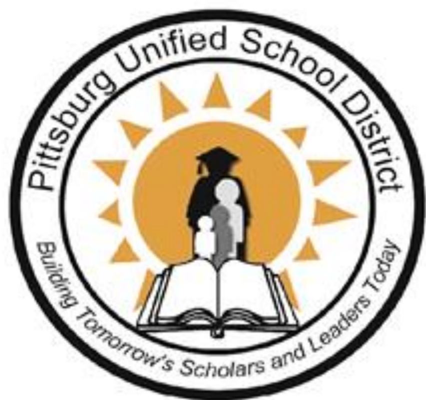

EMPLOYEE BENEFITS OVERVIEW

2022

Important Notice: Read Carefully

This benefits guide briefly describes your benefit choices and your options to enroll. All benefits, and your eligibility for benefits, are subject to the terms and conditions of the benefit plans, including group insurance contracts. This guide is not intended to be a complete description of the benefit plans and it is not a summary plan description or plan document. In the event of any conflict or discrepancy between this guide and the plan documents, the plan documents will govern. The Pittsburg Unified School District reserves the right to modify or terminate any of the described benefits at any time and for any reason. This guide is not a guarantee of current or future employment or benefits.

Welcome to Your Benefits Guide

The Pittsburg Unified School District (PUSD) takes pride in offering a generous benefits program that provides flexibility for the diverse and changing needs of our qualifying employees. Your benefits are a valuable addition to your overall compensation. Benefits include medical, dental, vision, life insurance, disability insurance, flexible spending accounts, employee assistance programs (EAP), and our retirement systems. Please make sure you get the most from them by taking the time to understand your options. If you have any questions, please contact the Human Resources office for clarification.

This guide provides information about the insurance plans and rates offered to eligible employees effective January 1, 2022 through December 31, 2022.

If you have any questions, please contact the Human Resources Department at (925) 473-2335

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Open Enrollment

The 2022 Open Enrollment period will be **September 20, 2021 through October 15, 2021**, with benefit changes effective January 1, 2022. Payroll deductions for health changes will begin with the December 2021 payroll as health changes are pre-paid one month in advance.

During Open Enrollment, you have the right to change group medical plans and add or drop dependent coverage.

2022 Benefit Highlights

All premiums have increased but premiums that have increased more than 9% are listed in the summary below

Plan Name	Significant Changes for 2022
Anthem Blue Cross Select	9.75% premium increase
Blue Shield Access+	Reenter into eight Bay Area counties: Alameda, Contra Costa, Marin, San Francisco, San Mateo, Santa Clara, Sonoma, and Solano
PERSCare	Transition to PERS Platinum. Retains the same 10% coinsurance benefit design, and network as PERSCare/PERS Choice
PERS Choice	Transition to PERS Platinum. Offers a 10% coinsurance benefit design, and retains the same broad network PERS Choice/PERSCare 12.95% premium increase
PERS Select	Transition to PERS Gold. Retains the same 20% coinsurance benefit design and network as PERS Select 23.75% premium increase

Eligibility for Benefits

Who Is Eligible?

The Pittsburg Unified School District offers a generous employee benefits program. The benefits program is designed to meet the specific individual and family needs of each eligible employee.

If you are an active, regular employee, working at least 20 hours per week, you are eligible to enroll in health benefits under the agency. Premiums and plan designs will vary depending on FTE.

Benefits begin the first of the month following the event date and receipt of all necessary paperwork.

Dependent Eligibility

Your dependents are eligible for coverage under your medical, dental and vision benefits as long as they meet the requirements specified for each plan. Coverage is never automatic; an application and proof of dependency is always required. ***Reminder:*** *Your dependents are only eligible for the plan(s) for which you are eligible.*

Eligible dependents include:

- **Your current spouse or state-registered domestic partner.**
  Definition of domestic partner pursuant to Family Code Section 297:

  A domestic partnership shall be established in California when both persons file a Declaration of Domestic Partnership with the Secretary of State, and at the time of filing, all of the following requirements are met:

  - Neither person is married to someone else or is a member of another domestic partnership with someone else that has not been terminated, dissolved, or adjudged a nullity.
  - The two persons are not related by blood in a way that would prevent them from being married to each other in this state.
  - Both persons are at least 18 years of age, except as provided in Section 297.1.
  - Both persons are capable of consenting to the domestic partnership

- **Your natural children, stepchildren, domestic partner's children, adopted children of which the employee is the legal guardian.**
  In addition, such children must be:
  1. Under age 26
  2. Disabled Dependent
     - To be eligible as a disabled dependent, the child must be 26 years old or older, and the following must be true:
       - The child is incapable of self-support because of a mental or physical condition.
       - The disability existed prior to reaching age 26 and continuously since age 26, as certified by a licensed physician.
       - Prior to enrollment, a Member Questionnaire for the CalPERS Disabled Dependent Benefit must be submitted. The physician must submit the Medical Report for the

CalPERS Disabled Dependent Benefit. Forms can be found on the calpers.ca.gov website.

3. A child for whom you are required to provide benefits by a court order and who satisfies the same conditions as listed above.
4. Parent-Child Relationship for CalPERS medical coverage, a child may be eligible if they are under age 26, have never been married, and a parent-child relationship exists.
   - A parent-child relationship occurs when the employee or annuitant assumes a parental role and is considered the primary care "parent." Please see Human Resources for further information.

Who Is Not Eligible

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

- Parents, grandparents, grandchildren, and siblings (unless certified by Parent-Child Relationship Affidavit).
- Any individual who is covered as an employee of Pittsburg Unified School District cannot also be covered as a dependent (double covered), except in the case of dental and/or vision coverage.
- Substitute employees, contract employees, or employees residing outside the United States, in accordance with the Affordable Care Act guidelines.

Note: It is against the law to enroll ineligible family members. If you do so, you may be responsible for the full cost of premiums provided to the ineligible family member. Please contact Human Resources if you have any questions about eligibility.

Did You Know?

As a CalPERS member you can use my|CalPERS to explore, learn, and decide on your health plan options. To help you manage your Open Enrollment decisions, your Health Plan Statement, 2022 Open Enrollment resources, and CalPERS publications are available online through my|CalPERS. A new health plan comparison tool, Find a Medical Plan, is now available on my|CalPERS. It will help you review health plans available in 2022, allowing you to set up side-by-side comparisons of plan features and premiums. Simply log into your my|CalPERS account at my.calpers.ca.gov, and select the Health tab, and then the Find a Medical Plan option.

Dependent Eligibility Verification

All employees adding/removing dependents must submit documentation to verify their dependent's eligibility and/or Qualifying Life Event. The following chart is an easy guide to what documents must be submitted along with the Health Enrollment/Change form.

- Dependent children verification includes birth or adoption certificate and social security number.
- Only provide first page of your prior year FEDERAL Tax Return that shows your dependents and black out any monetary amounts. STATE Returns are not acceptable.
- Proof of marriage must be a state issued marriage license or marriage certificate (not a church issued certificate) that includes the date of your marriage.
- State Registration Certificate is required for Domestic Partnership (DP).
- Affidavit of Parent-Child Relationship is required for eligible Parent-Child relationships.
- Birth Certificates must be state issued (not hospital issued).

	Nothing Required	Marriage Certificate	Birth Certificate/ Certificate of Adoption	State of California Domestic Partner (DP) Registration	Economically/ Disabled Dependent Child Affidavit and Federal Tax Return
Employee Only	X				
Employee & Spouse		X			
Employee & Children			X		
Employee & Parent-Child Relationship or Disabled Child(ren)			X		X
Employee, Spouse & Children		X	X		
Employee, Spouse & Parent-Child Relationship or Disabled Child(ren)		X	X		X
Employee and DP				X	
Employee, DP & Children			X	X	
Employee, DP & Parent-Child Relationship or Disabled Child(ren)			X	X	X

You are responsible for ensuring that the health enrollment information about you and your family members is accurate, and for reporting any changes in a timely manner. If you fail to maintain current and accurate health enrollment information, you may be liable for the reimbursement of health premiums or health care services incurred during the entire ineligibility period.

Notification must be made within 60 days of the date that the status change occurs. Failure to submit notification in a timely manner may impact dependent eligibility for health care continuation under COBRA, and may result in you incurring liability for medical expenses for non-eligible dependents.

When You Can Make Changes to Your Benefits

There are a limited number of opportunities to make changes to your benefits.
The most common opportunity to make changes is during the Open Enrollment period. Another opportunity to make changes to your dependents on a medical plan is during a "late enrollment". A late enrollment requires a 90-day waiting period. The last opportunity is during a "qualifying event" period.

The following are considered "qualifying events".

Changes to:

- Legal marital status, including marriage, divorce, legal separation, annulment, and death of spouse
- Number of dependents, including birth, adoption, placement for adoption, or death of a dependent child
- Employment status, including the start or termination of employment of you, your spouse, or your dependent child
- Child's dependent status, either newly satisfying the requirements for dependent child status or ceasing to satisfy them

OR

- A court order resulting from a divorce, legal separation, annulment, or change in legal custody (including a Qualified Medical Child Support order) requiring coverage for your child or dependent foster child
- An event that is a "special enrollment" event under HIPAA, including acquisition of a new dependent or spouse, or loss of coverage under another health insurance policy or plan if the coverage is terminated because of:
    - Voluntary or involuntary termination of employment or reduction in hours of employment;
    - Death
    - Divorce
    - Legal separation

Three (3) rules apply to making changes to your benefits during the year:

1. Any changes you make must be consistent with the change in status, AND

2. You must make the changes within 60 days of the date the *event* occurs (marriage, birth, etc.), otherwise you will need to wait until the Open Enrollment Period.

3. You may not change from one group medical plan to another (i.e. change from Kaiser HMO to Blue Shield HMO, or vice-versa) during the plan year, except during open enrollment.

When Your Benefits Terminate

Your medical benefits end on the first of the second month following the date of separation or loss of eligibility. Your dental and vision plan coverage ends on the last day of the month of your date of separation or loss of eligibility. Coverage for your Flexible Spending Accounts (FSA), Group Life/AD&D, Short Term Disability (STD), Long Term Disability (LTD), and Employee Assistance Program (EAP) end on the date of separation. As an example, if your last day is in the month of June, then your dental and vision will end June 30, and your medical will end on July 31.

You and any dependents you have covered under your medical, dental and vision coverage have the right to continue participation in group health coverage as allowed under the Consolidated Omnibus Budget Reconciliation Act (COBRA). COBRA allows you to continue coverage for a designated amount of time by paying the monthly premiums yourself. COBRA coverage will be offered following separation of employment, or during any period of unpaid leave. For more information, please contact Human Resources.

Benefits during the Family and Medical Leave (FMLA) and California Family Rights Act (CFRA)

An employee taking family/medical leave will be allowed to continue participating in any health and welfare benefit plan in which he/she was enrolled before the first day of leave for the duration of the FMLA/CFRA period. The employee and employer will continue to be responsible for their portions of the premiums as if the employee had continued working.

Note: For further information on Family and Medical Leave, please contact Human Resources

All employees must notify Human Resources at (925) 473-2335 as soon as possible regarding the need to take time off for their own serious health condition or that of a family member.

Medical Benefits

The goal of the Pittsburg Unified School District is to provide you with affordable, quality health care benefits. Our medical benefits are designed to help maintain wellness and protect you and your family from major financial hardship in the event of illness or injury. The agency offers a choice of medical plans through the CalPERS Medical Program. Medical premiums are taken a month in advance through payroll deductions.

Health Maintenance Organization (HMO)

Under the HMO plans, most services and medicines are covered with a small copayment. You select a Primary Care Physician (PCP) to coordinate your care. You have a choice between the CalPERS Anthem Blue Cross Select, Anthem Blue Cross Traditional, Blue Shield Access+, Kaiser Permanente, UnitedHealthcare Alliance, Western Health and HealthNet HMO plans.*

**Not all HMO plans are available in all California counties. To see if these plans are available in your zip code, please visit the CalPERS website at www.calpers.ca.gov and use the zip code finder search engine.*

Preferred Provider Organization (PPO)

The Anthem Blue Cross PPO plan is designed to provide choice, flexibility and value. The PPO plan is a managed care organization of medical doctors, hospitals, and other health care providers who have contracted with the Anthem Blue Cross to provide health care at reduced rates to you. Participants have a choice of using network providers or going directly to any other physician (non-network provider) without a referral. There is an annual deductible to meet before benefits apply. You are also responsible for a certain percentage of the charges (coinsurance), and the plan pays the balance up to the agreed upon amount. You have a choice between the CalPERS Anthem Blue Cross PERS Choice, PERS Select, and PERS Care.

Why Would I Choose the PPO Plan?	Why Would I NOT Choose the PPO Plan?
You have a doctor you like and would like to keep this doctor.	You do not want the extra responsibility of managing your own care.
You want to see specialists and other providers without having to first get a referral and/or preapproval.	PPOs are not as closely regulated by the government as HMOs.
You want the freedom to see providers who are not in the network.	You do not want to pay the higher out-of-pocket costs of a PPO.
You are confident that you can manage your own care.	You do not want to get bills from providers.
You do not want a primary care doctor.	You do not have enough savings to meet the deductible.

CalPERS plan availability and premium costs are generally based on where you reside. You may, however, enroll in a health plan using either your residential or work zip code if you are an active employee or working CalPERS retiree. Please pay careful attention to the available choices offered by CalPERS.

Medical Plans

Summary of Benefits and Coverage Notice (2022)

Choosing your health plan is an important decision. To assist you with this process, each health plan available to you 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 view the SBCs, CalPERS Health Plan Summaries and glossary online, visit www.calpers.ca.gov/page/active-members/health-benefits/plans-and-rates or any of the health plan websites below. To request a free paper copy of the SBC and glossary, please contact each health plan directly.

Anthem Blue Cross HMO

Member Services	(855) 839-4524
Website	http://www.anthem.com/ca/calpers

Blue Shield of California

Member Services	(800) 334-5847
Website	https://myoptions.blueshieldca.com/calpers

Health Net

Member Services	(888) 926-4921
Website	https://calpers.healthnetcalifornia.com/

Kaiser

Member Services	(800) 464-4000
Website	https://my.kp.org/calpers

United Healthcare

Member Services	(877) 359-3714
Website	https://calpers.welcometouhc.com/

Western Health Advantage

Member Services	(888) 942-7377
Website	https://www.westernhealth.com/calpers/

PERS Platinum/Gold PPO

Member Services	(877) 737-7776
Website	http://www.anthem.com/ca/calpers

Regional Rate Differences

Since health care costs vary throughout California, regional pricing adjusts premiums to reflect the actual cost of care in your specific region. To find your specific health plan premium rates, visit https://www.calpers.ca.gov/page/active-members/health-benefits/plans-and-rates/zip-search and select your specific region, or contact Human Resources with questions.

CalPERS Health Plan Summary - HMO

	Anthem Blue Cross EPO, Select & Traditional	Blue Shield Access+ & Trio	Health Net	Kaiser	United Healthcare	Western Health Advantage
Calendar Year Deductible						
Individual/Family	N/A	N/A	N/A	N/A	N/A	N/A
Maximum Calendar Year Co-Pay *(exc. pharmacy)*						
Individual	$1,500 *(co-pay)*	$1,500 *(co-pay)*	$1,500 *(co-pay)*	$1,500 *(co-pay)*	$1,500 *(co-pay)*	$1,500 *(co-pay)*
Family	$3,000 *(co-pay)*	$3,000 *(co-pay)*	$3,000 *(co-pay)*	$3,000 *(co-pay)*	$3,000 *(co-pay)*	$3,000 *(co-pay)*
Hospital						
Deductible (per admission)	N/A	N/A	N/A	N/A	N/A	N/A
Inpatient	No charge	No charge	No charge	No charge	No charge	No charge
Outpatient Facility/Surgery Services	No charge	No charge	No charge	$15	No charge	No charge
Emergency Services						
Emergency Room Deductible	N/A	N/A	N/A	N/A	N/A	N/A
Emergency *(co-pay waived if admitted)*	$50	$50	$50	$50	$50	$50
Non-Emergency *(co-pay waived if admitted)*	$50	$50	$50	$50	$50	$50
Physician Services						
Office Visits	$15	$15	$15	$15	$15	$15
Inpatient Visits	No charge	No charge	No charge	No charge	No charge	No charge
Outpatient Visits	$15	$15	$15	$15	$15	$15
Urgent Care Visits	$15	$15	$15	$15	$15	$15
Preventive Services	No charge	No charge	No charge	No charge	No charge	No charge
Surgery/Anesthesia/X-Ray/Lab	No charge	No charge	No charge	No charge	No charge	No charge
Prescription Drugs						
Deductible	N/A	N/A	N/A	N/A	N/A	N/A
Retail Pharmacy	Generic: $5 Brand: $20 Non-Pref: $50	Generic/Tier1: $5 Brand/Tier2: $20 NonPref/Tier3: $50 NonPref/Tier4: $30	Generic: $5 Brand: $20 Non-Pref: $50	Generic: $5 Brand: $20	Generic: $5 Brand: $20 Non-Pref: $50	Generic: $5 Brand: $20 Non-Pref: $50
Mail Order Pharmacy *Not to exceed 90-day supply*	Generic: $10 Brand: $40 NonPref: $100	Generic/Tier1: $10 Brand/Tier2: $40 NonPref/Tier3: $100 NonPref/Tier4: $60	Generic: $10 Brand: $40 NonPref: $100	Generic: $10 Brand: $40 (31-100 day supply)	Generic: $10 Brand: $40 Non-Pref: $100	Generic: $10 Brand: $40 Non-Pref: $100
Durable Medical Equipment	No charge	No charge	No charge	No charge	No charge	No charge
Occupational/Physical/Speech Therapy						
Inpatient	No charge	No charge	No charge	No charge	No charge	No charge
Outpatient	$15	$15	$15	$15	$15	$15
Acupuncture/Chiropractic *Up to 20 visits combined per year*	$15/visit	$15/visit	$15/visit	$15/visit	$15/visit	$15/visit

** The above summary and additional details can be found in the 2022 Health Benefits Summary at www.calpers.ca.gov*

CalPERS Health Plan Summary – PPO

All CalPERS PPO Plans are administered by Anthem Blue Cross

	PERS Gold		PERS Platinum	
Calendar Year Deductible	**PPO**	**Non-PPO**	**PPO**	**Non-PPO**
Individual	$1000	$1000	$500	$500
Family	$2,000	$2,000	$1,000	$1,000
Maximum Calendar Year Co-Pay *(exc. pharmacy)*				
Individual	$3,000 *(co-pay)*	Unlimited	$2,000 *(co-pay)*	Unlimited
Family	$6,000 *(co-pay)*	Unlimited	$4,000 *(co-pay)*	Unlimited
Hospital				
Deductible (per admission)	N/A	$250	N/A	N/A
Inpatient	20%	40%	10%	40%
Outpatient Facility/Surgery Services	20%	40%	10%	40%
Emergency Services – Deductible *(applies to hospital emergency room facility charges only)*	$50	$50	$50	$50
Emergency *applies to others services such as physician, x-ray, lab, etc.)*	20%	20%	10%	10%
Non-Emergency *(payment for physician charges only; emergency room facility charge is not covered)*	20%	40%	10%	40%
Physician Services				
Office Visits	$35	40%	$20	40%
Inpatient Visits	20%	40%	10%	40%
Outpatient Visits	$35	40%	$20	40%
Urgent Care Visits	$35	40%	$20	40%
Preventive Services	No charge	40%	No charge	40%
Surgery/Anesthesia	20%	40%	10%	40%
Diagnostic X-Ray/Lab	20%	40%	10%	40%
Prescription Drugs - Deductible	N/A	N/A	N/A	N/A
Retail Pharmacy	Generic: $5 Brand: $20 Non-Pref: $50	Generic: $5 Brand: $20 Non-Pref: $50	Generic: $5 Brand: $20 Non-Pref: $50	Generic: $5 Brand: $20 Non-Pref: $50
Mail Order Pharmacy *Not to exceed 90-day supply*	Generic: $10 Brand: $40 Non-Pref: $100	Generic: $10 Brand: $40 Non-Pref: $100	Generic: $10 Brand: $40 Non-Pref: $100	Generic: $10 Brand: $40 Non-Pref: $100
Durable Medical Equipment	20%	40%	10%	40%
Occupational/Physical/Speech Therapy				
Inpatient	No charge	No charge	No charge	No charge
Outpatient	20%	40% (OT 20%)	10%	40% (OT 10%)
Acupuncture/Chiropractic *(up to 20 combined visits per year)*	$15/visit	40%	$15/visit	40%

** The above summary and additional details can be found in the 2022 Health Benefits Summary at* ***www.calpers.ca.gov***

Delta Dental Benefits

All regular, active, full time (working 30 or more hours per week) employees are required to participate in the group dental plan provided under Delta Dental.

Regular, part-time employees working 30 or less hours per week may enroll in the voluntary dental plan provided by MetLife Dental, administered by SafeGuard.

Under the Delta Dental program, Preferred Provider Organization (PPO) plan, dental services are provided through the Delta Dental PPO network, but you may also choose to visit a Delta Dental Premier provider or you can choose to visit any dentist in any location inside or outside of the Delta Dental network.

Dental Contact & Group Plan Numbers

Member Services Website	(888) 335-8227 www.deltadentalca.com
Classified/Certificated/Management/Board	7103-0034
Superintendent	7103-0048

Dental Benefit Summary

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 (unpaid leave, separation from service, etc.), the percentage will reset and drop back to 70%.

DENTAL SERVICES	DELTA DENTAL'S CO-PAYMENT	YOUR CO-PAYMENT	CALENDAR YEAR MAXIMUM	CALENDAR YEAR DEDUCTIBLE
Diagnostic and Preventative Services	70-100%	30-0%	$1,700 for each Enrollee if services are provided by a Delta Dental PPO Dentist $1,500 for each Enrollee if services are provided by other dentists	There are **no** Deductible requirements.
Basic Services	70-100%	30-0%		
Crowns, Inlays, Onlays, and Cast Restorations	70-100%	30-0%		
Prosthodontic Services	50%	50%		
Dental Accident Services	100%	0%	$1,000 for each Enrollee	
Orthodontics For Adults and Children	50%	50%	$500 lifetime Maximum for each Enrollee	None

Dental ID Cards

Delta Dental will not automatically provide ID Cards, however, if you would like to print an ID card, please log in to www.deltadentalca.com and register your information on the website.

MetLife Dental

Regular, part-time employees working 30 or less hours per week may elect to enroll in the voluntary dental plan provided by MetLife Dental, administered by SafeGuard Health.

MetLife Dental Contact & Group Plan Numbers

Member Services Website	(800) 880-1800 www.metlife.com/safeguard
Group Number	SG85

Register for MyBenefits Account

MyBenefits provides employees with a personalized, integrated and secure view of your MetLife delivered benefits. You can take advantage of a number of self-service capabilities as well as easy to access information. As a first-time user, you will need to register on MyBenefits at www.mybenefits.metlife.com You can also find an in-network dentist and view the plan and forms on the website.

Dental Benefit Summary

Services must be contracted with a SafeGuard contracted dentist. For the full Summary of Benefits, please contact Human Resources.

DENTAL SERVICES	CO-PAYMENT
Diagnostic Treatment	$0 with a $5 office visit
Radiographs/Diagnostic Imaging (X-Rays)	$0
Preventative Services	$0 for most. $5 for sealants per tooth. $20 for space maintainers.
Crowns, Inlays, Onlays, and Cast Restorations	Varies from $0 to $225

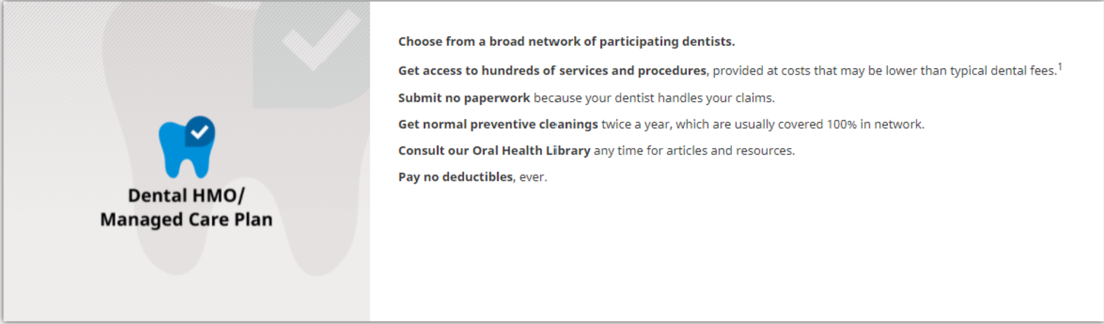
MetLife | Pittsburg Unified School District

My Group Benefits | Forms | Customer Support

My Group Benefits / Dental HMO/Managed Care Plans

Dental HMO / Managed Care

Comprehensive coverage to protect your dental health and your wallet.
(Please note: Dental HMO/Managed Care plans are only available to employees living in CA, FL, NJ, NY and TX)



Vision Benefits

The Pittsburg Unified School District provides a vision plan through Vision Service Plan (VSP) to all regular full-time and part-time employees and Board members. VSP provides coverage for eye exams and materials, such as lenses and frames. Rates are subject to FTE.

VSP Contact & Group Plan Numbers

Member Services	(800) 877-7195
Website	www.vsp.com
Group Number	30081849

VSP Benefit Summary

BENEFIT	DESCRIPTION	COPAY
WellVision Exam	Focuses on your eyes and overall wellness Available every 12 months	$15 for exam
Prescription Glasses		
Frame	• $175 allowances for a wide selection of frames • $195 allowance for featured frame brands • 20% savings on the amount over your allowance • $95 Costco frame allowance • Every 24 months	Combined with exam
Lenses	• Single vision, lined bifocal, and lined trifocal lenses • Polycarbonate lenses for dependent children • Every 24 months	Combined with exam
Lens Enhancements	• Standard progressive lenses • Premium progressive lenses • Custom progressive lenses • Average savings of 35-40% on other lens enhancements • Every 24 months	$0 $80 - $90 $120 - $160
Contacts (instead of glasses)	• $175 allowance for contacts and contact lens exam (fitting and evaluation) • 15% savings on a contact lens exam (fitting and evaluation) • Every 24 months	$0
Primary Eye care	• As a VSP member, you can visit your VSP doctor for medical and urgent eyecare. Your VSP doctor can diagnose, treat, and monitor common eye conditions like pink eye, and more serious conditions like sudden vision loss, glaucoma, diabetic eye disease, and cataracts. Ask your VSP doctor for details. • As needed	$5
Suncare	• $175 allowance for ready-made non-prescription sunglasses instead of prescription glasses or contacts	$15
Extra Savings	**Glasses and Sunglasses** • Extra $20 to spend on featured frame brands. • 30% savings on additional glasses and sunglasses, including lens enhancement, from the same VSP provider on the same day as your Wellness Exam. Or get 20% from any VSP provider within 12 months of your last Wellness Exam. **Retinal Screening** • No more than a $39 copay on routine retinal screening as an enhancement to a WellVision Exam **Laser Vision Correction** • Average 15% off regular price or 5% off the promotional price, discounts only available from contracted facilities	
Out-of-Network	VSP will provide some reimbursement if you see a provider other than a VSP provider. Log in to www.vsp.com for more details.	
VSP Tru Hearing	TruHearing is making hearing aids affordable by providing exclusive savings to all VSP members. To learn more about this benefit, log in to www.vsp.truhearing.com or call (877) 396-7194 and mention VSP.	

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

Basic Life Insurance

Administered by the Standard Insurance

Basic Life and AD&D Insurance for Classified and Certificated Employees

Life Benefits – Paid by PUSD	
Eligibility	Class one: Active, regular, full-time employees Class three: Active, regular, part-time employees working at least 4 hours per day
Eligibility Waiting Period	Eligible on date of hire
Benefit Amount	Class one: $15,000 Class three: $5,000
Benefit Reduction	65% at age 65 50% at age 75 Terminates at separation or retirement
Accelerated Death Benefit	80% of Life Benefit Up to a maximum of $8,000
Waiver of Premium	Included to Age 70 or Retirement Or if disabled before age 60
Conversion	At time of separation you may apply to convert your life insurance to an individual life insurance plan through CIGNA directly.
AD&D Insurance	Class one: $15,000 Class three: $5,000

Basic Life and AD&D Insurance for Management Employees

Life Benefits – Paid by PUSD	
Eligibility	Active, regular employees
Eligibility Waiting Period	Eligible on date of hire
Benefit Amount	$50,000
Benefit Reduction	65% at age 65 50% at age 75 Terminates at separation or retirement
Accelerated Death Benefit	80% of Life Benefit Up to a maximum of $40,000
Waiver of Premium	Included to Age 70 or Retirement Or if disabled before age 60
Conversion	At time of separation you may apply to convert your life insurance to an individual life insurance plan through CIGNA directly.
AD&D Insurance	$50,000

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Accidental Death & Dismemberment (AD&D) Insurance

Administered by MetLife

Basic $1,000 AD&D – Paid by Employer	
Eligibility	Active regular employees of PUSD who work a minimum of 15 hours per week.
Enrollment Period	First 30 days of employment or during the Open Enrollment Period.
Group Benefit Amount	$1,000
Additional Voluntary AD&D Available – Paid by Employee	
Eligibility	Active regular employees of PUSD who work a minimum of 15 hours per week.
Voluntary Benefit Amount	Multiples of $10,000 up to a maximum of 10 times annual earnings or $500,000, whichever is less.
Monthly Premium *11 month employees pay the 12 month premiums in 11 months so are slightly higher*	Employee Only: $.049 per $1,000 in coverage for 12 month employees Employee & Family: $.073 per $1,000 in coverage for 12 month employees
Benefit Reduction	50% at age 70
Family Coverage	The Family Plan, if elected, will automatically insure you for the Benefit Amount checked on the enrollment form. Your spouse will be eligible for 60% of the Benefit Amount if you have no children, OR 50% if you have eligible children. Each child will have 10% of the Benefit Amount elected, to a maximum of $50,000 per child.

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Additional Voluntary Life Insurance, Supplemental Disability Insurance, Cancer Insurance, Critical Illness Insurance and AD&D Insurance may be purchased through The Standard or American Fidelity.

For more information, please contact or email the vendors directly.

VENDOR	INSURANCE OPTION	CONTACT
The Standard	Disability coverage for Certificated staff only	Human Resources for forms
American Fidelity	Voluntary life, Disability, Cancer, Critical Illness, AD&D	Rep: Kelly Hildebrand (916) 683-8306 email www.afadvantage.com

Disability Insurance

Classified & Classified Management Employees

Administered by the Employment Development Department (EDD)

State Disability Insurance (SDI) is required for all active, regular, classified staff members and will be automatically deducted from pay warrants. Disability insurance is a component of the State Disability Insurance (SDI) program to provide partial wage replacement benefits to eligible employees who are unable to work due to a non-work-related illness, injury, or pregnancy. Benefits are payable for a maximum of 52 weeks. Disability amounts paid by SDI will be integrated with your PUSD earnings. Integration is when the amount paid by SDI is deducted from your PUSD earnings. The benefit is that you do not pay state taxes on the amount earned by SDI, and you will also use less sick leave time to cover the absence. For questions about integration, please contact the classified payroll department. Additional information about SDI can be found at www.edd.ca.gov/disability

Short Term and Long Term Disability Plan	
Eligibility - Required	Active, regular classified CSEA members or classified managers
Wait Period	Seven (7) day wait period before benefits begin
Weekly Benefit Percentage & Maximum	Weekly benefit amount (WBA) depends on your annual income. It is estimated as 60 to 70% of the wages you earned 5 to 18 months prior to the claim start date up to the maximum WBA of $1,357 in 2021.
Contribution Amount	Employee required to pay 1.2% of salary
Payment Frequency	Every two weeks
Benefit Duration	Up to a maximum of 52 weeks
To file claim	- Register on www.edd.ca.gov/disability - Visit an SDI office – for locations visit www.edd.ca.gov
For more Information	Visit www.edd.ca.gov/disability, or call 1-800-480-3287. Or call Human Resources at 925-473-2335

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

Paid Family Leave (PFL)

PFL is a component of the State Disability Insurance (SDI) program and eligibility for PFL is the same as SDI. The maximum claim benefit is six times the weekly benefit amount. No more than six weeks of PFL benefits may be paid within any 12-month period. PFL is commonly used to care for a seriously ill family member, or bond with a newborn. For more information, please visit http://www.edd.ca.gov/Disability/Paid_Family_Leave.htm

Please report all SDI and PFL claims to Payroll.
It is the responsibility of both the employer and the employee to ensure integration of SDI/PFL payments with PUSD pay.

Optional Disability Insurance

Certificated Employees

Administered by The Standard

For certificated staff there is no required disability plan, however, it is strongly encouraged to enroll in the Standard Disability and Life Insurance. The Standard is the only carrier endorsed by CTA. Disability insurance provides payments directly to you if you are unable to work due to illness, injury, pregnancy or childbirth.

For more information about the plan and to enroll, please visit www.standard.com/cta/disability

Short Term and Long Term Disability Plan	
Policy Number	501465
Eligibility	Active, regular PEA employees
Wait Period	Lesser of the first seven consecutive regular days of required attendance or 30 calendar days
Maximum Benefit Period *Varies depending on years of credited service under CalSTRS or CalPERS. See website for more details.*	Benefits are payable for up to two (2) benefit years following your fully paid sick leave, while you remain disabled.
During fully paid sick leave following the Benefit Waiting Period	You will receive $25 per day of required attendance while you are receiving fully-paid sick leave, once you satisfy the benefit waiting period.
During substitute differential or similar pay following sick leave	Your total income will be no less than 75% of your regular daily salary. You will receive up to 75% of your regular daily salary, minus the amount the district pays you and any other sources of deductible income you may have. The minimum benefit will be up to 25% of your regular daily salary (so long as your total income doesn't exceed 100% of your regular daily pay) or $30/day, whichever is greater
To file claim or form more information	- Contact The Standard at (800) 522-0406 - Visit their website at https://www.standard.com/cta/disability - Contact Human Resources at (925) 473-2335 for a claim application

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The Standard is the only carrier endorsed by CTA!

Disability insurance provides payments directly to you if you are unable to work due to illness, injury, pregnancy or childbirth.

Enrollment period is limited to first 270 days of work – so don't wait!

Employee Assistance Program

Administered by MHN

The Employee Assistance Program (EAP) is designed to help with short-term counseling needs. It offers quick and easy access to confidential, professional assistance and resources to help you and your family address difficulties related to emotional concerns, relationships, substance abuse, legal and financial concerns.

If it is determined that more than three (3) sessions are needed for your specific situation, the EAP will help coordinate your needs under your medical plan (sworn employees are eligible for eight sessions). Sessions are based on a fiscal year basis, therefore session limits reset every July 1.

All services are confidential and in accordance with professional ethics and Federal and state laws. Use of the EAP is strictly voluntary.

Work & Life Services

Depending on your needs, telephonic consultation may be available for:

- **Child and Eldercare Assistance** – Help accessing available community and financial resources and referrals to pre-screened providers for childcare, eldercare and more. You may also be entitled to help with adoption, parenting skills, child development, special needs, emergency care, relocation services and educational issues.
- **Financial Issues** – Budgeting, credit and financial guidance (tax or investment advice, loans and bill payments not included).
- **Federal Tax Assistance** – Help with IRS audits and unfiled or past-due tax returns (not a tax representation or preparation service).
- **Pre-Retirement Planning** – Guidance for planning a quality retirement (does not include investment, tax or legal advice).
- **Organizing Life's Affairs** – Help organizing records and vital documents and with arranging "final details" for a loved one.
- **Concierge Services** – Referrals for everyday errands, travel, event planning and more (does not cover the cost, nor guarantee delivery, of services).
- **Legal Services** – Telephonic or face-to-face legal consultations for issues relating to civil, consumer, personal and family law, financial matters, business law, real estate, criminal matters, the IRS and estate planning (excluding disputes or actions between members and their employer or MHN).

EAP services are accessible 24-hours a day for all locations.
Toll-free (800) 242-6220 or online at members.mhn.com
Access Code: pusd

Flexible Spending Accounts (FSA)

Administered by American Fidelity

The Flexible Spending Accounts (FSA) are a great way to use pre-tax dollars to pay for expenses paid with after-tax dollars! You may enroll in either or both the Healthcare Spending Account or the Dependent Care Spending Account. These accounts allow you to redirect a portion of your salary on a pre-tax basis into reimbursement accounts. Money from these accounts is then used to pay eligible expenses that are not reimbursed by your health plans, as well as reimbursement for dependent care expenses.

Pre-tax means the dollars you allocate toward these accounts are not subject to social security tax, Federal income tax and, in most cases, state and local taxes. The money you set aside may be used for qualified eligible expenses on a pre-tax basis.

At enrollment, you determine the amount of money to contribute to one or both of these accounts for the agency's plan year. The contributions are deducted pre-tax per pay period from your paycheck and deposited into the FSA account(s). You request reimbursement of qualified expenses as you incur the expenses from your FSA account(s).

FSA Eligibility Requirements:

- ❑ Active regular employees
- ❑ Work at least 15 hours per week

Health Care Spending Account

This account will reimburse you with pre-tax dollars for qualified out-of-pocket healthcare expenses not covered under your family's healthcare plans. The "Use it or Lose it" rule applies if you do not incur expenses by December 31st of the plan year, you lose the unexpended portion.

Medical-related expenses include out of pocket money for copays or deductibles for medical, dental and vision services. A detailed listing of all qualified expenses are available on the American Fidelity website at https://americanfidelity.com/claims/fsa-hsa-eligibility-list/

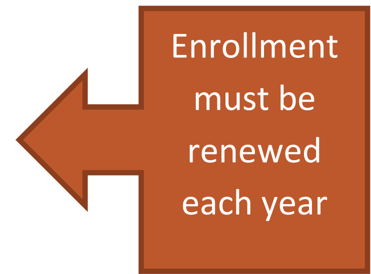
The maximum amount in 2022 you may contribute to the Healthcare Spending Account for the Plan Year is $2,750 per person, per plan.

USE IT OR LOSE IT!

Please estimate your annual contributions carefully! You will have the ability to incur expenses for an additional 2.5 months into the next calendar year, but any funds remaining after that period will be defaulted.

Enrollment must be renewed each Open Enrollment period to continue! NO AUTOMATIC RE-ENROLLMENT EACH YEAR

Dependent Care Account



You may use the Flexible Spending Dependent Care to pay for the day care of your dependent children under the age of 13, care for a dependent adult (eldercare), and dependents of any age who are incapable of self-care, live with you at least eight hours per day, and are claimed as dependents on your income tax return.

To be eligible, care must be provided while you (and your spouse, if you are married) work, look for work, or attend school full time. Eligible expenses include care in your home by an eligible provider or at a licensed facility.

The maximum amount you may contribute is $5,000 per household.

How the FSA Accounts Work?

Each year during the Open Enrollment period, you decide how much you want to contribute to your health care and dependent care spending account(s) for the next calendar year. *Commuter benefits may be enrolled in any time during the year.*

At the start of the plan year, money is deducted from your paycheck in equal increments before taxes. These funds are contributed to your FSA account, thus saving you tax dollars.

Once you enroll, you can only change your elected payroll deduction if there is a change in family status, such as marriage, divorce, death, birth, adoption, or change in employment status.

Questions about the FSA Plan?

Contact our American Fidelity representative Kelly Hildebrand at (916) 683-8306, or by email at Kelly.Hildebrand@americanfidelity.com

Commuter Benefits

Administered by EdenRed Commuter Benefits

To help save money on commuting costs, PUSD has implemented a tax-free commuter benefit program. With this benefit, all employees who commute to work by public transit (bus, rail, or ferry) or qualified vanpools can pay their fare with pre-tax dollars. The federal tax code allows employees to exclude up to $270 in transit or vanpool costs and $270 per month for parking expenses from their taxable income.

This means that you can save $520 or more per year in taxes, depending on your tax bracket and your monthly fare. In addition to saving money, by commuting to work by transit or vanpool you can avoid traffic congestion and help protect the environment.

For more information, please visit https://commuterbenefits.com

To apply, please contact Human Resources for an application.

Eligible Transit Expenses:

- Buses
- Trains & subways
- Ferries
- Vanpools
- Commuter highway vehicles
- Car Service Apps — uberPOOL and Lyft Line

Eligible Parking Expenses:

- Parking at or near your place of employment
- Parking at a location from which you commute to work

Ineligible Transit and Parking Expenses:

- Bridge tolls
- Highway tolls
- Expenses for someone other than you
- Fuel
- Mileage
- Uber and Lyft services not associated with uberPOOL and Lyft Line services

Business travel and other reimbursed expenses are also excluded from this benefit.

Retirement Plan Information

California State Teachers' Retirement System (CalSTRS)

CalSTRS provides retirement benefits for eligible full time and certain part time California public school educators. Your retirement benefit is based on a formula set by law using your age, service credit and final compensation.

As a result of 2012 legislation, CalSTRS now has two benefit structures: Members first hired on or before December 31, 2012, are under "CalSTRS 2% at 60", and those first hired on or after January 1, 2013, are under "CalSTRS 2% at 62".

This is a very important benefit. Please take advantage of the workshops provided each year so you can plan appropriately for your retirement. Go to https://my.calstrs.com and register to view your account balances, calculate your retirement benefits and sign up for workshops/webinars. Additionally, the CalSTRS website is filled with information regarding retirement eligibility, planning, forms and publications. Go to www.calstrs.com or you can contact CalSTRS at (800) 228- 5453.

This is just a brief overview of benefits and coverage for CalSTRS. In the event of any conflict or discrepancy between this guide and the STRS plan documents, the plan documents will govern. You should refer to CalSTRS member publications, available online at www.calstrs.ca.gov

California Public Employees Retirement System (CalPERS)

Classified employees who work at least 1,000 hours per fiscal year or work in a regular ongoing position for at least 4 hours per day become members of the California Public Employees Retirement System (CalPERS). Your retirement benefit is based on a formula set by law that includes your years of service credit, age at retirement, and final compensation.

As a result of 2012 legislation, CalPERS now has two benefit structures: Members first hired on or before December 31, 2012, are under "CalPERS 2% at 55", and those first hired on or after January 1, 2013, are under "CalPERS 2% at 62".

This is a very important benefit. Please take advantage by reading the plan material and attending workshops so you can plan appropriately for your retirement. The CalPERS website is filled with information regarding retirement eligibility, planning, forms and publications. Go to https://my.calpers.ca.gov and register to view your account balances, calculate and your future retirement benefits and sign up for workshops/webinars. You can also log onto CalPERS general website to obtain information at www.calpers.ca.gov or contact them at (888) 225-7377.

This is just a brief overview of benefits and coverage for CalPERS. In the event of any conflict or discrepancy between this guide and the plan documents, the PERS plan documents will govern. You should refer to CalPERS member publications, available online at www.calpers.ca.gov .

Supplemental Retirement Savings Plan

403(b) and 457(b) Options

You have the option of participating in a tax-deferred retirement savings program as authorized by Sections 403(b) and 457 of the Internal Revenue Code. Through these programs, you can shelter a portion of your compensation currently subject to Federal and State income tax to purchase supplemental retirement benefits. Your 403(b) and 457 contributions, with accumulated interest, are not subject to Federal or State income taxes until the funds are withdrawn (usually at retirement).

403(b) & 457(b) Plan

PUSD has contracted with Envoy Plan Services to serve as the 403(b) and 457(b) Plan's Third Party Administrator providing plan oversight and administration. Envoy is available to answer your questions and administer all plan related transactions and Salary Reduction Agreements.

The first step in the enrollment process is to establish an account with one of the approved companies/vendors. A list of participating vendors is available on the Envoy website at https://envoy.tsacg.com/index.php?e=3890 Once you have selected a company, call them to request literature on their 403(b) & 457(b) plan and account application. Once the account is established, you can either download the Salary Reduction Agreement (SRA) Form from the Envoy site under "FORMS" or complete the Online SRA. This form provides the necessary information for Envoy to contact PUSD with information to initiate your payroll deduction.

You may change or stop your deduction any time by submitting a new SRA form to Envoy. Changes are subject to month-to-month cutoff dates to meet payroll deadlines. Please keep or print copies of all completed forms for your records. Once you have established an account at Envoy you can make changes on-line or complete paper forms.

For questions or additional information please call Envoy at (800) 248-8858 or visit their main website at www.envoyplanservices.com

403B Compare

Another tool that can be useful in comparing the different plan choices is 403bCompare. On this site, you can compare different plans, learn about the differences between the 403(b) and the 457(b) savings, review average returns, and get detailed information about each plan. Find their website at https://www.403bcompare.com/employers/133

Annual Notices

The following pages are mandatory notices that all employers are required to provide to their employees. The contents of the messages may or may not apply to you. If you have any questions about these notices, please contact Human Resources at (925) 473-2333.

The Women's Health and Cancer Rights Act

Your health plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymph edema). Call your health plan's Member Services for more information.

HIPAA: Health Insurance Portability & Accountability Act Notice of Availability of HIPAA Privacy Notice

The federal Health Insurance Portability and Accountability Act of 1996 ("HIPAA") requires that we periodically remind you of your right to receive a copy of the County Office's HIPAA Privacy Notice. You can request a copy of the Privacy Notice by contacting the Pittsburg Unified School District Human Resources Office at 2000 Railroad Avenue, Pittsburg, CA 94565.

HIPAA Notice of Special Enrollment Rights for Medical/Health Plan Coverage

If you decline enrollment in the PUSD health plans for your dependents (including your spouse) because of other health insurance or group health plan coverage, you or your dependents may be able to enroll in a PUSD health plan without waiting for the next open enrollment period if you:

- Lose other health insurance or group health plan coverage. You must request enrollment within 30 days after the loss of other coverage.
- Gain a new dependent as a result of marriage, birth, adoption, or placement for adoption. You must request health plan enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.
- Lose Medicaid or Children's Health Insurance Program (CHIP) coverage because you are no longer eligible. You must request medical plan enrollment within 60 days after the loss of such coverage.

If you request a change due to a special enrollment event within the 30-day timeframe, coverage will be effective the first of the month following the special enrollment request. In addition, you may enroll in PUSD's health plan if your dependent becomes eligible for a state premium assistance program under Medicaid or CHIP. You must request enrollment within 60 days after you gain eligibility for medical plan coverage. If you request this change, coverage will be effective the first of the month following your request for enrollment. Specific restrictions may apply, depending on federal and state law. *Note: If your dependent becomes eligible for a special enrollment rights, you may add the dependent to your current coverage or change to another health plan.*

Changes Allowed Under the Children's Health Insurance Program Reauthorization Act of 2009

Effective April 1, 2009, the Children's Health Insurance Program Reauthorization Act of 2009 created a new special enrollment period that applies to group health plans, similar to those currently in effect for the loss of eligibility for other group coverage or qualifying life status changes. Under this Act, group health plans must permit those eligible for group health plan coverage to enroll in the plan if they:

- Lose eligibility for Medicaid or SCHIP coverage **OR**
- Become eligible to participate in a premium assistance program under Medicaid or SCHIP

In both cases you must request special enrollment within 60 days (of the loss of Medicaid/SCHIP or the eligibility determination).

The Newborns and Mothers Health Protection Act

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean delivery. 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 issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Patient Protection Notice

Your health plan may require or allow for the designation of a primary care provider. If so, you have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members, including a pediatrician, as the primary care provider. Until you make this designation, the health plan may designate one for you.

You do not need prior authorization from the health plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan or procedures for making referrals.

For information on how to select a primary care provider, a list of participating primary care providers, or a list of health care professionals who specialize in obstetrics or gynecology, contact your health plan.

Medicare Part D Creditable Coverage Notice

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

This notice has information about your current prescription drug coverage with PUSD 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. The Pittsburg Unified School District has determined that the prescription drug coverage offered by CalPERS is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

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

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

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

If you decide to join a Medicare drug plan, your PUSD coverage will not be affected. See below for more information about what happens to your current coverage if you join a Medicare drug plan.

Since the existing prescription drug coverage under CalPERS is creditable (e.g., as good as Medicare coverage), you can retain your existing prescription drug coverage and choose not to enroll in a Part D plan; or you can enroll in a Part D plan as a supplement to, or in lieu of, your existing prescription drug coverage.

If you do decide to join a Medicare drug plan and drop your PUSD prescription drug 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 PUSD 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 19 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 PUSD changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage

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

For more information about Medicare prescription drug coverage:

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

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

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

Date:	January 1, 2021
Name of Entity/Sender:	Pittsburg Unified School District
Contact-Position/Office:	Human Resources Department
Address:	2000 Railroad Avenue, Pittsburg CA 94565
Phone:	(925) 473-2335

General Notice of COBRA Continuation Coverage Rights

Introduction

You are receiving this notice because you are covered under the Pittsburg Unified School District's group health plan ("The Plan") provided by CalPERS Health. This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.

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 when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. For additional 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.

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as 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 coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

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

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- 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 any of the following qualifying events happens:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);

- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the plan as a "dependent child."

When Is COBRA 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. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, or the employee becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event.

You Must Give Notice of Some Qualifying Events

For the 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 the Pittsburg Unified School District, Human Resources Department, 2000 Railroad Avenue, Pittsburg, CA 94565.

How is COBRA 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. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability extension of 18-month period of continuation coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total 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 continuation coverage.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event while receiving 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 notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally

separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

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 ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), 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 the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep the Plan Administrator informed of 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.

Plan Contact Information

For more information on your benefit plans, please contact the following: Pittsburg Unified School District, Human Resources, 2000 Railroad Avenue, Pittsburg, CA 94565.

New Health Insurance Marketplace Coverage Options and Your Health Coverage

General Information

When key parts of the health care law took effect in 2014, there was a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the Marketplace and employment based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace began in October 2013 for coverage starting as early as January 1, 2014.

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

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

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

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.[1]

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

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact:

Stephanie Cox
Phone: (925) 473-2335
Email: scox@pittsburgusd.net

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

Information about Health Coverage Offered by Your Employer

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

3. Employer Name: Pittsburg Unified School District	**4. Employer Identification Number (EIN):**	
5. Employer address: 2000 Railroad Avenue	**6. Employer phone number: (925) 473-2335**	
7. City: Pittsburg	**8. State: CA**	**9. Zip Code: 94565**
10. Who can we contact about employee health coverage at this job? Stephanie Cox		
11. Phone number (if different from above)	**12. Email address: scox@pittsburgusd.net**	

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

• As your employer, we offer a health plan to:

☐All employees.

☒Some employees. Eligible employees are: Eligible employees are: Active “regular” part time or full time employees, following eligibility waiting period.

• With respect to dependents:

☒We do offer coverage. Eligible dependents are: Eligible dependents are: spouse (including same-sex spouse), domestic partner (registered and non-registered domestic partners), children to age 26 and disabled dependents at any age as long as proof of the ongoing disability is provided.

☐We do not offer coverage.

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

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

If you decide to shop for coverage in the Marketplace, **HealthCare.gov** will guide you through the process.

IMPORTANT: Effective January 1, 2014 and until further notice, all U.S. citizens and legal residents will be required to obtain qualifying coverage. Those who do not obtain coverage may be subject to a tax penalty. For more information go to: www.coveredca.com

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, 2021. Contact your State for more information on eligibility –

ALABAMA – Medicaid	CALIFORNIA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp Phone: 916-445-8322 Email: hipp@dhcs.ca.gov
ALASKA – Medicaid	**COLORADO– Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Health First Colorado Website: https://www.healthfirstcolorado.com Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.colorado/gov/pacific/hcpf/health-insurance-buy-program HIBI Customer Service: 1-855-692-6442

ARKANSAS – Medicaid	FLORIDA – Medicaid
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: https:///www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268
GEORGIA – Medicaid	**MASSACHUSETTS – Medicaid & CHIP**
Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162 ext 2131	Website: https://www.mass.gov/info-details/masshealth-premium-assistance-pa Phone: 1-800-862-4840
INDIANA – Medicaid	**MINNESOTA - Medicaid**
Health 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	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
IOWA– Medicaid and CHIP (Hawki)	**MISSOURI - 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: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 1-573-751-2005
KANSAS – Medicaid	**MONTANA – Medicaid**
Website: http://www.kancare.ks.gov Phone: 1-800-792-4884	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084
KENTUCKY – Medicaid	**NEBRASKA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-3628 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	Website: http://www.ACCESSNebraska.ne.gov Phone: (855) 632-7633 Lincoln: (402) 473-7000 Omaha: (402) 595-1178
LOUISIANA – Medicaid	**NEVADA – Medicaid**
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (Lahipp)	Medicaid Website: https://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900

MAINE – Medicaid	NEW HAMPSHIRE – Medicaid
Website: http://www.maine.gov/dhhs/ofi/APPLICATIONS-FORMS Phone: 1-800-442-6003 TTY: Maine relay 711	Website: https://www.dhhs.nh.gov/oii/hipp.htm Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 5218
NEW JERSEY – Medicaid and CHIP	**SOUTH DAKOTA - 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: http://dss.sd.gov Phone: 1-888-828-0059
NEW YORK – Medicaid	**TEXAS – Medicaid**
Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831	Website: http://gethipptexas.com/ Phone: 1-800-440-0493
NORTH CAROLINA – Medicaid	**UTAH – Medicaid and CHIP**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
NORTH DAKOTA – Medicaid	**VERMONT– Medicaid**
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
OKLAHOMA – Medicaid and CHIP	**VIRGINIA – Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: https://www.coverva.org/en/famis-select https://www.coverva.org/en/hipp Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-800-432-5924 http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
OREGON – Medicaid	**WASHINGTON – Medicaid**
Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075	Website: https://www.hca.wa.gov Phone: 1-800-562-3022
PENNSYLVANIA – Medicaid	**WEST VIRGINIA – Medicaid**
Website: http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm Phone: 1-800-692-7462	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
RHODE ISLAND – Medicaid	**WISCONSIN – Medicaid and CHIP**
Website: http://www.eohhs.ri.gov/ Phone: 855-697-4347, or 401-462-0311 (Direct Rite Share Line)	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
SOUTH CAROLINA – Medicaid	**WYOMING – Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	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, 2021, or for more information on special enrollment rights, contact either:

U.S. Department of Labor	U.S. Department of Health and Human Services
Employee Benefits Security Administration	Centers for Medicare & Medicaid Services
www.dol.gov/agencies/ebsa	**www.cms.hhs.gov**
1-866-444-EBSA (3272)	1-877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

Contact Information

Below is a listing of the contact information you can call with questions about the plans available to you. You can also use the web site (if listed) to access information from providers of various plans.

AGENCY	PHONE NUMBER	WEBSITE
Medical		
Anthem Blue Cross HMO	855-839-4524	www.anthem.com/ca/calpers.hmo
Blue Shield	800-334-5847	https://myoptions.blueshieldca.com/calpers
Health Net	888-926-4921	https://calpers.healthnetcalifornia.com/
Kaiser	800-464-4000	www.my.kp.org/calpers
United Healthcare	877-359-3714	https://calpers.healthnetcalifornia.com/
Anthem Blue Cross PPO	877-737-7776	www.anthem.com/ca/calpers
Delta Dental	888-335-8227	www.deltadentalins.com
MetLife Dental – SafeGuard Health	800-880-1800	www.metlife.com/safeguard
VSP Vision	800-877-7195	www.vsp.com
EAP - MHN	800-977-7593	www.members.mhn.com
Life & AD&D Insurance		
The Standard	800-522-0406	www.standard.com/w/p/sites/cta
MetLife (administered in HR)	925-473-2335	
Disability Insurance		
SDI/PFL (CL)	800-480-3287	www.edd.ca.gov/disability
Standard (CE)	800-522-0406	www.standard.com/w/p/sites/cta
Supplemental Insurances		
The Standard	800-522-0406	www.standard.com/w/p/sites/cta
American Fidelity	866-523-1857	www.americanfidelity.com
Flexible Spending Accounts		
American Fidelity	866-523-1857	www.americanfidelity.com
Commuter Benefits		
Edenred Commuter Benefits		www.commuterbenefits.com
457(b) and 403(b) Information		
Envoy	800-248-8858	www.Envoyplanservices.com
403b Compare	844-488-0270	www.403bcompare.com
CalPERS	888-225-7377	www.calpers.ca.gov
CalSTRS	888-228-5453	www.calstrs.com
Social Security Administration	800-772-1213	www.ssa.gov
Medicare	800-300-1506	www.medicare.gov

Please call Human Resources with questions at (925) 473-2335

Summary

The information in this brochure is a general outline of the benefits offered under The Pittsburg Unified School District's benefits program. This is not a legal document. Specific details and plan limitations are provided in the Evidence of Coverage (EOC), which is based on the official Plan Documents that may include policies, contracts and plan procedures. The EOC and plan documents contain all the specific provisions of the plans. In the event that information in this brochure differs from the plan documents, the plan documents will prevail. Benefit eligibility is also subject to MOU Agreements between the District and each bargaining unit. Copies of Evidence of Coverage booklets are available in the Human Resources Department.

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