued original birth certificate • Hospital in which child was born • U.S. Department of State (for children born outside of the U.S) • Social Security Administration

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EMPLOYEE BENEFITS

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STRONGER TOGETHER

La Habra City
School District