IMPORTANT NOTICE: READ CAREFULLY

This Benefits Guide briefly describes CalPERS medical coverage and where you can obtain information. It also outlines other 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 District's 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. This Guide is not a guarantee of current or future benefits and you are responsible for knowing and understanding the contents of this Guide. If after review you have any questions, you should contact the Office of Risk Management/Benefits Department immediately.

Understanding Your Rights: Read All Notices

Employees and family members eligible for the District's benefits may have rights under applicable federal or state laws. This Guide does not describe all these provisions or rights. If eligible, you will receive separate information and notices explaining those rights, such as:

Privacy Rule: The Health Insurance Portability and Accountability Act (HIPAA) includes provisions to protect the privacy of health information for group health plan participants. Provisions are explained in the District's Privacy Notice.

Health Plan Protections: Health plan benefits must meet the requirements of the Women's Health and Cancer Rights Act and the Mothers' and Newborns' Health Protection Act. These provisions are explained in the summary plan descriptions (SPD) and this Guide.

Coverage Continuation: The Consolidated Omnibus Budget Reconciliation Act (COBRA) offers the opportunity to continue your group health coverage after certain qualifying events (such as a child reaching the plan's age limit). These provisions are explained in the District's General/Initial COBRA Notice.

If you do not receive the above information or notices, or if you have any questions about this information, please contact the Office of Risk Management/Benefits Department.

(510) 644-6666

Welcome to Your Benefits Guide

This Guide provides some information regarding the CalPERS medical plans as well as informational meeting dates specifically for retirees. It is very important that you review your package from CalPERS which provides medical plan details and instructions for submitting your enrollment/changes to CalPERS.

For dental coverage, you are entitled to some of the same Open Enrollment rights as an active employee. You can switch dental plans offered by the District. **However, once you terminate your dental coverage or are terminated for non-payment, the benefit cannot be reinstated.**

Contents

Where to Obtain Information

CalPERS medical and Delta Dental information can be obtained in the following ways:

- Call CalPERS for your medical questions at (888) 225-7377
- The District's MyBenefits website
  https://pcms.plansource.com
  Username: BUSDRetiree
  Password: benefits
- The District's Office of Risk Management/Benefits Department
- The Informational Session / Open Enrollment Meeting (see page 4)

2019 Important Changes

CalPERS Medical— CHANGES TO PLANS AND/OR REGIONS

Listed below are the health plan changes for 2019. These changes to health plans may impact your decisions for coverage during open enrollment. **Please review carefully.** You may need to make a new medical plan choice during this open enrollment.

Blue Shield Access+
The carrier is withdrawing from eight Bay Area Counties: Alameda, Contra Costa, Marin, San Francisco, San Mateo, Santa Clara, Solano and Sonoma. Members currently enrolled in the BlueShield Access+ plan AND living in these counties will need to select a new medical plan during open enrollment.

United Healthcare
The carrier is withdrawing from the CalPERS Bay Area Region: Members currently enrolled in the United Healthcare plan AND living in the CalPERS Bay Area Region will need to select a new medical plan during open enrollment.

CalPERS PPO Plan Changes
PERS Care: Copayment for urgent care and specialist office visits will increase from $20 to $35

PERS Choice: Copayment for urgent care and specialist office visits will increase form $20 to $35

PERS Select: Changing to value-based insurance design (VBID). Personal Doctor visit copayment will decrease to $10; all other copayments will increase from $20 to $35.

CalPERS will be sending retirees medical information including summaries and enrollment forms, directly. This Guide will not summarize these retiree medical plans.

If you do not receive a CalPERS packet please contact them at (888) 225-7377

Reminder: CalPERS Medical Premiums— Your new monthly medical premium for the plan in which you are enrolled will automatically be deducted from your monthly PERS or STRS annuitant check effective January 1, 2019. If you receive a District subsidy for your medical, your subsidy will continue to come from BASIC pacific.

Delta Dental PPO and DHMO - No benefit changes; BASIC pacific will continue to bill for this premium minus any District subsidy. **If you do not wish to make any changes to your dental, no action is required.**

2019 Open Enrollment

Dental Open Enrollment for 2019 begins Monday, September 10th and will remain open until Friday, October 5th. Benefits you choose will become effective January 1, 2019 through December 31, 2019.

Remember, Open Enrollment is generally your one time of the year to make changes to your benefits, and you'll need to participate if you want to:

- Make changes to you dental coverage

Enroll/make changes in CalPERS medical coverage— Retirees that would like to enroll or make changes to their medical coverage will need to complete a CalPERS enrollment/change form. CalPERS will be sending retirees a packet of enrollment material. If you have not received a packet, please contact CalPERS at (888) 225-7377. **All medical enrollment forms and dependent certification copies need to be submitted directly to CalPERS.**

DO NOT SEND YOUR COMPLETED CalPERS ENROLLMENT FORMS TO THE DISTRICT. THEY MUST BE RETURNED TO CalPERS FOR PROCESSING.

Informational Session / Open Enrollment Meeting

September 20, 2018

11:00 am to 2:00 pm

Medicare Presentation starts promptly at 11:00 am

Board Room

1231 Addison Street

HICAP will be conducting a presentation on Medicare

Open Enrollment Checklist - IMPORTANT

Review the checklist below to ensure that you have considered all of your options during this open enrollment period as your next opportunity will not be until next year's open enrollment, unless you experience a qualifying event during the year.

- ☐ Medical Plan - If you would like to enroll, or make changes, please complete a CalPERS enrollment form. If you need assistance, contact CalPERS at (888) 225-7337.
  - ***IF YOU ARE ENROLLED IN A BLUE SHIELD ACCESS+ OR UNITED HEALTHCARE PLAN (SEE PAGE 3), YOU WILL NEED TO MAKE A NEW PLAN ELECTION.***
  - ***IF YOU ARE ENROLLED WITH ANY OTHER CARRIER AND NOT MAKING A CHANGE, YOU DO NOT NEED TO DO ANYTHING.***

  Please return all medical enrollment forms and dependent certification copies directly to CalPERS by October 5, 2018 in order to ensure that new coverage starts January 1, 2019. DO NOT SEND ORIGINAL DEPENDENT CERTIFICATION DOCUMENTS TO CALPERS AS THESE WILL NOT BE RETURNED TO YOU.

- ☐ Dental Plan - changing plans, complete an enrollment/change form. **If you are not making any changes to your dental coverage, you do not have to complete any paperwork.**
  - **All dental forms are due to the Office of Risk Management/Benefits Department no later than 6:00 pm on Friday, October 5, 2018.**

Office of Risk Management/Benefits Department Open Enrollment Window Hours

Walk-in submittals will be accepted at the Office of Risk Management/Benefits Department only during the following window hours:

Open Enrollment Window Hours		Informational Session / Open Enrollment Meeting
• September 10—September 13 (Monday through Thursday) 8:30 am—5:00 pm • September 17—September 19 (Monday through Wednesday) 8:30 am—5:00 pm • September 24—September 27 (Monday though Thursday) 8:30 am—5:00 pm	• October 1—October 3 (Monday—Wednesday) 8:30 am—5:00 pm • October 4 (Thursday) 7:30 am—6:00 pm • October 5 **—Last Day** (Friday) 7:30 am—6:00 pm	• **September 20, 2018 (RETIREE SESSION)** – Retiree meeting 11:00 am—2:00 pm Board Room 1231 Addison Street

Enrollment: What You Need to Do?

You will need to make choices about which benefits you'd like to participate in during "enrollment windows." Enrollment windows are specific times that will require you to take action and select your benefits. CalPERS will continue to be your Health Benefits Officer for medical coverage. You should take action:

- When you or your spouse (if enrolled) turn 65
- When you experience certain HIPAA special enrollment events such as getting married or adding a child; you must report these events within 30 days in order to make any allowable changes to your benefits.

Any changes you make to dental during this Open Enrollment period become effective January 1, 2019. Enrollment/ change in a medical plan will require CalPERS to receive your enrollment forms and other applicable documentation no later than October 5, 2018, for a January 1, 2019 effective date.

Enrolling in CalPERS Medical

1. Review your options, ask questions and talk with your family. CalPERS medical provides carrier options for both HMO and PPO. If you're enrolling in a CalPERS medical plan:
    a. Check with your doctors to find out which plans they participate in.
    b. If you take any prescription medications regularly, contact the new plan to find out how these drugs are covered (for example, formulary or non-formulary drugs).
    c. If you have questions, call CalPERS directly at (888) 225-7377 or you can contact the medical plan's Member Services number or visit its website (contact details can be found in the ***CalPERS 2019 Health Benefit Summary***).

2. Consider not only your current circumstances but also what may be happening in your life in the future. Outside of the Open Enrollment period, you will not be able to make changes to your benefits unless:
    a. You have a HIPAA special enrollment event (for example, you get married or have a child).
    b. You or your spouse (if enrolled) turns 65.
    c. You move out of your HMO service area.
3. Review the ***CalPERS 2019 Health Benefit Summary*** to view your medical options and this Guide for your dental options. Consider the following when choosing a medical plan:
    a. **What the plans cover**.
    b. **Your estimated usage**. Does your plan choice adequately cover the services you use most or will need in the future?
    c. **Flexibility in choice of doctors, hospitals and how you receive care**. Each plan may include a different set of doctors, hospitals or have different rules for how to receive care.
    d. **Verify service areas and provider availability** since all medical plans make ongoing changes during the year.
4. Use available tools to evaluate your needs and decide what's right for you.
    a. Go to **https://pcms.plansource.com** (Username: BUSDRetiree Password: benefits) to review medical and dental information or;
    b. Visit **www.calpers.ca.gov** to view medical plan information only. Under "**I Want To…**" Click on "**View Health Plan Rates.**" or ;
    c. go to: ***https://www.calpers.ca.gov/page/retirees/health-and-medicare/retiree-plans-and-rates***
5. **Have the right information handy**. When you start the enrollment process, you'll need:
    a. Your Social Security number
    b. The names, birth dates, and Social Security numbers of any dependents you wish to enroll, or of any beneficiaries you wish to designate;
    c. Dependent Certification—refer to the your CalPERS packet or call CalPERS at (888) 225-7377.

How to Submit Completed Enrollment/Change Forms

Medical:

1. Return CalPERS medical enrollment/change forms and supporting documents directly to CalPERS. The District will not collect **ANY** medical enrollment forms or dependent certifications.

   Remember you may need to elect a new medical plan. See page 3 for details.

Dental:

1. **Walk-in:** Retirees may submit the completed dental change form by coming to the Office of Risk Management/Benefits Department window (See window hours on page 5).
2. **Mail**: Retirees may submit the completed change form through **Postal Mail**. Forms must be received no later than **6:00 pm on October 5, 2018.** Postmarked submittals received after this date will not be accepted.
3. **E-mail**: Retirees may submit the completed enrollment/change form through **E-mail**. Please e-mail to ***openenrollment@berkeley.net.*** Forms must be received no later than **6:00 pm on October 5, 2018.** E-mailed submittals received after this date will not be accepted.
4. Retiree Informational Session / Open Enrollment Meeting: Please see page 4 for date and time.

Forms must be received no later than **6:00 pm on October 5, 2018**. Completed forms will not be accepted after this date. **Faxed copies will not be accepted.**

You Want to Know What Happens After Enrollment

ID Cards
After you enroll for the first time, you will receive an ID card from the CalPERS medical plan you select. You will not receive an ID card for dental coverage, unless enrolling in the DeltaCare DHMO Dental plan. Coverage for dental is effective January 1, 2019 **even if you do not receive a new ID card by this date**. Coverage for medical will depend upon your timely enrollment with CalPERS.

When you receive your ID card, confirm that all information is accurate. If not, contact CalPERS for medical and the Office of Risk Management/Benefits Department for dental right away.

Selecting Primary Care Physicians
You are not required to select a primary care physician (PCP) if you enroll in one of the CalPERS PPO plans. However, most HMOs (medical and dental) require that you and each of your covered dependents select a PCP from the plan's network. Kaiser is the only HMO medical carrier that does not require you to choose a PCP. With Kaiser, you can visit any of the primary care physicians at the facility of your choice. If you enroll in the DeltaCare (dental DHMO) plan, you must select a dental office.

When you first enroll, you'll need to designate your choice of PCP for CalPERS HMO medical plans and DeltaCare dental. If you don't designate your preferred PCP, the HMO will assign one for you. To choose a different PCP, call your plan carrier after you receive your ID card and request that your PCP be changed. PCP changes are not effective immediately. Generally, the change will occur the first of the following month.

Eligibility and Changes

Eligibility
Under present District policy, you, your spouse, domestic partner and eligible dependents may remain participant(s) in the BUSD health plan system. However, if at the time of your retirement or at any future date, you choose to leave the District's dental plan, you and your dependents do not have future eligibility.

Your Dependents

Your eligible dependents include:

- Your spouse (includes same and opposite sex partners)
- Your same-sex or opposite sex domestic partner who meets certain criteria (see page 8)
- Your children who are one of the following:
  - under age 26
  - age 26 or older with a physical or mental disability as defined by the Social Security Administration (provided they were on the plan prior to turning age 26)

Your children include:

- You or your domestic partner's natural or adopted children
- Your stepchildren whom you support and who live with you in a parent-child relationship
- Children placed in your home for adoption
- Any other children you support, you are the legal guardian or you are required to provide coverage as the result of a qualified medical child support order

You are required to provide certification of dependent status. Your dependents cannot be enrolled without providing such proof.

Domestic Partner Eligibility Criteria
If you are enrolling a non-registered domestic partner, you are required to have met all eligibility requirements listed below for the previous 6 months and complete a Domestic Partnership application/affidavit.

A Domestic Partnership shall exist between two persons regardless of gender and each of them shall be the domestic partner of the other if both complete and sign the affidavit and attest to the following:

1. The two parties reside together and share the common necessities of life;
2. The two parties are not married to anyone, not related by blood closer than would bar marriage in the State of California, and are mentally competent to consent to contract;
3. The two parties declare that they are each other's sole domestic partner and they are responsible for their common welfare;
4. The two parties agree to notify the Berkeley Unified School District's Office of Risk Management/Benefits Department if there is a change of circumstances attested to in the affidavit;
5. All dependents under Domestic Partnership coverage shall have permanent residency in the Domestic Partnership household and shall meet all other dependent coverage criteria;
6. It has been at least six months since either of the two parties has filed a statement of termination of a previous Domestic Partnership affidavit with the Office of Risk Management/Benefits Department.

Making Changes

You can enroll/change dental benefit plans during open enrollment. Coverage stays in effect for the entire plan year (January 1, 2019- December 31, 2019). You cannot change your coverage, start coverage or add any family members to your coverage during the plan year unless you have a HIPAA special enrollment event.

HIPAA Special Enrollment Rights
Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), a retiree has the right to enroll family members, if:

- You get married
- Your spouse loses other group coverage
- You have a child born to or placed for adoption

For any HIPAA special enrollment event, you must request enrollment within 30 days after you get married, your spouse's other group coverage ends or you acquire the new dependent.

For more information or to request special enrollment, contact the Office of Risk Management/Benefits Department at (510) 644-6666 or CalPERS.

PREMIUM COSTS

The collective bargaining contract in effect at the time of your retirement outlines the terms and conditions of your eligibility and defines if you qualify for a District contribution toward the cost of your retiree health insurance benefits (medical and/or dental). After the period during which the District has agreed to pay some or all of your premium, you may remain on the BUSD health plan by paying the entire amount of your own health plan premium.

CalPERS medical premium— can be found in your CalPERS packet. Premiums will be deducted from your monthly annuitant check effective January 1, 2019. If your check is not large enough to cover your medical premium, you will be billed . If you are receiving a District medical subsidy, reimbursement processes will continue through BASIC pacific.

Delta Dental premium—can be found on page 11. BASIC pacific will continue to bill for the dental premium minus any District subsidy.

Dental—If not making any changes, you do not need to do anything

Your Dental Plans

Choosing the right dental plan is as important as choosing your medical insurance plan. After considering your anticipated dental needs for the coming year, you can determine which dental plan will work best for you and your family by reviewing the deductibles, copays, and services covered under each plan. The following are the available plans offered to you:

- **Delta Dental –** DeltaCare DHMO
- **Delta Dental –** PPO (in-network and out-of-network)

DeltaCare DHMO is based on fixed copays for preventive, basic and major care. You must designate a primary care dentist when you enroll in this plan. The plan utilizes a network of dentists, and you must use a dentist who is a part of the DeltaCare network, and who you have been assigned to, to receive benefits. If you obtain services from a dentist other than your designated primary dentist, you will have no benefits.

Delta Dental PPO gives you the freedom to choose your own dentist and receive coverage from in-network and out-of-network providers. This plan is a preferred provider organization (PPO) made up of general dentists and specialists who have agreed to provide dental care at discounted fees. If you go to a dentist who participates in the PPO, you qualify for in-network coverage, higher calendar year maximum and benefit from discounted rates.

Below is a brief summary of the key features and costs for both in-network and out-of-network services.

IN - PPO Network Delta Dental PPO Dentist	Out-of-PPO Network Delta Dental Premier Dentists & Non-Delta Dental Dentists
You will usually pay the lowest amount for services when you visit a Delta Dental PPO dentist.	You are responsible for the difference between the amount Delta Dental pays and the amount your non-Delta Dental dentist bills. You will usually have the highest out-of-pocket costs when you visit a non-Delta Dental dentist.
PPO dentists agree to accept a reduced fee for PPO patients.	Delta Premier dentists may not balance bill above Delta Dental's approved amount, so your out-of-pocket costs may be lower than with non-Delta Dental dentists' charges.
You are charged only the patient's share at the time of treatment. Delta Dental pays its portion directly to the dentist.	Non-Delta Dental dentists may require you to pay the entire amount of the bill in advance and wait for reimbursement. Delta Premier dentists charge you only the patient's share at the time of treatment.
PPO dentists will complete claim forms and submit them for you at no charge.	You may have to complete and submit your own claim forms, or pay your non-Delta Dental dentist a service fee to submit them for you. Delta Premier dentists will complete claim forms and submit them for you at no charge.

	DeltaCare In Network	Delta Dental In / Out of Network	
Calendar Year Deductible	None	$25 single / $50 Family	
Calendar Year Maximum Benefit	Unlimited	$1,600	$1,500
Diagnostic/Preventive	Various copays apply	100% (Not subject to deductible or calendar year max)	100% (Not subject to deductible or calendar year max)
Basic	Various copays apply	100%	100%
Major	Various copays apply	70%	70%
Orthodontia	Various copays apply	50%	50%
Lifetime Orthodontia Maximum	None	$1,000	
Implants	Not covered	70%	70%
TMJ Treatment	Not covered	Not covered	
Waiting Period	None	None	None

The information presented in the chart is a summary only. The information does not include all of the detailed explanation of benefits, exclusions and limitations. Plan participants should refer to the Evidence of Coverage (EOC) document for coverage details. In the event information in this summary differs from the EOC, the EOC will prevail.

Vision—COBRA ONLY

Your Vision Plan

Unless you elected vision through COBRA, this benefit is not available to be added during open enrollment. BUSD offers vision coverage through Vision Service Plan (VSP). If enrolled, you pay the full premium for this coverage and a 2% administration fee. VSP has one of the most extensive network of optometrists and ophthalmologists as well as vision care specialists in the country. Under this plan, you can use a VSP provider or another provider of your choice. However, when you obtain vision care through a non-VSP provider, you will receive a reduced level of benefits.

Here is a summary of covered services and costs:

Copay	Vision Service Plan	
Exam/Glasses	$10 copay	
*Primary Eyecare	$20 copay	
Benefit Frequency		
Exam	Once every 12 months	
Lenses	Once every 12 months	
Frames	Once every 24 months	
Coverage	**In - Network**	**Out-of-Network**
Eye Exam	Covered in Full	up to $50
Single Lens	Covered in Full	up to $50
Bi-Focal Lenses	Covered in Full	up to $75
Tri-Focal Lenses	Covered in Full	up to $100
Lenticular Lenses	Covered in Full	up to $125
Frame Allowance	$140 allowance	up to $47
Contact Lenses		
Medically Necessary	Covered in Full	up to $210
Elective	$140 allowance ($60 copay for contact lens fitting)	up to $105

The information presented in the chart is a summary only. The information does not include all of the detailed explanation of benefits, exclusions and limitations. Plan participants should refer to the Evidence of Coverage (EOC) document for coverage details. In the event information in this summary differs from the EOC, the EOC will prevail.

Solid Tints and dyes (including photochromic lenses)

Patient Option	Single Vision*	Multifocal*
Solid Tints and Dyes (Pink I and II)	$0	$0
Solid Plastic Dye (except Pink I and II)	$13	$13
High Luster Edge Polish	$14	$14
Plastic Gradient Dye	$15	$15
UV Protection	$15	$15
Factory Applied Scratch-resistant Coating	$15	$15
Polycarbonate Lenses Polycarbonate lenses are covered in full for dependent children.	$25	$30
Anti-reflective Coating	$39	$39
Photochromic Lenses - Plastic	$36	$57
Progressive Lenses	N/A	$0 - $160

**Prices shown reflect the standard option price for each respective category. Premium options may vary. Prices are valid only through VSP Preferred Providers and are subject to change without notice.*

***Primary Eyecare** rider is designed for the detection, treatment and management of ocular conditions and/or systemic conditions which produce ocular or visual symptoms. A member can seek care from their vision provider versus their medical primary care physician for -

Symptoms - including but not limited to:

- ocular discomfort
- transient loss of vision
- flashes or floaters
- red eyes
- swollen lids
- pain in or around the eyes
- diplopia
- ocular trauma

Conditions - including but not limited to:

- ocular hypertension
- glaucoma
- cataracts
- pink-eye
- sty
- corneal abrasion
- corneal dystrophy
- macular degeneration
- retinal nevusble
- blepharitis

You are also eligible for certain discounts on non-covered lens options as well as Lasik vision correction surgery at contracted facilities. Discounts include:

- Average 35-40% savings on non-covered lens options and 30% off additional glasses and sunglasses
- Average of 15% off regularly priced services or procedures or 5% off promotionally priced services or procedures
- Discounts on hearing aids

After surgery, you can use your frame allowance (if applicable) to purchase sunglasses from any VSP network provider.

Monthly Premium—Dental

	Delta Dental PPO	DeltaCare DHMO
Composite Rate (Single/Family)	$102.77	$32.21

CalPERS medical premiums will be included in your CalPERS packet. If you have questions on your medical premiums contact CalPERS at (888) 225-7377

Contacts

If you have questions you can contact the District's Office of Risk Management/Benefits Department or the plan carriers. Use this chart to help guide you to the right resource on the first try.

PLAN INFO	WEBSITE	CONTACT	GROUP #
BUSD Office of Risk Management/Benefits Department			
(510) 644-6666	External: www.berkeley.net (click on "Staff Resources") Internal (Only accessible from a computer within the District): http://intranet.berkeley.net/ (Click on "Risk Management")		
Medical—CalPERS			
Medical Plans	www.calpers.ca.gov	(888) 225-7377	
Review your CalPERS *Health Benefit Summary* for specific carrier contact information			
Dental—Delta Dental			
PPO	www.deltadentalins.com	(866) 499-3001	7069
DeltaCare		(800) 422-4234	5827
Vision—Vision Service Plan (VSP)			
Vision PPO	www.vsp.com	(800) 877-7195	12314888
Retiree Subsidy Reimbursements/COBRA—BASIC pacific			
Administration	www.BASICpacific.com	(800) 574-5448	
Medicare			
General Information	www.medicare.gov	(800) MEDICARE	
Personal Information	www.MyMedicare.gov	(800) 633-4227	

Annual Notices

Special Enrollment Notice

If an eligible retiree acquires a new dependent as a result of marriage, birth, adoption or placement for adoption, the eligible retiree may be able to enroll any eligible dependents, provided that the eligible retiree requests enrollment within **30** days after the marriage, birth, adoption, or placement for adoption. If the eligible retiree otherwise declines to enroll, he/she may be required to wait until the group's next open enrollment to do so. The eligible retiree also may be subject to additional limitations on the coverage available at that time.

Furthermore, eligible retirees and their eligible dependents who are eligible for coverage but not enrolled, shall be eligible to enroll for coverage within 60 days after (a) becoming ineligible for coverage under a Medicaid or Children's Health Insurance Plan (CHIP) plan or (b) being determined to be eligible for financial assistance under a Medicaid, CHIP, or state plan with respect to coverage under the plan.

Newborns' and Mothers' Health Protection Act

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). If you would like more information on maternity benefits, contact your health plan.

Women's Health and Cancer Rights Act Annual Notice

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

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. If you would like more information on WHCRA benefits, call member services.

Patient Protection Notice

The CalPERS HMO Plans generally require the designation of a primary care provider. You have the right to designate any primary care provider who participates in the network and who is available to accept you or your family members. Until you make this designation, the plan designates one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact member services. For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from the 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 a list of participating health care professionals who specialize in obstetrics or gynecology, contact member services.

Summary of Benefits and Coverage (SBC)

As required by the Affordable Care Act (ACA), health plans and employer groups must provide the Summary of Benefits and Coverage (SBC) to eligible retirees and family members, who are:

- Currently enrolled in one of the group health plans or
- Eligible to enroll in one of the plans, but not yet enrolled

As such, we are providing you and your covered dependents an SBC for the health plan you are currently enrolled in, if applicable. The SBC provides important information about the Plan's benefits and your rights as a Plan participant.

ACA also provides for a Uniform Glossary of insurance and medical terms. A paper copy of this Glossary is available upon request. All SBCs and the Glossary can be found on the District's MyBenefits website.