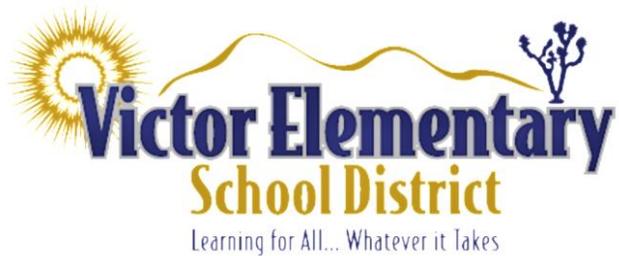


Combined Annual Benefits

Notice

2020/2021



Availability of HIPAA Notice of Privacy Practices

Victor Elementary School District Group Health Plans (Plans) maintain a Notice of Privacy Practices that provides information to individuals whose protected health information (PHI) will be used or maintained by the Plans. If you would like a copy of the Plan’s Notice of Privacy Practices, contact your medical provider directly using the toll-free number on your medical ID card or log on to your secure Aetna or Kaiser member website to request a copy: www.aetna.com | www.kp.org

Patient Protections

Victor Elementary School District Aetna HMO and Kaiser HMO medical plans generally require the designation of a primary care provider. 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. Until you make this designation, the plan will designate one for you. For information on how to select a primary care provider and for a list of the participating primary care providers, contact Aetna or Kaiser using the toll-free number on your medical ID card.

For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from the Aetna HMO plan, Kaiser HMO 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 Aetna or Kaiser using the toll-free number on your medical ID card.

Special Enrollment Rights

CHANGES TO YOUR HEALTH PLAN ELECTIONS

Once you make your benefits elections, they cannot be changed until the next Open Enrollment. Open Enrollment is held once a year during the first three weeks in May.

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if there is a loss of other coverage.

However, you must request enrollment no later than 30 days after that other coverage ends. If you declined coverage while Medicaid or the Children’s Health Insurance Program (CHIP) is in effect, you may be able to enroll yourself and / or your dependents in this plan if you or your dependents lose eligibility for that other coverage. However, you must request enrollment no later than 60 days after Medicaid or CHIP coverage ends.

If you or your dependents become eligible for Medicaid or CHIP premium assistance, you may be able to enroll yourself and/or your dependents into this plan. However, you must request enrollment no later than 60 days after the determination for eligibility for such assistance.

If you have a change in family status such as a new dependent resulting from marriage, birth, adoption or placement for adoption, divorce (including legal separation and annulment), death or Qualified Medical Child Support Order, you may be able to enroll yourself and/or your dependents. However, you must request enrollment **no later than 30 days** after the marriage, birth, adoption or placement for adoption or divorce (including legal separation and annulment).

You must submit official documentation of the qualifying event and original completed enrollment change forms to Personnel c/o Veronica Taylor, no later than 30 days after the qualifying event.

For information about Special Enrollment Rights contact Personnel Services at (760) 245-1691.

Women’s Health and Cancer Rights Act (WHCRA)

Your medical plan, as required by the Women’s Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema. For more information, you should review the Summary Plan Description or call your health plan provider directly using the toll-free number on your medical ID card.

COBRA Continuation Coverage

This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it. When you

become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

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

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

WHAT IS COBRA CONTINUATION COVERAGE?

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

If you are an employee, you will become a Qualified Beneficiary if you lose coverage under the Plan because of the following Qualifying Events:

- 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 of the following Qualifying Events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;

- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or,
- You become divorced or legally separated from your spouse.

Your dependent children will become Qualified Beneficiaries if they lose coverage under the Plan because of the following Qualifying Events:

- The parent-employee dies;
- 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."

Sometimes, the employer filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to Victor Elementary School District, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plans, the retired employee will become a qualified beneficiary. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plans.

WHEN IS COBRA CONTINUATION COVERAGE AVAILABLE?

The Plan will offer COBRA continuation coverage to Qualified Beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following Qualifying Events:

- The end of employment or reduction of hours of employment;
- Death of the employee;
- Commencement of a proceeding in bankruptcy with respect to the employer; or
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other Qualifying Events (e.g., divorce or legal separation of the employee and spouse, or a dependent child's losing eligibility for coverage as a dependent child, etc.), you must notify the Plan Administrator within 30 days after the Qualifying Event occurs. You must provide notice to Personnel c/o Veronica Taylor, Personnel Clerk.

Life insurance, accidental death and dismemberment benefits, and weekly income or long-term disability benefits (if part of the employer's plan), are not eligible for continuation under COBRA.

NOTICE AND ELECTION PROCEDURES

Each type of notice or election to be provided by a covered employee or a Qualified Beneficiary under this COBRA Continuation Coverage Section must be in writing, must be signed and dated, and must be mailed or hand-delivered to the Plan Administrator, properly addressed, no later than the date specified in the election form, and properly addressed to the Plan Administrator.

Each notice must include all of the following items: the covered employee's full name, address, phone number and Social Security Number; the full name, address, phone number and Social Security Number of each affected dependent, as well as the dependent's relationship to the covered employee; a description of the Qualifying Event or disability determination that has occurred; the date the Qualifying Event or disability determination occurred; a copy of the Social Security Administration's written disability determination, if applicable; and the name of this Plan. The Plan Administrator may establish specific forms that must be used to provide a notice or election.

HOW IS COBRA CONTINUATION COVERAGE PROVIDED?

Once the Plan Administrator receives notice that a Qualifying Event has occurred, COBRA continuation coverage will be offered to each of the Qualified Beneficiaries. Each Qualified Beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation on behalf of their dependent children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain Qualifying Events, or a second Qualifying Event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage. There are also ways in which the 18-month period of COBRA continuation coverage can be extended.

DISABILITY EXTENSION OF THE 18-MONTH PERIOD OF COBRA CONTINUATION COVERAGE

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

SECOND QUALIFYING EVENT EXTENSION OF 18-MONTH PERIOD OF COBRA CONTINUATION COVERAGE

If your family experiences another Qualifying Event during the 18 months of COBRA continuation of coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation of coverage, for a maximum of 36 months, if the Plan is properly notified about the second Qualifying Event. This extension may be available to the spouse and any dependent children receiving COBRA continuation of coverage if the employee or former employee dies; becomes entitled to Medicare (Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second Qualifying Event would have caused the spouse or the dependent child to lose coverage under the Plan had the first Qualifying Event not occurred.

OTHER OPTIONS BESIDES COBRA CONTINUATION COVERAGE

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

IF YOU IF YOU HAVE QUESTIONS CONCERNING COBRA

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

KEEP YOUR PLAN INFORMED OF ADDRESS CHANGES

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

COBRA PLAN CONTACT INFORMATION

To provide notice of qualifying event or for general questions regarding COBRA contact Personnel Services at (760) 245-1691.

For notices or plan changes when you are actively enrolled in COBRA, contact Infnisource directly at 1-800-594-6957. Infnisource is Victor Elementary School District’s third-party administrator for COBRA.

Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: 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 new 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 begins November 1, 2020 for coverage starting January 1, 2021.

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 coverage offered by your employer, please check your summary plan description or contact Personnel Services at (760) 245-1691.

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.

¹ An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

Part B: Information About Health Coverage Offered by Your Employer

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

3. Employer name Victor Elementary School District	4. Employer Identification Number (EIN) 95-6003412	
5. Employer Address 2219 Second Ave	6. Employer Phone Number (760) 245-1691	
7. City Victorville	8. State CA	9. ZIP Code 92395
10. Who can we contact about employee health coverage at this job? Veronica Taylor, Personnel Clerk		
11. Phone number (if different from above)	12. E-mail address vtaylor@vesd.net	

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

- As your employer, we offer a health plan to:
 - Some employees; eligible employees are:

Full time designation working 30+ hours per week on average each month during the year or variable hour designation averaging 30+ hours per week during the measurement period.
- With respect to dependents:
 - We offer coverage to dependents of eligible employees.

Eligible dependents are:
Spouse, domestic partner and children under the age of 26.
Contact Personnel or review your health insurance coverage EOC for details.
 - 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 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.

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 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 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 January 31, 2018. Contact your State for more information on eligibility.

ALABAMA – Medicaid

Website: <http://myalhipp.com/>
 Phone: 855.692.5447

ALASKA – Medicaid

The AK Health Insurance Premium Payment Program
 Website: <http://myakhipp.com/>
 Phone: 866.251.4861
 Email: CustomerService@MyAKHIPP.com
 Medicaid Eligibility:
<http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx>

ARKANSAS – Medicaid

Website: <http://myarhipp.com/>
 Phone: 855.MyARHIPP (855.692.7447)

COLORADO – Health First Colorado (Colorado’s Medicaid Program) & Child Health Plan Plus (CHP+)

Health First Colorado
 Website: <https://www.healthfirstcolorado.com/>
<https://colorado.gov/HCPF/Child-Health-Plan-Plus>
 Health First Colorado Member Contact Center:
 800.221.3943/ State Relay 711
 CHP+: <https://colorado.gov/HCPF/Child-Health-Plan-Plus>
 CHP+ Customer Service: 800.359.1991/ State Relay 711

FLORIDA – Medicaid

Website: <http://flmedicaidprecovery.com/hipp/>
 Phone: 877.357.3268

GEORGIA – Medicaid

Website: <http://dch.georgia.gov/medicaid>
 Click on Health Insurance Premium Payment (HIPP)
 Phone: 404.656.4507

INDIANA – Medicaid

Healthy Indiana Plan for low-income adults 19-64
 Website: <http://www.in.gov/fssa/hip/>
 Phone: 877.438.4479
 All other Medicaid
 Website: <http://www.indianamedicaid.com>
 Phone 800.403.0864

IOWA – Medicaid

Website: <http://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp>
 Phone: 888.346.9562

KANSAS – Medicaid

Website: <http://www.kdheks.gov/hcf/>
 Phone: 785.296.3512

KENTUCKY – Medicaid

Website: <http://chfs.ky.gov/agencies/dms>
 Phone: 800.635.2570

LOUISIANA – Medicaid

Website: <http://dhh.louisiana.gov/index.cfm/subhome/1/n/331>
 Phone: 888.695.2447

MAINE – Medicaid

Website: <http://www.maine.gov/dhhs/ofi/public-assistance/index.html>
 Phone: 800.442.6003
 TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP

Website: <http://www.mass.gov/eohhs/gov/departments/masshealth/>
 Phone: 800.862.4840

MINNESOTA – Medicaid

Website: <http://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/medical-assistance.jsp> | Phone: 800.657.3739

MISSOURI – Medicaid

Website: <https://www.dss.mo.gov/mhd/participants/pages/hipp.htm>
 Phone: 573.751.2005

MONTANA – Medicaid

Website: <http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP>
 Phone: 800.694.3084

NEBRASKA – Medicaid

Website: <http://www.ACCESSNebraska.ne.gov>
 Phone: 855.632.7633
 Lincoln: 402.473.7000
 Omaha: 402.595.1178

NEVADA – Medicaid

Medicaid Website: <https://dwss.nv.gov/>
 Medicaid Phone: 800.992.0900

NEW HAMPSHIRE – Medicaid

Website: <http://www.dhhs.nh.gov/oii/documents/hippapp.pdf>
 Phone: 603.271.5218
 NH Medicaid Service Center Hotline: 888.901.4999

NEW JERSEY – Medicaid and CHIP

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: 800.701.0710

NEW YORK – Medicaid

Website: https://www.health.ny.gov/health_care/medicaid/
 Phone: 800.541.2831

NORTH CAROLINA – Medicaid

Website: <https://dma.ncdhhs.gov/>
 Phone: 919.855.4100

NORTH DAKOTA – Medicaid

Website: <http://www.nd.gov/dhs/services/medicalserv/medicaid/>
 Phone: 844.854.4825

OKLAHOMA – Medicaid and CHIP

Website: <http://www.insureoklahoma.org>
 Phone: 888.365.3742

OREGON – Medicaid

Websites: <http://healthcare.oregon.gov/Pages/index.aspx>
<http://www.oregonhealthcare.gov/index-es.html>
 Phone: 800.699.9075

PENNSYLVANIA – Medicaid

Website: <http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepreiumpaymenthippprogram/index.htm>
 Phone: 800.692.7462

RHODE ISLAND – Medicaid

Website: <http://www.eohhs.ri.gov/>
 Phone: 855.697.4347

SOUTH CAROLINA – Medicaid

Website: <https://www.scdhhs.gov>
 Phone: 888.549.0820

SOUTH DAKOTA - Medicaid

Website: <http://dss.sd.gov> Phone: 888.828.0059

TEXAS – Medicaid

Website: <http://gethipptexas.com/>
 Phone: 800.440.0493

UTAH – Medicaid and CHIP

Medicaid Website: <https://medicaid.utah.gov/>
 CHIP Website: <http://health.utah.gov/chip> Phone: 877.543.7669

VERMONT– Medicaid

Website: <http://www.greenmountaincare.org/>
 Phone: 800.250.8427

VIRGINIA – Medicaid and CHIP

Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm
 Medicaid Phone: 800.432.5924
 CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm
 CHIP Phone: 855.242.8282

WASHINGTON – Medicaid

Website: <http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program>
 Phone: 800.562.3022 ext. 15473

WEST VIRGINIA – Medicaid

Website: <http://mywvhipp.com/>
 Toll-free phone: 855.MyWVHIPP (855.699.8447)

WISCONSIN – Medicaid and CHIP

Website: <https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf>
 Phone: 800.362.3002

WYOMING – Medicaid

Website: <https://wyequalitycare.acs-inc.com/>
 Phone: 307.777.7531

To see if any other states have added a premium assistance program since January 31, 2018, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
 Employee Benefits Security Administration
www.dol.gov/agencies/ebsa 866.444.3272

U.S. Department of Health and Human Services
 Centers for Medicare & Medicaid Services
www.cms.hhs.gov
 877.267.2323, Menu Option 4, Ext. 61565

Medicare Part D Creditable Coverage Notice

IMPORTANT NOTICE ABOUT YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with **Victor Elementary School District** (the “Plan Sponsor”) 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 Plan Sponsor has determined that the prescription drug coverage offered by the **High Desert & Inland Employee-Employer Trust** 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.

An outline of our current prescription drug coverage follows:

****The below information applies to Kaiser coverage:**

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

If you decide to join a Medicare drug plan, your current Plan Sponsor coverage will be affected. For those individuals who elect Part D coverage, coverage under the District’s plan will end for the individual and all covered dependents, etc.). See pages 7- 9 of the CMS Disclosure of Creditable Coverage To Medicare Part D Eligible Individuals Guidance (available at <http://www.cms.hhs.gov/CreditableCoverage/>), which outlines the prescription drug plan provisions/options that Medicare eligible individuals may have available to them when they become eligible for Medicare Part D.]

If you do decide to join a Medicare drug plan and drop your current Plan Sponsor coverage, be aware that you and your dependents may not be able to get this coverage back.

**High Desert & Inland Trust - Traditional Plan 1
Kaiser Permanente**

Prescription Drug Coverage	You Pay
Covered outpatient items in accord with our drug formulary guidelines:	
Most generic items at a Plan Pharmacy	\$10 for up to a 30-day supply
Most generic refills through our mail-order service.....	\$20 for up to a 100-day supply
Most brand-name items at a Plan Pharmacy	\$25 for up to a 30-day supply
Most brand-name refills through our mail-order service.....	\$50 for up to a 100-day supply
Most specialty items at a Plan Pharmacy.....	20% Coinsurance (not to exceed \$150) for up to a 30-day supply

****The below information applies to Aetna coverage:**

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

If you decide to join a Medicare drug plan, your current Plan Sponsor coverage will not be affected. They can keep this coverage if they elect Part D and this plan will coordinate with Part D coverage.

If you do decide to join a Medicare drug plan and drop your current Plan Sponsor coverage, be aware that you and your dependents may be able to get this coverage back.

High Desert & Inland Trust - Custom RX HMO 2

Aetna

PRESCRIPTION DRUG BENEFITS		IN-NETWORK
Pharmacy Plan Type		Aetna Premier Plus Open Formulary
Generic Drugs		
	Retail	\$8 copay
	Mail Order	\$16 copay
Preferred Brand-Name Drugs		
	Retail	\$25 copay
	Mail Order	\$50 copay
Non-Preferred Brand-Name Drugs		
	Retail	\$40 copay
	Mail Order	\$80 copay
Premier Plus Specialty Drugs		
	Preferred Specialty	20%
	Non-Preferred Specialty	20%
Pharmacy Day Supply and Requirements		
	Retail	Up to a 30 day supply
	Mail Order	Up to a 31-90 day supply from Aetna Rx Home Delivery®.
	Premier Plus Specialty	Up to a 30 day supply from Aetna Specialty Pharmacy Network. First prescription fill at any retail or specialty pharmacy. Subsequent fills must be through our preferred specialty pharmacy network.

Choose Generics with Dispense as Written (DAW) override - member pays applicable copay of the physician required brand. If the member requests brand when a generic is available, the member pays the applicable copay plus the difference between the generic price and the brand price.

Plan Includes: Diabetic supplies and Contraceptive drugs and devices obtainable from a pharmacy.
 Performance Enhancing Drugs limited to 4 tablets per month.
 Oral fertility drugs included.
 Oral chemotherapy drugs covered 100%
 Premier Plus Pre-certification for Specialty Drugs
 Premier Plus Step Therapy included
 One transition fill allowed within 90 days of member's effective date
 Affordable Care Act mandated female contraceptives and preventive medications covered 100% in-network.

**High Desert & Inland Trust - Custom RX PPO 2
Aetna**

PHARMACY	IN-NETWORK	OUT-OF-NETWORK
Pharmacy Plan Type	Aetna Premier Plus Open Formulary	
Generic Drugs		
Retail	\$8 copay	25% of submitted cost; after applicable copay
Mail Order	\$8 copay	Not Applicable
Preferred Brand-Name Drugs		
Retail	\$30 copay	25% of submitted cost; after applicable copay
Mail Order	\$45 copay	Not Applicable
Non-Preferred Brand-Name Drugs		
Retail	\$45 copay	25% of submitted cost; after applicable copay
Mail Order	\$60 copay	Not Applicable
Premier Plus Specialty Drugs		
Preferred Specialty	30% up to a \$150 copay maximum	Not Applicable
Non-Preferred Specialty	30% up to a \$150 copay maximum	Not Applicable
Pharmacy Day Supply and Requirements		
Retail	Up to a 30 day supply	
Mail Order	Up to a 31-90 day supply from Aetna Rx Home Delivery®.	
Premier Plus Specialty	Up to a 30 day supply from Aetna Specialty Pharmacy Network. First prescription fill at any retail or specialty pharmacy. Subsequent fills must be through our preferred specialty pharmacy network.	

Choose Generics with Dispense as Written (DAW) override - member pays applicable copay of the physician required brand. If the member requests brand when a generic is available, the member pays the applicable copay plus the difference between the generic price and the brand price.

Plan Includes: Diabetic supplies and Contraceptive drugs and devices obtainable from a pharmacy.
 Performance Enhancing Drugs limited to 4 tablets per month.
 Oral fertility drugs included.
 Oral chemotherapy drugs covered 100%
 Premier Plus Pre-certification for Specialty Drugs
 Premier Plus Step Therapy included
 One transition fill allowed within 90 days of member's effective date
 Affordable Care Act mandated female contraceptives and preventive medications covered 100% in-network.

**High Desert & Inland Trust - Custom RX PPO 8
Aetna**

(Calendar Year Deductible \$5,500 per individual / \$11,000 per family)

PHARMACY	IN-NETWORK	OUT-OF-NETWORK
The full cost of the drug is applied to the deductible before any benefits are considered for payment under the pharmacy plan.		
Pharmacy Plan Type	Aetna Premier Plus Open Formulary	
Generic Drugs		
Retail	\$10 copay	25% of submitted cost; after applicable copay
Mail Order	\$20 copay	Not Applicable
Preferred Brand-Name Drugs		
Retail	\$25 copay	25% of submitted cost; after applicable copay
Mail Order	\$50 copay	Not Applicable
Non-Preferred Brand-Name Drugs		
Retail	\$40 copay	25% of submitted cost; after applicable copay
Mail Order	\$80 copay	Not Applicable
Premier Plus Specialty Drugs		
Preferred Specialty	30% up to a \$200 copay maximum	Not Applicable
Non-Preferred Specialty	30% up to a \$200 copay maximum	Not Applicable
Pharmacy Day Supply and Requirements		
Retail	Up to a 30 day supply	
Mail Order	Up to a 31-90 day supply from Aetna Rx Home Delivery®.	
Premier Plus Specialty	Up to a 30 day supply from Aetna Specialty Pharmacy Network. First prescription fill at any retail or specialty pharmacy. Subsequent fills must be through our preferred Aetna Specialty Pharmacy network.	

Choose Generics with Dispense as Written (DAW) override - member pays applicable copay of the physician required brand. If the member requests brand when a generic is available, the member pays the applicable copay plus the difference between the generic price and the brand price.

Plan Includes: Diabetic supplies and Contraceptive drugs and devices obtainable from a pharmacy.
 Performance Enhancing Drugs limited to 4 tablets per month.
 Oral fertility drugs included.
 Oral chemotherapy drugs covered 100%
 Premier Plus Pre-certification for Specialty Drugs
 Premier Plus Step Therapy included
 One transition fill allowed within 90 days of member's effective date
 Affordable Care Act mandated female contraceptives and preventive medications covered 100% in-network.

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

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

FOR MORE INFORMATION ABOUT THIS NOTICE OR YOUR CURRENT PRESCRIPTION DRUG COVERAGE...

Contact the person listed below for further information. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through the Plan Sponsor changes. You also may request a copy of this notice at any time.

FOR MORE INFORMATION ABOUT YOUR OPTIONS UNDER MEDICARE PRESCRIPTION DRUG COVERAGE...

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

For more information about Medicare prescription drug coverage:

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

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

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

Date: October 7, 2019
Name of Entity/Sender: Victor Elementary School District
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