Downey Unified
SCHOOL DISTRICT

2020-2021 BENEFITS BOOKLET

10/01/2020 – 09/30/2021

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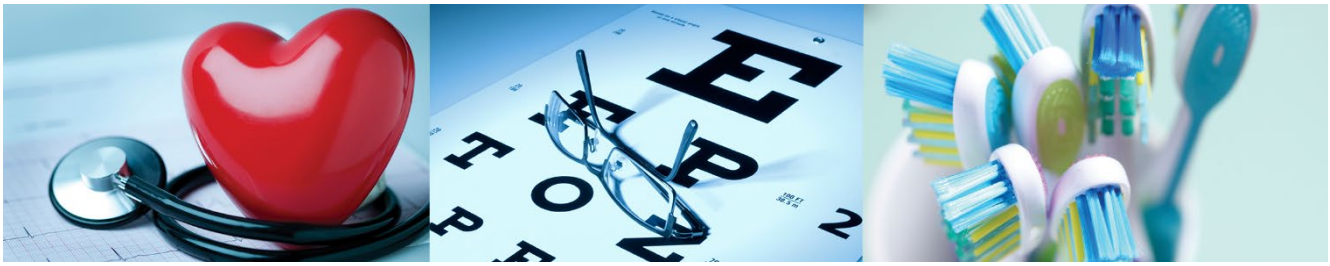
Medicare Part D Notice: If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a federal law gives you more choices about your prescription drug coverage. Please see Annual Notice on pages 24-25 for more details.



District Message

At Downey Unified School District we value your contributions to our success and want to provide you with a benefits package that protects your health and helps your financial security, now and in the future. We continually look for valuable benefits that support your needs, whether you are single, married, raising a family, or thinking ahead to retirement. We are committed to giving you the resources you need to understand your options and how your choices could affect you financially.

Please note the following 2020-2021 medical plan changes:

- Effective October 1, 2020, the Kaiser Traditional HMO plan is replaced with Kaiser Deductible HMO with HRA. See pages 7-8 for additional information.
- Effective October 1, 2020, the Blue Shield PPO plan will include a hearing aid benefit allowance. See page 9 for additional information.

We are providing you with this booklet to help you understand the benefits that are available to you and how to best use them. Please review it carefully and make sure to ask about any important issues that are not addressed here. A list of plan contacts and resources are provided on the back of this booklet.

While we've made every effort to make sure that this booklet is comprehensive, it cannot provide a complete description of all benefit provisions. For more information, please contact the Benefits Desk. The information in this booklet is a general outline of the benefits offered under the Downey Unified School District benefits program. Specific details and limitations are provided in the plan documents, such as the Summary of Benefits and Coverage (SBC), Evidence of Coverage (EOC) and/or insurance policies. The plan documents contain the relevant plan provisions. If the information in this booklet differs from the plan documents, the plan documents will prevail.

The benefits in this summary are effective:

October 1, 2020 – September 30, 2021

IMPORTANT EMPLOYEE RESPONSIBILITIES

Review your benefit options.

Employees waiving coverage must provide proof of other coverage.

If you have questions contact the Benefits Desk:
kquick@dusd.net or (562) 469-6624
www.dusd.net/benefits

Eligibility

WHO IS ELIGIBLE?

In general employees working 20 or more hours per week are eligible for the benefits outlined in this overview.

You can enroll the following family members in our medical, dental and vision plans:

- Your spouse (the person who you are legally married to under state law, including a same-sex spouse).
- If you have registered your domestic partnership with your state or local government, your domestic partner is eligible for coverage. Please contact the Benefits Desk if you would like to add a registered domestic partner. Any premiums for your domestic partner paid for by Downey Unified School District are taxable income and will be included on your W-2. Any premiums you pay for your domestic partner will be deducted on an after-tax basis.
- Your children (including your domestic partner's children):

MEDICAL

- Under age 26 are eligible to enroll in medical coverage. They do not have to live with you or be enrolled in school. They can be married and/or living and working on their own.
- Over age 26 ONLY if they are incapacitated due to a disability and primarily dependent on you for support.
- Named in a Qualified Medical Child Support Order (QMCSO) as defined by federal law.

DENTAL AND VISION

- Children age 19 to 23 must be a full time student to be eligible for dental and vision. Coverage terminates at the end of the month of their 24th birthday.
- If not a full time student, coverage terminates at the end of the month of their 19th birthday.
- Student Certification must be provided upon request.

DEPENDENT VERIFICATION

Adding dependents is subject to eligibility verification in order to ensure only eligible individuals are participating in our plans. You will be required to provide proof of one or more of the following within 31 days of their eligibility:

- Prior year's tax return and marriage certificate
- State-issued certificate of domestic partnership
- Birth Certificate
- Final decree of divorce
- Court documents showing legal responsibility for adopted children, foster children or children under legal guardianship
- Physician's written certification of disabling condition (for dependent children over age 26 incapable of self-support)

If you do not supply the proper documentation to add dependents within 31 day period, you will not be able to add the dependent(s) until the next open enrollment period.

WHO IS NOT ELIGIBLE?

Family members who are not eligible for coverage include (but are not limited to):

- Parents, grandparents, and siblings.
- Employees who work less than 50% of the annual salary rate for full-time assignment.

Please refer to the Summary Plan Description for complete details on how benefits eligibility is determined.

Eligibility Continued

WHEN CAN I ENROLL?

Open enrollment is the only time each year that employees can make changes to their benefit elections without a qualifying life event. Life events include (but are not limited to):

- Birth or adoption of a baby or child
- Loss of other healthcare coverage
- Eligibility for new healthcare coverage
- Marriage
- Divorce

If you qualify for a mid-year benefit change, you will be required to submit proof of the change. Changes must be submitted to the Benefits Desk within **31 days** of the life event. **An employee may be held responsible for substantial charges if services are provided for a person who is found to be ineligible.**

ELIGIBLE NEW HIRES

You must complete and return the enrollment forms and dependent verification documentation to the Benefits Desk as soon as possible and NO LATER THAN your first day of work.

Coverage for new full-time employees begins on the first of the month following date of hire.

QUALIFYING LIFE EVENTS

The following are considered qualifying life events:

- Change in legal marital status, including marriage, divorce, legal separation, annulment, and death of a spouse
- Change in number of dependents, including birth, adoption, placement for adoption, or death of a dependent child
- Change in employment status that affects benefit eligibility, including the start or termination of employment by you, your spouse, or your dependent child
- Change in work schedule, including a switch between part-time and full-time employment that affects eligibility for benefits
- Change in a child's dependent status, either newly satisfying the requirements for dependent child status or ceasing to satisfy them
- Change in place of residence or worksite, including a change that affects the accessibility or network providers
- Change in your health coverage or your spouse's coverage attributable to your spouse's employment
- Change in an individual's eligibility for Medicare or Medicaid
- A court order resulting from a divorce, legal separation, annulment, or change in legal custody (including a Qualified Medical Child Support Order) requiring coverage for your child
- An event that is a "special enrollment" under the Health Insurance Portability and Accountability Act (HIPAA) including acquisition of a new dependent by marriage, birth or adoption, or loss of coverage under another health insurance plan
- An event that is allowed under the Children's Health Insurance Program (CHIP) Reauthorization Act. Under provisions of the Act, employees have 60 days after the following events to request enrollment:
    - Employee or dependent loses eligibility for Medicaid
    - Employee or dependent becomes eligible to participate in a premium assistance program under Medicaid or CHIP

REMINDER: Three rules apply to making changes to your benefits during the year:

i. Any change you make must be consistent with the change in status;
ii. You must make the change within 31 days of the date the event occurs; and
iii. All proper documentation is required to cover dependents (marriage certificates, birth certificates, etc.)

Cost of Coverage - Tenthly

Employees working more than 75% or more (6-8 hours per day).

	Medical		Dental		Vision
	Kaiser DHMO	Blue Shield PPO	MetLife HMO	Delta PPO	VSP
Tenthly Premium	$701.98	$1,105.70	$20.30	$67.42	$12.62
District Contribution	$631.78	$995.14	$18.28	$60.68	$11.36
Employee Only Pays	$70.20	$110.56	$2.02	$6.74	$1.26
Tenthly Premium	$1,403.92	$2,211.40	$34.78	$137.10	$18.46
District Contribution	$1,263.54	$1,990.26	$31.30	$123.40	$16.60
Employee + 1 Pays	$140.38	$221.14	$3.48	$13.70	$1.86
Tenthly Premium	$2,070.38	$3,129.12	$52.14	$196.92	$33.58
District Contribution	$1,863.34	$2,816.22	$46.94	$177.22	$30.22
Employee + Family Pays	$207.04	$312.90	$5.20	$19.70	$3.36

Employees working more than 50% and less than 75% (more than 4 hours and less than 6 hours per day).

	Medical		Dental		Vision
	Kaiser DHMO	Blue Shield PPO	MetLife HMO	Delta PPO	VSP
Tenthly Premium	$701.98	$1,105.70	$20.30	$67.42	$12.62
District Contribution	$473.84	$746.34	$13.70	$45.50	$11.36
Employee Only Pays	$228.14	$359.36	$6.60	$21.92	$1.26
Tenthly Premium	$1,403.92	$2,211.40	$34.78	$137.10	$18.46
District Contribution	$947.66	$1,492.70	$23.48	$92.60	$16.60
Employee + 1 Pays	$456.26	$718.70	$11.30	$44.50	$1.86
Tenthly Premium	$2,070.38	$3,129.12	$52.14	$196.92	$33.58
District Contribution	$1,397.50	$2,112.16	$35.20	$132.90	$30.22
Employee + Family Pays	$672.88	$1,016.96	$16.94	$64.02	$3.36

Cost of Coverage Continued

Employees working 50% (4 hours per day).

	Medical		Dental		Vision
	Kaiser DHMO	Blue Shield PPO	MetLife HMO	Delta PPO	VSP
Tenthly Premium	$701.98	$1,105.70	$20.30	$67.42	$12.62
District Contribution	$315.90	$497.56	$9.14	$30.34	$11.36
Employee Only Pays	$386.08	$608.14	$11.16	$37.08	$1.26
Tenthly Premium	$1,403.92	$2,211.40	$34.78	$137.10	$18.46
District Contribution	$631.78	$995.14	$15.66	$61.70	$16.60
Employee + 1 Pays	$772.14	$1,216.26	$19.12	$75.40	$1.86
Tenthly Premium	$2,070.38	$3,129.12	$52.14	$196.92	$33.58
District Contribution	$931.68	$1,408.10	$23.46	$88.62	$30.22
Employee + Family Pays	$1,138.70	$1,721.02	$28.68	$108.30	$3.36

Kaiser Medical Deductible HMO with HRA

This plan is available only in certain California counties and cities ("Service Area") as described in the Evidence of Coverage. You must live and/or work in this select Service Area in order to enroll in this plan.

The Health Reimbursement Arrangement (HRA) pays the first $1,500 of medical expenses for each enrolled member. Rx copays are not reimbursable via the HRA. Please review page 8 for additional information.

	Deductible HMO Plan	Health Reimbursement Arrangement (HRA)
Accumulation Period	October 1 – September 30	October 1 – September 30
Medical Plan Deductible Self-Only Coverage Family Coverage	 $1,000 $2,000 (individual in a family $1,000)	**Member Deductible Cost** Self-Only Coverage $0 after HRA reimbursement Family Coverage $0 after HRA reimbursement
Drug Deductible Self-Only Coverage Family Coverage	 None None	 N/A N/A
Plan Out-of-Pocket Max Self-Only Coverage Family Coverage	 $2,000 $4,000 (individual in a family $2,000)	**Medical Member Out-of-Pocket Max Cost** Self-Only Coverage $500 after $1,500 HRA reimbursement Family Coverage $1,000 after $3,000 HRA reimbursement
Primary Care Physician	$20 per visit after deductible	HRA reimbursable
Physician Specialist	$20 per visit after deductible	HRA reimbursable
Preventive Services	No charge	N/A
Urgent Care	$20 per visit after deductible	HRA reimbursable
Outpatient Surgery	20% after deductible	HRA reimbursable
X-rays and Laboratory Tests	$10 per encounter after deductible	HRA reimbursable
Hospitalization Services	20% after deductible	HRA reimbursable
Emergency Room (waived if admitted)	20% after deductible	HRA reimbursable
Ambulance Services	$150 per trip after deductible	HRA reimbursable
Durable Medical Equipment	20% (deductible doesn't apply)	HRA reimbursable

Pharmacy Drug Coverage	Copay	Supply Limit	
Generic	$10 (ded. doesn't apply)	Up to 30 days	Not eligible for HRA reimbursement
Brand-Name	$30 (ded. doesn't apply)	Up to 30 days	Not eligible for HRA reimbursement
Specialty	20% up to $200 (ded. doesn't apply)	Up to 30 days	Not eligible for HRA reimbursement
Mail-Order Drug Coverage	**Copay**	**Supply Limit**	
Generic	$20 (ded. doesn't apply)	Up to 100 days	Not eligible for HRA reimbursement
Brand-Name	$60 (ded. doesn't apply)	Up to 100 days	Not eligible for HRA reimbursement
Specialty	N/A	N/A	N/A

Kaiser HRA Information

The Kaiser HMO health plan has a deductible and Health Reimbursement Arrangement (HRA). Downey Unified School District sets up the HRA account and puts money into it to help you pay for Kaiser medical care costs. The District contributes $1,500 to each enrolled member: family coverage is a family of two or more members.

A deductible is the amount that a member must pay before Kaiser will pay for certain covered services. You use the money in your HRA for your deductible. After you meet your deductible, you'll only need to pay a copayment (copay) or coinsurance for most covered services. You use the money in your HRA for copays and coinsurance. Rx copays are not reimbursable and are not covered under the HRA.

DUSD HRA:

- The $1,500 is first-dollar coverage and will pay for the medical deductible ($1,000), and then first $500 of copays and coinsurance.
- The HRA is an employer-funded account and employees cannot contribute to the account.
- Allocation can be used for any health plan covered services, except pharmacy.

  Tip: A Flexible Spending Account lets you set aside money before it's taxed through payroll deductions. The money can be used for eligible healthcare expenses (pharmacy, medical, dental or vision costs). To learn more visit the plans administrators website www.americanfidelity.com or contact (800) 365-9180 ext 0.

- Allocation cannot be used for services not covered by the health plan (e.g. dental services).
- No rollover of unused funds.
- Kaiser will mail employees a welcome letter with instructions on how to manage your account.

Out-of-Pocket Maximum(s) and Deductible(s)

For Services that apply to the plan out-of-pocket maximum, you will not pay any more cost share for the rest of the accumulation period once you have reached the amounts listed.

For services that are subject to the plan deductible, you must pay charges for covered services you receive during the accumulation period until you reach the deductible amounts listed. All payments you make toward your deductible(s) apply to the plan out-of-pocket maximum amounts listed.

HAVE QUESTIONS?

Kaiser Permanente Health Payment Services
(877) 761-3399
kp@healthaccountservices.com
Mon. – Fri. 5 a.m. - 7 p.m. PST (except holidays).

KAISER PAY TO PROVIDER MEMBER EXPERIENCE

- No payment at check-in for most medical services at KP facilities.
- KP processes the medical claim and submits to the account.
- Member will be billed if account funds are used up, and for any services that aren't eligible for reimbursement.

Exceptions to Pay to Provider Experience

Point-of-care experience: Cost share collection typically occurs for these services:

- Non-KP provider services
- Vision hardware
- Pharmacies
- Cosmetic surgery
- Chiropractic, acupuncture, and dental

Automatic payment or reimbursement: Not all medical services are included in Kaiser's claims exchange. Examples include:

- Vision hardware, chiropractic, acupuncture, dental (except KPNW, as applicable)
- Durable Medical Equipment (DME)
- Out of area emergency or urgent care
- Cosmetic surgery

Members can file a claim for reimbursement from their health payment account online or by email, fax, or mail.

MANAGING YOUR HRA ACCOUNT

You can access account information online 24 hours a day, seven days a week, at kp.org/healthpayment. You'll be able to view your account balance and information, process transactions, download forms, and see a list of qualified medical expenses.

You can also use the **KP Balance Tracker app** or call Health Payment Services to manage your HRA. Another way to view your balance is to request a cost estimate for services at kp.org/costestimate. Please note that your HRA balance won't appear on your Explanation of Benefits (EOB) or bills.

Blue Shield Medical PPO

Find an in-network provider by visiting www.blueshieldca.com/fap/app/find-a-doctor.html select Blue Shield of California PPO network or call member services (855) 256-9404.

	In-Network	Out-of-Network[1]
Medical Calendar Year Deductible	$250 individual/ $750 family	$500 individual/ $1,500 family
Medical Calendar Year Out-of-Pocket Max	$750 individual/ $2,250 family	$3,500 individual/ $10,500 family (combined with in-network)
Physician/Specialist Office Visit	10% coinsurance after deductible	30% coinsurance after deductible
Teladoc[2] - Online Visit	$10 copay per visit (deductible waived)	Not covered
Heal Physicians – Home Visit[3]	10% coinsurance after deductible	Not covered
Preventive Services	No charge	30% coinsurance after deductible
Diagnostic X-ray and Lab	10% coinsurance after deductible	30% coinsurance after deductible
Scans: CT, CAT, MRI, PET etc.	10% coinsurance after deductible	30% coinsurance after deductible
Inpatient Hospitalization	10% coinsurance after deductible	30% coinsurance after deductible
Physician Services	10% coinsurance after deductible	30% coinsurance after deductible
Outpatient Facility Services		
Surgery in an Ambulatory Surgery Center Surgery in a Hospital	10% coinsurance after deductible 10% coinsurance after deductible	30% coinsurance after deductible 30% coinsurance after deductible
Urgent Care	$30 copay after deductible	50% coinsurance after deductible
Emergency Room (copay waived if admitted)	$100 copay per visit (deductible waived)	
Ambulance Services (ground or air)	10% coinsurance after deductible	
Durable Medical Equipment	10% coinsurance after deductible	30% coinsurance after deductible
Acupuncture	Not covered	Not covered
Chiropractic Care (up to 50 visits per year)	10% coinsurance after deductible	30% coinsurance after deductible
Hearing Aids[4] (deductible waived)	$2,000 allowance every 24 months	$2,000 allowance every 24 months
Prescription Drugs[5]		
Calendar Year Deductible	None	
Calendar Year Out-of-Pocket Max	$250 individual/ $750 per family	
	Retail Pharmacy	**Mail Order**
Tier 1 drugs	$5 copay	$10 copay
Tier 2 drugs	$25 copay	$50 copay
Tier 3 drugs	$45 copay	$90 copay
Tier 4 drugs (excluding specialty drugs)	30% up to $150	30% up to $300
Tier 4 Specialty drugs	30% up to $150	Not covered
Supply Limit	Up to a 30-day	Up to a 90-day

[1] Non-participating providers can charge more than Blue Shield's allowable amounts. When members use non-participating providers, they must pay the applicable deductibles, copayments or coinsurance plus any amount that exceeds Blue Shield's allowable amount. Charges above the allowable amount do not count toward the calendar year medical deductible or out-of-pocket maximum.
[2] 24/7 virtual access to provider and therapists.
[3] Home visits by Heal doctors available. Visit www.heal.com for additional details.
[4] Review the plan document for coverage details and limitations or call member services.
[5] See benefit summary or SBC for non-participating retail copayments.

Blue Shield Member Resources

RX'N GO – FREE MAIL ORDER

Rx 'n Go is a mail-order Rx benefit that delivers up to a 90-day supply of medications right to your home for free.

Three Easy Steps to $0 Medications:

1. Check Medication Availability

2. Register in Minutes

3. Submit Your Prescription with Auto-Refills

To learn more or to register visit https://rxngo.com/ or contact Customer Service at pharmacy@gogomeds.com or (888) 697-9646.

TELADOC

Teladoc provides you with access to doctors, pediatricians and therapists who are available to resolve many of your health issues via phone or online video consultations. It's quality healthcare, when and where you need it. Doctors can even write a prescription, if necessary, for you to pick up at your local pharmacy.

Doctors are available 24/7 to treat many of your medical conditions, including:

- Cold and flu symptoms
- Respiratory Infection
- Ear Infection
- Urinary Tract Infection
- Allergies
- and more!

Member copay is $10 (deductible waived) per consultation. Behavioral Health consultations 10% after deductible.

Register by calling Teladoc at (800) 835-2362 or go online at teladoc.com/bsc.

Blue Shield members will need to have their member ID number and the name, address and phone number of the covered member who needs medical assistance.

PRENATAL PROGRAM

Each pregnancy is unique. That's why the Prenatal Program is designed to optimize a woman's health before pregnancy, improve the quality of care received during pregnancy and offer support to the new mom after delivery. The program aims to help women have healthy pregnancies and healthy babies.

WELLVOLUTION – available to members 18 and over.

Well-Being Assessment (WBA) - measures overall outlook, emotional and physical health, healthy behaviors, work environment, and access to health/life resources.

Daily Challenge – wellness program that focuses on overall well-being with simple daily actions and dozens of topics to choose from including Educated Eating, Money Matters, Stress Management, and more. Each day, Daily Challenge sends a text and/or email that asks you to complete one simple activity.

QuitNet - can get help quitting smoking with QuitNet, the largest quit-smoking community in the world. QuitNet offers online and mobile support from experts and peers with personalized email and text support.

Visit mywellvolution.com to get started!

CONDITION MANAGEMENT

Condition Management assists Blue Shield members living with chronic conditions such as heart disease, diabetes, musculoskeletal conditions, and asthma.

The program is designed to provide personalized support for members to help them live better with illness, recover from acute conditions, and navigate the healthcare system. Program includes a broad spectrum of interventions for short-term care coordination as well as ongoing case management. Also includes post-discharge follow up and care coordination services to help members access care.

Getting Care When You Need It Now

The ER is not your only option! This chart can help you understand your options for getting care.

Where to go	What is it	What can be treated
DUSD Wellness Clinic 	The Wellness Clinic provides primary care services to Blue Shield and Kaiser members. The clinic is located inside the PIH Medical Office Building. 11480 Brookshire Ave., Suite 301.	• Preventive services • Physicals • Cough, cold and flu • And more…
Virtual Care 	E-visits, telephone, and video visits are simple and secure ways to get care and save yourself an office visit.	• Sore throat, cough, cold and flu • Eye conditions • Rash • Sinus problems • Urinary tract infection • Mental Health • And more…
Nurse Line 	Speak directly to a registered nurse, 24/7 day or night who can help you with your health-related questions.	• Choosing appropriate medical care • Finding a doctor or hospital • Understanding treatment options • Achieving a healthier lifestyle • Answering medication questions
Your Doctor's Office 	Go to a doctor's office when you need preventive or routine care. Your doctor can access your medical records, manage your medications and refer you to a specialist, if needed.	• Annual Physical • Checkups • Preventive services • Minor skin conditions • Vaccinations • General health management
Urgent Care (UC) 	Urgent care is ideal for when you need care quickly, but it is not an emergency (and your doctor isn't available). Urgent care centers treat issues that aren't life threatening.	• Sprains • Strains • Minor burns • Minor infections • Minor broken bones • Cuts that may need a few stitches
Emergency Room (ER) 	The ER is for serious life-threatening or very serious conditions that require immediate care. This is also when to call 911.	• Breathing difficulty • Chest pain • Heavy bleeding • Major broken bones • Major burns • Severe head injury • Spinal injuries • Sudden weakness or trouble talking

Dental Plans – PPO or HMO

Delta Dental PPO Plan

Under the Delta Dental PPO plan, Delta Dental pays a percentage of the allowed fees for covered diagnostic, preventive, basic and major services. No member ID cards are distributed with this dental plan - simply provide your dentist with your name, social security number, and that you are on the Delta Dental PPO plan. To find a dentist visit deltadentalins.com/enrollees or call (800) 765-6003.

IF YOU HAVE ADDITIONAL COVERAGE (DUAL COVERAGE)

It is to your advantage to let your dentist and Delta Dental know if you have dental coverage in addition to this Delta Dental plan. Most dental carriers cooperate with one another to coordinate payments and still allow you to make use of both plans - sometimes paying 100% of your dental bill. For example, you might have some fillings that cost $100. If the primary carrier usually pays 80% for these services, it would pay $80. The secondary carrier might usually pay 50% for this service. In this case, however, the secondary plan's payment is limited to the amount of your out-of-pocket cost under the primary plan, the secondary carrier pays the remaining $20 only. Since this method pays 100% of the bill, you have no out-of-pocket expense.

MetLife SafeGuard DHMO Plan

You and your eligible dependents must select a primary dentist from the SafeGuard DHMO directory. To find a dentist visit www.metlife.com/mybenefits or call (800) 880-1800.

	Delta PPO[1]		MetLife DHMO
	In-Network	**Out-Of-Network[2]**	**In-Network**
Calendar Year Deductible	None		None
Annual Plan Maximum	$2,000 per person each calendar year **(January 1 – December 31)**		Not applicable
Diagnostic & Preventive Services Exams Cleanings X-Rays Sealants	Plan pays 100%		Copays vary by service; see contract for fee schedule
Basic Services Fillings, denture repair and relining Endodontics Periodontics Oral surgery	Plan pays 100%		Copays vary by service; see contract for fee schedule
Major Services Crowns, inlays, onlays, cast restorations Implants	Plan pays 100%		Copays vary by service; see contract for fee schedule
Prosthodontics Bridges and dentures	You pay 50%	You pay 50%	Copays vary by service; see contract for fee schedule
Orthodontic Services	Child to age 18		Adults and Children
Orthodontic Lifetime Maximum	50% up to $1,000		Up to $1,350 Copays vary by service; see contract for fee schedule

[1] You can visit any licensed dentist, but your out-of-pocket costs may be higher if you choose a non-PPO dentist. Network dentists are paid contracted fees. You are responsible for any applicable deductibles, coinsurance, and amounts over plan maximums and charges for non-covered services.

[2] Reimbursement is based on PPO contracted fees for PPO dentists, Premier contracted fees for Premier dentists and program allowance for non-Delta Dental dentists. Out-of-network reimbursement is 90% UCR (Usual, Customary and Reasonable) fees.

Delta Dental Cost Estimator Tool

Looking to budget your dental costs? Try Delta Dental's Cost Estimator. This online service gives you a personalized estimate of how much you'll pay for your next dentist visit. Whether you're getting braces or need a cavity filled, you'll choose from the top reasons for visiting the dentist, written in everyday language. The Cost Estimator organizes information logically, so you don't need to be concerned whether the service involves multiple procedure codes or visits.

ADVANTAGES

- **Easy to use**. Questions guide you through the process, letting you add services to your visit, like getting x-rays or a cleaning alongside your dental exam.
- **Based on real data**. Your cost estimate is calculated from actual claims Delta Dental has processed, updated daily.
- **Personalized**. You'll get a customized cost based on your actual benefits, taking into account any maximums and remaining deductible.
- **Available on desktop and mobile**. Get an estimate on your computer, tablet or phone.

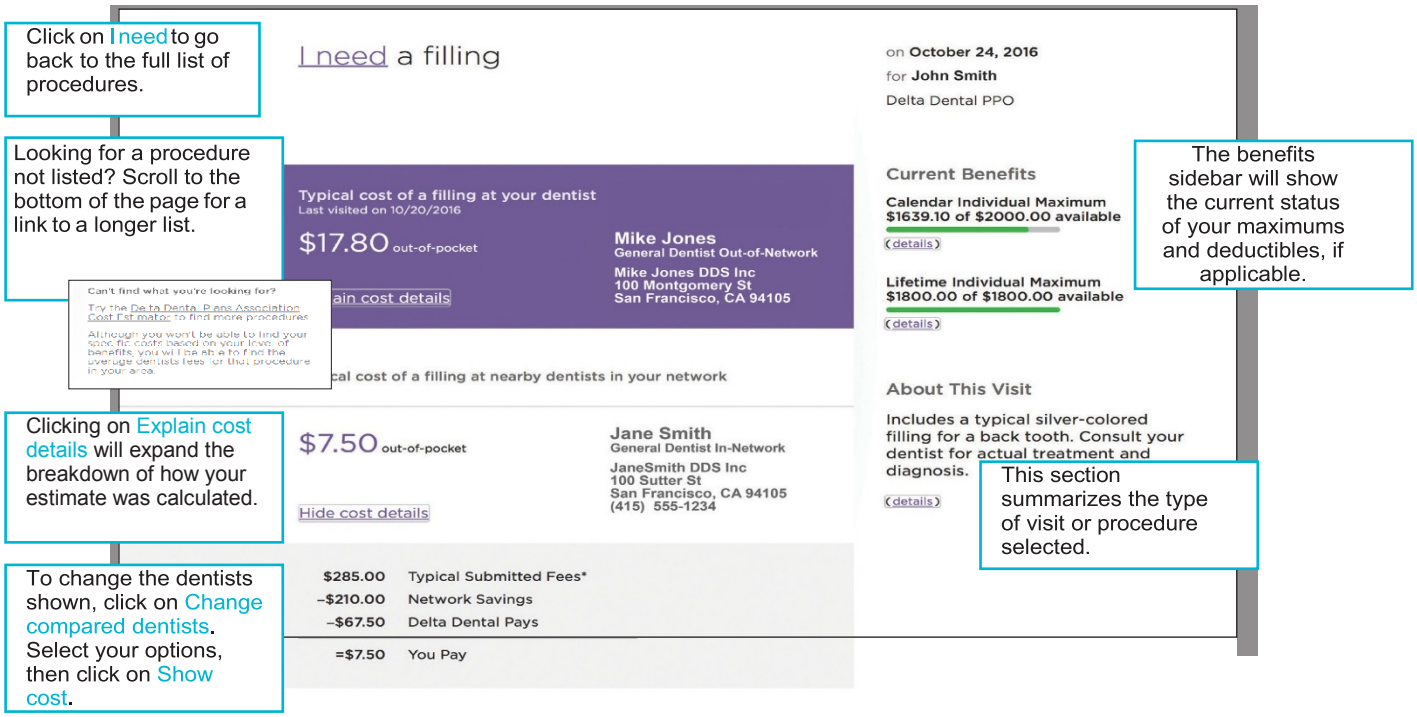
FEATURES

- **Change your dentist**. Want to know if you'd save by switching to another dentist? Test it out by comparing up to five dentists.
- **Personalize your procedure**. Specify which tooth is being treated, the type of filling you need or whether you're going to a specialist. The price will be calculated accordingly.
- **Keep track of your benefits**. A handy sidebar shows the current status of any deductibles and annual and lifetime maximums.

TRY IT OUT

Ready to get an estimate?

1. Log in to your account at **deltadentalins.com**. If you don't have one yet, click on Register.
2. Click on the Cost Estimator link by your name.
3. Start by selecting the service you need. As you explore, you can answer additional questions (like "Which tooth?" or "Are you a new patient?") to further customize your results. If you've been using your dental benefits, your current dentist will show up by default, but if you want to see other options, just click on **Select dentists to compare**. Whenever you're ready, click See cost.



Vision – VSP Choice

When you have an appointment, tell them you have VSP. There's no ID card necessary. If you'd like a card as a reference, you can print one on www.vsp.com. To find a Provider visit www.vsp.com or call (800) 877-7195.

Participating Retail Chains: Costco*, Cohen's, Visionworks and much more!

- A Costco membership is required to purchase eyewear (glasses and/or contacts) from Costco Optical
- A Costco membership is not required to receive an eye exam from a Costco optometrist

	VSP Provider Network: VSP Choice	
	In-Network	**Out-Of-Network[1]**
Examination		
Benefit	Plan pays 100%	Plan reimburses up to $45
Frequency	1 x every 12 months	In-network limitations apply
Eyeglass Lenses (Standard)		
Single Vision Lens	$0 copay	Plan reimburses up to $45
Bifocal Lens	$0 copay	Plan reimburses up to $65
Trifocal Lens	$0 copay	Plan reimburses up to $85
Frequency	1 x every 12 months	In-network limitations apply
Lens Enhancements		
Standard Progressive Lenses	$50	Plan reimburses up to $85
Premium Progressive Lenses	$80 - $90	Plan reimburses up to $85
Custom Progressive Lenses	$120 - $160	Plan reimburses up to $85
Tints/Photochromics/UV & Scratch Coating	Covered in full	Not covered
Frames[2]		
Benefit (copay combined with exam)	Plan pays up to $120 allowance + 20% discount Plan pays up to $120 allowance for Costco® frames Plan pays up to $140 allowance for Featured Frame Brands	Plan reimburses up to $47
Frequency	1 x every 24 months	In-network limitations apply
Contacts[3] (Elective)		
Benefit (fitting & evaluation)	Plan pays up to $120 allowance	Plan reimburses up to $105
Frequency	1 x every 12 months	In-network limitations apply

[1] If you choose to, you may receive covered benefits outside of the VSP Choice network. Just pay in full at the time of service, obtain an itemized receipt, and file a claim for reimbursement of your out-of-network allowance. In-network benefits and discounts will not apply. Out-of-Network Claim Forms located online: www.vsp.com. Login to your account and access the *Benefits & Claims* section. You will be asked to upload your receipts or you may mail in receipts.
[2] You may select an eyeglass frame and receive an allowance toward the purchase price.
[3] In-lieu of frames.

Flexible Spending Accounts (FSAs)

A Flexible Spending Account lets you set aside money—before it's taxed—through payroll deductions. The money can be used for eligible healthcare and dependent day care expenses 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. And reimbursements from your FSA accounts are tax-free. The catch is that you have to use the money in your account by December 31, 2020. You must re-enroll in this program each year. American Fidelity administers this program.

IMPORTANT CONSIDERATIONS

- Expenses must be incurred between **1/1/2020** and **12/31/2020** and submitted for reimbursement no later than **03/31/2021**.
- Elections cannot be changed during the plan year, unless you have a qualified change in family status (and the election change must be consistent with the event).
- **Healthcare FSA:** You can keep (roll-over) **up to $550** of unused money for use in the next plan year. Unused amounts above $550 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.
- FSA funds can be used for you, your spouse, and your tax dependents only.
- You can obtain reimbursement for eligible expenses incurred by your spouse or tax dependent children, even if they are not covered on the District's health plan.
- 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).
- Use **Health FSA Debit Card** to pay for eligible services and products. Payments are automatically withdrawn from your reimbursement account, so there are no out-of-pocket costs.
- **FSA Store.** For convenient online shopping, you may also use your card at **FSAStore.com**
- **Keep your receipts.** In most cases, you'll need to provide proof that your expenses were considered eligible for IRS purposes.

HEALTHCARE FSA (HFSA)

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 **$2,750** this year.

Looking for information on what expenses are eligible under a Health FSA?
Visit www.americanfidelity.com and use their interactive chart to search eligible expenses.

DEPENDENT CARE FSA

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 child care, 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.

AMERICAN FIDELITY
a different opinion

Member Services (800) 654-8489
www.americanfidelity.com

Life Insurance

If you have loved ones who depend on your income for support, having life and accidental death insurance can help protect your family's financial security and pay for large expenses such as housing and education, as well as day-to-day living expenses.

EMPLOYER PAID LIFE AND AD&D

Basic Life Insurance pays your beneficiary a lump sum if you die. AD&D provides another layer of benefits to either you or your beneficiary if you suffer from loss of a limb, speech, sight, or hearing, or if you die in an accident. All **active full-time or permanent part-time CSEA Unit 1 employees working 20+ hours per week** who are not participating in the District sponsored Medical Plan must elect the life insurance and complete the enrollment forms. The cost of coverage is **paid in full** by Downey Unified School District. Coverage is provided by **Guardian**.

Basic Life Amount	$25,000
Basic AD&D Amount	$25,000

BENEFICIARY REMINDER: Make sure that you have named a beneficiary for your life insurance benefit. It's important to know that many states require that a spouse be named as the beneficiary, unless they sign a waiver.

REMEMBER TO REVIEW OR UPDATE YOUR BENEFICIARY CONTACT

PLAN FEATURE:

Living Benefit (accelerated death benefit) - If you are terminally ill with less than 24 months to live, you can ask for up to 50% of your group term life benefits to be paid while you are living. If you take a Living Benefit payment, the amount your beneficiary gets after your death will be reduced by the amount you were paid.

EMPLOYER PAID LIFE

Basic Life Insurance pays your beneficiary a lump sum if you die. All **CSEA Unit 1 employees working less than 4 hours per day** must elect the life insurance and complete the enrollment forms. The cost of coverage is **paid in full** by Downey Unified School District. Coverage is provided by **Transamerica**.

Basic Life Amount	$5,000
Basic AD&D Amount	$5,000

PLAN FEATURE:

Living Benefit (accelerated death benefit) - If you are terminally ill with less than 12 months to live, you can ask for up to 50% of your group term life benefits to be paid while you are living. If you take a Living Benefit payment, the amount your beneficiary gets after your death will be reduced by the amount you were paid.

IMPORTANT REMINDER:

Accelerated Death Benefit - Benefit received may be treated as taxable income and may affect your eligibility for Medicaid or other government benefits or entitlements. You should consult your personal tax and/or legal advisor before you apply for an Accelerated Benefit.

Retirement Plans – 403(b) and Roth 403(b)

The IRS developed the 403(b) and Roth 403(b) plans to offer school employees a tax incentive to save for retirement. Both plans are administered by Schools First Federal Credit Union and they will typically offer several mutual fund options within the plan. You may choose to participate in one or both plans, account must be opened prior to your first contribution. If you have questions or would like to open an account, please contact our Retirement Plan representative.

403(b) PLAN OVERVIEW

Taxes: Contributions are made to your 403(b) before taxes are taken from your paycheck, reducing your taxable income. Taxes are paid on withdrawals, typically in retirement when you will likely be in a lower tax bracket.

Withdrawals: You may begin to take withdrawals from your 403(b) at age 59½. Penalties may apply to withdrawals taken before this time.

Loans: A loan may be taken against your 403(b) funds while you are still employed. Repayment terms and interest rates are determined by your plan administrator, Schools First Federal Credit Union.

ROTH 403(b) PLAN OVERVIEW

Taxes: Contributions to a Roth 403(b) are made after taxes are taken from your paycheck, allowing your earnings to grow—and withdrawals to be taken—tax-free if the account has been open for at least five years and you are age 59½ or older.

Withdrawals: You may make a withdrawal from your Roth 403(b) when you reach age 59½, upon severance of employment, or in case of hardship, disability or death.

Loans: A loan may be taken against your Roth 403(b) while you are still employed. Repayment terms and interest rates are determined by your plan administrator.

403(b) CONTRIBUTION LIMITS

In 2020, you may contribute up to $19,500 to a 403(b) and/or Roth 403(b), combined. It is possible to contribute up to $9,000 more than the standard limit if you meet the following requirements:

- Age 50+ in 2020 participant allowed an additional $6,500.
- With employer 15+ years and your deferral average for all previous years does not exceed $5,000. Participant allowed an additional $3,000 up to a maximum lifetime limit of $15,000.
- 2020 Maximum contribution total cannot exceed $28,000.

457(b) PLAN OVERVIEW

The 457(b) is a deferred compensation plan (DCP) that allows you to save pre-tax dollars for retirement. It is an employer-sponsored plan your district can choose to make available to you. Investment options with a 457(b) include mutual funds and Schools First FCU share certificates.[1]

Taxes: Contributions are made to your 457(b) before taxes are taken from your paycheck, reducing your taxable income. Taxes are paid on withdrawals, typically in retirement when you will likely be in a lower tax bracket.

Withdrawals: Regardless of age, you may withdraw from your 457(b) when you leave your employer, or in the case of death, disability or unforeseeable emergency. Supporting documentation is required and you may be subject to penalty fees. Distributed funds cannot be rolled back into the plan.

Loans: A loan may be taken against your 457(b) funds while you are still employed. Repayment terms and interest rates are determined by your plan's administrator, Schools First Federal Credit Union.

457(b) CONTRIBUTION LIMITS

In 2020, you may contribute up to $19,500 to 457(b). It is possible to contribute more than the standard limits if you meet the following requirements:

- Age 50+ in 2020 participant allowed an additional $6,500.
- Special 457(b) Catch-up provision. May allow a participant to contribute up to twice the standard limit for 3 consecutive years prior becoming eligible for Full Retirement benefits under PERS and STRS retirement system.

***Age 50+ catch-up cannot be used in conjunction with the Special 457(b) Catch-up.

- If an employee meets all three conditions, the maximum contribution $45,500.

If you have questions contact:

Amber Gaitan
Phone: (800) 462-8328 ext 4116
Email: agaitan@schoolsfirstfcu.org
Website: www.schoolsfirstfcu.org

[1] NRA is typically 62 or 65, check with your plan administrator.

Key Terms

Health insurance seems to have its own language. You will get more out of your plans if understand the most common terms, explained below in plain English.

MEDICAL

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.

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.

COINSURANCE - After you meet the deductible amount, you and your health plan share the cost of covered expenses. Coinsurance is always a percentage totaling 100%. For example, if the plan pays 70% coinsurance, you are responsible for paying your coinsurance share, 30% of the cost.

COPAY - A set fee you pay whenever you use a particular healthcare service, for example, when you see your doctor or fill a prescription. After you pay the copay amount, your health plan pays the rest of the bill for that service.

IN-NETWORK / OUT-OF-NETWORK - Network providers (doctors, hospitals, labs, etc.) are contracted with your health plan and have agreed to charge lower fees to plan members, as negotiated in their contract with the health plan. Services from out-of-network providers can cost you more because the providers are under no obligation to limit their maximum fees. With some plans, such as HMOs and EPOs, services from out-of-network providers are not covered at all.

OUT-OF-POCKET MAXIMUM - The most you would pay from your own money for covered healthcare expenses in one year. Once you reach your plan's out-of-pocket maximum dollar amount (by paying your deductible, coinsurance and copays), the plan pays for all eligible expenses for the rest of the plan year.

PRESCRIPTION DRUG

BRAND NAME - A drug sold under its trademarked name. For example, Lipitor is the brand name of a common cholesterol medicine. You generally pay a higher copay for brand name drugs.

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. You generally pay a lower copay for generic drugs.

PREFERRED DRUG - Each health plan has a list of prescription medicines that are preferred 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.

ADDITIONAL KEY TERMS

DUAL COVERAGE - If you and your family members are covered under two plans, dual coverage means added savings on costs. Dual coverage does not mean your benefits are doubled. When you're covered under two plans, one plan is considered your primary carrier. This carrier will pay a larger portion of your benefits, leaving a smaller amount to your secondary carrier. How much you save depends on whether your secondary carrier has a non-duplication of benefits clause. If the plan has this clause, your benefit will be slightly less than standard dual coverage.

NOTE: Downey's Delta Dental plan and VSP vision plan have standard coordination of benefits (COB) rules. If you have questions about dual coverage and how the two plans coordinate, please call the insurance carrier's Customer Service.

Important Plan Notices and Documents

Notices must be provided to plan participants on an annual basis. Notices available in this booklet include:

- **HIPAA Notice of Special Enrollment Rights**
  Describes when you can enroll yourself and/or dependents in health coverage outside of open enrollment.
- **Women's Health and Cancer Rights Act**
  Describes benefits available to those that will or have undergone a mastectomy.
- **Newborns' and Mothers' Health Protection Act**
  Describes the rights of mother and newborn to stay in the hospital 48-96 hours after delivery.
- **Exchange Notice**
  Provides basic information about the new Marketplace and employment-based health coverage offered by your employer.
- **Medicare Part D Notice**
  Describes options to access prescription drug coverage for Medicare eligible individuals.

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 life event. Please review this Notice carefully to make sure you understand your rights and obligations.

Summary of Benefits and Coverage (SBC)

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

- Kaiser Deductible HMO
- Blue Shield of California PPO

Summary Plan Description (SPD)

A Summary Plan Description, or SPD, is the legal document for describing benefits provided under the plan as well as plan rights and obligations to participants and beneficiaries.

Paper copies of these documents and notices are available if requested. If you would like a paper copy, please contact the Benefits Desk.

Statement of Material Modifications

This enrollment guide constitutes a Summary of Material Modifications (SMM) to the Downey Unified School District Group Health Plan. 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.

Required Federal Notices

NOTICE OF AVAILABILITY OF HIPAA PRIVACY NOTICE

The Federal Health Insurance Portability and Accountability Act of 1996 ("HIPAA") requires that we periodically remind you of your right to receive a copy of the HIPAA Privacy Notice. You can request a copy of the Privacy Notice by contacting the insurance carriers directly.

HIPAA Notice of Special Enrollment Rights

If you decline enrollment in Downey Unified School District 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 Downey Unified School District 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 31 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 31 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 31 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 Downey Unified School District 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.

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. Please see plan documents for deductibles and coinsurance. If you would like more information on WHCRA benefits, call your plan's member services.

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's member services.

Availability of Summary Information

As an employee, the health benefits provided by Downey Unified 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.

Downey Unified School District offers a variety of benefit plans to eligible employees. The federal health care reform law requires that eligible members of an employer plan receive a Summary of Benefits and Coverage (SBC) for any medical and pharmacy plans available. The SBC is intended to provide important plan information to individuals, such as common benefit scenarios and definitions for frequently used terms. The SBC is intended to serve as an easy-to-read, informative summary of benefits available under a plan. SBCs and any revisions or amendments of the plans offered by Downey Unified School District are available by contacting the Benefits Desk.

Health Insurance Marketplace Exchange Notice
Your Health Coverage Options

General Information

In 2014 a new way to buy health insurance took effect: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the Marketplace and employment-based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace runs from November to December. Coverage begins January 1st. For other essential enrollment information visit https://www.healthcare.gov/quick-guide.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.78%[1] of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.[2]

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

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact the Benefits Desk.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit **HealthCare.gov** for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

[1] ACA Shared-Responsibility Affordability Percentage for plan year 2020 is 9.78%.
[2] An employer-sponsored health plan meets the “minimum value standard” if the plan’s share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer name Downey Unified School District			4. Employer Identification Number (EIN) 95-6006586
5. Employer address 11627 Brookshire Ave			6. Employer phone number (562) 469-6624
7. City Downey		8. State CA	9. ZIP code 90241
10. Who can we contact about employee health coverage at this job? Benefits Desk			
11. Phone number (if different from above)	12. Email address		

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

- As your employer, we offer a health plan to:
  - ☐ All employees. Eligible employees are

  - ☒ Some employees. Eligible employees are: employees regularly working at least 20 or more hours per week.

- With respect to dependents:
  - ☒ We do offer coverage. Eligible dependents are: legally married spouse, registered domestic partner and children (including domestic partner's children).

  - ☐ We do not offer coverage.

☒ If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, HealthCare.gov will guide you through the process. Visit HealthCare.gov to find out if you can get a tax credit to lower your monthly premiums.

Medicare Part D Notice

Important Notice from Downey Unified School District About Your Prescription Drug Coverage and Medicare

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

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

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

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

When Can You Join A Medicare Drug Plan?

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

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

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your Downey Unified School District coverage may be affected. See below for more information about what happens to your current coverage if you join a Medicare drug plan. Important Retiree Note: If you are eligible for Downey Unified School District's Retiree Medical Program and you enroll in Kaiser's Senior Advantage plan your drug coverage will be affected if you decide to join a Medicare drug plan. When a subscriber and a spouse/domestic partner are both age 65 or older and retired, and are remaining on Kaiser's Senior Advantage plan, you are automatically enrolled in Medicare Part D. Do not enroll in a Medicare Part D plan outside of Kaiser. This will automatically disenroll you from your Kaiser Medicare Part D plan.

Since the existing prescription drug coverage under Downey Unified 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 Downey Unified School District prescription drug coverage, be aware that you and your dependents can only get this coverage back at open enrollment or if you experience an event that gives rise to a HIPAA Special Enrollment Right.

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 Downey Unified School District and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

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

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

Contact the person listed below for further information.

NOTE: You'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 Downey Unified School District changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage...

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'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).

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

Date:	October 1, 2020
Name of Entity/Sender:	Downey Unified School District
Contact-Position/Office:	Benefits Desk
Address:	11627 Brookshire Ave, Downey, CA 90241
Phone Number:	(562) 469-6624

Downey Unified SCHOOL DISTRICT

For Benefits Assistance

Provider	Plan	Phone Number	Website
Kaiser	DHMO with HRA	(877) 761-3399	www.kp.org
Blue Shield	PPO	(855) 256-9404	www.blueshieldca.com
Blue Shield	Teladoc	(800) 835-2362	teladoc.com/bsc
Blue Shield	Heal	(844) 644-4325	www.heal.com
Blue Shield	Nurse Help 24/7	(866) 304-0504	www.blueshieldca.com
Delta	Dental PPO	(800) 765-6003	www.deltadentalins.com
MetLife	Dental HMO	(800) 880-1800	www.metlife.com/mybenefits
VSP	Vision Care	(800) 877-7195	www.vsp.com
Guardian	Basic Life (CSEA Unit 1 in lieu of medical)	(800) 525-4542	www.guardiananytime.com
Transamerica	Basic Life (CSEA Unit 1 working less than 50%)	(800) 346-1608	www.transamericaemployee benefits.com
American Fidelity	FSA & Voluntary Benefits	(800) 365-9180 ext 0	americanfidelity.com
Schools First FCU	Retirement Plans	(800) 462-8328 ext 4116	www.schoolsfirstfcu.org

DUSD Wellness Clinic

11480 Brookshire Avenue, Suite 301
(located inside the PIH Medical Office Building)

Phone: (562) 904-4460

Monday, Wednesday, and Friday 7:30 am to 4:30 pm
Tuesday and Thursday 9:00 am to 6:00 pm
(closed 12-1pm)

Reminders: Blue Shield and Kaiser members must take the elevators to the third floor. Clinic provides primary care services.

District Benefits Desk

kquick@dusd.net or (562) 469-6624
http://www.dusd.net/benefits

Employee Benefits booklet designed and developed by
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in conjunction with Downey Unified School District.
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