Active and Early Retiree Benefits Guide

2024

Employee Benefits Guide 2024

General Information

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If you (and/or your dependents) have Medicare or you will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage.

Please see page 23 for more details.

The information in this brochure is a general outline of the benefits offered under Sacramento City Unified School District's benefits program. Specific details and plan limitations are provided in the Summary Plan Descriptions (SPD), which is based on the official Plan Documents that may include policies, contracts and plan procedures. The SPD and Plan Documents contain all the specific provisions of the plans. In the event that the information in this brochure differs from the Plan Documents, the Plan Documents will prevail.

General

Sacramento City Unified School District understands the importance of offering a comprehensive benefit program that meets the needs of our diverse workforce. We are pleased to continue to provide a suite of quality benefit plans to all benefit eligible employees for the 2024 plan year.

2024 Core Health Plan Offerings

- Medical Plan
- Dental Plan
- Vision Plan
- Employee Assistance Program (EAP)
- Group Life and AD&D

In addition to the core health plans, you can purchase any of the following Voluntary Products

- Optional Life Insurance

[redacted]

[redacted]

[redacted]

[redacted]

Medical HMO Plan Comparisons - Classified Employees

* The total amount of a member's financial responsibility for certain covered services received during the plan year. Copayments, coinsurance amounts or payments made toward a plan deductible apply to the maximum. For detailed information and which services apply to the out-of-pocket maximum, refer to the plan Evidence of Coverage booklet

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** **c G** **:** If a brand drug is requested when a generic version exists, member pays the generic copay plus the cost difference between the maximum allowed charge for generic and brand, unless physician has specified "dispense as written" (DAW) or when medically necessary; ***OR***
If a brand drug is dispensed and a generic is available, member is responsible for brand copay plus cost difference between generic and brand.

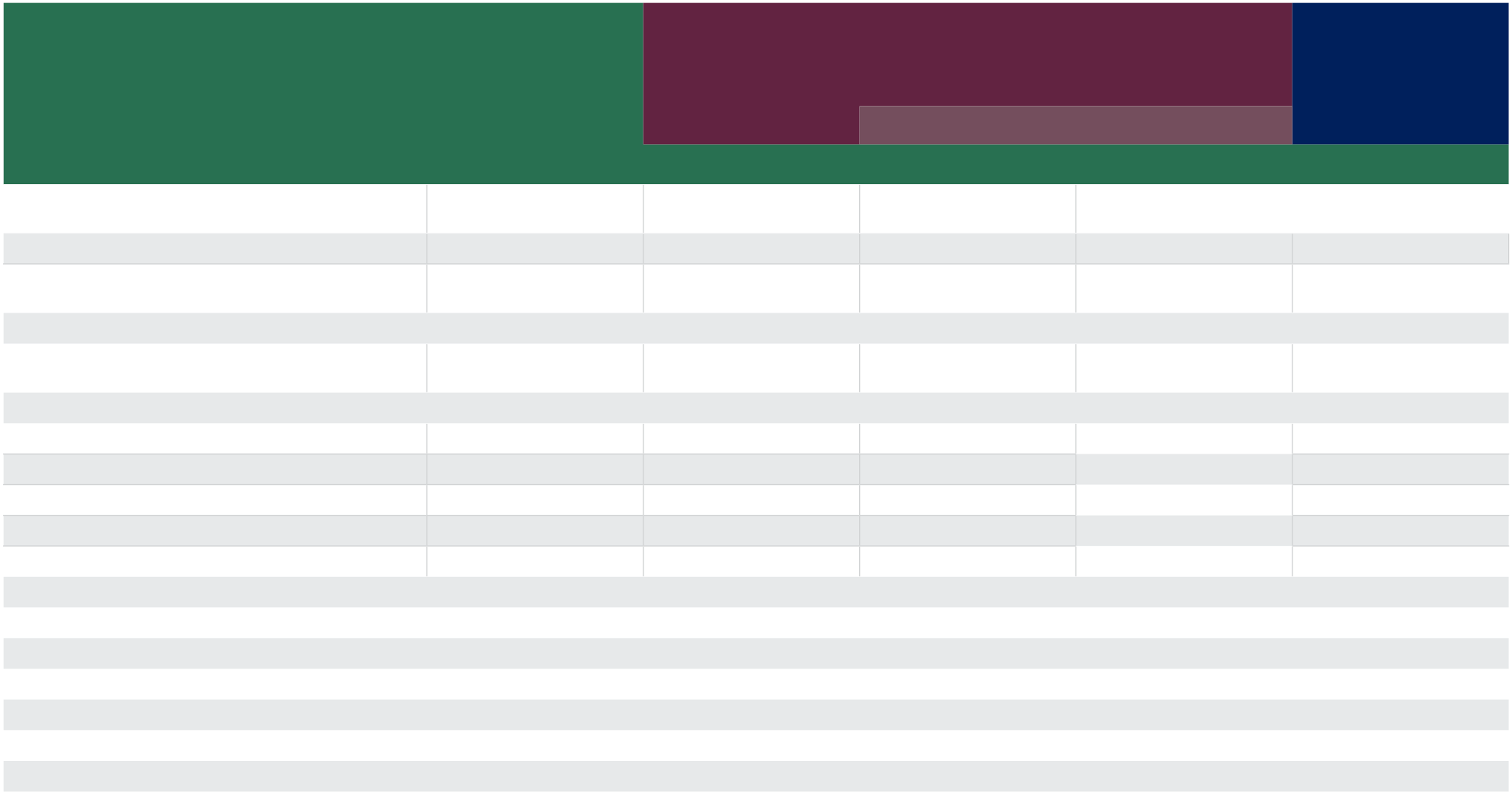
Medical HMO Plan Comparisons - Certificated Employees (continued)

B	K	H
	M	
G M		
- *(Non-preventive)*	$0 copay	$0 copay
, C , E C	$0 copay	$0 copay
F *(limited to 100 days/benefit period)*	$0 copay	$0 copay (prior authorization required)
C *(up to 100 visits/plan year)*	$0 copay	$0 copay (prior authorization required)
C	$0 copay	$0 copay (prior authorization required)
D E	$0 copay	$0 copay (prior authorization required)
M D A		
C *(pre-authorization required)*		

** G : If a brand drug is requested when a generic version exists, member pays the generic copay plus the cost difference between the maximum allowed charge for generic and brand, unless physician has specified "dispense as written" (DAW) or when medically necessary; ***OR***
If a brand drug is dispensed and a generic is available, member is responsible for brand copay plus cost difference between generic and brand.

The information described on this page is only intended to be a summary of benefits. It does not describe or include all benefit provisions, limitations, exclusions, or qualifications for coverage. Please review plan documents for full details. If there are any conflicts with information provided on this page, the plan documents will prevail.

Dental Plan Comparisons



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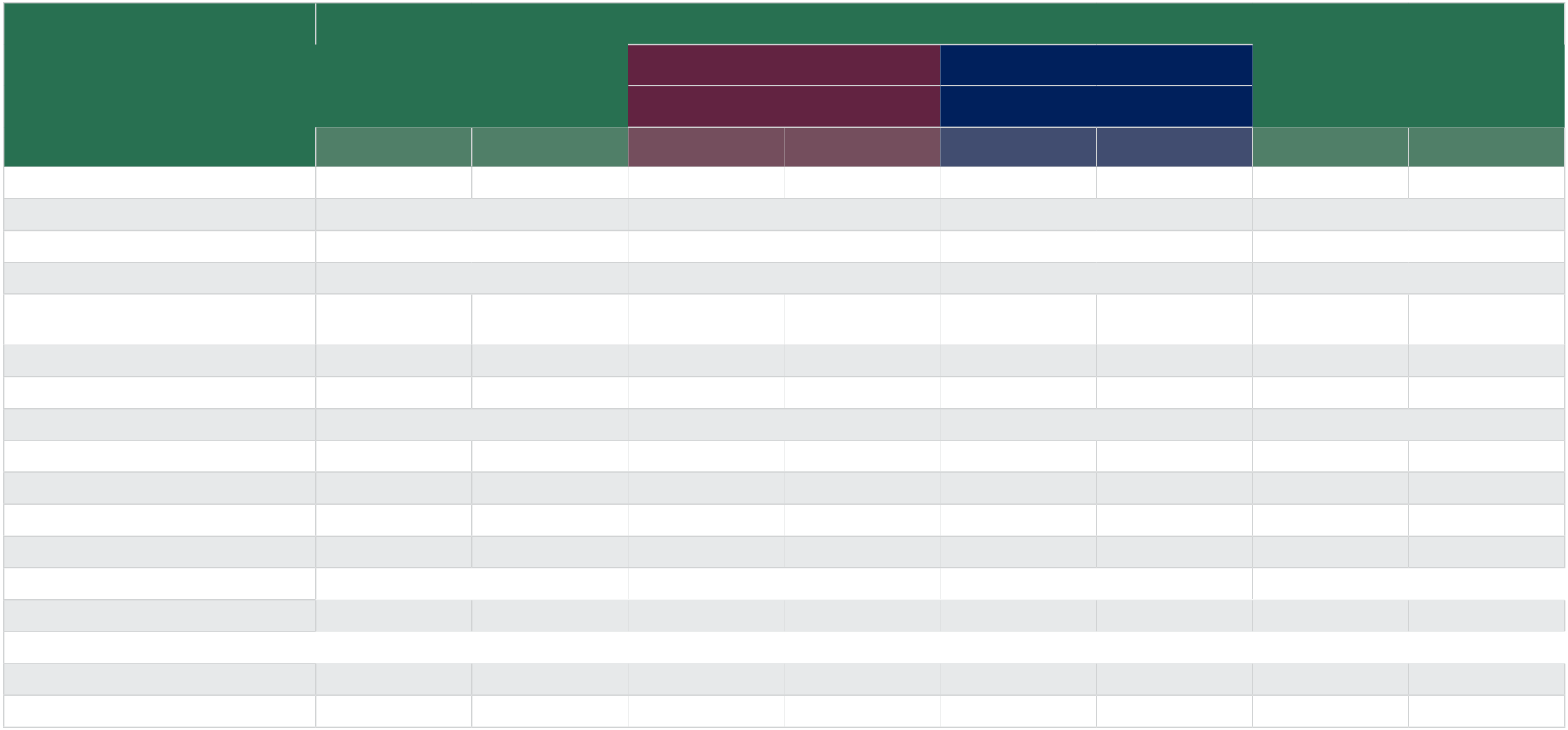
14. Services and supplies provided primarily for cosmetic purposes, except as specified in Schedule A.
15. Services and supplies which may not reasonably be expected to successfully correct the Member's dental condition for a period of at least three years, as determined by Us.
16. Orthodontic services, supplies, appliances and orthodontic-related services, unless an orthodontic rider was included in the policy.
17. Extraction of asymptomatic, pathology-free third molars (wisdom teeth).
18. Therapeutic drug injection.
19. Correction of congenital conditions or replacement of congenitally missing permanent teeth not covered, regardless of the length of time the deciduous tooth is retained.
20. General anesthesia or intravenous/conscious sedation, except as specified in Schedule A.
21. Excision of cysts and neoplasms, except as specified in Schedule A.
22. Osseous or muco-gingival surgery, except as specified in Schedule A.
23. Restorative procedures, root canals and appliances which are provided because of attrition, abrasion, erosion, wear, or for cosmetic purposes, except as specified in Schedule A.
24. Services and supplies provided as one dental procedure, and considered one procedure based on standard dental procedure codes, but separated into multiple procedure codes for billing purposes. The covered charge for the services is based on the single dental procedure code that accurately represents the treatment performed.
25. Replacement of stayplates.
26. Dispensing of drugs not normally supplied in a dental office.
27. Malignancies.
28. Additional treatment costs incurred because a dental procedure is unable to be performed in the dentist's office due to the general health and physical limitations of the Member.
29. The member will be responsible for the actual metal fees for any procedure involving the use of noble, high noble, or titanium metal.
30. Implant-supported dental appliances, implant placement, maintenance, removal and all other services associated with dental implants.
31.

Dental (continued)

D	ADA C- C	DHM 903 C-
E	D0120	$0
C . E	D0150	$0
F (F)	D0210	$0
	D0330	$0
- 、	D0220	$0
B -	D0274	$0
A C	D1110	$0
C C	D1120	$0
A /C *(to age 19)* F	D1203/1204	$0
1 2		

$0



Basic Life & AD&D

1 If the value of any pre-tax life insurance coverage is greater than $50,000, the amount over $50,000 is added to your taxable compensation as "imputed income."

Dependent Life – Classes 1, 2, and 3

- **:** $1,500
- **C (6 26):** $1,500
- **C (B 6):** $100

Classified and Management Employees

B	L A C
C A	
E	$15,000
M B	
E	$15,000
14 0 214 26)3(34 29 (1 3CID 12 0 214)3(A / 0 20 12 69 20)3((2 0 214 26	

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SIA has a new Employee Assistance Program partner as of July 1, 2023. Optum will provide counseling, management consulting, trainings, financial, legal and

Check your BenefitBridge Web site. BenefitBridge can be accessed 24/7 from work or home PCs and offers immediate answers to benefit questions. You can view and compare your benefit choices, link to carrier websites, download forms and analyze your benefit needs. This web-based forum contains helpful information and a multitude of decision support tools. A link to Personal Choices will be available on your online enrollment Web site.

- **B** : This section lists benefit plans offered to Sacramento City USD employees as well as a detailed description of each plan. This section can be used to compare and contrast different plans. It

Important Notices

Important Notices (continued)

ELECTION AND ELECTION PERIOD

COBRA continuation coverage may be elected during the period beginning on the date Plan coverage would otherwise terminate due to a Qualifying Event and ending on the later of the following: (1)

Important Notices (continued)

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

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and CO

Important Notices (continued)

Uniformed Services Employment and Reemployment Rights Act (USERRA)

If you leave your job to perform military service, you have the right to elect to continue your existing employer-based health plan coverage for you and your dependents (including your spouse) for up to 24 months while in the military. Even if you do not elect to continue coverage during your military service, you have the right to be reinstated in your employer's health plan when you are reemployed, generally without any waiting periods or exclusions for pre-existing conditions except for service-connected injuries or illnesses.

Flexible Spending Accounts (FSAs) – Termination and Claims Submission Deadlines

Note: If you lose eligibility for any reason during the Plan Year, your contributions to your Health and/or Dependent Care FSAs will end as of the date your eligibility terminates. You may submit claims for reimbursement from your FSAs for expenses incurred during the Plan Year prior to your eligibility termination. You must submit claims for reimbursement from your Health and/or Dependent Care FSAs no later than 30 days after the date your eligibility terminates. Any balance remaining in your FSAs will be forfeited after claims submitted prior to this date have been processed.

Special Enrollment Rights Notice

CHANGES TO YOUR HEALTH PLAN ELECTIONS

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

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able[A)-861.5 (ubm)-6.9 (i)9.1 (tv)14.5 (E)-11 (y)-11.5 (our0.5 (ab)]8(a)]TETQB(ei)9 (t)-94 (ou)14.7(33R2)0.7(ol)9 (7Td)-11.n(

Important Notices (continued)

REMEMBER

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

Date:	January 1, 2024
Name of Entity / Sender:	Sacramento City Unified School District
Contact:	Benefits Department
Address:	5735 47th Avenue Sacramento, CA 95824
Phone:	916.643.9432

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

Sacramento City Unified School District Group Health Plan (Plan) maintains a Notice of Privacy Practices that provides information to individuals whose protected health information (PHI) will be used or maintained by the Plan. If you would like a copy of the Plan's Notice of Privacy Practices, please contact the Benefits

Important Notices (continued)

Important Notices (continued)

Important Notices (continued)

TEXAS – Medicaid
Website: https://www.hhs.texas.gov/services/financial/health-insurance-premium-payment-hipp-program
Phone: 800-440-0493

UTAH – Medicaid and CHIP
Medicaid Website: https://medicaid.utah.gov/
CHIP Website: http://health.utah.gov/chip
Phone: 877-543-7669

VERMONT – Medicaid
Website: https://dvha.vermont.gov/members/medicaid/hipp-program
Phone: 800-250-8427

VIRGINIA – Medicaid and CHIP
Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select
https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs
Medicaid Phone: 800-432-5924
CHIP Phone: 800-432-5924

WASHINGTON – Medicaid
Website: https://www.hca.wa.gov/
Phone: 800-562-3022

WEST VIRGINIA – Medicaid and CHIP
Website: https://dhhr.wv.gov/bms/
http://mywvhipp.com/
Medicaid Phone: 304-558-1700
CHIP Toll-Free Phone: 855-MyWVHIPP (855-699-8447)

WISCONSIN – Medicaid and CHIP
Website:
https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm
Phone: 800-362-3002

WYOMING – Medicaid
Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/
Phone: 800-251-1269

To see if any other states have added a premium assistance program since July 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
866-444-EBSA (3272)

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

Affordable Care Act and Patient Protection (ACA)

Also called Health Care Reform, the ACA requires health plans to comply with certain requirements. The ACA became law in March 2010. Since then, the ACA has required some changes to medical coverage—like covering dependent children to age 26, no lifetime limits on medical benefits, covering preventive care without cost-sharing, etc, among other requirements.

Allowed Amount

Maximum amount on which payment is based for

Glossary (continued)

Health Savings Account (HSA)

A health savings account (HSA) is a portable savings account that allows you to set aside money for health care expenses on a tax-free basis. State taxes may apply. You must be enrolled in a high-deductible health plan in order to open an HSA. An HSA rolls over from year to year, pays interest, can be invested, and is owned by you—even if you leave the company.

Health Reimbursement Arrangements (HRAs)

Unlike HSAs, only an employer may fund an HRA and the funds revert back to the employer when the employee leaves the organization. HRAs are not subject to the same contribution limits as HSAs, and they may be paired with either high-deductible plans or traditional health plans.

In-Network

Doctors, clinics, hospitals and other providers with whom the health plan has an agreement to care for its members. Health plans cover a greater share of the cost for in-network health providers than for providers who are out-of-network.

Non-Preferred Provider

A provider who doesn't have a contract with your health insurer or plan to provide services to you. You'll pay more to see a non-preferred provider.

Out-of-Pocket Maximum

The most you pay each year "out-of-pocket" for covered expenses. Once you've reached the out-of-pocket maximum, the health plan pays 100% for covered expenses.

Out-Of-Network

A health plan may not cover treatment for doctors, clinics, hospitals and other providers who are out-of-network, but covered employees will pay more out-of-pocket to use out-of-network providers than for in-network providers.

Out-Of-Pocket Limit

The most an employee could pay during a coverage period (usually one year) for his or her share of the costs of covered services, including co-payments and co-insurance.

Plan Year

The year for which the benefits you choose during Annual Enrollment remain in effect. If you're a new employee, your benefits remain in effect for the remainder of the plan year in which you enroll, and you enroll for the next plan year during the next Annual Enrollment.

Preferred Provider

A provider who has a contract with your health insurer or plan to provide services to you at a discount.

Premium

The amount that must be paid for a health insurance plan by covered employees, by their employer, or shared by both. A covered employee's share of the annual premium is generally paid periodically, such as monthly, and deducted from his or her paycheck.

Preventive Care

Health care services you receive when you are not sick or injured— so that you will stay healthy. These include annual checkups, gender- and age-appropriate health screenings, well-baby care, and immunizations recommended by the American Medical Association.

Qualifying Life Event

A change in your life that can make you eligible for a Special Enrollment Period to enroll in health coverage. Examples of qualifying life events include moving to a new state, certain changes in your income, and changes in your family size.

Skilled Nursing Care

Services from licensed nurses in your own home or in a nursing home. Skilled care services are from technicians and therapists in your own home or in a nursing home.

Urgent Care

Care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room care.

CLICK HERE to watch a video on Benefits Key Terms Ex lained