2024-2025 Health and Wellness Benefits

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Benefits at-a-glance

The team at Grass Valley School District strives to bring you a choice of comprehensive medical plans, as well as the many other plans and options that make up your benefits program. We'll remain committed to maintaining a strong benefits program in 2024 and beyond. The following chart summarizes the benefit options available to you and your family.

Medical Plans	**Blue Shield of California:** Trio HMO Zero Admit 30 Access+ HMO Per Admit 20-500 PPO Combined Deductible 40-4000 PPO Savings 4000 HDHP / HSA PPO Savings 4400 HDHP / HSA
Dental Plan	**MetLife Dental PPO**
Vision Plan	**Blue Shield of California -Eyemed**
Basic Life & AD&D	**Blue Shield of California**
Employee Assistance Program	**Blue Shield of California**
Health Savings Account (HSA)	**Optum Bank**

Eligibility

Eligibility

Employees who are scheduled to work at least 50% FTE (Full Time Equivalency) or greater are eligible for the benefit plans described in this guide. Eligible employees may also choose to enroll family members, including a legal spouse/registered domestic partner (as legally defined under state and local law) and or eligible children.

Eligible Dependents

- Your legal spouse
- Your same- or opposite-gender domestic partner and their eligible dependent children (rates subject to additional taxation)
- Your natural or adopted children until they turn 26
- Unmarried, disabled dependent children of any age (you may be required to provide proof of disability)

Enrollment

Our plan year begins each year on July 1 and ends the following June 30. You can change your benefits coverage if you experience one of the following events:

- Annual Open Enrollment – Once a year, typically in May/June
- Newly Hired – 30-day enrollment period from date of hire
- Qualified Life Event – 30-day enrollment period from date of a qualifying event such as marriage, divorce, birth or adoption of a child, death of a family member or loss of coverage

Eligibility

Plan	Benefit Begins	Benefit Ends
Medical	1st of the month following date of hire. If you are hired on the 1st, your benefits eligibility begins that day	End of the month of termination
Dental	1st of the month following date of hire. If you are hired on the 1st, your benefits eligibility begins that day	End of the month of termination
Vision	1st of the month following date of hire. If you are hired on the 1st, your benefits eligibility begins that day	End of the month of termination
Basic Life/AD&D	1st of the month following date of hire. If you are hired on the 1st, your benefits eligibility begins that day	Date of termination

Making Benefits Changes

Making Benefits Changes

In most cases, you may only make changes to your benefits during Open Enrollment. However, if you have a "qualified life event," you may make changes to certain benefits, as defined by the plan documents, related to that event.

Qualified Life Events

Your marriage	Your divorce or legal separation	Birth, adoption, or placement for adoption of an eligible child
Death of your spouse or covered child	Change in your or your spouse's work status that affects benefits eligibility	A significant change in your or your spouse's health coverage attributable to your spouse's employment
A change in your children's eligibility for benefits	Becoming eligible for Medicare or Medicaid during the year or losing eligibility for Medicaid	Becoming eligible for domestic partner status in accordance with Grass Valley's Domestic Partner policy

You MUST complete the steps below within 30 CALENDAR DAYS of the qualifying life event to make changes to your benefit elections. For most events, changes are effective on the first of the month following the completion of the following steps:

1

Go online to your PlanSource account to enter your qualified life event www.plansource.com

2

Gather supporting documentation of the life event.

3

Send the documentation to Grass Valley Benefits Team.

Making benefit changes

Mid-Year Coverage Start and End Dates

start date

The first of the month following notification date (Exception: Changes made due to the birth or adoption of a child are effective on the date of birth or adoption.)

end date

Last day of the month for Medical, Dental, and Vision

Basic Life and AD&D coverage ends on the date your employment ends

COBRA

Under certain circumstances, you and your enrolled dependents can choose to continue coverage under your health and welfare plans including the healthcare flexible spending account, beyond the time coverage would have ordinarily ended. You may elect continuation of coverage for yourself and your dependents if you lose coverage under the plan because of one of the following qualifying events:

- Termination (for reasons other than gross misconduct)
- Reduction in employment hours
- Retirement

In addition, continuation of coverage may be available to your eligible dependents if:

- You die
- You and your spouse divorce or legally separate
- A covered child ceases to be an eligible dependent

If you experience a COBRA qualifying event you will receive a COBRA election notice from our COBRA administrator with information regarding your cost and instructions on how to apply for COBRA continuation.

If you and your spouse legally separate or divorce or your covered child ceases to be an eligible dependent, you must notify Grass Valley School District within 30 days of the event.

What benefits are eligible for COBRA?

- Medical
- Dental
- Vision
- FSA (if applicable)
- HRA (if applicable)

Choice and Cost Summary

Choice and cost summary

Monthly Premium paid by Grass Valley School District

	Employee only	Employee + spouse	Employee + child(ren)	Employee + family
Medical – Blue Shield of California				
Trio HMO Zero Admit 30	$773.50	$1,701.73	$1,392.32	$2,397.89
Access+ HMO Per Admit 20-500	$1,200.93	$2,642.04	$2,161.68	$3,722.88
PPO Combined Deductible 40-4000	$1,119.87	$2,463.73	$2,015.79	$3,471.63
PPO Savings 4000 HDHP / HSA	$925.81	$2,036.79	$1,666.47	$2,870.03
PPO Savings 4400 HDHP / HSA	$839.21	$1,846.27	$1,510.59	$2,601.56
Dental – MetLife				
PPO Dental	$44.32	$98.82	$89.94	$141.35
Vision – Blue Shield of California				
PPO Vision	$8.20	$17.48	$17.85	$28.78

Medical, Dental, and Vision Plans

Medical plan options

Your Medical Plan Options

Grass Valley School District provides access to high-quality, comprehensive care. The plans differ largely in the way the cost of care is structured and strategies you can use to control your expenses:

Choosing a Plan

Think about how you like to manage any buying decision. Do you tend to buy the whole package up front, or pay as you go depending on what you need?

Selecting a health plan can offer much the same choice. Do you prefer to pay lower premiums per paycheck, but potentially higher out-of-pocket costs? Or would you rather trade higher premiums for greater predictability? Whatever your style, be sure to choose the plan that meets your medical and financial needs.

Free Preventive Health Care

The Federal Health Care Reform law now requires insurance companies to cover preventive care services in full, saving you money and helping you maintain your health. Such preventive services include:

- Routine doctor's visits
- Annual checkups
- Well-baby and child visits
- Several types of immunizations/screenings

HMO Plans	Health Maintenance Organization (HMO) plan offers an all-in-one approach to healthcare, with predictable copays with zero deductibles that make managing your life, your health, and your budget simpler. HMO plans offer a comprehensive, convenient approach, but require that you seek care within the HMO network, and that patients select a primary care physician that will refer care to specialists. An HMO covers only in-network care except in life-threatening emergencies. When you enroll, you choose a primary care physician who can provide routine care as well as referrals to a broad network of specialists and facilities. You and your family members do not have to select the same PCP. For most services you pay a flat "copay" amount, rather than a percentage of the cost. Preventive care is covered at no cost to you. Please keep in mind the following: • You must live or work within 30 miles of your PCP • If your PCP withdraws from the network, you must choose a new PCP. If you do not select a PCP, one will be assigned to you based on your home address

Medical plan options

PPO Plans	PPO plans let you choose care inside or outside of the plan network, but you will incur a higher out-of-pocket cost for service, if you use out of network providers. PPO plans are a traditional plan that gives you the greatest flexibility, combined with lower costs when you choose a provider within its broad National network. Choosing health professionals who participate in the United Healthcare network keep your costs lower and eliminate paperwork. How the plan works: • It is recommended, however not required, that you choose a primary care physician (PCP) to serve as your personal doctor and help coordinate all your healthcare needs. Keep in mind; no referrals are necessary to see specialists in the Select Plus, Choice Plus or Core UHC Networks. Just choose a participating doctor and make an appointment. • Visit any licensed physician inside or outside the network. You will pay more when you get care outside the network. Either way, most routine services require a copay or coinsurance, and may involve meeting an annual deductible as well. Preventive care is paid at 100% in network. • All outpatient surgeries and hospital stays require pre-treatment authorization. Network doctors may take care of this for you. If you go to a non-network provider and do not obtain pre-treatment authorization, you may be subject to a non-compliance penalty, and services determined not to be medically necessary may not be covered.
HDHP HSA Plans	HDPHP HSA plans are high deductible medical plans that help protect against large claims and cover preventive care at 100% (deductible is waived for preventive services). If you enroll in this plan, you are eligible to open and contribute to a Health Savings Account (HSA) which can be used to help pay for qualified medical expenses. The High-Deductible Health Plans have what is called an “embedded” family deductible and family out-of-pocket maximum. This means that if you cover any dependents, your family must pay the total family deductible (not just the individual deductible) before the plan begins to share costs with you. Note: All plan deductibles and/or out-of-pocket maximums are based on a calendar year and will reset on January 1st .

Medical plan options

Using Prescription Drug Coverage

Many FDA-approved prescription medications are covered through the benefits program. Regardless of the plan you have, you may save money by filling prescription requests at participating pharmacies. Additional important information regarding your prescription drug coverage is outlined below:

- Tiered prescription drug plans require varying levels of payment depending on the drug's tier and your copayment or coinsurance will be higher with a higher tier number.
- Blue Shield has a preferred drug list (PDL), or list of prescription drugs including both generic and brand-name medications, that are preferred.
- Generic drugs are required by the FDA to contain the same active ingredients as their brand-name counterparts.
- A brand-name medication is protected by a patent and can only be produced by one specified manufacturer.
- Although you may be prescribed non-preferred prescriptions, these types of drugs are not preferred and will not be covered under the benefit plan.
- For a current version of the prescription drug lists, go to www.blueshieldca.com and search '***Prescription',*** click link under Large Groups (101+employee groups).

Watching Your Wallet?

There are a few ways you might save money through the Prescription Drug plan:

Generic Drugs: Talk to your doctor or pharmacist about trying generic drugs, which contain the same active ingredients as the brand-name equivalent and may reduce your pharmacy expenses.

Mail Order: Save time and money by utilizing your mail order service for your medications. A 90-day supply of your medication will be shipped directly to the address on file, instead of purchasing a typical 30-day at a retail pharmacy. Please visit www.blueshieldca.com for more information about the mail order service.

Price Compare: Some pharmacies, such as those at warehouse clubs or discount stores, may offer less expensive prescriptions than others. By calling ahead, you may determine which pharmacy provides the most competitive prices.

Informing you of Health Care Reform

Starting with the 2019 plan year the Federal Shared Responsibility Payment no longer applies however some states have their own individual health insurance mandate, requiring you to have qualifying health coverage or pay a fee with your state taxes.

To avoid paying the penalty this year and in future years, you can obtain health insurance through our benefits program or purchase coverage elsewhere, such as a State Health Insurance Exchange.

For more information regarding Health Care Reform, please visit www.healthcare.gov. California residents can also visit www.coveredca.com to review information specific to the Covered California State Health Insurance Exchange.

Medical plan options -
Additional information on HDHP / HSA

HDHP (High Deductible Health Plan)

When you are covered by a HDHP, you are eligible to participate in a Health Savings Account (HSA). An HSA is an investment tool that helps you save for health care expenses, including deductibles and coinsurance. Contributions to your HSA account are pre-tax, and any interest earned on the account is tax-free.

In 2024, you may contribute via payroll deduction up to $4,150, if you have individual coverage, or up to $8,300 if you are covering yourself and at least one additional family member. If you are age 55 or older, you may contribute an additional $1,000 to your account.

Contributions to your HSA roll over from year to year and accumulate if not used. You may use the funds to pay for any qualified health expenses incurred after the account is opened. You may pay the bill directly via the HSA debit card, or you may use the HSA to reimburse yourself for payments that you make.

Payments and withdrawals made from your HSA to cover qualified health care expenses are tax-free.

Watch the HDHP HSA video to learn about things you should know about HDHP and HSA before making your election.

You can make and receive contributions to the HSA

HSA offers a triple tax advantage:
- **Pretax contributions**
- **Tax free earnings**
- **Tax free distributions**

HDHP comes with lower premium cost

No use it or lose it rule

Your HSA is portable

Medical plan options –
Additional information on HDHP / HSA

Am I eligible to participate in an HSA?
To be eligible you must meet a few criteria:

Must be covered by a qualified HDHP	**Cannot be enrolled in Medicare or TRICARE***	**Cannot be claimed as a dependent on someone else's tax return**	**Cannot be covered by another medical plan that is not HSA qualified. If your spouse is participating in a healthcare spending account, you will not be able to make contributions into an HSA**

NOTE: HSA participants cannot participate in the Healthcare Flexible Spending account (FSA). However, you can participate in a Limited Purpose Healthcare FSA. Eligible expenses with a Limited Purpose Healthcare FSA include most unreimbursed dental and vision expenses (including expenses for your dependents).

*Some exceptions apply.

HSA withdrawals

- Qualified medical expenses include anything from doctor's office visits to dental or vision care, prescription medications, over the counter medications, and menstrual care products.
- You can also use HSA funds to pay COBRA and long-term care insurance premiums, though health insurance premiums are not qualified unless you are receiving unemployment benefits.
- Withdrawals for non-qualified expenses are taxable and carry a 20% penalty unless you are age 65 or older. If you are age 65 or older, you can withdraw funds for non-qualified expense and pay ordinary income taxes.

What is it?

By enrolling in the Blue Shield PPO Savings 4000 or Blue Shield PPO Savings 4400, you will have access to a Health Savings Account (H.S.A), which provides tax advantages and can be used to pay for qualified health care expenses.

How do I access my HSA funds?

Direct payment: When you use your HSA debit card, your expense is automatically paid from your account

Pay yourself back: Pay for eligible expenses with cash, check or your personal credit card, then withdraw funds from your HSA to reimburse yourself. You can even have your payment deposited directly into your checking or savings account. For more details visit https://www.optumbank.com/

How do I get started?

If you're ready to activate your H.S.A. you can:

1. **Go to www.optumbank.com and click the Log In button under "view your account"**
2. **As a first-time user, click Enroll Now and follow the prompts.**
3. **In the "Medical – Information High Deductible Health Plan, section, enter GVSD Optum Bank Group # HB899942.**

Medical plan options –
Additional information on HDHP / HSA

HSA Contribution

The money in your HSA is yours and can be used for any qualified eligible expense as defined by IRS Section 213(d). Any money left at the end of the year remains in your account and rolls over to the following calendar year.

- Family coverage for HSA includes one or more dependents.
- For employees age 55 and older, an additional $1,000 "catch-up" contribution is allowed.

	Annual IRS Limit $4,150 total	Additional "catch-up" contributions for ages 55-65
Single	You can contribute up to the IRS limit	$1,000
	Annual IRS Limit $8,300 total	
Family	You can contribute up to the IRS limit	$1,000

HSA Process

1

Visit your doctor

Preventive care is paid at 100% with the deductible waived if you use in-network providers

2

Present your insurance card

3

You will receive an Explanation Of Benefits (EOB) to explain what's covered and what you owe

4

The provider will send you a bill for the amount not covered

Tip: Do not pay the invoice until you verify what has been paid by your insurance

5

You pay the provider bill using your HSA (debit card/ checkbook/ online bill pay/ fund transfer)

You can also pay out of pocket then reimburse yourself at any time in the future

Important terms

Summary of Benefits and Coverage (SBC) and Uniform Glossary

Group health plans are required to provide you with an easy-to-understand summary about a health plan's benefits and coverage so that you can better evaluate your choices.

The SBC form also includes details, called "coverage examples," which are comparison tools that allow you to see what the plan would generally cover in two common medical situations. The SBC's standardized and easy to understand information about health plan benefits and coverage allows you to more easily make "apples to apples" comparisons between our insurance options.

You are encouraged to read and explore the SBC's and Uniform Glossary available for your medical plans posted on PlanSource

Important Terms

Coinsurance
The amount you pay for covered services after you pay the deductible. For example, if your plan has coinsurance of 20% and you have already paid the deductible, the plan pays 80% of the costs and you pay 20%.

Copay
The amount you pay up-front for your visit.

Covered services
Those services deemed by your plan to be medically necessary for the care and treatment of an injury or illness.

Deductible
The amount you pay before the plan starts to pay. For example, a PPO plan requires a $1,000 deductible for an individual using in-network services. This means that you pay the first $1,000 in medical care you use (please note, the deductible is not applicable to all services).

Formulary
A list that contains the approved medications that are part of your prescription drug plan.

Generic
An FDA-approved drug, composed of virtually the same chemical formula as a brand-name drug.

Out-of-pocket maximum
The most you will pay for covered medical expenses in a year. Once you reach your out-of-pocket maximum, the plan pays 100% of your covered medical expenses for the balance of the year.

Explanation of benefits (EOB)
It's not a bill, but a statement sent by your health insurance company to explain what medical treatments and/or services were paid for on your behalf.

Get the right care at the right price

With many options for getting care, how do you choose? This chart can help you understand where to go for what—and how you can save money.

Where to get care/cost	What is it	Examples of care provided
Telemedicine – Virtual Visit **Free**	A virtual visit lets you see a doctor via your smartphone, tablet or computer. Note: Telehealth visits may be provided without a charge if the health plan has adopted this.	• Allergies • Bronchitis • Diarrhea • Pink eye • Seasonal flu • Sore throats • Stomach aches
Primary Care Physician **$$**	Go to a doctor's office when you need preventive or routine care. Your primary doctor can access your medical records, manage your medications and refer you to a specialist, if needed.	• Check ups • Preventive services • Minor skin conditions • Vaccinations • General health management
Urgent Care **$$**	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 • Minor burns • Strains • Minor infections • Small cuts that may need a few stitches • Minor broken bones
Emergency Room **$$$$**	The ER is for life-threatening or very serious conditions that require immediate care. This is also when to call 911.	• Heavy bleeding • Chest pain • Major burns • Spinal injuries • Breathing difficulty

HMO plans

	Trio HMO Zero Admit 30 – Limited Network		Access+ HMO Per Admit 20-500 Full Network	
Accumulation period	1/1 – 12/31		1/1 – 12/31	
Calendar Year Deductible	None		None	
Out-of-pocket maximum - Individual - Family	$1,500 $3,000 ($1,500/Individual)		$2,500 $5,000 ($2,500/Individual)	
Outpatient Services	**You Pay**		**You Pay**	
Preventive Health Services	$0		$0	
Office Visits • Primary • Specialty (PCP Referral) • Specialty (Self Referral)	 $30/visit $30/visit $30/visit		 $20/visit $20/visit $30/visit	
Teledoc / Virtual Visits	$0		$0	
Diagnostic lab & x-ray *(lab center)*	$0		$0	
Complex imaging *(radiology center)*	$0		$0	
Chiropractic/Acupuncture *Up to 30 visits/year combined*	$10/visit		$10/visit	
Physical therapy	$30/visit		$20/visit	
Outpatient Hospital (surgery)	$0		$300/surgery	
Inpatient Services	**You Pay**		**You Pay**	
Inpatient Hospital	$0		$500/admission	
Emergency Services	**You Pay**		**You Pay**	
Emergency Room	$100/visit		$100/visit	
Urgent Care	$30/visit		$20/visit	
Ambulance	$100/transport		$100/transport	
Prescription drugs:	**Network Pharmacy**		**Network Pharmacy**	
Prescription drugs:	Retail – 30 Days	Mail Order – 90 Days	Retail – 30 Days	Mail Order – 90 Days
Tier 1	$15	$30	$15	$30
Tier 2	$30	$60	$30	$60
Tier 3	$45	$90	$45	$90
Tier 4	20% up to $250	20% up to $500	20% up to $250	20% up to $500

Note: This is a summary of benefits and does not include all provisions in the plan that may apply or be available to you. Please refer to PlanSource at www.plansource.com for more detailed plan information, and www.blueshieldca.com for more general information and to locate a provider.

PPO plans

PPO Combined Deductible 40-4000

	In Network		Out of Network	
Accumulation period	1/1 – 12/31			
Calendar Year Deductible (CYD) - Individual - Family	$4,000 $8,000 ($4,000/Individual)			
Out-of-pocket maximum - Individual - Family	$6,850 $13,700 ($6,850/Individual)		$14,000 $28,000 ($14,000/Individual)	
Outpatient Services	**You Pay**	**CYD**	**You Pay**	**CYD**
Preventive Health Services	$0		Not Covered	
Office visits / specialist visit	$40 / $45 visit		50%	✓
Teledoc / Virtual Visits	$0		Not Covered	✓
Diagnostic lab & x-ray *(lab center)*	$40/visit	✓	50%	✓
Complex imaging *(radiology center)*	20%	✓	50%	✓
Chiropractic *Up to 20 visits/year*	$25/visit	✓	50%	✓
Acupuncture care *Up to 20 visits/year*	$25/visit	✓	50%	✓
Physical therapy	$40/visit	✓	50%	✓
Outpatient Hospital (surgery)	25%	✓	50% subject to a benefit maximum of $350/day	✓
Inpatient Services	**You Pay**	**CYD**	**You Pay**	**CYD**
Inpatient Hospital	20%	✓	50% subject to a benefit maximum of $600/day	✓
Emergency Services	**You Pay**	**CYD**	**You Pay**	**CYD**
Emergency Room	$150/visit + 20%		$150/visit + 20%	
Urgent Care	$40/visit	✓	50%	✓
Ambulance	20%	✓	20%	✓
Prescription drugs:	**Retail – 30 Days (Network Pharmacy)**	**CYD**	**Mail Order – 90 Days (Network Pharmacy)**	**CYD**
Tier 1 – Per prescription	$15		$30	
Tier 2 – Per prescription	$30		$60	
Tier 3 – Per prescription	$45		$90	
Tier 4 – Per prescription	30% up to $250		30% up to $500	

Note: This is a summary of benefits and does not include all provisions in the plan that may apply or be available to you. Please refer to PlanSource at www.plansource.com for more detailed plan information, and www.blueshieldca.com for more general information and to locate a provider.

PPO plans

PPO Savings 4000 HDHP / HSA

	In Network		Out of Network	
Accumulation period	1/1 – 12/31			
Calendar Year Deductible (CYD) - Individual - Family	$4,000 $8,000 ($4,000/Individual)			
Out-of-pocket maximum - Individual - Family	$6,000 $12,000 ($6,000/Individual)		$10,000 $20,000 ($10,000/Individual)	
Outpatient Services	**You Pay**	**CYD**	**You Pay**	**CYD**
Preventive Health Services	$0		Not Covered	
Office visits / specialist visit	20% / 20%		50%	✓
Teledoc / Virtual Visits	$0		Not Covered	✓
Diagnostic lab & x-ray *(lab center)*	20%	✓	50%	✓
Complex imaging *(radiology center)*	20%	✓	50%	✓
Chiropractic *Up to 20 visits/year*	20%	✓	50%	✓
Acupuncture care *Up to 20 visits/year*	20%	✓	50%	✓
Physical therapy	20%	✓	50%	✓
Outpatient Hospital (surgery)	20%	✓	50% subject to a benefit maximum of $350/day	✓
Inpatient Services	**You Pay**	**CYD**	**You Pay**	**CYD**
Inpatient Hospital	20%	✓	50% subject to a benefit maximum of $600/day	✓
Emergency Services	**You Pay**	**CYD**	**You Pay**	**CYD**
Emergency Room	$150/visit + 20%	✓	$150/visit + 20%	✓
Urgent Care	20%	✓	50%	✓
Ambulance	20%	✓	20%	✓
Prescription drugs:	**Retail – 30 Days (Network Pharmacy)**	**CYD**	**Mail Order – 90 Days (Network Pharmacy)**	**CYD**
HDHP Preventive	$0		0%	
Tier 1 – Per prescription	$15		$30	
Tier 2 – Per prescription	$30		$60	
Tier 3 – Per prescription	$45		$90	
Tier 4 – Per prescription	30% up to $250		30% up to $500	

Note: This is a summary of benefits and does not include all provisions in the plan that may apply or be available to you. Please refer to PlanSource at www.plansource.com for more detailed plan information, and www.blushieldca.com for more general information and to locate a provider.

PPO plans

PPO Savings 4400 HDHP / HSA				
	In Network		**Out of Network**	
Accumulation period	1/1 – 12/31			
Calendar Year Deductible (CYD) - Individual - Family	$4,400 $8,800 ($4,400/Individual)			
Out-of-pocket maximum - Individual - Family	$4,400 $8,800 ($4,000/Individual)		$10,000 $20,000 ($10,000/Individual)	
Outpatient Services	**You Pay**	**CYD**	**You Pay**	**CYD**
Preventive Health Services	$0		Not Covered	
Office visits / specialist visit	$0 / $0	√	50%	✓
Teledoc / Virtual Visits	$0	√	Not Covered	✓
Diagnostic lab & x-ray *(lab center)*	$0	✓	50%	✓
Complex imaging *(radiology center)*	$0	✓	50%	✓
Chiropractic *Up to 20 visits/year*	$0	✓	50%	✓
Acupuncture care *Up to 20 visits/year*	$0	✓	50%	✓
Physical therapy	$0	✓	50%	✓
Outpatient Hospital (surgery)	$0	✓	50% subject to a benefit maximum of $350/day	✓
Inpatient Services	**You Pay**	**CYD**	**You Pay**	**CYD**
Inpatient Hospital	$0	✓	50% subject to a benefit maximum of $600/day	✓
Emergency Services	**You Pay**	**CYD**	**You Pay**	**CYD**
Emergency Room	$0	✓	$0	✓
Urgent Care	$0	✓	50%	✓
Ambulance	$0	✓	$0	✓
Prescription drugs:	**Retail – 30 Days (network pharmacy)**	**CYD**	**Mail Order – 90 Days (network pharmacy)**	**CYD**
HDHP Preventive	$0		$0	
Tier 1 – Per prescription	$0	✓	$0	✓
Tier 2 – Per prescription	$0	✓	$0	✓
Tier 3 – Per prescription	$0	✓	$0	✓
Tier 4 – Per prescription	$0	✓	$0	✓

Note: This is a summary of benefits and does not include all provisions in the plan that may apply or be available to you. Please refer to PlanSource at www.plansource.com for more detailed plan information, and www.blueshieldca.com for more general information and to locate a provider.

Dental

Grass Valley School District offers a competitive PPO dental plan to help you maintain your oral health. If you choose to use a dentist that is not part of the network, your benefit will be based on the Usual and Customary (U&C) allowance for the dental procedure performed. You will be responsible for the charges over the Usual and Customary allowance in addition to your portion of the coinsurance.

Network providers will submit claims on your behalf directly to MetLife. You will not receive an ID card.

Providers

To locate a provider in your area, you can visit the website
https://providers.online.metlife.com/findDentist

MetLife – PDP Plus Network		
	In Network	Out of Network
	Plan pays	Plan pays
Plan year deductible (individual / family)	$50 / $150	
Maximum benefit	$1,500 per person	
Diagnostic & Preventive services deductible waived	100%	100% of Usual & Customary
Basic services	80%	80% of Usual & Customary
Major services	50%	50% of Usual & Customary
Orthodontia [Adult & child]	50%	50% of Usual & Customary
Orthodontia lifetime maximum	$1,500 / lifetime	

Note: This is a summary of benefits and does not include all provisions in the plan that may apply or be available to you. Please refer to PlanSource at www.plansource.com for more detailed plan information, and https://www.metlife.com for more general information and to locate a provider.

Vision

The Grass Valley School District's vision plan gives you the freedom to see any provider. Keep in mind, however, that you can save a significant amount if you choose a network provider — plus they'll handle all the paperwork for you.

Providers

To locate a provider in your area, you can visit the website at http://www.blueshieldcavision.com/

Blue Shield of California – *Administered by Eyemed*		
	In Network	Out of Network
	You pay	Plan pays
Frequency (months)	12 exam / 12 lenses / 12 frames	
Examination - **Ophthalmologic** - **Optometric** - **Retinal Imaging**	No Charge No Charge $39 Copay	All cost above $60 All cost above $50 Not Covered
Lenses - **Single** - **Bifocal** - **Trifocal**	$25 Copay $25 Copay $25 Copay	All cost above $43 All cost above $60 All cost above $75
Frames	$25 Copay + all cost above $130	All cost above $40
Contacts - **Medically Necessary** - **Cosmetic**	$25 copay + all cost above $200-$250 $25 Copay + all cost above $130	All cost above $200-$250 All cost above $130
Note: This is a summary of benefits and does not include all provisions in the plan that may apply or be available to you. Please refer to PlanSource at www.plansource.com for more detailed plan information, and www.blueshieldcavision.com for more general information and to locate a provider.		

Income Protection

Life and AD&D

Basic Term Life and Accidental Death & Dismemberment (AD&D)

Grass Valley School District provides basic term life and Accidental Death & Dismemberment (AD&D) coverage to you at no cost through Blue Shield of California at no cost to you.

	Life	AD&D
Life and AD&D Benefit	$25,000	$25,000

Be sure to go into PlanSource at www.plansource.com to make sure your beneficiary information remains up to date.

Wellness and Perks

Wellness

Your medical coverage through Blue Shield of California includes many programs directed at specific aspects of your physical and emotional wellbeing, one of which is the program *Wellvolution*. The programs focus on managing weight, diabetes, quitting smoking, and managing stress. You can learn more about the programs by visiting https://www.wellvolution.com

Yes Health
Control diabetes risk and lose weight with nutrition and fitness coaching

WW
Reach your goals with the #1 Dr. recommended weight-loss program!

Headspace
Learn meditation and mindfulness to reduce stress and boost mood

Virgin Pulse
Develop healthy habits with personal coaching and wellness programs

HabitNu
Help prevent diabetes and lose weight with a CDC-developed program

MonjWell
Reduce weight and reach your health goals with food plans and coaching

Ginger
Get expert mental health care online, when you need it

Virta
Treat diabetes and lose weight with no calorie-counting or exercise

Clickotine
Quit smoking with science-backed methods, free nicotine replacement, etc.

Restore Health
Improve sleep, stress, nutrition, and exercise with coaching and digital tools

Ex Program
Beat tobacco with help from Mayo Clinic experts, free nicotine patches, etc.

Betr Health
Lose weight, address chronic conditions, and restore your gut health.

Employee Assistance Program (EAP)

The LifeReferrals 24/7 program is a confidential program offered through Blue Shield and provided by Magellan Health Services, whose services include helping you and family members in your household address life's issues. These may include things like stress, anxiety, depression, relationship problems, job or work stress, parenting, alcohol and drugs, legal issues, and financial concerns and dependent care issues.

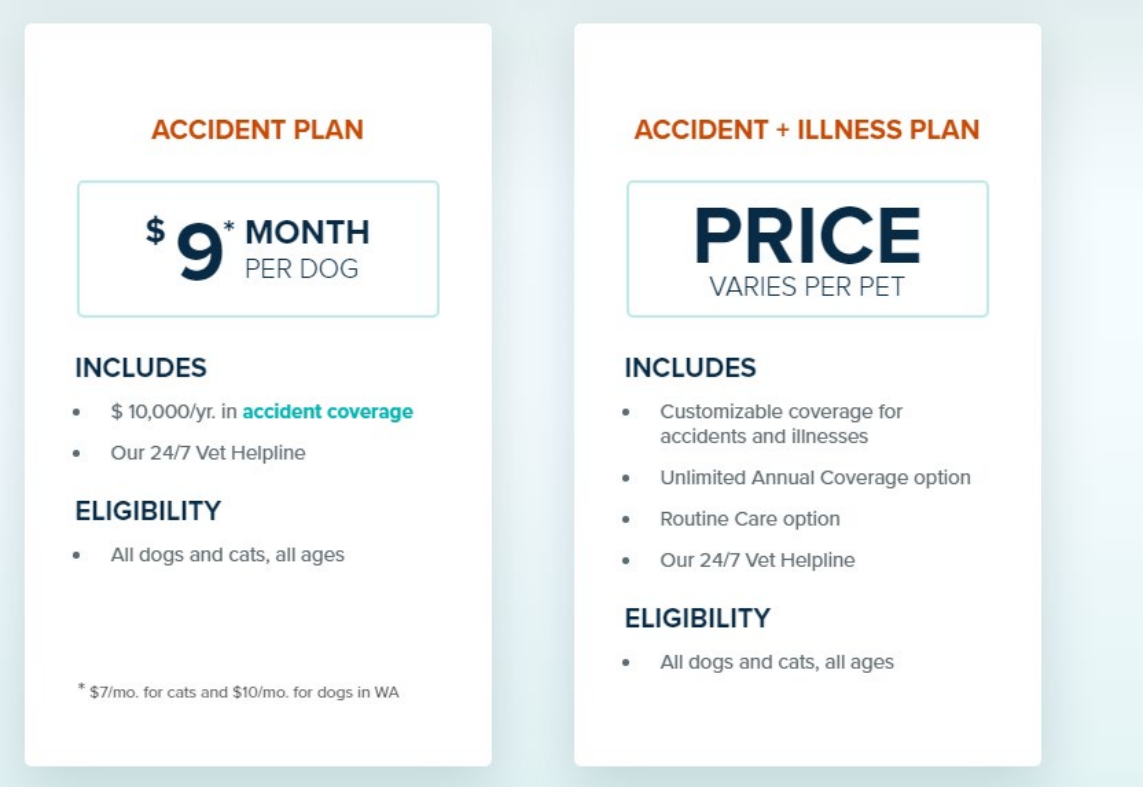
You have up to three counseling sessions available to you in any six-month period, and the service is paid for by Grass Valley School District and provided at no cost to you.

Services are provided 24/7 and available to you and all those who reside in your home.
Call LifeReferrals 24/7 toll-free at (800) 985-2405.

To learn more about the program navigate to:
http://www.lifereferrals.com/ the access code is BSC

Pet Insurance – New Partner

Pets Best PET HEALTH INSURANCE | Newfront



Go to:
www.petsbest.com/newfrontsd

Call 888-984-8700 referral/discount code: NEWFRONTSD

Pets Best PET HEALTH INSURANCE

Benefit Questions

Carrier contacts

Benefit Type	Group #	Tel#	Website/Email
Human Resources: Janell Kays		530-273-4483 Ext. 2001	Jkays@gvsd.us
Medical Coverage Blue Shield of California • Trio HMO • Access+ HMO • PPO Combined Deductible • PPO Savings 4000 HDHP/ HSA • PPO Savings 4400 HDHP / HSA	W0069590	HMO: 855-829-3566 PPO: 888-256-1915	www.blueshieldca.com
Dental Coverage MetLife PPO	5384941	800-GET-MET8	www.metlife.com
Vision Coverage Blue Shield of California (administered by Eyemed)	W0096590	877-601-9083	https://member.eyemedvisioncare.com/bscavision/en
Life and AD&D Blue Shield of California	W0096590	888-800-2742	www.blueshieldca.com
Employee Assistance Program Blue Shield of California	W0096590	800-985-2405	www.lifereferrals.com Code = BSC
Health Savings Account (H.S.A.) Optum Bank	HB899942	866-234-8913	www.optumbank.com
Pet Insurance Pets Best	N/A	888-984-8700	www.petsbest.com/newfrontsd Code: NEWFRONT

ANNUAL NOTIFICATION OF BENEFIT RIGHTS

2024 Medicare Part D Notice of Creditable Coverage

Important Notice from Grass Valley 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 Grass Valley 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. Grass Valley School District has determined that the prescription drug coverage offered by the Blue Shield of California Trio HMO, Access+ HMO, Full Combined PPO and Full PPO Saving HDHP/HSA, and Full PPO Savings 4400 HDHP/HSA is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

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

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

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

If you decide to join a Medicare drug plan, your current Grass Valley School District coverage may be affected.

If you do decide to join a Medicare drug plan and drop your current Grass Valley School District coverage, be aware that you and your dependents will not be able to get this coverage back until the plan's next open enrollment period.

ANNUAL NOTIFICATION OF BENEFIT RIGHTS

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 Grass Valley 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 number 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 Grass Valley 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 www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227).
  TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit
Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

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

For more information, contact the HR Department.

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2023. Contact your State for more information on eligibility –

ALABAMA – Medicaid	ALASKA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid	**CALIFORNIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**FLORIDA – Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecover y.com/hipp/index.html Phone: 1-877-357-3268

GEORGIA – Medicaid	INDIANA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health- insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization- act-2009-chipra Phone: 678-564-1162, Press 2	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone: 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	**KANSAS – Medicaid**
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid- a-to-z/hipp HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
KENTUCKY – Medicaid	**LOUISIANA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid	**MASSACHUSETTS – Medicaid and CHIP**
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid	**MISSOURI – Medicaid**
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and- services/other-insurance.jsp Phone: 1-800-657-3739	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
MONTANA – Medicaid	**NEBRASKA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178

NEVADA – Medicaid	NEW HAMPSHIRE – Medicaid
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 5218
NEW JERSEY – Medicaid and CHIP	**NEW YORK – Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/ dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**OREGON – Medicaid**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	**RHODE ISLAND – Medicaid and CHIP**
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP- Program.aspx Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	**SOUTH DAKOTA - Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS – Medicaid	**UTAH – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
VERMONT– Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427	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/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)

WISCONSIN – Medicaid and CHIP	WYOMING – Medicaid
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

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
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 1/31/2026)

ANNUAL NOTIFICATION OF BENEFIT RIGHTS

Women's Health and Cancer Rights Act (WHCRA)

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

- Reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and physical complications for all stages of a mastectomy, including Lymphedemas (swelling associated with the removal of lymph nodes).

These benefits may be subject to annual deductibles and coinsurance provisions that are appropriate and consistent with other benefits under your plan or coverage. If you would like more information on WHCRA benefits, contact the HR Department.

Notice of HIPAA Enrollment Rights

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

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

To request special enrollment or obtain more information, contact the HR Department.

Patient Protections Notice

If a qualifying benefit option under a group health plan maintained by the employer generally requires or allows the designation of a primary care provider, the covered individual has the right to designate any primary care provider who participates in the Plan's network and who is available to accept the covered individual. Until the covered individual makes this designation, the Plan may designate a primary care provider for him or her. For children, the covered employee or spouse may designate a pediatrician as the primary care provider. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the HR Department.

For any qualifying benefit option, covered individuals do not need prior authorization from the group health plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in the Plan's network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the HR Department.

ANNUAL NOTIFICATION OF BENEFIT RIGHTS

ADA Notice Regarding Wellness Program

The Grass Valley School District wellness program is a voluntary wellness program available to all employees. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information a voluntary health risk assessment or "HRA" that asks a series Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. If you choose to participate in the wellness program you may be asked to complete s of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (e.g., cancer, diabetes, or heart disease). You may also be asked to complete a biometric screening, which may include a blood test. If so, you are not required to complete the HRA or to participate in the blood test or other medical examinations.

However, employees who choose to participate in the wellness program may receive an incentive. Although you are not required to complete the HRA or participate in the biometric screening (if any), the program may provide that only employees who do so will receive the incentive.

Additional incentives of up to 30% of the cost of coverage may be available for employees who participate in certain health-related activities or achieve certain health outcomes. If you are unable to participate in any of the health- related activities or achieve any of the health outcomes required to earn an incentive, you may be entitled to a reasonable accommodation or an alternative standard. You may request a reasonable accommodation or an alternative standard by contacting the HR Department.

The information from your HRA and the results from your biometric screening (if any) will be used to provide you with information to help you understand your current health and potential risks and may also be used to offer you services through the wellness program. You also are encouraged to share your results or concerns with your own doctor.

Protections from Disclosure of Medical Information

We are required by law to maintain the privacy and security of your personally identifiable health information. Although the wellness program and the employer may use aggregate information it collects to design a program based on identified health risks in the workplace, the wellness program will never disclose any of your personal information either publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements. Only individuals necessary to administer the program will receive your personally identifiable health information in order to provide you with services under the wellness program.

In addition, all medical information obtained through the wellness program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the wellness program will be used in making any employment decision. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you immediately.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate.

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact the HR Department.

Annual notification of benefit rights

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 Grass Valley School District		4. Employer identification number (EIN) 02-0723471
5. Employer address 10840 Gilmore Way		6. Employer phone number 530.273.4483
7. City Grass Valley	8. State CA	9. ZIP code 95945
10. Who can we contact about employee health coverage at this job? Janell Kays		
11. Phone number (if different from above) 530.273.4483	12. Email address Jkays@gvsd.us	

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:

Regular employee working 50% FTE (full-time equivalent) or greater

❑ Some employees. Eligible employees are:

- **With respect to dependents:**

☑ We do offer coverage to dependents. Eligible dependents are:

Legal spouse, same-sex or opposite-sex registered domestic partner, dependent children to age 26, and disabled dependents at any age with proof of ongoing disability

❑ 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, www.HealthCare.gov will guide you through the process. This notice includes the employer information you'll need when you visit HealthCare.gov to find out if you can get a tax credit to lower your monthly premiums.

This document is subject to change without notice. Grass Valley School District does not warrant that the material contained in this document is error-free. If you find any problems with this document, please report them to Grass Valley School District Human Resources, in writing.

Grass Valley School District reserves the right to terminate, suspend, withdraw, or modify the benefits described in this document, in whole or in part, at any time. No statement in this or any other document, and no oral representation, should be construed as a waiver of this right.

This is not a legal document. Please refer to the summary plan descriptions for detailed information. This document is not intended to cover every option detail. Complete details are in the legal documents, contracts, and administrative policies that govern benefit operation and administration.

If there should ever be any differences between the summaries in this handbook and these legal documents, contract, policies, the documents contracts and policies will be the final authority.