ROWLAND
UNIFIED SCHOOL DISTRICT
INNOVATIVE LEARNING FOR ALL

Employee Benefits Guide

January 2024
December 2024

Welcome to Your Rowland Unified School District Employee Benefits

This guide provides a summary of your benefit options and is designed to help you make choices and enroll for coverage. If you would like more information about any of the benefits described here, please contact Risk Management.

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Take advantage of the online resources available through our insurance carriers. You can locate network providers, manage your claims, obtain health and wellness information, and much more. Insurance carrier website addresses are located on page **14** of this guide.

Enrollment Information

Who May Enroll

If you are a regular full-time employee working at least 30 hours per week (75% Classified and 50% Certificated), you and your eligible dependents may participate in Rowland Unified School District's benefits program. Your eligible dependents include:

- Legally married spouse
- Registered domestic partner
- Children under the age of 26, regardless of student or marital status
- Children over the age of 26, with disabilities. (Physician Certification required.)

When You Can Enroll

As an eligible employee, you may enroll at the following times:

- As a new hire, you may participate in the company's benefits program on the first day of the month following your hire date pending receipt of your enrollment forms.
- Each year, during open enrollment
- Within 30 days of a qualifying event as defined by the IRS (see Changes To Enrollment below)

Paying For Your Coverage

You and Rowland Unified School District share in the cost of the Medical, Dental, and Vision benefits you elect. Any voluntary benefits you elect will be paid by you at discounted group rates. Your Medical, Dental, and Vision contributions are deducted before taxes are withheld which saves you tax dollars. Paying for benefits before-tax means that your share of the costs are deducted before taxes are determined, resulting in more take-home pay for you. As a result, the IRS requires that your elections remain in effect for the entire year. You cannot drop or change coverage unless you experience a qualifying event.

Changes To Enrollment

Our benefit plans are effective January 1st through December 31st of each year. There is an annual open enrollment period each year, during which you can make new benefit elections for the following January 1st effective date. Once you make your benefit elections, you cannot change them during the year unless you experience a qualifying event as defined by the IRS. Examples include, but are not limited to the following:

- Marriage, divorce, legal separation or annulment
- Birth or adoption of a child
- A qualified medical child support order
- Death of a spouse or child
- A change in your dependent's eligibility status
- Loss of coverage from another health plan
- Change in your residence or workplace (if your benefit options change)
- Loss of coverage through Medicaid or Children's Health Insurance Program (CHIP)
- Becoming eligible for a state's premium assistance program under Medicaid or CHIP

Coverage for a new dependent is not automatic. If you experience a qualifying event, you have 30 days to update your coverage. Please contact the Risk Management Department immediately following a qualifying event to complete the appropriate election forms as needed. If you do not update your coverage within 30 days from the qualifying event, you must wait until the next annual open enrollment period to update your coverage.

Medical Benefits

Rowland Unified School District provides regular, full time and part time (Certificated 50% or more and Classified 75% or more) employees with eleven medical plans to choose from, including two Anthem Blue Cross HMO Plans, two Blue Shield of California HMO Plans, one Health Net HMO Plans, one Kaiser HMO Plan, two United Healthcare HMO Plans and two Anthem Blue Cross PPO plans. See the following pages for highlights of each plan. Employees are eligible to enroll on the first of the month following their hire date upon receipt of their enrollment forms. Employees have 30 days from their date of hire in which to enroll.

HMO Plans

With this plan you must select a Primary Care Physician (PCP who coordinates and manages your health care services. Your PCP provides routine care and refers you to specialists when necessary. You may choose a different PCP for each family member. Non-PCP referred services are not eligible for coverage under this plan, except in emergency situations.

HMO: Maximum Calendar Year Medical & Pharmacy Financial Responsibility

There is a Maximum Calendar Year Financial Responsibility of $9,450 per Member and $18,900 per family. This maximum financial responsibility is broken down into a maximum medical responsibility ($1,500 per Member and $3,000 per family) and maximum Pharmacy responsibility ($7,950 per Member and $15,900 per family). The maximum medical responsibility, in general, is accumulated by the Calendar Year Deductible, Coinsurance, and Copayments, for services provided by Preferred Providers.

PPO Plans

Each of the Anthem Blue Cross Preferred Providers Organization (PPO) plans utilizes a PPO network through Anthem Blue Cross of California and is administered by Cal PERS. A PPO plan provides for both in-network and out-of-network benefits. Employees and their dependents can choose, at time of care, whether to use in-network or out-of-network providers.

PPO: Maximum Calendar Year Medical & Pharmacy Financial Responsibility

There is a Maximum Calendar Year Financial Responsibility of $9,450 per Member and $18,900 per family. This maximum financial responsibility is broken down into a maximum medical responsibility ($7,450 per Member and $14,900 per family) and maximum Pharmacy responsibility ($2,000 per Member and $4,000 per family). The maximum medical responsibility, in general, is accumulated by the Calendar Year Deductible, Coinsurance, and Copayments, for services provided by Preferred Providers.

The Benefits of Using In-Network Providers for the PPO Plans

There are significant advantages to using in-network providers for your medical care, such as negotiated rates (up to 30%-40% discounts), no balance billing, self-referrals to in-network specialist and no claim forms require.

We encourage all employees to locate an in-network provider for you and for your family members. Establishing a relationship with your provider through routine annul check-ups assists your doctor in managing your overall care and well-being. We also encourage you to locate the nearest urgent care facilities to your home. Knowing where to access the most convenient and cost effective care before a situation arises can save you both time and money.

Finding In-Network Medical Providers

- Anthem Blue Cross providers: **www.anthem.com/ca/calpers**
- Blue Shield providers: **www.blueshieldca.com/calpers**
- Health Net providers: **www.healthnet.com/calpers**
- United Healthcare providers: **www.unitedhealthcare.com/calpers**
- Kaiser Permanente providers: **www.kaiserpermanente.org/calpers**

Medical Benefits

Understand How Health Plans Work

Video – Learn About Medical Plan Terms
Medical plan terms, such as deductibles, copays, coinsurance and out-of-pocket maximums, can sometimes be confusing. For a quick video that shows how these work, visit **http://video.burnhambenefits.com/terms**.

Benefits Glossary

Allowable Charge	Sometimes known as the "allowed amount," "maximum allowable," and "usual, customary, and reasonable (UCR)" charge, this is the dollar amount considered by a health insurance company to be a reasonable charge for medical services or supplies based on the rates in your area.
Claim	A request by a plan member, or a plan member's health care provider, for the insurance company to pay for
Coinsurance	The amount you pay to share the cost of covered services after your deductible has been paid. The coinsurance rate is usually a percentage. For example, if the insurance company pays 80% of the claim, you pay 20%.
Copayment	One way you share in your medical costs. You pay a flat fee for certain medical expenses (e.g., $10 for every
Deductible	The amount of money you must pay each year to cover eligible medical expenses before your
Explanation of Benefits	The health insurance company's written explanation of how a medical claim was paid. It contains detailed information about what the company paid and what portion of the costs you are responsible for.
Out-of-Pocket Maximum	The most money you will pay during a year for coverage. It includes deductibles, copayments, and coinsurance, but is in addition to your regular premiums. Beyond this amount, the insurance company will pay all expenses for the remainder of the year.
Health Maintenance Organization (HMO)	A health care financing and delivery system that provides comprehensive health care services for enrollees in a particular geographic area. HMOs require the use of specific, in-network plan providers.
Preferred Provider Organization (PPO)	A health insurance plan that offers greater freedom of choice than HMO (health maintenance organization) plans. Members of PPOs are free to receive care from both in-network or out-of-network (non-preferred) providers, but will receive the highest level of benefits when they use
In-Network Provider	A health care professional, hospital, or pharmacy that is part of a health plan's network of preferred providers. You will generally pay less for services received from in-network providers because they have negotiated a discount for their services in exchange for the insurance company sending more patients their
Non-Network or Out-of-Network Provider	A health care professional, hospital, or pharmacy that is not part of a health plan's network of preferred providers. You will generally pay more for services received from out-of-network providers.
Network	The group of doctors, hospitals, and other health care providers that insurance companies contract with to provide services at discounted rates. You will generally pay less for services received from providers in your network.
Premium	The amount you or your employer pays each month in exchange for insurance coverage.
Provider	Any person (i.e., doctor, nurse, dentist) or institution (i.e., hospital or clinic) that provides medical care.
Primary Care Physician	A physician who provides both the first contact for a person with an undiagnosed health concern as well as continuing care of varied medical conditions, not limited by cause, organ system, or diagnosis.

Medical Benefits

	Anthem Select HMO *(Anthem Select HMO Network)* OR Anthem Traditional HMO *(Anthem CA Care HMO Network)*	Blue Shield Access+ HMO *(Blue Shield Access+ Network)* OR Blue Shield HMO Trio *(Blue Shield TRIO Network)*	Health Net Salud *(Health Net Salud Network)*
	In-Network Only	In-Network Only	In-Network Only
Calendar Year Deductible	Individual / Family $0 / $0	Individual / Family $0 / $0	Individual / Family $0 / $0
Out-of-Pocket Maximum – Medical[3] – Pharmacy	Individual / Family $1,500 / $3,000 $7,950 / $15,900	Individual / Family $1,500 / $3,000 $7,950 / $15,900	Individual / Family $1,500 / $3,000 $7,950 / $15,900
Lifetime Maximum	Unlimited	Unlimited	Unlimited
Medical Benefits	**You Pay**	**You Pay**	**You Pay**
PCP[1]	$15 copay	$15 copay	$15 copay
Specialist Visits[1]	$15 copay	$15 copay	$15 copay
Urgent Care	$15 copay	$15 copay	$15 copay
Preventive Care	No charge	No charge	No charge
Physical Therapy	$15 copay	$15 copay	$15 copay
Diagnostic X-Ray & Lab	No charge	No charge	No charge
Hospital Room & Board / Surgeon's Fees / Maternity—Delivery	$0 copay	$0 copay	$0 copay
Outpatient Surgery	$0 copay	$0 copay	$0 copay
Emergency Room Facility	$50 copay (waived if admitted)	$50 copay (waived if admitted)	$50 copay (waived if admitted)
Chiropractic/Acupuncture (20 Visits/Year Combined)	$15 copay	$15 copay	$15 copay
Pharmacy Benefits	**You Pay**	**You Pay**	**You Pay**
Retail – Generic – Brand Name – Non-Formulary – Supply Limit	**Provided through OptumRx** $5 copay $20 copay $50 copay 30 Days[2]	**Provided through Blue Shield** $5 copay $20 copay $50 copay 30 Days	**Provided through OptumRx** $5 copay $20 copay $50 copay 30 Days[2]
Mail Order for Maintenance Medication – Generic – Brand Name – Non-Formulary – Supply Limit	**Provided through OptumRx** $10 copay $40 copay $100 copay 90 Days	**Provided through Blue Shield** $10 copay $40 copay $100 copay 90 Days	**Provided through OptumRx** $10 copay $40 copay $100 copay 90 Days

(1) Office visit copays waived for maternity care.

(2) Mail service is mandatory after the second fill of a prescription drug at a retail pharmacy, or you will be charged the appropriate mail service copay for a one-month supply at a retail pharmacy.

**This sheet is only a brief summary of benefits. Please review the benefit summaries, plan booklets or evidence of coverage for details, limitations and exclusions.*

Medical Benefits

	Kaiser HMO *(Kaiser Network)*	United Healthcare Alliance HMO *(Signature Value Alliance Network)* *OR* United Healthcare Harmony HMO *(Harmony Network)*
	Kaiser Providers and Facilities Only	**In-Network Only**
Calendar Year Deductible	Individual / Family $0 / $0	Individual / Family $0 / $0
Out-of-Pocket Maximum – Medical[3] – Pharmacy	Individual / Family $1,500 / $3,000 $7,950 / $15,900	Individual / Family $1,500 / $3,000 $7,950 / $15,900
Lifetime Maximum	Unlimited	Unlimited
Medical & Hospital Benefits	**You Pay**	**You Pay**
PCP[1]	$15 copay	$15 copay
Specialist Visits[1]	$15 copay	$15 copay
Urgent Care	$15 copay	$15 copay
Preventive Care	No charge	No charge
Physical Therapy	$15 copay	$15 copay
Diagnostic X-Ray & Lab	No charge	No charge
Hospital Room & Board / Surgeon's Fees / Maternity—Delivery	No charge	No charge
Outpatient Surgery	$15 copay	No charge
Emergency Room Facility	$50 copay (waived if admitted)	$50 copay (waived if admitted)
Chiropractic/Acupuncture (20 Visits/Year Combined)	$15 copay	$15 copay
Pharmacy Benefits	**You Pay**	**You Pay**
Retail – Generic – Brand Name – Non-Formulary – Supply Limit	**Provided through Kaiser Permanente** $5 copay $20 copay N/A 30 Days	**Provided through OptumRx** $5 copay $20 copay $50 copay 30 Days[2]
Mail Order for Maintenance Medication – Generic – Brand Name – Non-Formulary – Supply Limit	**Provided through Kaiser Permanente** $10 copay $40 copay N/A 100 Days	**Provided through OptumRx** $10 copay $40 copay $100 copay 90 Days

(1) Office visit copays waived for maternity care.

(2) Mail service is mandatory after the second fill of a prescription drug at a retail pharmacy, or you will be charged the appropriate mail service copay for a one-month supply at a retail pharmacy.

**This sheet is only a brief summary of benefits. Please review the benefit summaries, plan booklets or evidence of coverage for details, limitations and exclusions.*

Medical Benefits

	PERS Platinum PPO *(Anthem Prudent Buyer PPO Network)*		PERS Gold PPO *(Anthem Select PPO Network)*	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**
Calendar Year Deductible – Individual – Family	$500 / $2,000 $1,000 / $4,000		$1,000[3]/$2,500 $2,000[3]/ $5,000	
Out-of-Pocket Maximum – Medical[3]	Individual / Family $7,450 / $14,900 *($2,000 / $4,000 limit for coinsurance)*	Unlimited	Individual / Family $7,450 / $14,900 *($3,000 / $6,000 limit for coinsurance)*	Unlimited
– Pharmacy	$2,000 / $4,000	Unlimited	$2,000 / $4,000	Unlimited
Lifetime Maximum	Unlimited		Unlimited	
Medical Benefits	**You Pay**		**You Pay**	
PCP[1]	$20 copay	40%[2]	$10[4]/$35[4] copay	40%[2]
Specialist Visits[1]	$35 copay	40%[2]	$35 copay	40%[2]
Urgent Care	$35 copay	40%[2]	$35 copay	40%[2]
Preventive Care	No charge	40%[2]	No charge	40%[2]
Physical Therapy	10%[2]	40%[2]	20%[2]	40%[2]
Diagnostic X-Ray & Lab	10%[2]	40%[2]	20%[2]	40%[2]
Hospital Room & Board / Surgeon's Fees / Maternity—Delivery	10% after $250 copay	40% after $250 copay	Facility & Physician 20%[2]	40%[2]
Outpatient Surgery	10%[2]	40%[2]	20%[2]	40%[2]
Emergency Room Facility	$50 copay (waived if admitted) + 10%[2]		$50 copay (waived if admitted) + 20%[2]	
Chiropractic/Acupuncture (20 Visits/Year Combined)	$15 copay	40%[2]	$15 copay	40%[2]
Pharmacy Benefits	**You Pay**		**You Pay**	
Retail	**OptumRx**		**OptumRx**	
– Generic	$5 copay	Not covered	$5 copay	Not covered
– Brand Name	$20 copay	Not covered	$20 copay	Not covered
– Non-Formulary	$50 copay	Not covered	$50 copay	Not covered
– Supply Limit	30 Days	N/A	30 Days	N/A
Mail Order for Maintenance Medication (OptumRx)	**OptumRx**		**OptumRx**	
– Generic	$10 copay	Not covered	$10 copay	Not covered
– Brand Name	$40 copay	Not covered	$40 copay	Not covered
– Non-Formulary	$100 copay	Not covered	$100 copay	Not covered
– Supply Limit	90 Days	N/A	90 Days	N/A

(1) Includes medical deductible, coinsurance amounts and copays. The out-of-pocket maximum for prescription drugs is a separate out-of-pocket maximum.

(2) Subject to deductible. Out-of-Network benefits are paid based on an allowed amount.

(3) Incentives available to reduce individual deductibles (max. $500) or family deductible (max $1,000) include: getting a biometric screening ($100 credit); receiving a flu shot ($100 credit); getting a non-smoking certification ($100 credit); getting a virtual second opinion ($100 credit); and getting a condition care certification ($100 credit).

(4) There is a $10 copay when the member sees an assigned PCP; $35 for all other primary care doctors or specialists in the plan

**This sheet is only a brief summary of benefits. Please review the benefit summaries, plan booklets or evidence of coverage for details, limitations and exclusions.*

Medical Benefits

Telemedicine Benefits

Phone and/or video visits are an excellent option for convenient, accessible care when you don't need a doctor to see you in person. They are also a good choice when away from home or if you need short term prescription drug refills. The District provides telemedicine coverage with all our medical plans.

Anthem HMO Plans and PERS PPO Plans

Telemedicine for Anthem HMO plans and PERS PPO plans is provided through LiveHealth Online.

- **www.lifehealthonline.com**
- **(888) 548-3432**

Blue Shield Medical Plans

Telemedicine for Blue Shield HMO plans is provided through Teladoc.

- **www.blueshieldca.com/teladoc**
- **(800) 835-2362**

HealthNet Medical Plans

Telemedicine for HealthNet HMO plans is provided through Teladoc.

- **www.teladoc.com**
- **(800) 835-2362**

Kaiser Permanente HMO

Telemedicine for the Kaiser Permanente HMO plan is provided directly through Kaiser.

- **www.kp.org**
- **(800) 464-4000**

United Healthcare HMO Plans

Telemedicine for the United Healthcare HMO plans is provided through UHC Virtual Visits

- **www.myuhc.com/virtualvisits**
- **(877) 359-3714**

When to Use Telemedicine

Phone and/or video visits can be good choices for:

- Follow up care on an existing medical issue
- Getting or renewing prescriptions
- Medical advice on non-severe, non-life threatening conditions such as:
  - Sore throat
  - Headache
  - Stomachache
  - Conjunctivitis
  - Bronchitis
  - Fever
  - Cold and flu
  - COVID-19
  - Allergies
  - Diarrhea
  - Skin issues
  - Rash
  - Acne
  - UTIs
  - And more

Dental Benefits

Delta Care DHMO Dental Plan

With the Dental Health Maintenance Organization (DHMO) plan through Delta Dental, you are required to select a general dentist to provide your dental care. If specialty care is needed, your general dentist will provide the necessary referral. You pay the copay or coinsurance fee described in your DHMO plan booklet for covered services. Please keep a copy of your booklet to refer to when utilizing your dental care.

Delta Dental PPO Dental Plan

With the Delta Dental Preferred Provider Organization (PPO) dental plan, you may visit a PPO dentist and benefit from the negotiated rate or visit a non-network dentist. When you utilize a PPO dentist, your out-of-pocket expenses will be less. You may also obtain services using a non-network dentist. Please note that when you receive services from non-network providers, you are responsible for the difference between the covered amount (allowance) and the actual charges.

We strongly recommend you ask your dentist for a predetermination if total charges are expected to exceed $300.

Predetermination enables you and your dentist to know in advance what the payment will be for any service that may be in question.

	Delta Dental DHMO Plan	Delta Dental PPO Dental Plan	
	In-Network Only	**In-Network**	**Out-of-Network**
Calendar Year Maximum Benefit	Unlimited	$1,500	
Annual Deductible	N/A	N/A	
Preventive Services	**You Pay**	**You Pay**	
Exams, Cleanings, X-rays, Sealants	No charge for most preventive services	No charge	Any amount above allowance
Basic Services	**You Pay**	**You Pay**	
Fillings, Composites, Root Canals, Gum Treatment, Oral Surgery	See Copay Schedule	No charge	Any amount above allowance
Major Services	**You Pay**	**You Pay**	
Crowns, inlays, onlays and cast restorations	See Copay Schedule	No charge	Any amount above allowance
Prosthodontics	**You Pay**	**You Pay**	
Fixed and Removable Prosthodontics, Implants	30%	50%	
Orthodontia Services	**You Pay**	**You Pay**	
Coverage	Children: $1,600 copay Adults: $1,800 copay	50% for children and adults	50% plus any amount above allowance
Maximum Benefit Per Individual	$1,500	$1,500	

Finding In-Network Dental Providers

- DHMO: Go to www.deltadentalins.com or call **(800) 765-6003** and refer to the DeltaCare network
- PPO: Go to www.deltadentalins.com or call **(866) 499-3001** and refer to the Delta Dental network

Vision Benefits

EyeMed PPO Vision Plan

The EyeMed vision plan provides professional vision care and high quality lenses and frames through a broad network of optical specialists. You will receive richer benefits if you utilize a network provider. Please note that when you receive services from non-network providers, you are responsible for the difference between the covered amount (allowance) and the actual charges, and you will need to file a claim for reimbursement.

	EyeMed PPO Vision Plan	
	In-Network	**Out-of-Network**
Exam Services (Once every 12 months)	**You Pay**	
Exam from EyeMed PLUS Provider	No charge	Amount above $40 allowance
Exam from Provider	$10 copay	Amount above $40 allowance
Retinal Imaging	Up to $39	Not covered
Frequency	Once every 12 months	
Frame	**You Pay**	
Frame from EyeMed PLUS Provider	Amount above $180 allowance after 20% discount	Amount above $91 allowance
Frame: Retail	Amount above $130 allowance after 20% discount	Amount above $91 allowance
Frequency	Once every 12 months	
Standard Plastic Lenses	**You Pay**	
Single Vision	$10 copay	Amount above $30 allowance
Bifocal	$10 copay	Amount above $50 allowance
Trifocal	$10 copay	Amount above $70 allowance
Lenticular	$10 copay	Amount above $70 allowance
Progressive: Standard	$10 copay	Amount above $50 allowance
Progressive: Premium Tier 1 –4	$95 – $185 copay	Amount above $50 allowance
Frequency	Once every 12 months	
Contact Lenses	**You Pay**	
Contacts: Conventional	Amount above $130 allowance after 15% discount	Amount above $91 allowance
Contacts: Disposable	Amount above $130 allowance	Amount above $91 allowance
Contacts: Medically Necessary	No charge	Amount above $300 allowance
Frequency	Once every 12 months in lieu of frame and lenses	

Finding In-Network Vision Providers

Go to www.eyemed.com or call **(866) 939-3633**

Life Insurance Benefits

MetLife Basic Life Insurance

Life insurance protects your family or other beneficiaries in the event of your death while you are still actively employed with the District. Rowland Unified School District pays for coverage, offered through MetLife, in the amount of:

- Management: $75,000
- Certificated: $15,000
- Classified: $15,000
- Confidential & Supervisors: $38,000
- Assistant Superintendents: $125,000

If your death is due to a covered accident or injury, your beneficiary will receive an additional amount through Accidental Death and Dismemberment (AD&D) coverage.

Life Balance Benefits

Employee Assistance Program

The Employee Assistance Program provided through MetLife (LifeWorks US Inc.) provides you and your household members with free, confidential services to help with the everyday challenges of life that may affect your health, family life and desire to excel at work. Services are available 24 hours a day, 7 days a week via a toll-free nationwide number.

Counseling Services

You and your household members can receive up to 5 counseling sessions with a licensed clinician per issue, per individual, per calendar year.

Work and Life Services

- **Financial Services:** Budgeting, credit and financial guidance (investment advice, loans and bill payments not included), retirement planning and assistance with tax issues.
- **Childcare and Eldercare Assistance:** Consultation plus referrals to childcare and eldercare providers.
- **Identity Theft Recovery Services:** Information on ID theft prevention, plus an ID theft emergency response kit and help from a fraud resolution specialist if you are victimized.
- **Legal Services:** Consultations for issues relating to civil, consumer, personal and family law, financial matters, business law, real estate, estate planning and more (excluding disputes or actions between you and MetLife/LifeWorks/the District).
- **Daily Living Services:** Referrals to consultants and businesses that can help with event planning, transportation services, pet services and more (does not cover the cost nor guarantee delivery of vendors' services).
- **Online Member Services:** LifeWorks' EAP website and app is available to you and features a wide range of tools and information to help you take charge of your well-being and simplify your life.

How to Access the Employee Assistance Program

Call **(888) 319-7819** or visit metlifeeap.lifeworks.com (user name: metlifeeap and password: eap)

Tax Savings Benefits

American Fidelity Flexible Spending Accounts

You can set aside money in Flexible Spending Accounts (FSA) before taxes are deducted to pay for certain health and dependent care expenses, lowering your taxable income and increasing your take home pay. Only expenses for services incurred during the plan year are eligible for reimbursement from your accounts. You submit a claim along with your receipts online or via mobile app. Also, all receipts should be itemized to reflect what product or service was purchased. Credit card receipts are not sufficient per IRS guidelines.

American Fidelity can be contacted at **(800) 365-9180** or **www.americanfidelity.com**.

Health Care Spending Account

This plan is used to pay for expenses not covered under your health plans, such as deductibles, coinsurance, copays and expenses that exceed plan limits. Employees may defer up to $3,050 pre-tax per year.

Dependent Care Assistance Plan

This plan is used to pay for eligible expenses you incur for child care, or for the care of a disabled dependent, while you work. Employees may defer up to $5,000 pre-tax per year.

FSAs offer sizable tax advantages. The trade-off is that these accounts are subject to strict IRS regulations, including the use-it-or-lose-it rule. According to this rule, you must forfeit any money left in your account(s) after your expenses for the year have been reimbursed. The IRS does not allow the return of unused account balances at the end of the plan year, and remaining balances cannot be carried forward to a future plan year. If you are unable to estimate your health care expenses accurately, it is better to be conservative and underestimate rather than overestimate your expenses.

Video – Learn How Flexible Spending Accounts Can Help Save You Money

For a better understanding of how Flexible Spending Accounts work, watch this quick video at **http://video.burnhambenefits.com/fsa**.

Example: How You Can Save Money With an FSA	Without the Health Care FSA	With the Health Care FSA
Gross Annual Pay	$45,000	$45,000
Pre-Tax Health Care FSA	Not Elected	$1,200
Taxable Gross Income	$45,000	$43,800
Payroll Taxes (at 30%)	$13,500	$13,140
Health Care Cost	$1,200	$0
Net Pay	$30,300	$30,660
Annual Net Pay Increase	$0	**$360**

Important Note: Your FSA elections expire each year on December 31st. Balances of $500 or less will rollover to the next plan year. Excess funds will be forfeited at the end of the plan year. If you plan to participate in the FSA for the upcoming plan year, you are required to re-enroll.

Benefit Contact Information

	Phone	Website
Medical Benefits		
Anthem Blue Cross HMO & EPO	(855) 839-4524	www.anthem.com/ca/calpers
Blue Shield of CA HMOs	(800) 334-5847	www.blueshieldca.com/calpers
HealthNet HMOs	(888) 926-4921	www.healthnet.com/calpers
Kaiser Permanente HMO	(800) 464-4000	www.kp.org/calpers
United Healthcare HMOS	(877) 359-3714	www.uhc.com/calpers
PERS Platinum PPO / PERS Gold PPO	(877) 737-7776	www.anthem.com/ca/calpers
Dental Benefits		
DeltaCare HMO	(800) 422-4234	www.deltadentalins.com
Delta Dental PPO	(866) 499-3001	www.deltadentalins.com
Vision Benefits		
EyeMed Vision PPO	(866) 939-3633	www.eyemed.com
Life Insurance Benefits		
MetLife Life Insurance	(800) 438-6388	www.metlife.com
Life Balance Benefits		
MetLife—Lifeworks Employee Assistance Plan	(888) 319-7819	www.metlifeeap.lifeworks.com *User name: metlifeeap* *Password: eap*
Tax Savings Benefits		
American Fidelity Flexible Spending Accounts: Health Care and Dependent Care FSAs	(800) 365-9180	www.americanfidelity.com

The Burnham Advocate Help-Line: (800) 391-6812

The Burnham Advocate toll-free customer service help-line can provide assistance with insurance related issues when you are unable to resolve them directly with your insurance carriers. You will receive fast, skilled assistance with Medical, Dental and Vision provider issues, referral assistance, and claims management.

For help, simply call the Burnham Advocate help-line at (800) 391-6812. For more complicated questions or claims issues, the Burnham claims specialist works as your insurance advocate, researching and resolving problems quickly and effectively. If further action is required, the Burnham Advocate will provide regular updates until the issues are resolved.

Health Benefit Contributions

Your cost for coverage will vary depending on the option and level of coverage you choose. Employee contributions for Medical, Dental, and Vision are deducted from your paycheck with pre-tax dollars unless specified by the Employee. This means that contributions are taken from your earnings before taxes, resulting in lower taxes and increased take home pay.

- **Certificated/Management/Confidential & Supervisors:** Please select your plans and deduct **$1,500**
- **Classified:** Please select your plans and deduct **$1,500**

Rates are tenthly rates (deducted ten times per year) - No deductions will be taken in June and July.

HMO Medical Plans	2024 Pre-Tax Rates
Anthem Blue Cross HMO Select	
– Employee only	$1,009.36
– Employee + 1 dependent	$2,018.71
– Employee + 2 or more dependents	$2,624.33
Anthem Blue Cross HMO Traditional	
– Employee only	$1,251.20
– Employee + 1 dependent	$2,430.41
– Employee + 2 or more dependents	$3,159.53
Blue Shield Access + HMO	
– Employee only	$907.98
– Employee + 1 dependent	$1,815.96
– Employee + 2 or more dependents	$2,360.75
Blue Shield Trio HMO	
– Employee only	$845.63
– Employee + 1 dependent	$1,691.26
– Employee + 2 or more dependents	$2,198.63
Health Net Salud HMO	
– Employee only	$756.16
– Employee + 1 dependent	$1,512.31
– Employee + 2 or more dependents	$1,966.01
Kaiser Permanente HMO	
– Employee only	$1,038.49
– Employee + 1 dependent	$2,076.98
– Employee + 2 or more dependents	$2,700.08
United Healthcare HMO Alliance	
– Employee only	$991.73
– Employee + 1 dependent	$1,983.46
– Employee + 2 or more dependents	$2,578.49
United Healthcare Harmony HMO	
– Employee only	$881.71
– Employee + 1 dependent	$1,763.42
– Employee + 2 or more dependents	$2,292.46

PPO Medical Plans	2023 Pre-Tax Rates
PERS Gold PPO (Anthem) CA Only	
– Employee only	$942.34
– Employee + 1 dependent	$1,884.67
– Employee + 2 or more dependents	$2,450.08
PERS Platinum PPO (Anthem) CA and Out of State	
– Employee only	$1,357.76
– Employee + 1 dependent	$2,715.53
– Employee + 2 or more dependents	$3,530.18

Cash In Lieu of Medical Benefits

If other medical coverage is provided, Employee may waive medical coverage and receive $450 per month (tenthly).

CalPERS Declaration of Health coverage (Form HBD-12A) must be submitted.

Health Benefit Contributions

Dental Plans	2024 Pre-Tax Rates
Delta Care Dental HMO	
– Employee only	$14.94
– Employee + 1 dependent[1]	$28.57
– Employee + 2 or more dependents[1]	$44.65
Delta Dental PPO	
– Employee only	$62.41
– Employee + 1 dependent [1]	$121.67
– Employee + 2 or more dependents[1]	$168.48

Vision Plan	2024 Pre-Tax Rates
EyeMed Vision PPO	
– Employee only	$7.42
– Employee + 1 dependent	$12.10
– Employee + 2 or more dependents[1]	$16.66

(1) Dental and Vision dependent coverage is **District Paid** for Management and Confidential/Supervisory Employees

Pre-Tax Deductions

All medical, dental, and vision deductions are paid on a pre-tax basis unless specified by the employee.

Calculating Benefit Costs

Tenthly Medical Rate		______________
Tenthly Dental Rate	+	______________
Tenthly Vision Rate	+	______________
Sub-Total Tenthly Cost[1]	=	______________
District Contribution	-	______________
Total Employee Contribution	=	______________

(1) If the sub-total tenthly cost is less than the District Contribution enter $0 for total employee contribution.

(2) For an online version of the calculator, please visit rowlandschools.org, under "Departments" go to "Risk Management & Employee Benefits."

Important Information

The Affordable Care Act and You

Even though the Affordable Care Act (ACA)'s penalty for not having health coverage (known as the individual mandate) has been reduced to zero, if you are a taxpayer in California, you will still be required to have health coverage (unless you qualify for an exemption) or pay a penalty for the 2024 tax year. In addition, several other states, including Massachusetts, New Jersey, and Vermont, as well as the District of Columbia, have reinstated an individual mandate requirement, and others are considering doing so. You may consider these options below to satisfy this requirement:

- Enroll in a medical plan offered by Rowland Unified School District or another group medical plan meeting the requirements for minimum essential coverage;
- Purchase coverage through a health insurance marketplace;
- Enroll in coverage through a government-sponsored program if eligible.

However, if you choose to purchase coverage through the marketplace, because Rowland Unified School District's medical plans are considered affordable and meet minimum value under the Affordable Care Act, you may not be eligible for a subsidy, and you may not see lower premiums or out-of-pocket costs through the marketplace. In addition, employer contributions to your medical benefits will be lost and your portion of medical premiums will no longer be paid via payroll deductions on a pre-tax basis.

For More Information on the Affordable Care Act

To learn more about the Affordable Care Act, visit **www.healthcare.gov**.

Annual Notices

Various state and federal laws require that employers provide disclosure and annual notices to their plan participants. Rowland Unified School District has posted all federally required annual notices on our intranet for you to download and read at your convenience. Rowland Unified School District will distribute all federally required annual notices upon hire and during each annual open enrollment period. Annual notices include the following:

- Medicare Part D Notice of Creditable Coverage
- Women's Health and Cancer Rights Act (WHCRA)
- Newborns' and Mothers' Health Protection Act
- Medicaid & Children's Health Insurance Program
- HIPAA Notice of Privacy Practices
- Special Enrollment Rights

2024 Summary of Benefits and Coverage Notice

Choosing your health plan is an important decision. To assist you with this process, each health plan available through the California Public Employees' Retirement System has produced a Summary of Benefits and Coverage (SBC). In addition, the federal government has compiled a glossary of common health insurance terms. Together, these documents provide important information to help you better understand your health benefit coverage and more easily compare health plan options.

To access the SBCs and glossary online, visit **www.calpers.ca.gov** and select **View Health Plan Rates** to access the **Plans & Rates** page, or visit any of the health plan websites on page 14. To request a free paper copy of the SBC and glossary, or if you require assistance with your benefit questions following open enrollment, contact each health plan directly. If you are unable to resolve your issues or questions with the insurance carriers, please contact Risk Management .

Notes

Notes

2211 Michelson Drive, Suite 1200 | Irvine, California 92612

Telephone: (949) 833-2983 | Fax: (949) 833-9549

This Employee Benefits Guide provides an overview of some of your benefit plan choices. It is for informational purposes only. It is not intended to be an agreement for continued employment. Neither is it a legal plan document. If there is a disagreement between this guide and the plan documents, the plan documents will govern.

In addition, the plans described in this guide are subject to change without notice. Continuation of any benefit plan or coverage is at the company's discretion and in accordance with federal and state laws. If you need additional information or have any questions about the benefit program, please contact the Risk Management Department.

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