Employee Benefits Guide

2024

OID
OAKDALE IRRIGATION DISTRICT

Employee Benefits Guide 2024

Core Benefits

Miscellaneous

Click this icon in your benefits guide to watch a video explaining the associated topic. See page 29 for a glossary of terms.

If you (and/or your dependents) have Medicare or you will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage.

Please see page 21 for more details.

Please note that this guide provides highlights of the benefits available to you. You may find a complete description of each plan, including policy provisions, limitations, exclusions, and insurance contracts, in the summary plan descriptions and official plan documents. If a conflict arises between this guide and the official plan documents, the plan documents will govern. Oakdale Irrigation District reserves the right to modify or terminate any of the described benefits at any time and for any reason. The descriptions of these benefits are not guarantees of current or future employment or benefits.

Medical

Kaiser Permanente

	Kaiser Options		
	Kaiser Base	Kaiser Buy Ups	
	Kaiser 70 1900/65 (Silver HMO)	Kaiser 80 250/35 (Gold HMO)	Kaiser 90 0/20 (Platinum HMO)
Benefit	HMO Network		
Individual Ded	$1,900	$250	$0
Family Ded	$3,800 (embedded)	$500 (embedded)	$0
Individual OOP Max	$8,750 (incl ded)	$7,800 (incl ded)	$4,500
Family OOP Max	$17,500 (incl ded)	$15,600 (incl ded)	$9,000
Co-insurance	45%	0%	0%
Lifetime Max	Unlimited	Unlimited	Unlimited
Primary/Specialist Visit	$65/$100 ded waived	$35/$55 ded waived	$20/$30
Adult Preventive Care	No charge	No charge	No charge
Child Preventive Care	No charge	No charge	No charge
Pre/Postnatal Care	No charge	No charge	No charge
Physical Therapy	$65 ded waived	$35 ded waived	$20
Chiropractic Care	$15 ded waived; 20 visits/yr.	Not covered	Not covered
Inpatient Hospital	45% after ded	$600/day after ded up to 5 days	$250/day up to 5 days
Inpatient Surgery	N/A	N/A	N/A
Maternity Delivery/IP	45% after ded	$600/day after ded up to 5 days	$250/day up to 5 days
Mental Health IP	45% after ded	$600/day after ded up to 5 days	$250/day up to 5 days
Substance Abuse IP	45% after ded	$600/day after ded up to 5 days	$250/day up to 5 days
Outpatient Facility	45% after ded	$335 after ded	$125
Outpatient Surgery	N/A	N/A	N/A
Lab/X-Ray	$30/$75 ded waived	$35/$55 ded waived	$20/$30
Advanced Radiology	$400 after ded	$250 after ded	$100
Mental Health OP	$0 ded waived	$35 ded waived	$20
Substance Abuse OP	$0 ded waived	$35 ded waived	$20
Emergency Room	45% after ded	$250 (waived if admitted) after ded	$150 (waived if admitted)
Ambulance	45% after ded	$250 after ded	$150
Urgent Care	$65 ded waived	$35 ded waived	$20
Rx Generic	$20 ded waived	$15 ded waived	$5
Rx Preferred	$100 ded waived	$40 ded waived	$20
Rx Non-Preferred	$100 ded waived	$40 ded waived	$20

CLICK HERE to watch a video on Health Maintenance Organizations (HMO)

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Medical (continued)

Kaiser Permanente (continued)

	Kaiser Options		
	Kaiser Base	Kaiser Buy Ups	
	Kaiser 70 1900/65 (Silver HMO)	Kaiser 80 250/35 (Gold HMO)	Kaiser 90 0/20 (Platinum HMO)
Benefit	HMO Network		
Rx Specialty	20% up to $250 after ded	20% up to $250 ded waived	10% up to $250
Rx Mail Order	2x retail (100 day supply)	2x retail (100 day supply)	2x retail (100 day supply)
Home Health Care	No charge; 100 visits/yr.	$30 ded waived; 100 visits/yr.	$20; 100 visits/yr.
Skilled Nursing	45% after ded; 100 days/yr.	$300/day after ded up to 5 days; 100 days/yr.	$150/day up to 5 days; 100 days/yr.
Infertility Treatment	Not covered	Not covered	Not covered
DME	45% ded waived/45% after ded (base/supplemental)	20% ded waived/20% after ded (base/supplemental)	10% (base and supplemental)
Hospice Services	No charge	No charge	No charge
Pediatric Vision	No charge; 1 pair/yr.	No charge; 1 pair/yr.	No charge; 1 pair/yr.
Pediatric Dental	Bundled w/copay plan	Bundled w/copay plan	Bundled w/copay plan

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Medical (continued)

Sutter Health

	Sutter Buy Up		
	Sutter Health Plus MS94 (Silver HMO)	Sutter Health Plus MS93 (Gold HMO)	Sutter Health Plus MS90 (Platinum HMO)
Benefit	**HMO Network**		
Individual Ded	$2,500	$250	$0
Family Ded	$5,000	$500	$0
Individual OOP Max	$8,750 (incl ded)	$7,800 (incl ded)	$4,500
Family OOP Max	$17,500 (incl ded)	$15,600 (incl ded)	$9,000
Co-insurance	30%	0%	0%
Lifetime Max	Unlimited	Unlimited	Unlimited
Primary/Specialist Visit	$55/$90 ded waived	$35/$55 ded waived	$20/$30
Adult Preventive Care	No charge	No charge	No charge
Child Preventive Care	No charge	No charge	No charge
Pre/Postnatal Care	No charge	No charge	No charge
Physical Therapy	$55 ded waived	$35 ded waived	$20
Chiropractic Care	Optional rider	Optional rider	Optional rider
Inpatient Hospital	35% after ded	$600/day after ded; 5 days/admit	$250/day; 5 days/admit
Inpatient Surgery	35% after ded	No charge	No charge
Maternity Delivery/IP	35% after ded	$600/day after ded; 5 days/admit	$250/day; 5 days/admit
Mental Health IP	35% after ded	$600/day after ded; 5 days/admit	$250/day; 5 days/admit
Substance Abuse IP	35% after ded	$600/day after ded; 5 days/admit	$250/day; 5 days/admit
Outpatient Facility	35% after ded	$300 after ded	$100
Outpatient Surgery	35% after ded	$35 ded waived	$25
Lab/X-Ray	$55/$90 ded waived	$35/$55 ded waived	$20/$30
Advanced Radiology	$300 after ded	$250 after ded	$100
Mental Health OP	$55 ded waived	$35 ded waived	$20
Substance Abuse OP	$55 ded waived	$35 ded waived	$20
Emergency Room	35% after ded (waived if admitted)	$250 after ded (waived if admitted)	$150 (waived if admitted)
Ambulance	35% after ded	$250 after ded	$150
Urgent Care	$55 ded waived	$35 ded waived	$20
Rx Generic	$19 ded waived	$15 ded waived	$5
Rx Preferred	$85 after $300 Rx ded	$40 ded waived	$20
Rx Non-Preferred	$110 after $300 Rx ded	$70 ded waived	$30

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 review plan documents for full details. If there are any conflicts with information provided on this page, the plan documents will prevail.

Medical (continued)

Sutter Health (continued)

	Sutter Buy Up		
	Sutter Health Plus MS94 (Silver HMO)	**Sutter Health Plus MS93 (Gold HMO)**	**Sutter Health Plus MS90 (Platinum HMO)**
Benefit	**HMO Network**		
Rx Specialty	30% up to $250 after $300 Rx ded	20% up to $250 ded waived	10% up to $250
Rx Mail Order	2x retail copay	2x retail copay	2x retail copay
Home Health Care	$45 ded waived	$30 ded waived	$20
Skilled Nursing	40% after ded	$300/day after ded; 5 days/admit	$150/day; 5 days/admit
Infertility Treatment	Not covered	Not covered	Not covered
DME	40% ded waived	30% ded waived	10%
Hospice Services	No charge	No charge	No charge
Pediatric Vision	No charge; 1 pair/yr.	No charge; 1 pair/yr.	No charge; 1 pair/yr.
Pediatric Dental	No charge	No charge	No charge

Dental

Delta Dental

The chart below briefly states the benefits and covered services. Please refer to the policy for the complete benefit details.

	Delta Dental	
Benefit	**In Network**	**Out of Network**
Deductibles	$25 per person/$50 per family each calendar year	
Maximums	$1,500 per person each calendar year	
Diagnostic & Preventive Services *(Exams, cleanings & x-rays)*	100%	100%
Basic Services *(Filings, posterior composites & sealants)*	80%	80%
Endodontics (Root Canals) *(Covered under Basic Services)*	80%	80%
Periodontics (Gum Treatment) *(Covered under Basic Services)*	80%	80%
Oral Surgery *(Covered under Basic Services)*	80%	80%
Major Services *(Crowns, inlays, onlays & cast restorations)*	50%	50%
Prosthodontics* *(Bridges, dentures & implants)*	50%	50%
Orthodontic Benefits* *(Dependent children)*	50%	50%
Orthodontic Maximums	$2,000 Lifetime	$2,000 Lifetime

* 12-month waiting period on Prosthodontic and Orthodontic services; meaning you or your dependent must be enrolled in the plan for at least 12-months before the plan benefits will apply for these services.

- Save with a PPO Dentist. Visit a dentist in the PPO network to maximize your savings. These dentists have agreed to reduced fees, and you won't get charged more than your expected share of the bill. Find a PPO dentist at deltadentalins.com.
- You can still visit any licensed dentist, but your out-of-pocket costs may be higher if you choose a non-PPO dentist.
- Get LASIK and hearing aid discounts. With access to Qualsight and Amplifon Hearing Health Care, you can save as much as 50% on LASIK procedures and more than 60% on hearing aids. This is not an insured benefits, they are made available to you to provide access to preferred pricing.

Vision

VSP

The chart below briefly states the benefits and covered services. Please refer to the policy for the complete benefit details.

Benefit	Description	Copay	Frequency
Your Coverage with a VSP Provider			
WellVision Exam	Focuses on your eyes and overall wellness	$5 for exam and glasses	Every 12 months
Prescription Glasses			
Frame	• $150 allowance for a wide selection of frames • $170 allowance for featured frame brands • 20% savings on the amount over your allowance • $80 Costco frame allowance	Combined with exam	Every 24 months
Lenses	• Single vision, lined bifocal, and lined trifocal lenses • Polycarbonate lenses for dependent children	Combined with exam	Every 12 months
Lens Enhancements	• Anti-reflective coating • Standard progressive lenses • Premium progressive lenses • Custom progressive lenses • Average savings of 35-40% on other lens enhancement	$25 $0 $80 - $90 $120 - $160	Every 12 months
Contacts *(instead of glasses)*	• $150 allowance for contacts and contact lens exam *(fitting and evaluation)* • 15% savings on a contact lens exam *(fitting and evaluation)*	$0	Every 12 months
Diabetic Eyecare Plus Program	• Retinal screening for eligible members with diabetes. • Additional exams and services for members with diabetic eye disease, glaucoma or age-related macular degeneration (AMD). Limitations and coordination with medical coverage may apply. Ask your VSP doctor for details	$0 $20 per exam	As needed
Extra Savings	**Glasses and Sunglasses** Extra $20 to spend on featured frame brands. Go to vsp.com/offers for details. 30% savings on additional glasses and sunglasses, including lens enhancements, form the same VSP provider on the same day as your WellVision Exam. Or get 20% frame any VSP provider within 12 months of your last WellVision Exam.		
	Retinal Screening No more than a $39 copay on routine retinal screening as an enhancement to a Well Vision Exam.		
	Laser Vision Correction Average 15% off the regular price or 5% off the promotional price; discounts only available from contracted facilities. After surgery, use your frame allowance *(if eligible)* for sunglasses from any VSP doctor.		

Using your VSP benefit is easy, just follow the steps below:

Find an eye care provider: to find a VSP doctor or affiliate, visit VSP.com or call 1-800-877-7195; Review your plan before your appointment, you can access your plan by visiting the web-site above; and at your appointment tell the provider that you have VSP, as there is no ID card necessary for the insurance.

Go to eyeconic.com and use your vision benefits to shop over 50 brands of contacts, eyeglasses and sunglasses.

Create an account at vsp.com to view your in-network coverage, find the VSP network doctor who's right for you and discover savings with exclusive member extras.

Life Insurance

Lincoln Financial Group

Benefits that you will receive:

	Life Insurance	Accidental Death & Dismemberment
Represented Employees	$20,000	$20,000
Confidential Employees	$50,000	$50,000
Supervisory Employees	$75,000	$75,000
Managerial Employees	$100,000	$100,000

The cost paid 100% by the employer.

Employee Assistance Program (EAP)

Sutter Employee Assistance Program

Benefits You Receive:

The Employee Assistance Program is offered to all employees and their Eligible family members through Sutter EAP at no cost. Sutter EAP is a confidential assistance program that offers information, consultation, and counseling for employees and their immediate family members. The counseling offered by EAP can help with anxiety and stress, depression, relationships, grief and loss, self-image, balancing work and home, addictions, domestic violence and abuse, and anger .

Through Sutter EAP you can receive up to 3 free sessions per six months for the above services.

Sutter EAP also can assist with referrals for resources such as child care, elder care, adoption assistance, schools, colleges, pet services, relocation services, and financial and legal consultations.

Flexible Spending Accounts (FSA)

Ameriflex

Benefits you Receive:

Flexible spending accounts (FSAs) are pre-tax accounts set up by an employer to reimburse employees for certain expenses. The FSA account allows you to set aside funds to be able to use for medical or dependent care, also the amount contributed is not taxable therefore saving you money on medical expenses.

Health Care Reimbursement FSA

The FSA program allows Oakdale Irrigation District employees to pay for certain IRS-approved medical care expenses with pre-tax dollars. Currently the limit on salary reduction contributions to a health FSA offered under a cafeteria plan is $3,050 (this could change annually per IRS). Some examples of eligible expenses include:

- Vision services, including contact lenses, solution, eye examinations, and eyeglasses
- Dental services and orthodontia
- Chiropractic and acupuncture services
- Prescriptions
- For a complete list visit www.irs.gov

Dependent Care FSA

The dependent care FSA allows employees to use pre-tax dollars for costs of providing day care for dependent children younger than 13 or for disabled adults who live with the employee. The maximum that can be contributed for this benefit is $5,000 per calendar year for singles or married couples filing jointly ($2,500 for married couples filing separately).

CLICK HERE to watch a video on Flexible Spending Accounts (FSA)

HRA, FSA, HSA numbers are reflected for the 2023 calendar year. 2024 amounts are not typically determined until after the release of the Benefit Guide. Employees making elections for the 2024 year should keep this in mind.

Voluntary Coverage

We are excited to announce benefit options available to you through Colonial Life.

The Following Benefits are Now Available

- **Group Accident:** For a covered accident, policyholders receive cash benefits for use as they see fit.
- **Cancer Assist:** The cancer plan is designed to pay cash benefits that can be used to help offset cancer-related expenses
- **Term Life 5000:** Helps with peace of mind knowing your family is taken care of.
- **Individual Short Term Disability 3000:** Provides a monthly benefit to help you cover your ongoing expenses if an injury or sickness prevents you from working.

** See the following pages for plan descriptions & rates

Insurance coverage has exclusions and limitations that may affect benefits payable. For a complete description of benefits, limitations and exclusions, please refer to an outline of coverage, sample policy/certificate, proposal description or see your Colonial Life benefits counselor. Coverage type, benefits and rates vary by state. Coverage may not be available in all states. Rates provided are illustrative and your actual premium may be different depending on your particular situation and plan choices.

Group Accident

Colonial Life's voluntary accident insurance policy is a medical indemnity plan that provides employees and their families with hospital, doctor, accidental death and catastrophic accident benefits in the event of a covered accident.

Base Policy Benefits	Basic	Preferred
Accident Emergency Treatment • For treatment in a doctor's office, urgent care facility, emergency room within the first 72 hours of the accident. • If initially treated after 72 hours, please see Accident Follow-up Doctor's Visit	$100	$150
Accident Follow-Up Doctor Visit	$50/visit up to 3 visits per accident	$50/visit up to 4 visits per accident
Accidental Death	$25,000 Employee $25,000 Spouse $5,000 Child(ren)	$50,000 Employee $50,000 Spouse $10,000 Child(ren)
Accidental Death: Common Carrier	$100,000 Employee $100,000 Spouse $20,000 Child(ren)	$200,000 Employee $200,000 Spouse $40,000 Child(ren)
Accidental Dismemberment: *(Loss of Finger/Toe/Hand/Foot or Sight)*	$1,050 - $15,000	$1,050 - $18,000
Ambulance *(Air)*	$1,000	$1,500
Ambulance *(Ground)*	$200	$300
Appliances *(such as wheelchair, crutches)*	$75	$100
Blood/Plasma/Platelets	$300	$400
Burns *(based on size and degree)*	$750 - $12,000	$1,000 - $15,000
Burns *(Skin Graft)*	50% of burn benefit	50% of burn benefit
Catastrophic Accident – prior to 65 *(For severe injuries that result in the total and irrevocable: loss of one hand and one foot; loss of both hands or both feet; loss of sight in both eyes; loss of hearing of both ears; loss of the ability to speak.)* • 6-month elimination period • Amounts reduced for covered persons over age 65	$50,000 EE/SP $25,000 CH	$50,000 EE/SP $25,000 CH
Coma *(duration of at least 14 days)*	$7,500	$10,000
Concussion	$275	$375
Dislocation *(Based on joint and if repaired by open or closed reduction)*	$140 - $4,000	$200 - $6,000
Emergency Dental Work	$150 (crown, implant or denture) or $50 (extract)	$300 (crown, implant or denture) or $100 (extract)
Eye Injury	$200	$300
Fractures *(Based on bone and if repaired by open or closed reduction)*	$200 - $4,500	$200 - $7,500
Hospital Admission*	$750/accident	$1,000/accident
Hospital Confinement *(Per day up to 365 days)*	$175	$250
Hospital ICU Admission*	$1,500/accident	$1,750/accident
Hospital ICU Confinement *(Up to 15 days per accident)*	$300	$400

Group Accident (continued)

Base Policy Benefits	Basic	Preferred
Knee Cartilage *(Torn)*	$500	$750
Laceration *(based on size and repair)*	$75 - $600	$50 - $600
Lodging *(Companion)*	$150 per day up to 30 days	$200 per day up to 30 days
Medical Imaging Study *(Limit one accident per year)*	$150 per accident	$200 per accident
Prosthetic Device/Artificial Limb	$750 (1); $1,500 (2 or more)	$1,250 (1); $2,500 (2 or more)
Rehabilitation Unit Confinement • Up to 15 days per confinement per covered accident. • Maximum of 30 days per calendar year.	$100/day	$150/day
Ruptured Disc	$600	$900
Surgery *(Cranial, Open Abdominal, Thoracic)*	$1,000	$1,500
Surgery *(Hernia)*	$250	$300
Surgery *(Exploratory or Arthroscopic)*	$150	$225
Tendon/Ligament/Rotator Cuff	$600 (1); $1,200 (2 or more)	$900 (1); $1,800 (2 or more)
Therapy *(Occupational and Physical Therapy Benefit)*	$35 per day (10 visits/accident)	$45 per day (10 visits/accident)
Transportation *(up to 3 trips per accident)*	$400 per trip	$600 per trip
X-Ray Benefit	$50	$60
Health Screening Benefit *(Per covered person per calendar year)*	$50	$50

* We will pay either the Hospital Admission or Hospital ICU Admission benefit, but not both.

Sample Deductions

Sample CA rates shown include on/off job coverage with Health Screening. Accident coverage is pre-tax eligible.

	Issue Age	Named Insured	Employee & Spouse	One-Parent Family	Two-Parent Family
Semi-monthly Rates (24 Pay Periods)					
Basic	17-64	$7.64	$12.95	$12.81	$18.13
Preferred	17-64	$10.27	$17.32	$18.08	$25.14

Cancer Assist

Colonial Life's individual cancer insurance product helps to provide valuable financial protection for America's workers and their families in times of need, when medical bills and other expenses related to cancer diagnosis and treatment may limit their ability to focus on what's most important - getting well.

Benefits	Level 2
Air Ambulance *(per trip)*	$2,000
Maximum trips per confinement	2
Ambulance *(per trip)*	$250
Maximum trips per confinement	2
Anesthesia *(General)*	25% of Surgical Procedures Benefit
Anesthesia *(Local, per procedure)*	$30
Anti-Nausea Medication *(per day)*	$40
Maximum per month	$160
Blood/Plasma/Platelets/Immunoglobulins *(per day)*	$150
Maximum per calendar year	$10,000
Bone Marrow or Peripheral Stem Cell Donation *(per donation, maximum one per lifetime)*	$500
Bone Marrow Stem Cell Transplant *(per transplant)*	$4,000
Peripheral Stem Cell Transplant *(per transplant)*	$4,000
Maximum transplants *(per lifetime)*	2
Companion Transportation *(per mile)*	$0.50
Maximum per round trip	$1,000
Egg (s) Extraction or Harvesting or Sperm Collection *(one per lifetime)*	$700
Egg (s) or Sperm Storage *(one per lifetime)*	$200
Experimental Treatment *(per day)*	$250
Maximum per lifetime	$12,500
Family Care *(per day)*	$40
Maximum per calendar year	$2,000
Hair/External Breast/Voice Box Prosthesis *(per calendar year)*	$200
Home Health Care Services *(per day)*	$75
Maximum per calendar year	**Examples include:** physical therapy, occupational therapy, speech therapy, and audiology, prosthesis and orthopedic appliances and rental or purchase of medical equipment. 30 days or twice the days confined
Hospice *(Initial)*	$1,000
Hospice *(Daily)*	$50
Maximum combined Initial and Daily per lifetime	$15,000
Hospital Confinement *(30 days or less, per day)*	$150
Hospital Confinement *(31 days or more, per day)*	$300
Lodging *(per day)*	$50
Maximum days per calendar year	70
Medical Imaging Studies *(per study)*	$125
Maximum per calendar year	$250

Cancer Assist (continued)

Benefits	Level 2
Outpatient Surgical Center *(per day)*	$200
Maximum per calendar year	$600
Private Full-time Nursing Services *(per day)*	$75
Prosthetic Device/Artificial Limb *(per device or limb)*	$1,500
Maximum per lifetime	$3,000
Radiation/Chemotherapy	
Injected chemotherapy by medical personnel *(one per week)*	$500
Radiation delivered by medical personnel *(one per week)*	$500
Self-Injected Chemotherapy *(one per month)*	$200
Pump Chemotherapy *(one per month)*	$200
Topical Chemotherapy *(one per month)*	$200
Oral Hormonal Chemotherapy *(1-24 months)*, one per month	$200
Oral Hormonal Chemotherapy *(25+ months)*, one per month	$100
Oral Non-Hormonal Chemotherapy *(one per month)*	$200
Reconstructive Surgery *(per surgical unit)*	$40
Maximum per procedure, including 25% for general anesthesia	$2,500
Second Medical Opinion *(one per lifetime)*	$200
Skilled Nursing Care Facility *(Per day up to the number of days for hospital confinement)*	$100
Skin Cancer Initial Diagnosis *(one per lifetime)*	$300
Supportive/Protective Care Drugs/Colony Stimulating Factors *(per day)*	$100
Maximum per calendar year	$800
Surgical Procedures *(per unit)*	$50
Maximum per procedure	$3,000
Transportation *(per mile)*	$0.50
Maximum per round trip	$1,000
Additional Benefits	
Bone Marrow Donor Screening *(Maximum of one per lifetime)*	$50
Cancer Vaccine Benefit *(Maximum of one per lifetime)*	$50
Waiver of Premium	Yes
Health Screening Benefit *(Per covered person per calendar year)*	$75

Sample Deductions

Sample CA Rates shown at the bottom includes $75 Health Screening. Cancer coverage is pretax eligible.

	Issue Age	Named Insured	Employee & Spouse	One-Parent Family	Two-Parent Family
Semi-monthly Rates (24 Pay Periods)					
Level 2	17-75	$18.09	$31.18	$18.49	$31.58

Term Life 5000

Colonial Life's Term Life insurance plan offers life insurance protection where the benefit remains the same through the life of the policy. At the end of the term period selected by the employee (10-, 15-, 20-, or 30-years), the policy maybe continued on a yearly renewable basis, without proof of good health.

Benefits	Description
Death Benefit Amounts available vary by age	Range from $10,000 to $250,000
Term Levels Varies by age, provides coverage for set amount of years with guaranteed level premiums and may be renewed annually thereafter without evidence of insurability	10, 15, 20, and 30-year terms available
Terminal Illness Accelerated Death Benefit Automatically included in the base policy at no additional premium, allows policy owner to receive an advance of up to 75% of face amount, up to a maximum of $150,000 *(in most states)*	Can request up to 75% of death benefit if diagnosed with a terminal illness has a life expectancy of 12 months or less
Additional Benefits:	**Description**
Spouse Term Rider Spouse signature not required, may convert to a cash value policy	Death benefits range from $10,000 to $50,000,10 and 20-year term options available
Children's Term Rider Covers all dependent children for one level premium, may convert to a cash value policy	Death benefits range from $1,000 to $20,000
Accidental Death Benefit Rider Up to a maximum of $150,000	Doubles benefit amount if insured dies as a result of an accident before age 70
Waiver of Premium Benefit Rider Total disability is considered permanent when the total disability continues with no interruptions for at least six consecutive months.	Waives all premiums due on the base policy & attached riders during the total and permanent disability of the primary insured before age 65

Sample Deductions

Sample Rates shown at the bottom are based off non-tobacco and tobacco rates. Term Life coverage is post-tax.

Non-Tobacco Rates	20 Year Term	
	Issue Age	$50,000
Semi-monthly Rates (24 Pay Periods)		
	35	$8.23
	45	$13.82
	55	$28.65

Tobacco Rates	20 Year Term	
	Issue Age	$50,000
Semi-monthly Rates (24 Pay Periods)		
	35	$12.75
	45	$25.65
	55	$58.50

Individual Short Term Disability 3000

Colonial Life's individual short term disability insurance policy helps protect your income if an injury or sickness prevents you from earning a paycheck, disability insurance can provide a monthly benefit to help you cover ongoing expenses.

Total disability definition

Totally disabled or total disability means that as a result of sickness or injury, you are not able to perform with reasonable continuity, the substantial and material acts necessary to perform your usual occupation in the usual and customary way, and you choose not to work at any occupation.

How partial or residual disability works

If you are able to return to work part-time after at least 1 day of being paid for a total disability, you may be able to still receive 50% of your total disability benefit.

Waiver of premium

We will waive your premium payments after 90 consecutive days of a covered disability.

Geographical limitations

If you are disabled while outside of the United States, Canada or Mexico, you may receive benefits for up to 60 days before you have to return to the U.S. in order to continue receiving benefits.

Issue age

Coverage is available from ages 17 to 74.

Keep your coverage

You can keep your coverage to age 75 at no additional cost, even if you change jobs, as long as you pay your premiums when they are due.

Premium

Your premium is based on your age when you purchase coverage and the amount of coverage you are eligible to buy. Your premium will not change as you age.*

* Premiums can be changed only if we change them on all policies in the state where they are issued.

	Coverage Options
Monthly Benefit Amount for off-job injury and off-job sickness	$400 - $6,500
Elimination Period	7 -14 days after an Injury or Sickness
Benefit Period	6-months

Sample Deductions

Sample CA rates shown below are for off job injury and sickness.

6-month Benefit Period	Issue Age	$500*	$800*	$1,000*
Semi-monthly Rates *(24 Pay Periods)*				
7-day Injury/Sickness Elimination Period	17 - 49	$9.65	$15.44	$19.30
	50 - 64	$13.58	$21.72	$27.15
	65 - 74	$16.45	$26.32	$32.90
14-day Injury/Sickness Elimination Period	17 - 49	$6.93	$11.08	$13.85
	50 - 64	$9.28	$14.84	$18.55
	65 - 74	$11.23	$17.96	$22.45

* Monthly benefit amount

Important Notices

No Surprises Act Notice

Our medical plans are subject to the No Surprises Act, which limits the amount covered persons may have to pay for some out-of-network surprise medical bills. More information about surprise billing requirements included under the No Surprises Act and similar state laws can be found on the medical insurance company's website or the Plan Sponsor's website. Additional information may be found in your Explanation of Benefits for any affected claims.

Discrimination is Against the Law

Oakdale Irrigation District complies with the applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin (including limited English proficiency and primary language), age, disability, or sex (including pregnancy, sexual orientation, gender identity, and sex characteristics). Oakdale Irrigation District does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Newborns' and Mothers' Health Protection Act (NMHPA)

Benefits for pregnancy hospital stay (for delivery) for a mother and her newborn may not be restricted to less than 48 hours following a vaginal delivery or 96 hours following a cesarean section. Also, any utilization review requirements for inpatient hospital admissions will not apply to this minimum length of stay. Early discharge is permitted only if the attending health care provider, in consultation with the mother, decides an earlier discharge is appropriate.

Women's Health and Cancer Rights Act (WHCRA) Annual Notice

Your 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 Plan Administrator at 209.840.5519 for more information.

Patient Protections

The medical plan requires 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, please contact your carrier.

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

You do not need prior authorization from the plan or any other person (including a primary care provider) 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, please contact your carrier.

Networks/Claims/Appeals

The major medical plans described in this booklet have provider networks with Kaiser Permanente and Sutter Health Plus. The listing of provider networks will be available to you automatically and free of charge. A list of network providers can be accessed immediately by using the Internet address found in the Summary of Benefits and Coverage that relates to the Plan. You have a right to appeal denials of claims and a right to a response within a reasonable amount of time. Claims that are not submitted within a reasonable time may be denied. Please review your Summary Plan Description or contact the Plan Administrator for more details.

COBRA Continuation Coverage

This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under covered medical, dental, and vision plans (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.

Important Notices (continued)

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 federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally 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 their 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 their 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 CONTINUATION COVERAGE AVAILABLE?

The Plan will offer COBRA continuation coverage to Qualified Beneficiaries only after the Plan Administrator has been notified of a Qualifying Event:

- 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).

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 60 days after the Qualifying Event occurs. You must provide this notice to your employer.

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, or as otherwise permitted by the COBRA administrator, no later than the date specified in the election form, and properly submitted to the Plan Administrator.

Important Notices (continued)

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 each 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.

ELECTION AND ELECTION PERIOD

COBRA continuation coverage may be elected during the period beginning on the date Plan coverage would otherwise terminate due to a Qualifying Event and ending on the later of the following: (1) 60 days after coverage ends due to a Qualifying Event, or (2) 60 days after the notice of the COBRA continuation coverage rights is provided to the Qualified Beneficiary.

If, during the election period, a Qualified Beneficiary waives COBRA continuation coverage rights, the waiver can be revoked at any time before the end of the election period. Revocation of the waiver will be an election of COBRA continuation coverage. However, if a waiver is revoked, coverage need not be provided retroactively (that is, from the date of the loss of coverage until the waiver is revoked). Waivers and revocations of waivers are considered to be made on the date they are sent to the employer or Plan Administrator.

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.

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. (See Notice and Election Procedures.)

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. (See Notice and Election Procedures.)

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, Children's Health Insurance Program (CHIP), or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

Important Notices (continued)

ENROLLMENT IN MEDICARE INSTEAD OF COBRA

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period[1] to sign up for Medicare Part A or B, beginning on the earlier of:

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

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

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

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

IF YOU HAVE QUESTIONS

For more information about the Marketplace, visit www.healthcare.gov.

The U.S. Department of Health and Human Services (HHS), through the Centers for Medicare & Medicaid Services (CMS), has jurisdiction with respect to the COBRA continuation coverage requirements of the Public Health Service Act (PHSA) that apply to state and local government employers, including counties, municipalities, public school districts, and the group health plans that they sponsor (Public Sector COBRA). COBRA can be a daunting and complex area of federal law. If you have any questions or issues regarding Public Sector COBRA, you may contact the Plan Administrator or email HHS at phig@cms.hhs.gov.

[1] https://www.medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b/part-a-part-b-sign-up-periods

KEEP YOUR PLAN INFORMED OF ADDRESS CHANGES

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

EFFECTIVE DATE OF COVERAGE

COBRA continuation coverage, if elected within the period allowed for such election, is effective retroactively to the date coverage would otherwise have terminated due to the Qualifying Event, and the Qualified Beneficiary will be charged for coverage in this retroactive period.

COST OF CONTINUATION COVERAGE

The cost of COBRA continuation coverage will not exceed 102% of the Plan's full cost of coverage during the same period for similarly situated non-COBRA beneficiaries to whom a Qualifying Event has not occurred. The "full cost" includes any part of the cost which is paid by the employer for non-COBRA beneficiaries.

The initial payment must be made within 45 days after the date of the COBRA election by the Qualified Beneficiary. Payment must cover the period of coverage from the date of the COBRA election retroactive to the date of loss of coverage due to the Qualifying Event (or the date a COBRA waiver was revoked, if applicable). The first and subsequent payments must be submitted and made payable to the Plan Administrator or COBRA Administrator. Payments for successive periods of coverage are due on the first of each month thereafter, with a 30-day grace period allowed for payment. Where an employee organization or any other entity that provides Plan benefits on behalf of the Plan Administrator permits a billing grace period greater than the 30 days stated above, such period shall apply in lieu of the 30 days. Payment is to be made on the date it is sent to the Plan or Plan Administrator.

The Plan will allow the payment for COBRA continuation coverage to be made in monthly installments, but the Plan can also allow for payment at other intervals. The Plan is not obligated to send monthly premium notices.

The Plan will notify the Qualified Beneficiary, in writing, of any termination of COBRA coverage based on the criteria stated in this Section that occurs prior to the end of the Qualified Beneficiary's applicable maximum coverage period. Notice will be given within 30 days of the Plan's decision to terminate.

Important Notices (continued)

Such notice shall include the reason that continuation coverage has terminated earlier than the end of the maximum coverage period for such Qualifying Event and the date of termination of continuation coverage.

See the Summary Plan Description or contact the Plan Administrator for more information.

Uniformed Services Employment and Reemployment Rights Act (USERRA)

If you leave your job to perform military service, you have the right to elect to continue your existing employer-based health plan coverage for you and your dependents (including your spouse) for up to 24 months while in the military. Even if you do not elect to continue coverage during your military service, you have the right to be reinstated in your employer's health plan when you are reemployed, generally without any waiting periods or exclusions for pre-existing conditions except for service-connected injuries or illnesses.

Flexible Spending Accounts (FSAs) – Termination and Claims Submission Deadlines

Note: If you lose eligibility for any reason during the Plan Year, your contributions to your Health and/or Dependent Care FSAs will end as of the date your eligibility terminates. You may submit claims for reimbursement from your FSAs for expenses incurred during the Plan Year prior to your eligibility termination. You must submit claims for reimbursement from your Health and/or Dependent Care FSAs no later than 90 days after the date your eligibility terminates. Any balance remaining in your FSAs will be forfeited after claims submitted prior to this date have been processed.

Special Enrollment Rights Notice

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.

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 to remain eligible 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).

For information about Special Enrollment Rights, please contact:

Kim Bukhari
Human Resources Administrator
209.840.5519

Medicare Part D – 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 Oakdale Irrigation District and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

Important Notices (continued)

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

- **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 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.**
- **Oakdale Irrigation District has determined that the prescription drug coverage offered by Oakdale Irrigation District Medical Plan 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 current Oakdale Irrigation District coverage will not be affected. If you keep this coverage and elect Medicare, the Oakdale Irrigation District coverage will coordinate with Part D coverage.

If you do decide to join a Medicare drug plan and drop your current Oakdale Irrigation District coverage, be aware that you and your dependents will 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 Oakdale Irrigation District and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without Creditable Coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (i.e., 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 will get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Oakdale Irrigation District changes. You also may request a copy of this notice at any time.

FOR MORE INFORMATION ABOUT YOUR OPTIONS UNDER MEDICARE PRESCRIPTION DRUG COVERAGE

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You will 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 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 www.socialsecurity.gov, or call them at 800-772-1213 (TTY 800-325-0778).

Important Notices (continued)

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).

Name of Entity / Sender: Oakdale Irrigation District

Contact: Kim Bukhari

Address: 1205 East F Street
Oakdale, CA 95361

Phone: 209.840.5519

Availability of Health Insurance Portability and Accountability Act (HIPAA) Notice of Privacy Practices

Oakdale Irrigation District Group Health Plan (Plan) maintains a Notice of Privacy Practices that provides information to individuals whose protected health information (PHI) will be used or maintained by the Plan. If you would like a copy of the Plan's Notice of Privacy Practices, please contact Kim Bukhari at 209.840.5519.

Important Notices (continued)

Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: GENERAL INFORMATION

This notice provides you with information about Oakdale Irrigation District in the event you wish to apply for coverage on the Health Insurance Marketplace. All the information you need from Human Resources is listed in this notice. If you wish to have someone assist you in the application process or have questions about subsidies that you may be eligible to receive, (for California residents only) you can contact KeenanDirect at 855-653-3626 or at www.KeenanDirect.com, or (for everyone) contact the Health Insurance Marketplace directly at www.Healthcare.gov.

WHAT IS THE HEALTH INSURANCE MARKETPLACE?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget by offering "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a tax credit that lowers your monthly premium right away.

Open Enrollment for health insurance coverage through Covered California will begin on November 1, 2023, and end on January 31, 2024. For more information on Open Enrollment and other opportunities to enroll, visit www.coveredca.com or KeenanDirect at 855-653-3626 or www.KeenanDirect.com.

Open Enrollment for most other states begins on November 1 and closes on January 15 of each year. For more information on Open Enrollment and other opportunities to enroll, visit www.healthcare.gov.

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 you coverage, offers medical coverage that is not "Affordable," or does not provide "Minimum Value." If the lowest cost plan from your employer that would cover you (and not any other members of your family) is more than 8.39% (for 2024) of your household income for the year, then that coverage for you is not Affordable. Affordability for dependent family members is determined separately and is based on the total cost of family coverage. Moreover, if the medical coverage offered covers less than 60% of the benefits costs, then the plan does not provide Minimum Value.

DOES EMPLOYER HEALTH COVERAGE AFFECT ELIGIBILITY FOR PREMIUM SAVINGS THROUGH THE MARKETPLACE?

Yes. If you have an offer of medical coverage from your employer that is both Affordable and provides Minimum Value, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's medical plan. If you receive premium savings for Marketplace coverage, the IRS may seek reimbursement of those funds.

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 medical 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.

STATES WITH INDIVIDUAL MANDATE

Taxpayers in CA, DC, MA, NJ, RI, and VT (this list is neither complete nor exhaustive) are reminded that your state imposes an individual mandate penalty (tax) should you, your spouse, and children choose to not have (and keep) medical/rx coverage for each tax year. Please consult your tax advisor for how a non-election for health coverage may affect your tax situation.

Important Notices (continued)

PART B: INFORMATION ABOUT HEALTH COVERAGE OFFERED BY YOUR EMPLOYER

In the event you wish to apply for coverage on the Exchange, all the information you need from Human Resources is listed below. If you are located in California and wish to have someone assist you in the application process or have questions about subsidies that you may be eligible to receive, you can contact KeenanDirect at 855-653-3626 or at www.KeenanDirect.com. The information is numbered to correspond to the Marketplace application.

3. Employer name Oakdale Irrigation District	**4. Employer Identification Number (EIN)** 94-6003464	
5. Employer address 1205 East F Street	**6. Employer phone number** 209.840.5519	
7. City Oakdale	**8. State** CA	**9. ZIP code** 95361
10. Who can we contact about employee health coverage at this job? Kim Bukhari, Human Resources Administrator		
11. Phone number (if different from above)	**12. Email address** kbukhari@oakdaleirrigation.com	

As your employer, we offer coverage that meets the minimum value standard to the employees as described in this Guide. The coverage offered to you meets the minimum value standard and the cost of this coverage to you is intended to be affordable based on employee wages.

Important Notices (continued)

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 July 31, 2023. 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:
https://health.alaska.gov/dpa/Pages/default.aspx

ARKANSAS – Medicaid
Website: http://myarhipp.com/
Phone: 855-MyARHIPP (855-692-7447)

CALIFORNIA – Medicaid
Health Insurance Premium Payment (HIPP) Program Website:
http://dhcs.ca.gov/hipp
Phone: 916-445-8322
Fax: 916-440-5676
Email: hipp@dhcs.ca.gov

COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHIP+)
Health First Colorado Website:
https://www.healthfirstcolorado.com/
Health First Colorado Member Contact Center:
800-221-3943 | TTY: Colorado relay 711
CHP+: https://hcpf.colorado.gov/child-health-plan-plus
CHP+ Customer Service:
800-359-1991 | TTY: Colorado relay 711
Health Insurance Buy-In Program (HIBI):
https://www.mycohibi.com/
HIBI Customer Service: 855-692-6442

FLORIDA – Medicaid
Website:
http://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html
Phone: 877-357-3268

GEORGIA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp/
Phone: 678-564-1162, press 1
GA CHIPRA Website:
https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra
Phone: 678-564-1162, press 2

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: https://www.in.gov/medicaid/
Phone: 800-457-4584IOWA – Medicaid and CHIP (Hawki)
Medicaid Website: https://dhs.iowa.gov/ime/members
Medicaid Phone: 800-338-8366
Hawki Website: http://dhs.iowa.gov/Hawki
Hawki Phone: 800-257-8563
HIPP Website:
https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp
HIPP Phone: 888-346-9562

Important Notices (continued)

KANSAS – Medicaid
Website: https://www.kancare.ks.gov/
Phone: 800-792-4884
HIPPA Phone: 800-967-4660

KENTUCKY – Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website:
https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx
Phone: 855-459-6328
Email: KIHIPP.PROGRAM@ky.gov
KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx
Phone: 877-524-4718
Medicaid Website: https://chfs.ky.gov/agencies/dms

LOUISIANA – Medicaid
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp
Phone: 888-342-6207 (Medicaid hotline) or
855-618-5488 (LaHIPP)

MAINE – Medicaid
Enrollment Website:
https://www.mymaineconnection.gov/benefits/s/?language=en_US
Phone: 800-442-6003 | TTY: Maine relay 711
Private Health Insurance Premium Webpage:
https://www.maine.gov/dhhs/ofi/applications-forms
Phone: 800-977-6740 | TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP
Website: https://www.mass.gov/masshealth/pa
Phone: 800-862-4840 | TTY: Massachusetts relay 711
Email: masspremassistance@accenture.com

MINNESOTA – Medicaid
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.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
Email: HHSHIPPProgram@mt.gov

NEBRASKA – Medicaid
Website: http://www.ACCESSNebraska.ne.gov
Phone: 855-632-7633
Lincoln: 402-473-7000
Omaha: 402-595-1178

NEVADA – Medicaid
Medicaid Website: http://dhcfp.nv.gov/
Medicaid Phone: 800-992-0900

NEW HAMPSHIRE – Medicaid
Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program
Phone: 603-271-5218
HIPP Program Toll-Free Phone: 800-852-3345, ext. 5218

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://medicaid.ncdhhs.gov/
Phone: 919-855-4100

NORTH DAKOTA – Medicaid
Website: https://www.hhs.nd.gov/healthcare
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
Phone: 800-699-9075

PENNSYLVANIA – Medicaid and CHIP
Website:
https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx
Phone: 800-692-7462
CHIP Website: https://www.dhs.pa.gov/CHIP/Pages/CHIP.aspx
CHIP Phone: 800-986-KIDS (5437)

RHODE ISLAND – Medicaid and CHIP
Website: http://www.eohhs.ri.gov/
Phone: 855-697-4347 or 401-462-0311 (Direct RIte Share Line)

SOUTH CAROLINA – Medicaid
Website: https://www.scdhhs.gov
Phone: 888-549-0820

SOUTH DAKOTA – Medicaid
Website: http://dss.sd.gov
Phone: 888-828-0059

Important Notices (continued)

TEXAS – Medicaid
Website: https://www.hhs.texas.gov/services/financial/health-insurance-premium-payment-hipp-program
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: https://dvha.vermont.gov/members/medicaid/hipp-program
Phone: 800-250-8427

VIRGINIA – Medicaid and CHIP
Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select
https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs
Medicaid Phone: 800-432-5924
CHIP Phone: 800-432-5924

WASHINGTON – Medicaid
Website: https://www.hca.wa.gov/
Phone: 800-562-3022

WEST VIRGINIA – Medicaid and CHIP
Website: https://dhhr.wv.gov/bms/
http://mywvhipp.com/
Medicaid Phone: 304-558-1700
CHIP Toll-Free Phone: 855-MyWVHIPP (855-699-8447)

WISCONSIN – Medicaid and CHIP
Website:
https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm
Phone: 800-362-3002

WYOMING – Medicaid
Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/
Phone: 800-251-1269

To see if any other states have added a premium assistance program since July 31, 2023, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
866-444-EBSA (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

Glossary

Affordable Care Act and Patient Protection (ACA)

Also called Health Care Reform, the ACA requires health plans to comply with certain requirements. The ACA became law in March 2010. Since then, the ACA has required some changes to medical coverage—like covering dependent children to age 26, no lifetime limits on medical benefits, covering preventive care without cost-sharing, etc, among other requirements.

Allowed Amount

Maximum amount on which payment is based for covered health care services. This may be called "eligible expense," "payment allowance" or "negotiated rate." If your provider charges more than the allowed amount, you may have to pay the difference. (See Balance Billing.)

Balance Billing

When a provider bills you for the difference between the provider's charge and the allowed amount. For example, if the provider's charge is $100 and the allowed amount is $70, the provider may bill you for the remaining $30. A preferred provider may not balance bill you.

Brand Name Drug

The original manufacturer's version of a particular drug. Because the research and development costs that went into developing these drugs are reflected in the price, brand name drugs cost more than generic drugs.

COBRA (Consolidated Omnibus Budget Reconciliation Act)

The Consolidated Omnibus Budget Reconciliation Act allows people who lose their jobs to continue their employer-sponsored insurance coverage for up to 18 months.

Children's Health Insurance Program (CHIP)

The government program that provides free or low-cost health coverage for children up to age 19 in families whose income is too high to qualify for Medicaid but too low to afford private insurance. CHIP covers U.S. citizens and eligible immigrants. In some states, CHIP covers pregnant people. CHIP goes by different names in some states.

Claim

A request for payment that you or your health care provider submits to your health insurer to be paid or reimbursed for items or services you have received. Most often, you will not be responsible for making claim requests. Usually, billing and claims specialists employed by the health care provider (e.g. primary care office, hospital) will make the claim on your behalf.

Coinsurance

A percentage of costs you pay "out-of-pocket" for covered expenses after you meet the deductible.

Copayment (Copay)

A fee you have to pay "out-of-pocket" for certain services, such as a doctor's office visit or prescription drug.

Comprehensive Coverage

A health insurance plan that covers the full range of care that you may need. This may include preventive services (like flu shots), physical exams, prescription drugs, and doctor or hospital care.

Deductible

The amount you pay "out-of-pocket" before the health plan will start to pay its share of covered expenses.

Formulary

A list of prescription drugs covered by the health plan, often structured in tiers that subsidize low-cost generics at a higher percentage than more expensive brand-name or specialty drugs.

Generic Drug

Lower-cost alternative to a brand name drug that has the same active ingredients and works the same way.

High-Deductible Health Plan (HDHP)

High-deductible health plans (HDHPs) are health insurance plans with lower premiums and higher deductibles than traditional health plans. Only those enrolled in an HDHP are eligible to open and contribute tax-free to a health savings account (HSA).

Glossary (continued)

Health Savings Account (HSA)

A health savings account (HSA) is a portable savings account that allows you to set aside money for health care expenses on a tax-free basis. State taxes may apply. You must be enrolled in a high-deductible health plan in order to open an HSA. An HSA rolls over from year to year, pays interest, can be invested, and is owned by you—even if you leave the company.

Health Reimbursement Arrangements (HRAs)

Unlike HSAs, only an employer may fund an HRA and the funds revert back to the employer when the employee leaves the organization. HRAs are not subject to the same contribution limits as HSAs, and they may be paired with either high-deductible plans or traditional health plans.

In-Network

Doctors, clinics, hospitals and other providers with whom the health plan has an agreement to care for its members. Health plans cover a greater share of the cost for in-network health providers than for providers who are out-of-network.

Non-Preferred Provider

A provider who doesn't have a contract with your health insurer or plan to provide services to you. You'll pay more to see a non-preferred provider.

Out-of-Pocket Maximum

The most you pay each year "out-of-pocket" for covered expenses. Once you've reached the out-of-pocket maximum, the health plan pays 100% for covered expenses.

Out-Of-Network

A health plan may not cover treatment for doctors, clinics, hospitals and other providers who are out-of-network, but covered employees will pay more out-of-pocket to use out-of-network providers than for in-network providers.

Out-Of-Pocket Limit

The most an employee could pay during a coverage period (usually one year) for his or her share of the costs of covered services, including co-payments and co-insurance.

Plan Year

The year for which the benefits you choose during Annual Enrollment remain in effect. If you're a new employee, your benefits remain in effect for the remainder of the plan year in which you enroll, and you enroll for the next plan year during the next Annual Enrollment.

Preferred Provider

A provider who has a contract with your health insurer or plan to provide services to you at a discount.

Premium

The amount that must be paid for a health insurance plan by covered employees, by their employer, or shared by both. A covered employee's share of the annual premium is generally paid periodically, such as monthly, and deducted from his or her paycheck.

Preventive Care

Health care services you receive when you are not sick or injured— so that you will stay healthy. These include annual checkups, gender- and age-appropriate health screenings, well-baby care, and immunizations recommended by the American Medical Association.

Qualifying Life Event

A change in your life that can make you eligible for a Special Enrollment Period to enroll in health coverage. Examples of qualifying life events include moving to a new state, certain changes in your income, and changes in your family size.

Skilled Nursing Care

Services from licensed nurses in your own home or in a nursing home. Skilled care services are from technicians and therapists in your own home or in a nursing home.

Urgent Care

Care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room care.

CLICK HERE to watch a video on Benefits Key Terms Explained

Contact Information

Plan	Phone Number	Web Site
Medical		
• Kaiser Permanente	800-464-4000	www.kp.org
• Sutter Health	916-733-8800	www.sutterhealth.org
Dental		
• Delta Dental	844-222-3308	www.dentalinsurance.com
Vision		
• VSP	800-877-7195	www.vsp.com
Life Insurance		
• Lincoln Financial Group	800-423-2765	www.lincolnfinancial.com
Employee Assistance Program		
• Sutter Employee Assistance Program	800-477-2258	www.sutterhealth.org/eap
Flexible Spending Account		
• Ameriflex	Phone: 888-868-3539 Email: service@myameriflex.com	www.myameriflex.com
Voluntary		
• Colonial Life	800-325-4368	www.coloniallife.com/individuals