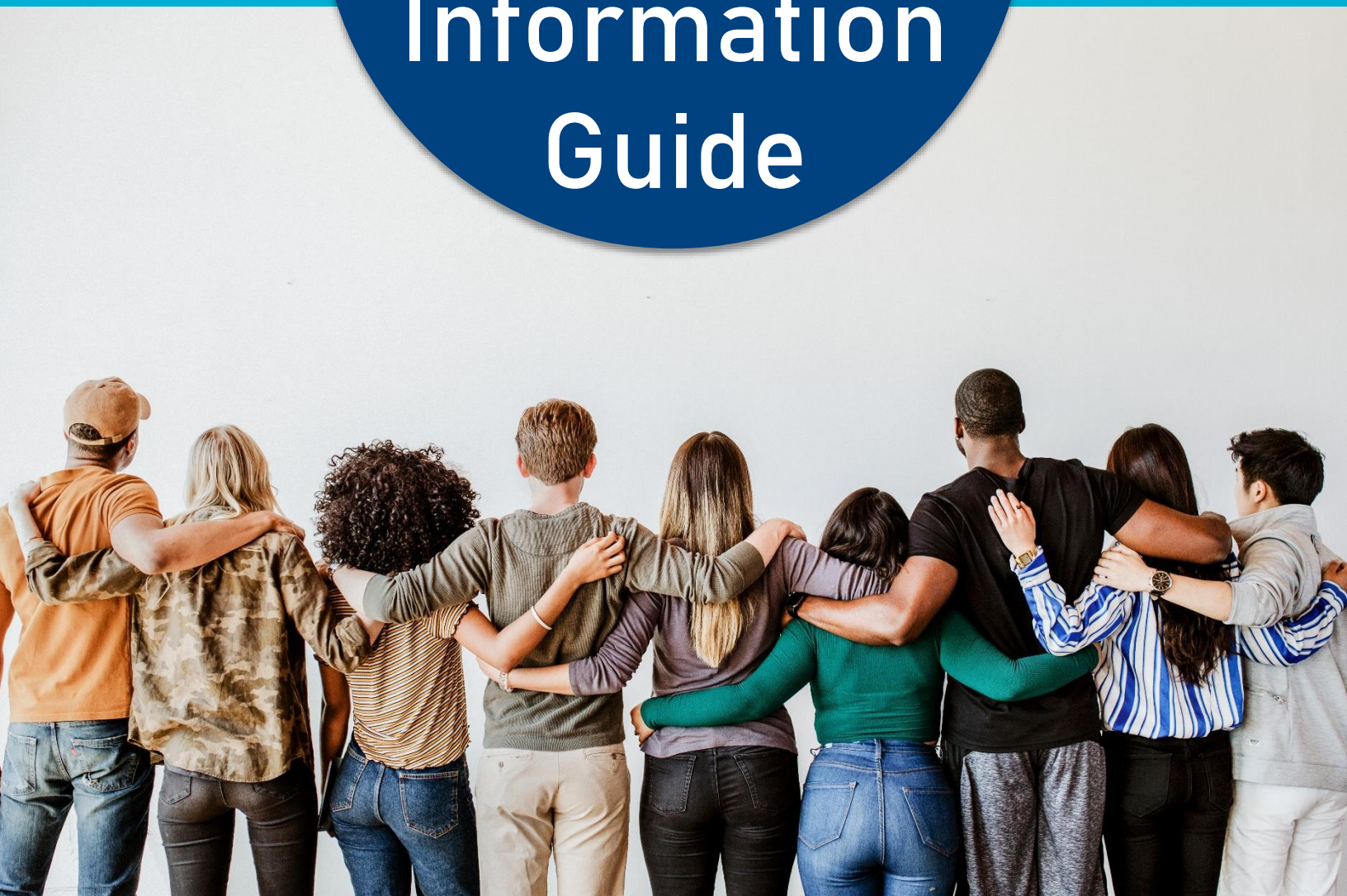
2024

Benefits Information Guide



Guidelines/Evidence of Coverage

The benefit summaries listed on the following pages are brief summaries only. They do not fully describe the benefits coverage for your health and welfare plans. For details on the benefits coverage, please refer to the plan's Evidence of Coverage. The Evidence of Coverage or Summary Plan Description is the binding document between the elected health plan and the member.

A health plan physician must determine that the services and supplies are medically necessary to prevent, diagnose, or treat the members' medical condition. These services and supplies must be provided, prescribed, authorized, or directed by the health plan's network physician unless the member enrolls in the PPO plan where the member can use a non-network physician.

For details on the benefit and claims review and adjudication procedures for each plan, please refer to the plan's Evidence of Coverage. If there are any discrepancies between benefits included in this summary and the Evidence of Coverage or Summary Plan Description, the Evidence of Coverage or Summary Plan Description will prevail.

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 2 months, Federal law gives you more choices about your prescription drug coverage. Please see page (41) for more details.

The rates quoted for these benefits may be subject to change based on final enrollment and/or final underwriting requirements. This material is for informational purposes only and is neither an offer of coverage nor medical advice. It contains only a partial, general description of the plan or program benefits and does not constitute a contract. Consult your plan documents (Schedule of Benefits, Certificate of Coverage, Group Agreement, Group Insurance Certificate, Booklet, Booklet-certificate, Group Policy) to determine governing contractual provisions, including procedures, exclusions and limitations relating to your plan. All the terms and conditions of your plan or program are subject to applicable laws, regulations, and policies. In case of a conflict between your plan document and this information, the plan documents will always govern.

Discover Your Benefits

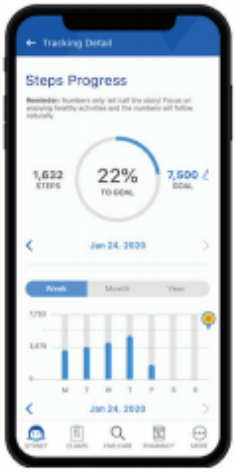
Let's explore your benefit plan options, programs and resources.

*Login Instructions for the IGOE Flexible Spending Accounts and The Hartford Voluntary Products can be found on page 35 in the Guide.

Access your medical benefits from anywhere, anytime!

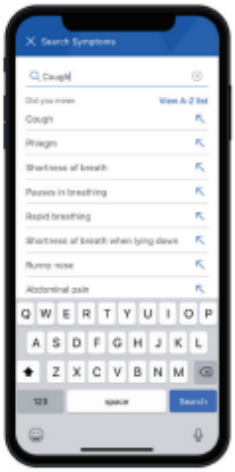
Benefits on the Go with Anthem:

Working with you



- Reminding you about important preventive care needs*
- Planning and tracking your health goals, fitness, and rewards
- Guiding you with insights based on your history and changing health needs
- Empowering you with personalized tools to find and compare healthcare providers and check costs*

Working for you



- Giving you instant access to your vision, dental, and spending account benefits*
- Storing your member ID card so you can show, email, or fax it right from your phone
- Providing answers quickly through real-time live chat with Anthem Health Guides and nurses
- Connecting you directly to care through a virtual video or text visit

Download Sydney Health today

Download on the App Store

Google play

Eligibility & Enrollment

Eligibility & Enrollment

Time to answer some questions…

Who can enroll?

If you are an employee that is expected to regularly work a minimum of 4 hours per day, you are eligible to participate in the medical/dental/vision program. 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.

An employee may be unable to pay for and/or receive employer contributions on a pre-tax basis for the cost of the benefits of an employee's state registered/unregistered domestic partner that does not meet the definition of the employee's tax dependent under IRC Section 152.

When does coverage begin?

Who can enroll? You are eligible to enroll on the first of the month following employment.

Your enrollment choices remain in effect through the end of the benefits plan year, October 1, 2024 – September 30, 2025. If you miss the enrollment deadline, you may not enroll in a benefit plan unless you have a change in status event during the plan year. Please check with your plan administrator and your Section 125 plan document on any applicable status change events that would allow you to make a mid-year election change.

What if my needs change during the year?

You are permitted to make changes to your benefits after the open enrollment period if you have a change in status event as defined by the IRS. Generally, you may add or remove dependents from your benefits, as well as add, drop, or change coverage if you submit your request for change within 30 days of the status change event. Change in status examples include:

- Marriage, divorce, or legal separation.
- Birth or adoption of a child.
- Death of a dependent.
- You or your spouse's loss or gain of coverage through our organization or another employer.
- You enroll, or intend to enroll, in a Qualified Health Plan (QHP) through the State Marketplace or Federal Exchange due to open enrollment or special enrollment period, and coverage is effective no later than the day immediately following the revocation of your employer-sponsored coverage.

If your change during the year is a result of the loss of eligibility or enrollment in Medicaid, Medicare, or state health insurance programs, you must submit the request for change within 60 days. For a complete explanation of status change events, please refer to the "HIPAA Special Enrollment Rights Notice" contents at the end of this guide.

Do I have to enroll?

Although the federal penalty requiring individuals to maintain health coverage has been reduced to $0, some states have their own state-specific individual mandates.

To avoid paying the penalty in some states, you can obtain health insurance through our benefits program or purchase coverage elsewhere, such as from a State or Federal Health Insurance Exchange.

For information regarding Healthcare Reform and the Individual Mandate, please contact Health Benefits Department or visit www.cciio.cms.gov. You can also visit www.coveredca.com to review information specific to the Covered California State Health Insurance Exchange.

You may elect to "waive" medical/dental/and/or vision coverage if you have access to coverage through another plan. To waive coverage, you will need to complete a Declination of Coverage Form which can be found on the district benefits site (www.bcsd.com/healthbenefits). It is important to note that if you waive our medical coverage, you must maintain medical/health coverage through another source. It is also important to note that if coverage is waived, the next opportunity to enroll in our group benefit plans would be on October 1, 2025, unless a change in status event occurs.

MDLive

Visit a doctor by phone, secure video, or MDLIVE App. Pediatricians are available 24/7, and family members are eligible. Behavioral health and Psychiatric visits are available from the convenience of your own home. Your copay is **$10** for all visits through September 30, 2025.

We treat over 50 routine medical conditions including:

- Acne.
- Allergies.
- Cold / Flu.
- Constipation.
- Cough.
- Fever.
- Sore Throats.
- Ear Problems.
- Headache.
- Insect Bites.
- Nausea / Vomiting.
- Pink Eye.
- Rash.
- Respiratory Problems.
- Urinary Problems / UTI.
- And more.

U.S. board-certified doctors with an average of 15 years of experience.

Consultations are convenient, private, and secure.

Prescriptions can be sent to your nearest pharmacy, if medically necessary.

Call 800.657.6169
Visit MDLIVE.com/sisc

Download the app.
Join for free. Visit a doctor.

Medical

Medical

Which plan type is right for you?

Anthem Classic PPO

A Preferred Provider Organization (PPO) Plan contracts with medical providers, such as hospitals and doctors, to create a network of participating providers. Using providers that belong in the plan's network will provide a higher benefit, but you have the flexibility to see a provider outside the network, generally for an additional cost.

Advantages
- Broader choice of providers.
- No referrals required for specialists.

Out-of-pocket costs
You'll be responsible for copays and coinsurance.

Deductible Required
Yes, there is $100 (Individual deductible) and $300 (Family deductible).

Chiropractic Care
Chiropractic Care through American Specialty Health (ASH) is covered as long as it is medically necessary. It is important that ASH give the OK, because the medical necessity review is required in order for the provider to be paid.

Note:
You may choose in or out-of-network care. However, in-network care provides you a higher level of benefit.

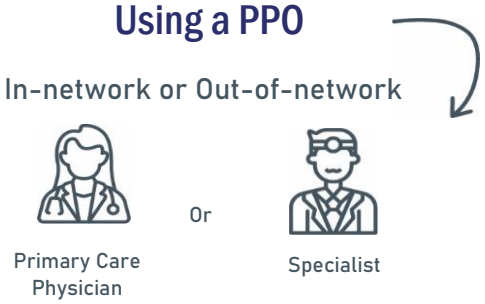
Please note the above examples are used for general illustrative purposes only. Please consult with your Human Resources department for more specific information as it relates to your specific plan. For a detailed view of your medical plan summaries, visit www.bcsd.com/healthbenefits.

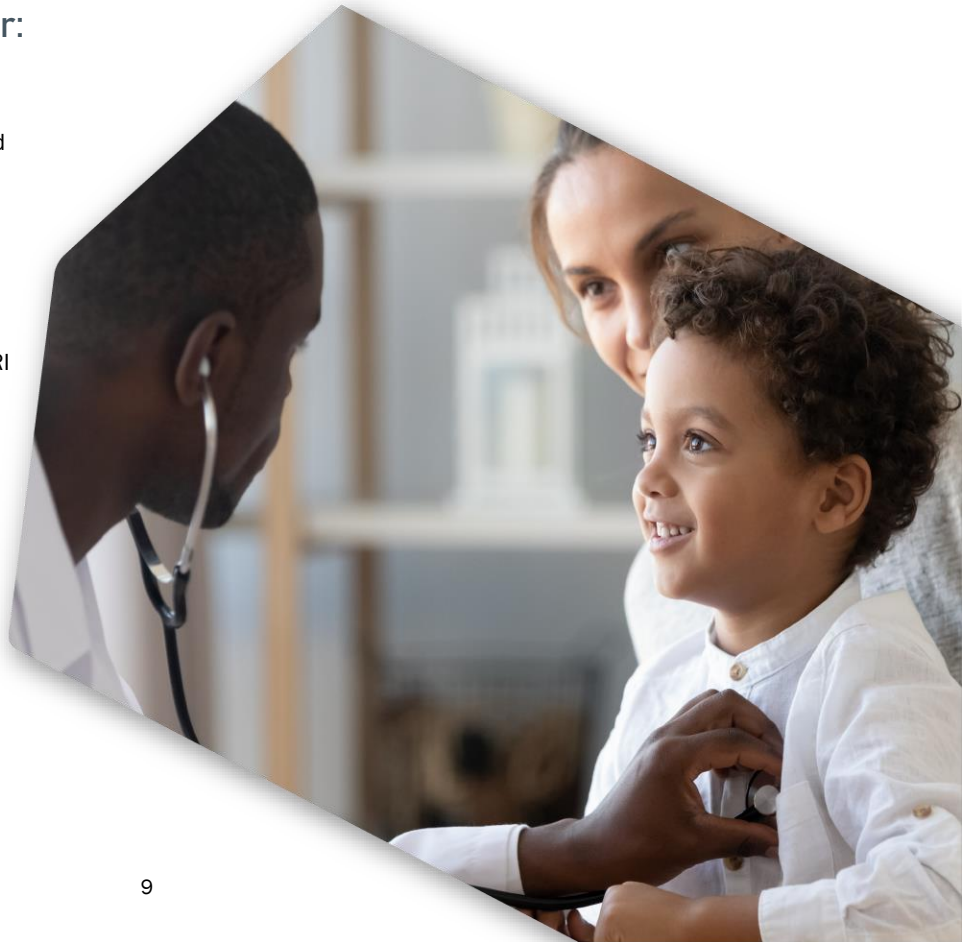
How do I find a provider?

To find an in-network PPO provider:

Anthem Classic PPO Plan

- Go to www.anthem.com/ca/sisc/ and select "Find Care" from the Menu button in the top left corner.
- "Search for a Doctor" by Plan.
- Select the "PPO Plan" and click on Search for a PPO Network Provider.
- Search by Zip or search by specialty or name
- Search Care Provider by selecting Primary Care, Behavioral Health, Lab (Blood Work), Imaging (MRI or X-ray) or Hospital.
- Physician profiles and locations available will appear.





Need to see a doctor on demand?

Telehealth Services

With telehealth, you can connect with leading board-certified physicians for many non-emergency illnesses through the internet, video chat or telephone. By leveraging these virtual visits, you can avoid emergency rooms or urgent care centers and quickly refill your prescriptions so you can get back on your feet in no time.

If your telehealth doctor prescribes you medication, you are able to conveniently pick up your prescription in your local area. You may also use mail-order services for delivery of your prescription.

Through Teladoc, telehealth services are paid for 100% by company for all dependents on your health plan.

Start your eVisit today!

- By phone: 800.835.2362
- Online: www.teladoc.com/sisc
- Download the Teladoc app

Prescription Drug (Rx) Benefits

Many FDA-approved prescription medications are covered through the benefits program. Tiered prescription drug plans require varying levels of payment depending on the drug's tier.

Generic formulary: Generic drugs contain the same active ingredients as their brand-name counterparts but are less expensive.

Brand name medications: A brand-name medication can only be produced by one specified manufacturer and is proven the most effective in its class.

Specialty prescriptions: Specialty medications most often treat chronic or complex conditions and may require special storage or close monitoring.

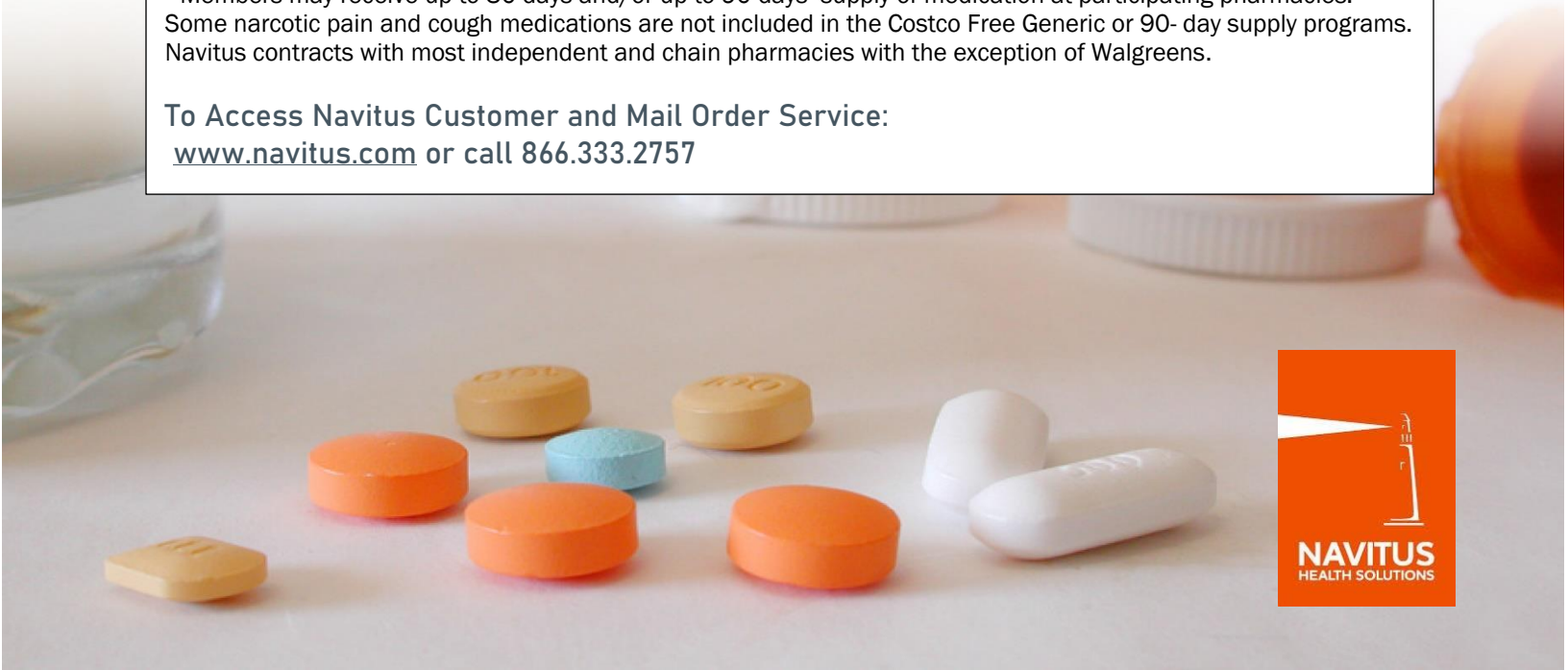
Why pay more for prescriptions?

	Walk-In				Mail	
	Network		Costco		Costco	Navitus
Days' Supply*	30	90	30	90	90	30
Generic	$3	N/A	**FREE**	**FREE**	**FREE**	N/A
Brand	$15	N/A	$15	$35	$35	N/A
Specialty	N/A	N/A	N/A	N/A	N/A	$15

Out-of-Pocket Maximum	$1,500 Individual / $2,500 Family

*Members may receive up to 30 days and/or up to 90 days' supply of medication at participating pharmacies. Some narcotic pain and cough medications are not included in the Costco Free Generic or 90- day supply programs. Navitus contracts with most independent and chain pharmacies with the exception of Walgreens.

To Access Navitus Customer and Mail Order Service:
www.navitus.com or call 866.333.2757



"I need specific medical care! How much does it cost?"

Plan Highlights

Anthem Classic PPO

	In-network (Prudent Buyer PPO)		Out-of-network
Annual Calendar Year Deductible [1]			
Individual / Family	$100 / $300		
Maximum Calendar Year Out-of-pocket			
Individual	$1,000		$1,000
Family	$3,000		$3,000
Professional Services			
Primary Care Physician (PCP)	No Copay		See footnote[2]
Specialist	No Copay		See footnote[2]
Virtual Visits "LiveHealth Online"	No Copay		Not covered
Preventive Care / Screening / Immunization	No Copay		Not covered
Diagnostic X-ray and Lab	0% coinsurance		Not covered
Complex Diagnostics (MRI/PET/CAT Scan)	0% coinsurance		Limited to $800 per test, plus all billed amounts exceeding $800 per test
Therapy (Physical & Occupational)	0% coinsurance		Not covered
Speech Therapy	0% coinsurance		Paid at 100% of the maximum allowed amount [1,2]
Chiropractic Services	0% coinsurance		Not covered
Hospital Services			
Inpatient	0% coinsurance		Limited to $600 max per day, plus all billed amounts exceeding $600 per day
Outpatient Surgery	0% coinsurance		See footnote[2]
Emergency Room (Copay waived if admitted)	$100 copay, then 0% coinsurance		$100 copay, then 0% coinsurance
Ambulance (Air and Ground)	$100 copay, then 0% coinsurance		$100 copay, then 0% coinsurance
Urgent Care	No Copay		See footnote[2]
Maternity Care			
Physician Services (prenatal or postnatal)	No Copay		See footnote[2]
Hospital Services	0% coinsurance		Limited to $600 max per day, plus all billed amounts exceeding $600 per day
Mental Health & Substance Abuse			
Inpatient	0% coinsurance		Limited to $600 max per day, plus all billed amounts exceeding $600 per day
Outpatient	No Copay		See footnote[2]
Out-of-Pocket RX Maximum	$1,500 Individual / $2,500 Family		
Retail Prescription Drugs (30-day supply)	Network (30-day supply)	Costco (30 / 90-day supply)	
Generic[3]	$3	$0 / $0	Not covered
Brand	$15	$15 / $35	
Specialty	N/A	N/A	
Mail Order Prescription Drugs (90-day supply)	Navitus (30-day supply)	Costco (90-day supply)	
Generic	N/A	$0	Not covered
Brand	N/A	$35	
Specialty	$15	N/A	

1. All medical services subject to a coinsurance are also subject to the annual medical deductible, including services listed with a 0% coinsurance.
2. When using Non-network PPO Providers, members are responsible for any difference between the maximum allowed and actual charges, as well as any deductible & percentage copay.
3. Generic drugs: If you or your physician requests the brand name when a generic equivalent is available, you will pay the generic copay plus the difference in cost between the brand and generic. This cost difference will not count towards the Annual Out-of-Pocket maximum.

The above information is a summary only. Please refer to your Evidence of Coverage for complete details of Plan benefits, limitations, and exclusions.

Supplemental Health Plans

Supplemental Health Plans

Be prepared for the unexpected.

Critical Illness Coverage – Core Plan 100% ER Paid

Critical illness coverage offered on a voluntary basis through The Hartford pays you a lump sum benefit if you are diagnosed with a covered illness or condition. All benefits are paid directly to you, and you may use the funds as you see fit.

What can critical illness coverage pay for?

- Medical expenses, such as copays, deductibles, or co-insurance
- Lost income
- Everyday expenses such as groceries and utilities
- Alternative treatments
- Lodging and travel to a specialist

What are examples of covered illnesses or conditions?

- Cancer
- Heart Attack
- Stroke
- Benign Brain Tumor
- Heart Failure
- Heart Transplant

Critical Illness Coverage – Buy-up Plan

You also have the option to elect additional Voluntary Critical Illness (Buy-up) through The Hartford, this is 100% employee cost and is deducted through payroll deductions.

Monthly post-tax rates are outlined below:

Monthly Premium Amount

Premiums are based on the employee's current age and increase as the employee enters each new age category.

Benefit Amount	Coverage Tier	>25	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75-79
$5,000	EE + Children	$2.85	$3.33	$3.64	$4.37	$5.74	$8.33	$11.15	$14.83	$20.41	$27.69	$36.71	$48.68
	EE + Family	$6.35	$7.27	$7.89	$9.36	$12.16	$17.56	$23.48	$31.23	$42.93	$57.56	$76.43	$100.72
$10,000	EE + Children	$4.53	$5.42	$6.00	$7.45	$10.12	$15.23	$20.86	$28.20	$39.37	$53.67	$71.97	$95.90
	EE + Family	$10.05	$11.76	$12.92	$15.81	$21.27	$31.91	$43.73	$59.21	$82.61	$111.86	$149.60	$198.19
$15,000	EE + Children	$6.21	$7.51	$8.36	$10.53	$14.50	$22.12	$30.56	$41.57	$58.32	$79.77	$107.23	$143.13
	EE + Family	$31.74	$16.24	$17.94	$22.26	$30.37	$46.25	$63.97	$87.18	$122.28	$166.16	$222.76	$295.64
$20,000	EE + Children	$7.89	$9.59	$10.72	$13.61	$18.87	$29.02	$40.27	$54.94	$77.28	$105.87	$142.48	$190.35
	EE + Family	$17.44	$20.73	$22.97	$28.72	$39.47	$60.60	$84.22	$115.16	$161.95	$220.45	$295.93	$393.10
$30,000	EE + Children	$11.26	$13.77	$15.45	$19.76	$27.62	$42.81	$59.68	$81.69	$115.19	$158.08	$212.99	$284.80
	EE + Family	$24.84	$29.69	$33.02	$41.62	$57.67	$89.29	$124.71	$171.11	$241.30	$329.04	$442.25	$558.02

Benefit options

Election	Benefit Amounts & Guaranteed Issue
Employee	$5,000; 10,000; $15,000; $20,000 or $30,000
Spouse	50% of Employee's coverage amount
Child(ren)	50% of Employee's coverage amount

Want to learn more?

To learn more about Critical Illness insurance, visit The Hartford's interactive benefits education tool at: https://mytomorrow.thehartfordtools.com/bakersfield-city-school-district/BakersfieldCitySchoolDistrict/landing/

Login instructions for The Hartford Voluntary Products can be found on page 35 in the Benefits Guide.

Hospital Indemnity

Planned or unplanned, a trip to the hospital can be unsettling, especially if your primary medical insurance doesn't cover the majority of your costs. Hospital insurance offered on a voluntary basis through The Hartford pays out cash to you or your family to offset both medical and non-medical bills resulting from a hospital stay.

How can hospital insurance help?

The cash benefits can be used to pay for services or expenses your traditional medical plan might not cover. Since benefits are paid directly to you, you choose how to use them. Here are a few examples:

- Copayments
- Deductibles
- Transportation expenses
- Groceries
- Lodging expenses for a companion
- Car expenses
- Lost income

Here's an example of how Hospital Insurance works

Meet Trevor. Trevor had some complications from gallbladder removal surgery, which resulted in a 5-day hospital stay. Through his primary medical insurance, Trevor owed a $500 deductible and $3,000 in co-insurance. With the help of his Hospital Insurance coverage, which paid a $1,000 admission benefit plus $150 for each additional day, he was only out of pocket $1,900 instead of $3,500.

Out-of-Pocket Expenses	Hospital Indemnity Plan Benefits
$500 deductible	$1,000 admission benefit
$3,000 co-insurance	$150/day x 4 additional days = $600
Total: $3,500	**Total benefits paid to Trevor: $1,600**

100% Employee-paid

If you elect the voluntary hospital insurance plan, **100%** of the cost is deducted through payroll deductions. Monthly post-tax rates are outlined below:

Election	Monthly Contribution
Employee Only	$9.15
Employee + Spouse	$16.65
Employee + Child(ren)	$17.10
Family	$25.92

Want to learn more?

To learn more about Hospital Indemnity insurance, visit The Hartford's interactive benefits education tool at: https://mytomorrow.thehartfordtools.com/bakersfield-city-school-district/BakersfieldCitySchoolDistrict/landing/

Login instructions for The Hartford Voluntary Products can be found on page 35 in the Benefits Guide.

Accident Insurance Plan

Accident insurance offered on a voluntary basis through The Hartford provides coverage for specific injuries and treatments resulting from a covered accident. The amount of the benefit paid depends on the type of injury and care received.

How can accident insurance help?

Since benefits are paid directly to you, you choose how to use them, such as paying medical bills, subsidizing lost income, or covering everyday expenses. What are some common covered benefits?

- Emergency room visit
- Ambulance
- Doctor visits
- Hospital admission
- Surgery
- Medical equipment
- Outpatient therapy
- Diagnostic imaging

Covered Event/Injury	Benefit Amount
Ambulance (ground)	$400
Emergency room care	$300
Physician follow-up ($100 x 2)	$200
X-ray	$150
Concussion	$200
Total benefit paid by Kathy's Accident Plan	**$1,250**

100% Employee-paid

If you elect the voluntary accident insurance plan, **100%** of the cost is deducted through payroll deductions.

Monthly post-tax rates are outlined here:

Election	Monthly Contribution
Employee Only	$12.14
Employee + Spouse	$19.12
Employee + Child(ren)	$20.02
Family	$31.64

Want to learn more?

To learn more about Accident insurance, visit The Hartford's interactive benefits education tool at:
https://mytomorrow.thehartfordtools.com/bakersfield-city-school-district/BakersfieldCitySchoolDistrict/landing/

Login instructions for The Hartford Voluntary Products can be found on page 35 in the Benefits Guide.

Employee Value Added Services

Value Added Services through SISC

The Smarter Surgery Benefit
Carrum Health

Consult top-quality surgeons on hip and knee replacements and certain spine surgeries. Benefit covers all related travel and medical bills. Call 888.855.7806 or visit carrumhealth.com/SISC for more information.

Access to 24/7 Primary Care
Eden Health

As part of your SISC PPO Medical Benefits, you have 24/7 access to a Care Team who works together to offer you primary care, mental health support, and answers to follow-up care questions through one app.

"Just Ask Eden" app helps you to schedule appointments, prescription refills, diagnoses and treatments and more. To get started, download the Eden Health app, and register for your free Eden Health membership.

Physical Therapy for Back or Joint Pain
Hinge Health

Exercise therapy, without leaving home. Get access to free wearable sensors and monitoring devices, unlimited one-on-one coaching, and personalized exercise therapy. Call 855.902.2777 or visit hingehealth.com/for/SISC for more information.

Support at every stage of Pregnancy
Maven

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

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

Personalized guidance and support for SISC PPO members facing a Cancer diagnosis
Cancer Care Direct

SISC is providing PPO member with Cancer Care Direct to support their members no matter what may come. You may not need cancer treatment support today, but we want you to know what's available should the need ever arise.

Facing a cancer diagnosis can be overwhelming. Cancer Care Direct is here to help with personalized guidance, support, and more.

- Guided Support
- Accessing Excellent Care
- Expert Review and Advice

Learn more at CancerCareDirect.com or download our app

Dental Plan

Liberty Dental HMO Plan

A smile is the nicest thing you can wear.

Using the HMO Plan

You and your enrolled eligible dependents must first select a primary care dentist who participates in the Liberty Dental network. To receive benefits in the Dental HMO plan, your primary care dentist must provide the service or refer you to a specialist. If you receive services from any other dentist, you would be responsible for paying the entire dental bill yourself. In order to receive dental coverage when using an HMO, it is important that you determine whether the dental office is in a network that your insurance covers.

To confirm you have found a dentist in the right network, visit www.libertydentalplan.com/ under **Members** search, choose **Group & Plan Partner Sites**, and then click on **Bakersfield City School District**. From the **Welcome** site, you may "Register" for the first time or "Login". Should you have any questions **Member Services** can be reached at **888.704.9831**.

Plan Highlights

Plan Highlights	Liberty Dental HMO (LR-130)
	In-Network
Calendar Year Deductible	
Individual / Family	None
Annual Maximum	
Individual / Family	None
Preventive	
Exam, Cleaning (twice a year), Office visit (regular hours)	$0 copay
Basic Services	
Amalgam one surface, Endodontics, Periodontal Services	Refer to Schedule of Benefits for copays
Major Services	
Crown, Dentures, Implant Services	Refer to Schedule of Benefits for copays
Orthodontia Services[1]	
Adult – Comprehensive treatment	$1,000 copay
Adolescent – Comprehensive treatment	$1,000 copay

1. Orthodontic coverage is limited to 24 months of treatment, followed by 24 months of retention office visits.
2. Please note there may be other fee schedule copays associated with orthodontic treatment.

The above information is a summary only. Please refer to your Evidence of Coverage for complete details of Plan benefits, limitations, and exclusions.

Delta Dental Plan PPO $2,000 & Incentive Plans

A smile is the nicest thing you can wear.

Using the Delta POS Plan

A Dental POS plan combines characteristics of the traditional Health Maintenance Organization (HMO) and Preferred Provider Organization (PPO) plans, providing you the option to select which plan method to utilize at the time service is rendered. The POS plan contains three levels of benefits and depending on the level of benefits utilized, you may have a different selection of dentists or specialists to receive your services.

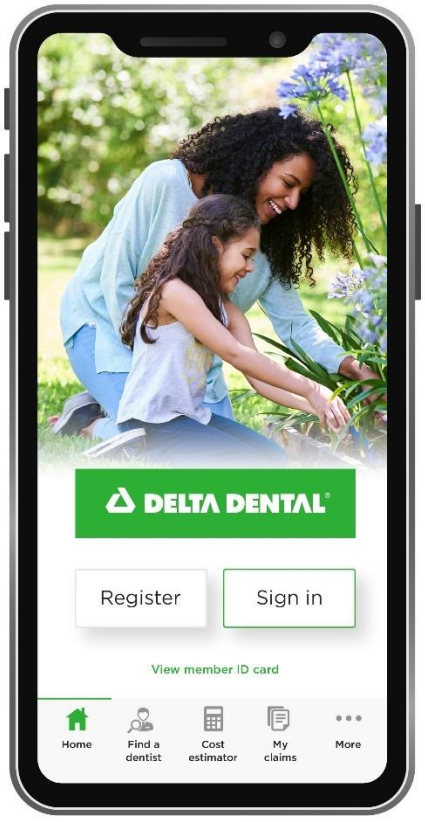
Using the Plan

Level 1: (PPO Network)	Utilizes Delta's contracted fees for PPO dentists, a larger network of professionals providing deeper discounts.
Level 2: (Premier Network)	Utilizes Delta's Premier Network of dentists, which is a smaller group of professionals also providing discounts.
Level 3: (Non-network)	This may be the costliest but gives you the option to see any dentist who does not participate in the other networks. However, since these dentists are not under contract with the insurance company, you may pay more out-of-pocket to seek services.

Delta Dental Mobile App.

Delta Dental's mobile website makes it easy and convenient for you to access multiple functions. The tools that you use most are streamlined so you can get what you need on the go — with just a few clicks.

- View Plan Information
- Download Forms
- View Claims
- Find a Dentist
- Get an Estimate of cost for treatment



"I need specific dental care! How much does it cost?"

Plan Highlights

Delta Dental PPO $2,000 Plan

	Level 1[1] Delta PPO Network	Level 2[1] Delta Premier Network	Level 3[1] Non-Network
Calendar Year Deductible			
Per Person	$0	$25	$25
Family Maximum	$0	$75	$75
Calendar Year Annual Maximum[2]	$2,000	$1,000	$1,000
Preventive			
Office Visit	100%	50%	50%
X-rays	100%	50%	50%
Cleanings	100%	50%	50%
Restorative			
Amalgam Fillings	100%	50%	50%
Composite Fillings	100%	50%	50%
Periodontics (gum treatment)			
Scaling & Root Planing	100%	50%	50%
Gingivectomy	100%	50%	50%
Endodontics (root canal therapy)			
Pulpotomy	100%	50%	50%
Root Canal (anterior and bicuspid)	100%	50%	50%
Root Canal (molar teeth)	100%	50%	50%
Oral Surgery			
General Anesthesia	100%	50%	50%
Simple Extraction	100%	50%	50%
Soft Tissue Impaction	100%	50%	50%
Complete or Partial Bony Impaction	100%	50%	50%
Crowns & Bridges			
Inlay/Onlay (2 surfaces)	100%	50%	50%
Crowns	100%	50%	50%
Prosthetics (dentures)			
Denture Adjustment	50%	50%	50%
Complete or Partial Denture	50%	50%	50%
Other			
Implants	50%	50%	50%
Dental Accident Benefits	100% (separate $1,000 maximum per person per calendar year)		

1. Reimbursement based on PPO contracted fees for PPO dentists, Premier contracted fees for Premier dentists, and program allowance for non-Delta Dental dentists.
2. **This plan provides an additional $1,000 toward the calendar year maximum when you visit a PPO dentist.** Look for this information for the dentist of your choice on the Delta find a provider website to take advantage of this additional amount: (Other network affiliations: Delta Dental PPO). The maximum benefit paid per calendar year remains at $1,000 per person when visiting providers in either the Premier network or when going out-of-network.

The above information is a summary only. Please refer to your Evidence of Coverage for complete details of Plan benefits, limitations, and exclusions.

To find a dentist that is right for you go to www1.deltadentalins.com/ or call 866.499.3001 for further assisance.

Plan Highlights

Delta Dental Incentive PPO Plan

	Level 1[1] Delta PPO Network	Level 2[1] Delta Premier Network	Level 3[1] Non-Network
In this incentive plan, Delta Dental pays 70% of the contract allowance for covered basic services and major services during the first year of eligibility. The coinsurance percentage will increase by 10% each year (to a maximum of 100%) for each enrollee if that person visits the dentist at least once during the year. If an enrollee does not use the plan during the calendar year, the percentage remains at the level attained the previous year. If an enrollee becomes ineligible for benefits and later regains eligibility, the percentage will drop back to 70%.			
Calendar Year Deductible			
Per Person	$0	$0	$0
Family Maximum	$0	$0	$0
Calendar Year Maximum[2]	$2,000	$1,500	$1,500
Preventive			
Office Visit	70 – 100%	70 – 100%	70 – 100%
X-rays	70 – 100%	70 – 100%	70 – 100%
Cleanings	70 – 100%	70 – 100%	70 – 100%
Restorative			
Amalgam Fillings	70 – 100%	70 – 100%	70 – 100%
Composite Fillings	70 – 100%	70 – 100%	70 – 100%
Periodontics (gum treatment)			
Scaling & Root Planing	70 – 100%	70 – 100%	70 – 100%
Gingivectomy	70 – 100%	70 – 100%	70 – 100%
Endodontics (root canal therapy)			
Pulpotomy	70 – 100%	70 – 100%	70 – 100%
Root Canal (anterior and bicuspid)	70 – 100%	70 – 100%	70 – 100%
Root Canal (molar teeth)	70 – 100%	70 – 100%	70 – 100%
Oral Surgery			
General Anesthesia	70 – 100%	70 – 100%	70 – 100%
Simple Extraction	70 – 100%	70 – 100%	70 – 100%
Soft Tissue Impaction	70 – 100%	70 – 100%	70 – 100%
Complete or Partial Bony Impaction	70 – 100%	70 – 100%	70 – 100%
Crowns & Bridges			
Inlay/Onlay (2 surfaces)	70 – 100%	70 – 100%	70 – 100%
Crowns	70 – 100%	70 – 100%	70 – 100%
Prosthetics (dentures)			
Denture Adjustment	50%	50%	50%
Complete or Partial Denture	50%	50%	50%
Other			
Implants	50%	50%	50%
Dental Accident Benefits	100% (separate $1,000 maximum per person per calendar year)		

1. Reimbursement based on PPO contracted fees for PPO dentists, Premier contracted fees for Premier dentists, and program allowance for non-Delta Dental dentists.
2. **This plan provides an additional $500 toward the calendar year maximum when you visit a PPO dentist.** Look for this information for the dentist of your choice on the Delta find a provider website to take advantage of this additional amount: (Other network affiliations: Delta Dental PPO). The maximum benefit paid per calendar year remains at $1,500 per person when visiting providers in either the Premier network or when going out-of-network.

The above information is a summary only. Please refer to your Evidence of Coverage for complete details of Plan benefits, limitations, and exclusions

Vision Plan

Vision Plan

Keep a clear focus on your sight.

Vision coverage is offered through EyeMed as a Preferred Provider Organization (PPO) plan. As with a traditional PPO, you may take advantage of the highest level of benefit by receiving services from in-network vision providers and doctors. However, if you receive services from an out-of-network doctor, you pay all expenses at the time of service and submit a claim for reimbursement up to the allowed amount. To locate an in-network vision provider, visit eyemed.com and then click on "Find an eye doctor".

"I need specific vision care! How much does it cost?"

Plan Highlights

	EyeMed	
	In-Network	Out-of-Network
Exam copay – Every 12 months	$0 copay	Up to $40
Material copay	$0 copay	
Lenses – Every 12 months		
Single	Covered 100%	Up to $30
Bifocal	Covered 100%	Up to $50
Trifocal	Covered 100%	Up to $70
Frames – Every 24 months	Up to $175[1,2]	Up to $123
Contacts – Every 12 months, **in lieu** of lenses & frames		
Medically Necessary	Covered 100% (with authorization)	Up to $300
Cosmetic or Convenience	Up to $175	UP to $123
Additional Benefits		
Additional Pairs of Glasses	40% Discount	
LASIK Discount	Lasik or PRK from US Laser Network 15% off retail or 5% off promotional price.	

1. Additional $50 at PLUS Providers. 20% off balance over allowance.

The above information is a summary only. Please refer to your Evidence of Coverage for complete details of Plan benefits, limitations, and exclusions.

Spending Accounts

IGOE - Flexible Spending Accounts (FSA)

A flexible spending account lets you use pre-tax dollars to cover eligible healthcare, and dependent care expenses. There are different types of FSAs that help to reduce your taxable income when paying for eligible expenses for yourself, your spouse, and any eligible dependents, as outlined below:

FSA Type	Detail
Healthcare FSA	• Can reimburse for eligible healthcare expenses not covered by your medical, dental, and vision insurance. • Maximum contribution for 2024 is $3,200. • Carryover provision allows you to carryover up to $640 of unused funds from the 2024 plan year to the 2025 plan year

For more details about using an FSA, contact IGOE Administration Services at (800) 633-8818 opt #1.

How does an FSA work?

- You select the contributions amount you wish to deduct from your paycheck on a pre-tax basis to the FSA, reducing your taxable income.
- Effective October 1 there is no waiting - you will have immediate access to your full annual election on the first day of the plan year, regardless of the amount you have actually contributed to date.
- Make an eligible medical purchase.
- You are able to pay directly from your account using a benefits debit card, if available. It can be used anywhere debit cards are accepted. You may also use online bill payment to pay for expenses or submit a claim to reimburse yourself for a qualified out-of-pocket expense. If you pay for medical expenses out of pocket, you will need to submit a claim for reimbursement on your Health Financial Account portal.
- Reimbursement claim may be submitted electronically using the online claim entry feature on IGOE's Participant Portal or via Igoe Mobile App. If you are unable to use these secure tools, you can use the FSA Reimbursement Request Form. Form can be found at goigoe.com/Forms.

The Form may be sent the following ways.

- Email to flex@goigoe.com.
- Fax to 800.456.9083.
- Mail to Igoe Administrative Services, P.O. Box 501480, San Diego, CA 92150-1480.

Questions? Please contact Participant Services at flex@goigoe.com, 1.800.633.8818, Opt. #1.

FSA-Eligible Medical Items:

Acne Treatments	Cold & Flu Medicine	Glucosamine & Chondroitin	Oximeters
Allergy & Sinus Medicine	Contact Lens Care	Hearing Aids & Accessories	Pain Relief
Baby & Mom	CPAP Accessories	High Blood Pressure	Period Underwear
Baby Skin Care	Diabetes	Home Health Care	Personal Protective Equipment (PPE)
Bandages	Diagnostic Products	Home Tests	Prenatal Vitamins
Blood Pressure Monitors	Digestive Health	Hot & Cold Packs	Reading Glasses
Breast Pumps & Accessories	Drug-Free Pain Relief	Itch Relief	Sunscreen Lotion & Cream
Braces & Elastic Supports	Eczema	Menstrual Pads	Smoking Cessation
Bundles	Feminine Care	Mobility	Tampons

For a complete list of eligible expenses as defined by the IRS, view IRS publication 502.
Login instructions for the IGOE Flexible Spending Account can be found on page 35 in the Benefits Guide.

Dependent Care Assistance Plan (DCAP)

The Dependent Care Assistance Plan (DCAP) is an employer sponsored benefit that allows you to set aside a portion of your income on a pre-tax basis and use that money to pay for eligible daycare related expenses.

To qualify for this program, you must meet your employer's benefit eligibility requirements. You must also have a tax-dependent that is under the age of **13** or is deemed medically incapable of caring for themselves. Lastly, expenses must be incurred in order for you to maintain or seek gainful employment, as outlined below:

FSA Type	Detail
 Dependent Care FSA	• Can be used to pay for a child's (up to the age of **13**) childcare expenses and/or care for a disabled family member in the household, who is unable to care for themselves. • Maximum contribution for 2024 is $5,000.
Examples of Qualified Expenses	• Childcare (including before and after school care) • In home daycare services (including nanny services) • Summer Day Camp
Examples of Non-Qualified Expenses	• School tuition (children who are 5 and older) • Sports programs • Food expenses (unless inseparable from care)

For more details about the DCAP benefit, contact IGOE Administration at 800.633.8818, opt #1 or visit www.goigoe.com. On the other hand, access the IGOE Mobile App is an easy way to maximize your tax savings, view balances, search for services, file claims, and more.

Available on the App Store

GET IT ON Google Play


Life &
Disability

Life & Disability

Protection for your loved ones.

Basic Life and AD&D

In the event of your passing, life insurance will provide your family members or other beneficiaries with financial protection and security. Additionally, if your death is a result of an accident or if you become dismembered, your accidental death & dismemberment (AD&D) coverage may apply.

Paid for in full by **Bakersfield City School District**, the benefits outlined below are provided by **Guardian**:

- Basic Life Insurance of **$50,000**.
- Basic Life includes Enhanced Accidental Death and Dismemberment (AD&D) of **$50,000**.
- Your eligible Spouse/Domestic Partner is eligible for benefit amount of **$5,500**.
- Your dependent Children (birth to age 26) are eligible for benefit amount of **$5,500**.
- Please note benefits may reduce when you reach age 65.

IRS Regulation: Employees can receive employer paid life insurance up to $50,000 on a tax-free basis and do not have to report the payment as income.

Manage Your Benefits:	Need Assistance?
Go to www.GuardianAnytime.com to access secure information about your Guardian benefits. Your on-line account will be set up within 30 days after your plan effective date.	Call the Guardian Helpline (888) 600-1600, weekdays, 8:00 AM to 8:30 PM, EST. Refer to your member ID (social security number) and your plan number: 00501890

Voluntary Term Life

If you would like to supplement your employer paid insurance, additional Life insurance plan for you and/or your dependents is available on a voluntary basis through payroll deductions from **Guardian**.

For employees:	$50,000 increments to a maximum of $150,000. Employee Guarantee Issue: $150,000 (If you enroll within 30 days of your initial eligibility.
For your spouse:	$5,000 increments to a maximum of $50,000. Spouse Guarantee Issue: $50,000. Spouse/DP coverage is based on Employee age.
For your child(ren):	Your dependent children age birth to age 26 years: $10,000. Infant coverage is limited for the first two weeks of infant's life.
Guarantee Issue:	The "guarantee" means you are not required to answer health questions to qualify for coverage up to and including the specified amount when you sign up for coverage during the initial enrollment period.
Benefit Reductions:	Benefits are reduced by a certain percentage as an employee age. ○ 30% at age 65 ○ 50% at age 70 ○ 70% at age 75

Please note Benefits coverage may reduce when you reach age 65. Restrictions may apply if you and/or your dependent(s) are confined in the hospital or terminally ill. Please refer to your Summary Plan Description for exclusions and further detail.

Are your beneficiaries up to date?

Beneficiaries are individuals or entities that you select to receive benefits from your policy.

- You can change your beneficiary designation at any time.
- You may designate a sole beneficiary or multiple beneficiaries to receive payment in the percent allocated.
- You may update your beneficiary at any time by completing a beneficiary form, which is located in the Health Benefits Department.

Short Term Disability

As an employee of Bakersfield City School District, we do not pay into State Disability. If you are unable to work for a short period due to a non-work-related condition, illness or injury, short-term disability insurance offers financial protection by paying you a portion of your earnings.

Short Term Disability coverage is available and paid for by you.

Coverage Level	Benefit Information
Short Term Disability (STD) Option 1	• Administered by The Harford, STD coverage provides a benefit equal to 20% of your earnings, up to maximum of **$2,200** per week for a period up to **12** weeks.
Short Term Disability (STD) Option 2	• Administered by The Harford, STD coverage provides a benefit equal to 40% of your earnings, up to maximum of **$2,200** per week for a period up to **12** weeks.
Short Term Disability (STD) Option 3	• Administered by The Harford, STD coverage provides a benefit equal to 60% of your earnings, up to maximum of **$2,200** per week for a period up to **12** weeks.
Waiting Period (Elimination Period)	• Within each of the 3 STD options shown above, you will also have the option to select the waiting period for which the plan would start paying the benefits. ➢ **Option A** - plan begins paying these benefits on the 8th day after you have been absent from work for **7** consecutive days, for either Sickness or Injury. ➢ **Option B** - plan begins paying these benefits on the 15th day after you have been absent from work for **14** consecutive days, for either Sickness or Injury. ➢ **Option C** - plan begins paying these benefits on the 30th day after you have been absent from work for **29** consecutive days, for either Sickness or Injury.

The above information is a summary only.

To learn more about Short Term Disability insurance, visit:
https://mytomorrow.thehartfordtools.com/bakersfield-city-school-district/BakersfieldCitySchoolDistrict/landing/

Login instructions for The Hartford Voluntary Products can be found on page 35 in the Benefits Guide.

Long Term Disability

If you are unable to work for an extended period due to a non-work-related condition, illness or injury, Long Term disability insurance offers financial protection by paying you a portion of your monthly earnings.

Long Term Disability coverage is available and paid for by **YOU**.

Benefit % (Percentage of Your Earnings)

- Administered by The Harford
- If you are disabled for more than 90 days and you meet the requirements, you may be approved to receive 60% of your monthly earnings to a maximum benefit of $7,000 per month.

Term Life and AD&D

More financial protection administered by The Hartford. Life and AD&D for your loved ones to help pay for things like burial and final expenses, debts, future expenses like college tuition, retirement savings and elderly parent care.

Term Life and AD&D coverage is available and paid for by **YOU**.

APPLICANT	LIFE COVERAGE	AD&D COVERAGE
Employee	Benefit: Increments of $10,000 Maximum the lesser of 5x earnings or $500,000	AD&D: Included
Spouse	Benefit: Increments of $5,000 Maximum the lesser of 100% of your supplemental coverage or $250,000	AD&D: Not Included
Children	Benefit: $10,000	AD&D: Not Included

The above information is a summary only.

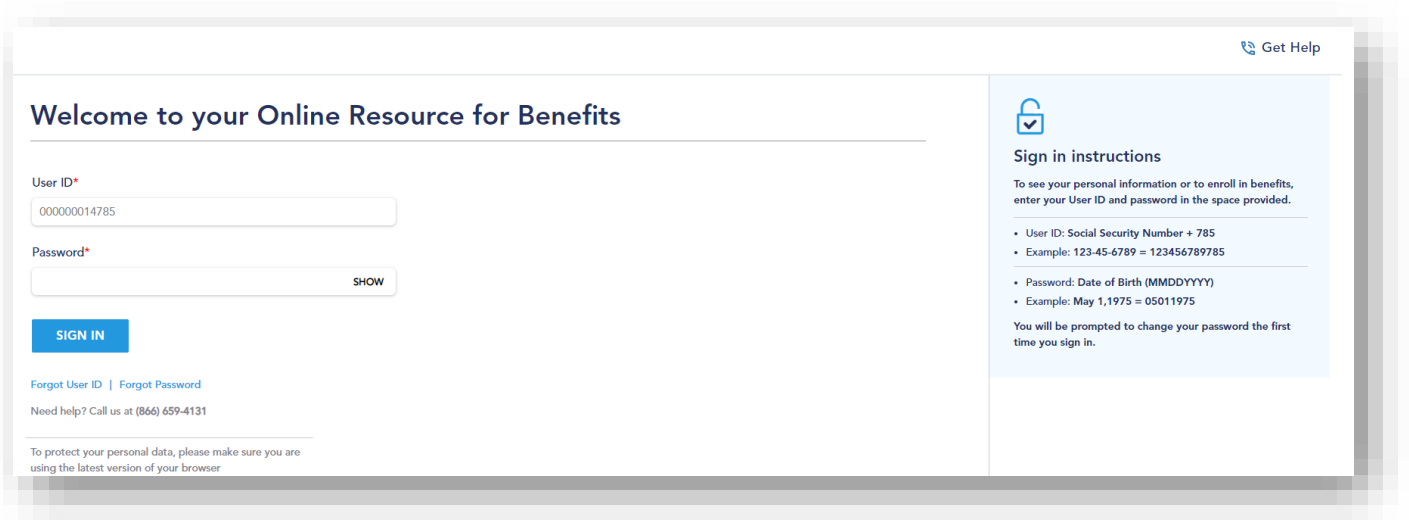
To learn more about Long Term Disability and Term Life and AE&D insurance, visit
https://mytomorrow.thehartfordtools.com/bakersfield-city-school-district/BakersfieldCitySchoolDistrict/landing/

Login instructions for The Hartford Voluntary Products can be found on page 35 in the Benefits Guide.

Benefits Harbor Login Instructions

Benefit Harbor – Login Instructions for IGOE Flexible Spending Account and Hartford Voluntary Products only

Once you have clicked on Bakersfield City School District URL: **www.memberbenefitlogin.com**, you will be taken to the Benefit Harbor homepage or login page.



Sign In Instructions

You will find login instructions on the right side (in picture above) in a light blue box notated with a lock symbol.

Follow these ID and password login instructions to gain access to the benefit enrollment platform. Your login ID should be your SSN + 3 Digit Employer ID code (785). See example below for proper formatting.

Example: John's SSN is 123-45-6789. It should be written without dashes like this 123456789, and the 3-digit code should be added at the end with no spacing or markings. The results should be 123456789785, which is John's login ID.

Your password should be your full date of birth with a 2-digit month, 2-digit day and 4-digit year for a total of 8 digits.
See example below for proper formatting:

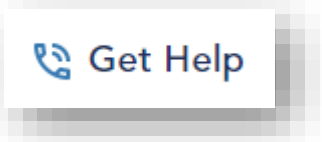
Date of Birth (MMDDYYYY)
Example: John's birthday is May 1st, 1975, so his password should be written as 05011975.

Trouble with your Login ID

If you're having trouble with your login ID, click on the "Forgot User ID" link. You will be taken to a new page where you can enter in your personal information to identify yourself. If the system still does not recognize your credentials, you may need to call the Help Line at 1.866.659.4131 listed at the bottom of the screen.

If you have forgotten your password, or it does not work, click on the "Forgot Password" link, and you be redirected to a new page where you will be asked to put in your login ID. If the system still does not recognize your credentials, you may need to call the Help Line at 1.866.659.4131 listed at the bottom of the screen.

The second place you can go for assistance is the "**Get Help**" button in the top right-hand corner of your login screen. The button looks like this:



Please note these instructions are **only** for the **IGOE Flexible Spending Accounts** and **Hartford Voluntary Products**.

Employee Assistance Program (EAP)

Employee Assistance Program (EAP)

Your free and confidential go-to resource.

Bakersfield City School District understands we can all use an extra helping hand from time to time. Whether you need support with a personal relationship or professional challenge, or you're seeking guidance on a particular subject, the Employee Assistance Program (EAP) provides the tools you need to thrive. Through the EAP, you have access to resources, information, and counseling that are fully confidential and no cost to you.

Program Component	Coverage Details
Number of sessions	6 face-to-face visits, per situation, confidential EAP services available to you and members of your household.
How to access	Phone or face-to-face sessions
Topics may include	Mental Health Support: • Marital, relationship or family problems • Bereavement or grief counseling • Substance abuse and recovery Community Support: • Childcare and eldercare • Legal services and Identity theft • Financial support • Educational materials
Who can utilize	All employees, dependents of employees, and members of your household

Get in touch:

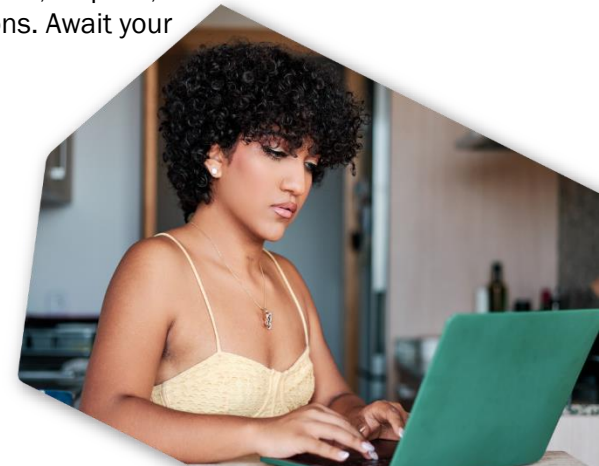
- By phone: 800.999.7222
- Online: www.AnthemEAP.com

Connect with a therapist – anytime, anywhere

Talkspace

Talkspace is a digital space for private and convenient mental health support. With Talkspace, you can choose your therapist from a list of recommended, licensed providers and receive support day and night from the convenience of your device (iOS, Android, and Web).

To get started, register at talkspace.com/associatecare. Enter the letters "EAP", a space, and SISC in the "Organization name" field. Complete the QuickMatch provider finder questions. Await your provider match, then send a message or schedule a virtual session.



Directory & Required Notices

Directory & Resources

Below, please find important contact information and resources for Bakersfield City School District.

Information Regarding	Group / Policy #	Contact Information		Questions Regarding
Enrollment & Eligibility				
Health Benefits Department		661.631.4722	www.bcsd.com/healthbenefits	Provider directories & change forms (name / address / dep.)
Medical Coverage				
Anthem • PPO Prudent Buyer	40028	800.322.5709	www.anthem.com/ca/sisc/	Medical Claims, Health Benefits, Dependent Coverage, Providers, Insurance ID Card
Blue Cross SISC III		661.636.4410		Customer Service
Navitus – Prescription		866.333.2757	www.navitus.com	Rx Claims and Coverage
Costco - Mail order Pharmacy		800.607.6861		Mail Order Prescriptions
Physicians may fax an RX:		800.633.0334		Fax Prescriptions
Dental Coverage				
Delta Dental • DPPO Incentive • DPPO $2000	7073-8304 7073-8504	866.499.3001	www.deltadentalins.com	Coverage and Claims
Liberty Dental • DHMO LR-130	101306	888.704.9831	www.libertydentalplan.com/bcsd	Coverage, Claims, ID Cards, Providers
Vision Coverage				
EyeMed • Vision PPO	1038291	866.939.3633	www.eyemed.com	Coverage and Provider List
Life & AD&D				
Guardian • Basic Life / AD&D • Voluntary Life / AD&D	501890	800.525.4542	www.guardianlife.com	Customer Service Questions Basic & Voluntary Life Policies
Flexible Spending Accounts				
IGOE Administration • Flexible Spending Account • Dependent Care Account		800.633.8818 Opt. #1	www.goigoe.com	IRS Section 125, Pre-Tax Benefit Plan Enrollment
Voluntary Disability / Income Protection Plans				
The Hartford • Certificated and Classified		800.365.9180	www.thehartford.com/benefits/bcsd	Income Protection
• American Fidelity Claims		800.662.1113		Disability Claims
Pacific Educators • Certificated and Classified		800.722.3365		Income Protection
The Standard (Certificated)		800.522.0406		Income Protection
Employee Assistance Plan				
Anthem EAP		800.999.7222	www.anthemEAP.com	Employee Assistance Program
Critical Illness Plan				
The Hartford		661.325.5999		Coverage
Teachers Retirement				
State Teachers Retirement System	(STRS)	800.228.5453	www.calstrs.com	Retirement Benefits - Certificated
Regional Counseling Services Kern County Supt. Of Schools	(STRS)	661.636.4880		STRS Benefits & Individual Consultations
Public Employees Retirement Systems	(PERS)	888.225.7377	www.calpers.ca.gov	Retirement Benefits - Classified
Human Resources	(PERS) Fresno	877.720.7377		PERS Fresno Regional Office
SISC Defined Benefit Plan	(PERS)	661.631.4857 661.636.4710		PERS Information and Forms Retirement Benefits – P/T EE's

Bakersfield City School District Health and Welfare
Benefits Annual Notice Packet

For the 2024 Plan Year

Dear Valued Employee,

Enclosed is a packet of notices and disclosures that pertain to your employer-sponsored health and welfare plans, as required by federal law.

Enclosures:

- ☐ Medicare Part D Creditable Coverage Notice
- ☐ HIPAA Special Enrollment Rights Notice
- ☐ HIPAA Notice of Privacy Practices
- ☐ Children's Health Insurance Program (CHIP) Notice
- ☐ Women's Health and Cancer Rights Act (WHCRA) Notice
- ☐ Newborns' Mothers Health Protection Act (NMHPA) Notice
- ☐ General Notice of COBRA Continuation Rights

Should you have any questions regarding the content of the notices, please contact us at

Bakersfield City School District
Employee Health Benefits Department
1300 Baker Street
Bakersfield, CA 93305
661.631.4722

Medicare Part D
Creditable Coverage Notice

Important Notice from Bakersfield City School District
About Your Prescription Drug Coverage and Medicare

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

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

1. **Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.**
2. **Bakersfield City School District has determined that the prescription drug coverage offered by Navitus 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 while enrolled in Bakersfield City School District coverage as an active employee, please note that your Bakersfield City School District coverage will be the primary payer for your prescription drug benefits and Medicare will pay secondary. As a result, the value of your

Medicare prescription drug benefits may be significantly reduced. Medicare will usually pay primary for your prescription drug benefits if you participate in Bakersfield City School District coverage as a former employee.

You may also choose to drop your Bakersfield City School District coverage. If you do decide to join a Medicare drug plan and drop your current Bakersfield City School District coverage, be aware that you and your dependents may not be able to get this coverage back.

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

If you go 63 continuous days or longer without 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 Bakersfield City School District changes. You also may request a copy of this notice at any time.

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

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit 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).

Bakersfield City School District
Employee Health Benefits Department

1300 Baker Street
Bakersfield, CA 93305
661.631.4722

HIPAA Special Enrollment Rights Notice

If you are declining enrollment in Bakersfield City School District group health coverage for yourself or your dependents (including your spouse) because of other health insurance 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.

Finally, you and/or your dependents may have special enrollment rights if coverage is lost under Medicaid or a State health insurance ("CHIP") program, or when you and/or your dependents gain eligibility for state premium assistance. You have 60 days from the occurrence of one of these events to notify the company and enroll in the plan.

To request special enrollment or obtain more information, contact the Employee Health Benefits Department at 661.631.4722.

HIPAA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Bakersfield City School District, Inc. ("Bakersfield City School District") sponsors certain group health plan(s) (collectively, the "Plan" or "We") to provide benefits to our employees, their dependents and other participants. We provide this coverage through various relationships with third parties that establish networks of providers, coordinate your care, and process claims for reimbursement for the services that you receive. This Notice of Privacy Practices (the "Notice") describes the legal obligations of Bakersfield City School District, the Plan and your legal rights regarding your protected health information held by the Plan under HIPAA. Among other things, this Notice describes how your protected health information may be used or disclosed to carry out treatment, payment, or health care operations, or for any other purposes that are permitted or required by law.

We are required to provide this Notice to you pursuant to HIPAA. The HIPAA Privacy Rule protects only certain medical information known as "protected health information." Generally, protected health information is individually identifiable health information, including demographic information, collected from you or created or received by a health care provider, a health care clearinghouse, a health plan, or your employer on behalf of a group health plan, which relates to:

(1) your past, present or future physical or mental health or condition;
(2) the provision of health care to you; or
(3) the past, present or future payment for the provision of health care to you.

Note: If you are covered by one or more fully-insured group health plans offered by Bakersfield City School District, you will receive a separate notice regarding the availability of a notice of privacy practices applicable to that coverage and how to obtain a copy of the notice directly from the insurance carrier.

Contact Information

If you have any questions about this Notice or about our privacy practices, please contact the Bakersfield City School District HIPAA Privacy Officer:

Bakersfield City School District
Attention: HIPAA Privacy Officer
Sherry Gladin, Assistant Superintendent, Business Services
Office: (661) 631-4675
Fax: (661) 324-2497

Effective Date

This Notice as revised is effective October 1, 2024.

Our Responsibilities

We are required by law to:

- maintain the privacy of your protected health information;
- provide you with certain rights with respect to your protected health information;
- provide you with a copy of this Notice of our legal duties and privacy practices with respect to your protected health information; and
- follow the terms of the Notice that is currently in effect.

We reserve the right to change the terms of this Notice and to make new provisions regarding your protected health information that we maintain, as allowed or required by law. If we make any material change to this Notice, we will provide you with a copy of our revised Notice of Privacy Practices. You may also obtain a copy of the latest revised Notice by contacting our Privacy Officer at the contact information provided above. Except as provided within this Notice, we may not disclose your protected health information without your prior authorization.

How We May Use and Disclose Your Protected Health Information

Under the law, we may use or disclose your protected health information under certain circumstances without your permission. The following categories describe the different ways that we may use and disclose your protected health information. For each category of uses or disclosures we will explain what we mean and present some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose protected health information will fall within one of the categories.

For Treatment

We may use or disclose your protected health information to facilitate medical treatment or services by providers. We may disclose medical information about you to providers, including doctors, nurses, technicians, medical students, or other hospital personnel who are involved in taking care of you. For example, we might disclose information about your prior prescriptions to a pharmacist to determine if a pending prescription is inappropriate or dangerous for you to use.

For Payment

We may use or disclose your protected health information to determine your eligibility for Plan benefits, to facilitate payment for the treatment and services you receive from health care providers, to determine benefit responsibility under the Plan, or to coordinate Plan coverage. For example, we may tell your health care provider about your medical history to determine whether a particular treatment is experimental, investigational, or medically necessary, or to determine whether the Plan will cover the treatment. We may also share your protected health information with a utilization review or precertification service provider. Likewise, we may share your protected health information with another entity to assist with the adjudication or subrogation of health claims or to another health plan to coordinate benefit payments.

For Health Care Operations

We may use and disclose your protected health information for other Plan operations. These uses and disclosures are necessary to run the Plan. For example, we may use medical information in connection with conducting quality assessment and improvement activities; underwriting, premium rating, and other activities relating to Plan coverage; submitting claims for stop-loss (or excess-loss) coverage; conducting or arranging for medical review, legal services, audit services, and fraud & abuse detection programs; business planning and development such as cost management; and business management and general Plan administrative activities. The Plan is prohibited from using or disclosing protected health information that is genetic information about an individual for underwriting purposes.

To Business Associates

We may contract with individuals or entities known as Business Associates to perform various functions on our behalf or to provide certain types of services. In order to perform these functions or to provide these services, Business Associates will receive, create, maintain, use and/or disclose your protected health information, but only after they agree in writing with us to implement appropriate safeguards regarding your protected health information. For example, we may disclose your protected health information to a Business Associate to administer claims or to provide support services, such as utilization management, pharmacy benefit management or subrogation, but only after the Business Associate enters into a Business Associate Agreement with us.

As Required by Law

We will disclose your protected health information when required to do so by federal, state or local law. For example, we may disclose your protected health information when required by national security laws or public health disclosure laws.

To Avert a Serious Threat to Health or Safety
We may use and disclose your protected health information when necessary to prevent a serious threat to your health and safety, or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat. For example, we may disclose your protected health information in a proceeding regarding the licensure of a physician.

To Plan Sponsors
For the purpose of administering the Plan, we may disclose to certain employees of the Employer protected health information. However, those employees will only use or disclose that information as necessary to perform Plan administration functions or as otherwise required by HIPAA, unless you have authorized further disclosures. Your protected health information cannot be used for employment purposes without your specific authorization.

Special Situations

In addition to the above, the following categories describe other possible ways that we may use and disclose your protected health information. For each category of uses or disclosures, we will explain what we mean and present some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

Organ and Tissue Donation
If you are an organ donor, we may release your protected health information to organizations that handle organ procurement or organ, eye, or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

Military and Veterans
If you are a member of the armed forces, we may release your protected health information as required by military command authorities. We may also release protected health information about foreign military personnel to the appropriate foreign military authority.

Workers' Compensation
We may release your protected health information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks
We may disclose your protected health information for public health actions. These actions generally include the following:

- to prevent or control disease, injury, or disability;
- to report births and deaths;
- to report child abuse or neglect;
- to report reactions to medications or problems with products;
- to notify people of recalls of products they may be using;
- to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
- to notify the appropriate government authority if we believe that a patient has been the victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree, or when required or authorized by law.

Health Oversight Activities

We may disclose your protected health information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes
If you are involved in a lawsuit or a dispute, we may disclose your protected health information in response to a court or administrative order. We may also disclose your protected health information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement
We may disclose your protected health information if asked to do so by a law enforcement official—

- in response to a court order, subpoena, warrant, summons or similar process;
- to identify or locate a suspect, fugitive, material witness, or missing person;
- about the victim of a crime if, under certain limited circumstances, we are unable to obtain the victim's agreement;
- about a death that we believe may be the result of criminal conduct;
- about criminal conduct; and
- in emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Directors
We may release protected health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about patients to funeral directors as necessary to carry out their duties.

National Security and Intelligence Activities
We may release your protected health information to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

Inmates
If you are an inmate of a correctional institution or are in the custody of a law enforcement official, we may disclose your protected health information to the correctional institution or law enforcement official if necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

Research
We may disclose your protected health information to researchers when:

(1) the individual identifiers have been removed; or
(2) when an institutional review board or privacy board has (a) reviewed the research proposal; and (b) established protocols to ensure the privacy of the requested information, and approves the research.

Required Disclosures

The following is a description of disclosures of your protected health information we are required to make.

Government Audits
We are required to disclose your protected health information to the Secretary of the United States Department of Health and Human Services when the Secretary is investigating or determining our compliance with the HIPAA privacy rule.

Disclosures to You
When you request, we are required to disclose to you the portion of your protected health information that contains medical records, billing records, and any other records used to make decisions regarding your health care benefits. We are also required, when requested, to provide you with an accounting of most disclosures of your protected health information if the disclosure was for reasons other than for payment, treatment, or health care operations, and if the protected health information was not disclosed pursuant to your individual authorization.

Notification of a Breach.
We are required to notify you in the event that we (or one of our Business Associates) discover a breach of your unsecured protected health information, as defined by HIPAA.

Other Disclosures

Personal Representatives
We will disclose your protected health information to individuals authorized by you, or to an individual designated as your personal representative, attorney-in-fact, etc., so long as you provide us with a written notice/authorization and any supporting documents (i.e., power of attorney). Note: Under the HIPAA privacy rule, we do not have to disclose information to a personal representative if we have a reasonable belief that:

(1) you have been, or may be, subjected to domestic violence, abuse or neglect by such person;
(2) treating such person as your personal representative could endanger you; or
(3) in the exercise or professional judgment, it is not in your best interest to treat the person as your personal representative.

Spouses and Other Family Members
With only limited exceptions, we will send all mail to the employee. This includes mail relating to the employee's spouse and other family members who are covered under the Plan, and includes mail with information on the use of Plan benefits by the employee's spouse and other family members and information on the denial of any Plan benefits to the employee's spouse and other family members. If a person covered under the Plan has requested Restrictions or Confidential Communications (see below under "Your Rights"), and if we have agreed to the request, we will send mail as provided by the request for Restrictions or Confidential Communications.

Authorizations
Other uses or disclosures of your protected health information not described above, including the use and disclosure of psychotherapy notes and the use or disclosure of protected health information for fundraising or marketing purposes, will not be made without your written authorization. You may revoke written authorization at any time, so long as your revocation is in writing. Once we receive your written revocation, it will only be effective for future uses and disclosures. It will not be effective for any information that may have been used or disclosed in reliance upon the written authorization and prior to receiving your written revocation. You may elect to opt out of receiving fundraising communications from us at any time.

Your Rights

You have the following rights with respect to your protected health information:

Right to Inspect and Copy
You have the right to inspect and copy certain protected health information that may be used to make decisions about your health care benefits. To inspect and copy your protected health information, submit your request in writing to the Privacy Officer at the address provided above under Contact Information. If you request a copy of the information, we may charge a reasonable fee for the costs of copying, mailing, or other supplies associated with your request. We may deny your request to inspect and copy in certain very

limited circumstances. If you are denied access to your medical information, you may have a right to request that the denial be reviewed and you will be provided with details on how to do so.

Right to Amend
If you feel that the protected health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the Plan. To request an amendment, your request must be made in writing and submitted to the Privacy Officer at the address provided above under Contact Information. In addition, you must provide a reason that supports your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

3. is not part of the medical information kept by or for the Plan;
4. was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
5. is not part of the information that you would be permitted to inspect and copy; or
6. is already accurate and complete.

If we deny your request, you have the right to file a statement of disagreement with us and any future disclosures of the disputed information will include your statement.

Right to an Accounting of Disclosures
You have the right to request an "accounting" of certain disclosures of your protected health information. The accounting will not include (1) disclosures for purposes of treatment, payment, or health care operations; (2) disclosures made to you; (3) disclosures made pursuant to your authorization; (4) disclosures made to friends or family in your presence or because of an emergency; (5) disclosures for national security purposes; and (6) disclosures incidental to otherwise permissible disclosures.

To request this list or accounting of disclosures, you must submit your request in writing to the Privacy Officer at the address provided above under Contact Information. Your request must state a time period of no longer than six years (three years for electronic health records) or the period ABC Company has been subject to the HIPAA Privacy rules, if shorter.

Your request should indicate in what form you want the list (for example, paper or electronic). We will attempt to provide the accounting in the format you requested or in another mutually agreeable format if the requested format is not reasonably feasible. The first list you request within a 12-month period will be provided free of charge. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions
You have the right to request a restriction or limitation on your protected health information that we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on your protected health information that we disclose to someone who is involved in your care or the payment for your care, such as a family member or friend. For example, you could ask that we not use or disclose information about a surgery that you had.

We are not required to agree to your request. However, if we do agree to the request, we will honor the restriction until you revoke it or we notify you. To request restrictions, you must make your request in writing to the Privacy Officer at the address provided above under Contact Information. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure, or both; and (3) to whom you want the limits to apply—for example, disclosures to your spouse.

Right to Request Confidential Communications

You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. To request confidential communications, you must make your request in writing to the Privacy Officer at the address provided above under Contact Information. We will not ask you the reason for your request. Your request must specify how or where you wish to be contacted. We will accommodate all reasonable requests if you clearly provide information that the disclosure of all or part of your protected information could endanger you.

Right to a Paper Copy of This Notice
You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. To obtain a paper copy of this notice, telephone or write the Privacy Officer as provided above under Contact Information.

For more information, please see Your Rights Under HIPAA**.**

Complaints
If you believe that your privacy rights have been violated, you may file a complaint with the Plan or with the Office for Civil Rights of the United States Department of Health and Human Services. You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting https://www.hhs.gov/hipaa/filing-a-complaint/complaint-process/index.html.

To file a complaint with the Plan, telephone write the Privacy Officer as provided above under Contact Information. You will not be penalized, or in any other way retaliated against, for filing a complaint with the Office of Civil Rights or with us. You should keep a copy of any notices you send to the Plan Administrator or the Privacy Officer for your records.

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/flmedicaidtplrecovery.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: masspremiumassistance@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	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000

Email: HHSHIPPProgram@mt.gov	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

Women's Health Cancer Rights Act (WHCRA) Notice

Do you know that your Plan, as required by the Women's Health and Cancer Rights Act of 1998 (WHCRA), provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema?

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. If you would like more information on WHCRA benefits, contact your plan administrator at 661.631.4722.

Newborns' and Mothers' Health Protection Act (NMHPA) Notice

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 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).

Model General Notice of
COBRA Continuation Coverage Rights

** Continuation Coverage Rights Under COBRA**

Introduction

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

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

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

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation must pay for COBRA continuation coverage.

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

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

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

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

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

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

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

- The end of employment or reduction of hours of employment;
- Death of the employee; or
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to: Bakersfield City School District, Employee Health Benefits Department, 1300 Baker Street, Bakersfield, CA 93305, 661.631.4722

How is COBRA continuation coverage provided?
Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

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

Second qualifying event extension of 18-month period of continuation coverage
If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the

second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?
Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicare, Medicaid, Children's Health Insurance Program (CHIP), or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at **www.healthcare.gov**.

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?
In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period[1] to sign up for Medicare Part A or B, beginning on the earlier of:

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

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

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit https://www.medicare.gov/medicare-and-you.

If you have questions
Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit **www.dol.gov/agencies/ebsa**. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit **www.HealthCare.gov**.

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

[1] https://www.medicare.gov/basics/get-started-with-medicare/sign-up/when-does-medicare-coverage-start. These rules are different for people with End Stage Renal Disease (ESRD).

Plan contact information

Name of Entity/Sender: Bakersfield City School District
Contact--Position/Office: Employee Health Benefits Department
Address: 1300 Baker Street, Bakersfield, CA 93305
Phone Number: 661.631.4722

APPENDIX

These are additional notices that may be appropriate based upon an employer's circumstances. We included the Surprise Billing Notice to assist with an employer's obligation to post the notice on its website (in those rare circumstances where it may be necessary).

- ☐ Medicare Part D Cross-Reference
- ☐ Medicare Part D Non-Creditable Coverage Notice
- ☐ HIPAA Privacy Notice of Availability
- ☐ HIPAA Wellness Program Reasonable Alternative Standards (RAS) Notice – Medical plans with wellness programs that offer health contingent incentives
- ☐ Surprise Billing Notice – "Your Rights and Protections Against Surprise Medical Bills"

Medicare Part D
Cross-Reference

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 page 41 for more details.

Medicare Part D
Non-Creditable Coverage Notice

Important Notice from Bakersfield City School District About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Bakersfield City School District and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are three 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. **Bakersfield City School District has determined that the prescription drug coverage offered by Navitus is, on average for all plan participants, NOT expected to pay out as much as standard Medicare prescription drug coverage pays. Therefore, your coverage is considered Non-Creditable Coverage. This is important because, most likely, you will get more help with your drug costs if you join a Medicare drug plan, than if you only have prescription drug coverage from Navitus. This also is important because it may mean that you may pay a higher premium (a penalty) if you do not join a Medicare drug plan when you first become eligible.**
3. **You can keep your current coverage from Navitus. However, because your coverage is non-creditable, you have decisions to make about Medicare prescription drug coverage that may affect how much you pay for that**

coverage, depending on if and when you join a drug plan. When you make your decision, you should compare your current coverage, including what drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area. Read this notice carefully - it explains your options.

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 decide to drop your current coverage with Bakersfield City School District, since it is employer/union sponsored group coverage, you will be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan; however you also may pay a higher premium (a penalty) because you did not have creditable coverage under Navitus.

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

If you decide to join a Medicare drug plan while enrolled in Bakersfield City School District coverage as an active employee, please note that your Bakersfield City School District coverage will be the primary payer for your prescription drug benefits and Medicare will pay secondary. As a result, the value of your Medicare prescription drug benefits may be significantly reduced. Medicare will usually pay primary for your prescription drug benefits if you participate in Bakersfield City School District coverage as a former employee.

You may also choose to drop your Bakersfield City School District coverage. If you do decide to join a Medicare drug plan and drop your current Bakersfield City School District coverage, be aware that you and your dependents may not be able to get this coverage back.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

Since the coverage under Navitus is not creditable, you may pay a penalty to join a Medicare drug plan depending on how long you go without creditable prescription drug coverage. Starting with the end of the last month that you were first eligible to join a Medicare drug plan but didn't join, if you go 63 continuous days or longer without prescription drug coverage that's creditable, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

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

Contact the person listed below for further information. **NOTE:** You will 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 Bakersfield City School District changes. You also may request a copy of this notice at any time.

For More Information about Your Options under Medicare Prescription Drug Coverage…

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit 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).

Name of Entity/Sender: Bakersfield City School District
Contact--Position/Office: Employee Health Benefits Department
Address: 1300 Baker Street, Bakersfield, CA 93305
Phone Number: 661.631.4722

HIPAA Notice of Availability of Notice of Privacy Practices

The Bakersfield City School District, Inc. Group Health Plan (Plan) maintains a Notice of Privacy Practices that provides information to individuals whose protected health information (PHI) will be used or maintained by the Plan. If you would like a copy of the Plan's Notice of Privacy Practices, please contact the Employee Health Benefits Department at (661) 631-4722.

HIPAA Wellness Program Reasonable Alternative Standards Notice

Your group health plan is committed to helping you achieve your best health. Rewards for participating in a wellness program are available to all eligible employees. If you think you might be unable to meet a standard for a reward under this wellness program, you might qualify for an opportunity to earn the same reward by different means. Contact us at 661.631.4722 and we will work with you (and, if you wish, with your doctor) to find a wellness program with the same reward that is right for you in light of your health status.

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing. In these cases, you should not be charged more than your plan's copayments, coinsurance and/or deductible.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, like a copayment, coinsurance, or deductible. You may have additional costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" describes providers and facilities that haven't signed a contract with your health plan to provide services. Out-of-network providers may be allowed to bill you for the difference between what your plan pays and the full amount charged for a service. This is called "**balance billing**." This

amount is likely more than in-network costs for the same service and might not count toward your plan's deductible or annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider. Surprise medical bills could cost thousands of dollars depending on the procedure or service.

You are protected from balance billing for:

Emergency services

If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most they can bill you is your plan's in-network cost-sharing amount (such as copayments, coinsurance, and deductibles). You **can't** be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers can bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **can't** balance bill you and may **not** ask you to give up your protections not to be balance billed.

If you get other services at these in-network facilities, out-of-network providers **can't** balance bill you, unless you give written consent and give up your protections.

You're <u>never</u> required to give up your protections from balance billing. You also aren't required to get out-of-network care. You can choose a provider or facility in your plan's network.

When balance billing isn't allowed, you also have the following protections:

1. You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay any additional costs to out-of-network providers and facilities directly.

2. Generally, your health plan must:

    - Cover emergency services without requiring you to get approval for services in advance (also known as "prior authorization").

    - Cover emergency services by out-of-network providers.

    - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.

    - Count any amount you pay for emergency services or out-of-network services toward your in-network deductible and out-of-pocket limit.

If you believe you've been wrongly billed, the following information and resources are available to help you understand your rights:

<u>Assistance by telephone</u> – You may contact the U.S. Department of Health & Human Services at (800) 985-3059 to discuss whether you may have any surprise billing protection rights for your situation.

Available online assistance – You can also visit the U.S. Centers for Medicare & Medicaid Services website to learn more about protections from surprise medical bills and for contact information for the state department of insurance or other similar agency/resource in your state to learn if you have any rights under applicable state law. Please click on your state in the map for contact information to appear.

Notes

Notes

Notes

Prepared by: Marsh & McLennan Insurance Agency LLC
www.MarshMMA.com | CA Insurance License: 0H18131