Employee Benefits Guide

July 1, 2021 – June 30, 2022

Introduction & Employee Resources

Flexible Solutions For Your Benefits Needs

We consider our employee benefits program to be one of our most important investments. Because we recognize the value our employees bring to our organization, we are committed to providing you with a complete benefits program as part of your total compensation.

This guide has been prepared to assist you in making informed decisions regarding your health insurance benefits and provide a brief overview of our overall employee benefits program.

Gallagher Employee Support Center

Gallagher Employee Support Center (ESC) provides a dedicated team of specialized representatives ready to assist you and your dependents.

The ESC team can support you as you utilize your employee health insurance benefits. The licensed representatives will work with both providers and the insurance companies on your behalf while protecting the privacy of your healthcare information.

You can also contact the ESC if you have questions or need assistance selecting the right health insurance plan for you and your family.

Your Employee Support Center (ESC) Supporting You With…

- Benefits Inquiry
- Claims Assistance
- Eligibility
- Materials/Forms Request
- Plan Education
- Provider Network Inquiries
- Referral/Pre-authorization

Monday - Friday | 8am - 4pm
855.670.2222
LosAngeles.ESC@ajg.com

Due to privacy regulations, our representatives will be required to obtain personal identifying information such as full name, contact information, address, date of birth and in some cases SSN or Member ID #. Please have this information ready. Some inquiries may require for you to provide HIPAA release in order for our advocates to work efficiently in resolving your issue with your provider or carrier.

Eligibility & Enrollment

New Hires/Newly Eligible for Benefits

All full-time regular and project employees who work on average at least 30 hours per week throughout the year are eligible for benefits.

Your benefits are effective 1st of the month following your date of hire. Once you have completed your new hire waiting period, you must enroll by the deadline date. If you do not enroll within that time period, you will not be eligible for benefits until the next Open Enrollment, unless you have a Qualifying Family Status Change.

Eligible Dependents

Your eligible dependents include your legally married spouse, registered domestic partner, and children. Due to Health Care Reform, your medical, dental, and vision plans cover dependents to age 26. However, for other plans, age limits may apply.

Coverage may be available for a mentally or physically disabled child who is age 19 or older. Requirements for such coverage and documentation of disability depend on the insurance carrier. Please contact your Benefits Administrator if you believe this applies to your family.

Open Enrollment

During Open Enrollment, you will have the opportunity to make changes to your benefit elections. You must enroll by the Open Enrollment deadline for your benefits to be effective July 1st. Except for a Qualifying Status Change, you will not be able to change your elections until the next year's Open Enrollment.

Qualifying Status Change

If you have a qualifying family status change, you may be able to change your benefits before the next Open Enrollment. You must notify Human Resources within 30 days of the change.

Qualifying Status Includes:

- Newly hired as full-time benefits-eligible
- Change in work schedule for you or your spouse (part-time to full-time)
- Change in employment for you, your spouse or dependent (i.e. your spouse loses their job and benefits)
- Change in marital status or dependents
- Gaining other coverage through your spouse
- Loss of other coverage for your dependent
- Change in residence causing loss of coverage
- Medicare or Medicaid entitlement for you, your spouse or dependent
- Qualified Medical Child Support Order (QMCSO)

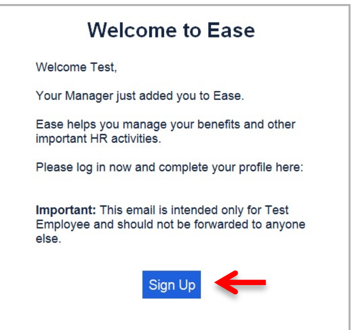
Easy Online Enrollment

This year, all health insurance enrollment will take place online in an interactive portal, Ease! This portal will be available to you 24/7 throughout the year. You can update your information throughout the year, as well as update your life insurance beneficiary information.

https://sequoiagrove.ease.com

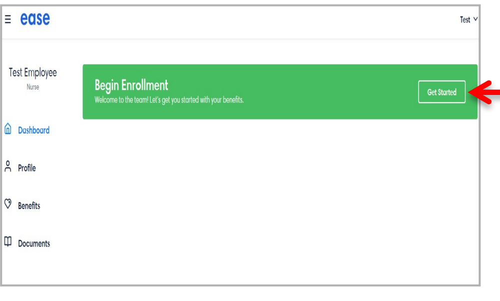
Step 1

Follow your email link for enrollment and select **"Sign Up"**.



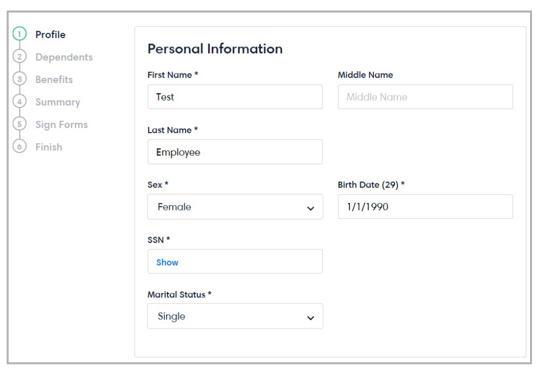
Step 2

Begin your enrollment by selecting **"Get Started"**.



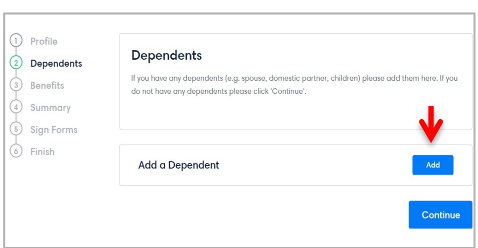
Step 3

Complete your profile.



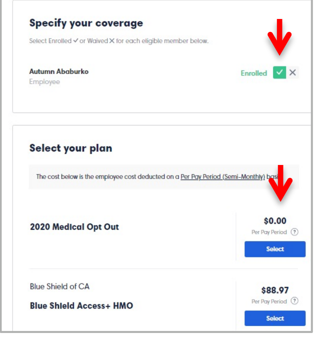
Step 4

To add dependents simply select **"Add Dependent"**.



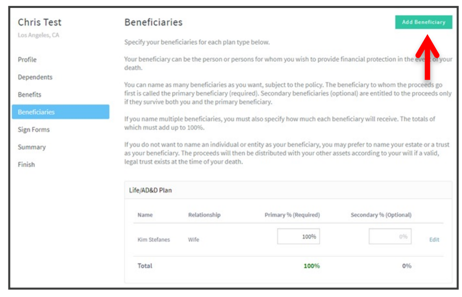
Step 5

Make your benefit selection checking off the icon next to the plan. Scroll down and click **"Continue"**.



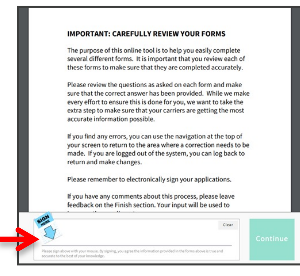
Step 6

To add beneficiaries select **"Add Beneficiary"**.



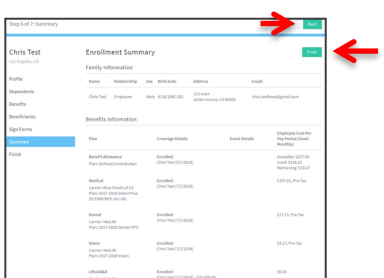
Step 7

After selecting your plans you will then sign the electronic enrollment forms.



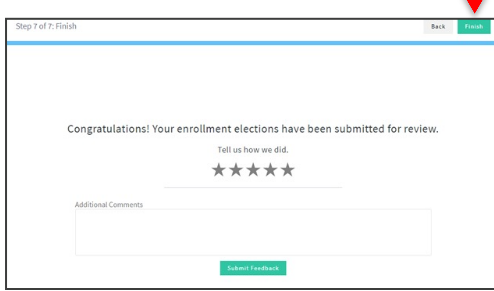
Step 8

Confirm your election summary by clicking **"Next"** and you may also print them for your records.



Step 9

Select **"Finish"** and you have then completed the enrollment process.



Benefits At A Glance

Costs Shared By You & Sequoia Grove	
Medical	• Sutter Health HMO 20 • Health Net SmartCare HMO 20/20% • Health Net PPO 1000 • Health Net PPO HSA 2800 • Kaiser HMO 20
Dental	• MetLife Dental HMO Plan • MetLife Dental PPO Low Plan • MetLife Dental PPO High Plan
Vision	• MetLife/VSP
Benefits Provided By Sequoia Grove	
Basic Life and AD&D	• MetLife: $50,000 Benefit
Employee Assistance Plan (EAP)	• MetLife: 24/7 unlimited telephonic counseling services plus 5 face-to-face visits
Voluntary Employee-Paid Benefits	

Supplemental Life and AD&D	• MetLife:
	  • Employee coverage in increments of $10,000 up to $500,000 or 5 times salary (guaranteed $100,000)
	  • Spouse coverage in increments of $5,000 up to $100,000 or 50% of employee election (guaranteed $30,000)
	  • Child(ren) coverage under the age of 15 days is $100, 15 days to 6 months is $1,000 and 6 months to 26 years (full-time student) is $1,000, $2,000, $4,000, $5,000, or $10,000 (guaranteed $10,000)

Disability Benefit	• MetLife: Short Term Disability

Worksite Benefits	• Transamerica:
	  • Accident
	  • Critical Illness
	  • Hospital Indemnity

Flexible Spending Accounts (FSA)	• The Advantage Group
	  • Health Care FSA: $2,750 maximum plan year contribution
	  • Dependent Care FSA: $5,000 maximum plan year contribution

403b Savings Plan	• Teacher's Pension Exchange (TPX)
Voluntary Pet Insurance	• ASPCA

Employee Pay-period Contributions

Medical Coverage	Sutter HMO	Health Net HMO	Health Net PPO	Health Net PPO HSA	Kaiser HMO
Employee	$0.00	$97.85	$118.07	$0.00	$0.00
Employee + Spouse	$66.40	$317.04	$405.56	$117.65	$81.05
Employee + Child(ren)	$44.35	$215.27	$272.08	$86.96	$54.03
Employee + Family	$116.18	$418.80	$539.04	$148.34	$141.83

Dental Coverage	MetLife Dental HMO Plan	MetLife Dental PPO Low Plan	MetLife Dental PPO High Plan
Employee	$2.63	$10.00	$15.00
Employee + Spouse	$8.06	$30.00	$40.00
Employee + Child(ren)	$9.87	$35.00	$45.00
Employee + Family	$13.91	$50.00	$65.00

Vision Coverage	MetLife/VSP Vision
Employee	$2.00
Employee + Spouse	$4.00
Employee + Child(ren)	$5.00
Employee + Family	$8.00

Voluntary Coverage*	Transamerica Accident Plan	Transamerica Hospital Plan
Employee	$6.55	$9.77
Employee + Spouse	$10.18	$20.89
Employee + Child(ren)	$8.87	$16.18
Employee + Family	$12.75	$24.97

***Rates for Voluntary Life/AD&D, Short Term Disability, and Critical Illness are based on individual age & salary. Refer to Ease for pay-period costs.**

Medical Plan Options

Sutter Health Plus HMO

Sutter Health Plus HMO is affiliated with the Sutter Health organization. Many of Sutter Health's hospitals, physician organizations, surgery centers, outpatient sites, urgent care centers and other health care services are available through the HMO plan. The Primary Care Physician will oversee all of your medical care. Other providers and specialists must be referred by your Primary Care Physician. You may change to a different Primary Care Physician whenever you choose.

Health Net HMO

If you choose the Health Net HMO, you must select a primary care physician who will manage your care and refer you to a specialist when it is needed. You pay a copayment for some products and services, and there is no annual deductible.

Health Net PPO & HSA

The PPO plan offers a network of providers who have agreed to discount their fees for their services. You may choose to have your treatment provided by a PPO provider and receive a higher level of benefit with a lower out-of-pocket cost to you. You may also choose to go outside the network; however, generally, benefits are reimbursed at a lower level and you may have higher out-of-pocket costs.

Kaiser HMO

Kaiser Permanente operates its own facilities and hires all physicians directly. Most services are provided at little or no cost to the enrollees. Under most circumstances, you must use Kaiser facilities and physicians, although emergency care is covered when you are away from home.

HMO Plans

WHAT YOU PAY	Sutter Network	SmartCare Network	Kaiser Network
Calendar Year Deductible (Single/Family)	None	None	None
Calendar Year Out-of-Pocket Maximum (Single/Family)	$1,500/$3,000	$2,500/$7,500	$3,000/$6,000
Preventive Services	No Charge	No Charge	No Charge
Office Visits (Primary/ Specialist/Telehealth)	$20/$20/$20	$20/$40/$0	$20/$20/$0
Chiropractic/Acupuncture	$10 (30 visits/year)	$15 (10 visits/year)	$15 (20 visits/year)
Fertility Services*	Not Covered	50%	50%
Lab & X-ray	Lab: $20 X-Ray: No Charge	No Charge	$10
Complex Radiology (Includes CT, PET and MRI)	No Charge	$100	$100
Inpatient Hospital Services (Includes maternity)	$250/admit	20%	$500/day (3-days max)
Outpatient Surgery	$100	Facility: 10% Hospital: 20%	$250
Urgent Care (Co-pay waived if admitted)	$20	$40	$20
Emergency Room (Co-pay waived if admitted)	$100	$100	$150
Ambulance	$50	$100	$150
PRESCRIPTION DRUGS			
Calendar Year Drug Deductible	None	None	None
Retail Prescription (Tier 1/Tier 2/Tier 3/Specialty)	$10/$30/$60/ 20% up to $250 (up to 30-day supply)	$10/$30/$50/ 30% up to $250 (up to 30-day supply)	$15/$35/ 30% up to $200 (generic/brand/specialty) (up to 30-day supply)
Mail-Order Prescription (Tier 1/Tier 2/Tier 3)	$20/$60/$120 (up to 90-day supply)	$20/$75/$125 (up to 90-day supply)	$30/$70/ Not Covered (generic/brand/specialty) (up to 100-day supply)

*Fertility benefits limited to diagnosis of fertility issues and artificial insemination. Lifetime maximum benefit coverage apply. Refer to individual carrier policy for more details.

PPO Plans

	PPO Plan		PPO HSA Plan	
WHAT YOU PAY	**In-Network**	**Out-of-Network****	**In-Network**	**Out-of-Network****
Calendar Year Deductible (Single/Family)	$1,000/$3,000	$2,000/$6,000	$2,800/$5,600	$5,600/$11,200
Calendar Year Out-of-Pocket Maximum (Single/Family)	$3,000/$9,000	$6,000/$18,000	$5,000/$10,000	$10,000/$20,000
Preventive Services	No Charge (deductible waived)	Not Covered	No Charge (deductible waived)	Not Covered
Office Visits (Primary/ Specialist/ Telehealth)	$30/$50/$0 (deductible waived)	40%/40%/Not Covered (after deductible)	30%/30%/$0 (after deductible)	50%/50%/Not Covered (after deductible)
Chiropractic/ Acupuncture	$30 (deductible waived)/ 20% (after deductible)	40% (after deductible)	30%/30% (after deductible)	50% (after deductible)
Fertility Services*	50% (after deductible)	Not Covered	50% (after deductible)	50% (after deductible)
Lab & X-ray	20% (after deductible)	40% (after deductible)	30% (after deductible)	50% (after deductible)
Complex Radiology (Includes CT, PET and MRI)	20% (after deductible)	40% (after deductible)	30% (after deductible)	50% (after deductible)
Inpatient Hospital Services (Includes maternity)	20% (after deductible)	40% (after deductible)	30% (after deductible)	50% (after deductible)
Outpatient Surgery	Facility: 10% Hospital: 20% (after deductible)	40% (after deductible)	Facility: 20% Hospital: 30% (after deductible)	50% (after deductible)
Urgent Care (Co-pay waived if admitted)	$50 (deductible waived)	40% (after deductible)	30% (after deductible)	50% (after deductible)
Emergency Room (Co-pay waived if admitted)	$100 + 20% (after deductible)	$100 + 20% (after deductible)	$100 + 30% (after deductible)	$100 + 30% (after deductible)
Ambulance	$50 + 20% (after deductible)	$50 + 40% (after deductible)	30% (after deductible)	30% (after deductible)
PRESCRIPTION DRUGS				
Calendar Year Drug Deductible	None		Medical Plan Deductible Applies	
Retail Prescription (Tier 1/Tier 2/Tier 3/Specialty)	$10/$30/$50/ 30% up to $250 (up to 30-day supply)	Retail co-pay + 50%	$15/$35/$55/ 30% up to $250 (up to 30-day supply)	Retail co-pay + 50%
Mail-Order Prescription (Tier 1/Tier 2/Tier 3)	$20/$75/$125 (up to 90-day supply)	Not Covered	$30/$87.50/$137.50 (up to 90-day supply)	Not Covered

*Fertility benefits limited to diagnosis of fertility issues and artificial insemination. Lifetime maximum benefit coverage apply. Refer to individual carrier policy for more details.
**Out of Network services are limited to a maximum allowed amount/fee schedule reimbursement.

Medical Provider Search

1. Visit www.sutterhealthplus.org
2. Click on "Find a Provider" and enter your Zip Code or City & State
3. If you know what kind of doctor you are interested in select an option from the "Primary Care Specialties" box
4. Click on the "Accepting new patients" box and then click "Search Doctors" and a list of contracted providers that are accepting new patients will be generated

Remember: Choosing Sutter means staying within the Sutter network, with the limited exception for an approved referral for an outside provider from your PCP.

1. Visit www.healthnet.com
2. Click on "Find a Provider" and select a location type from the drop-down menu. Then enter your location details (city & state or zip code).
3. Under "Filter by type of Plan/Network" choose from the below:
    - For **HMO**: select "HMO - SmartCare Network Large Group"
    - For **PPO or HSA**: select "PPO - Large Group"
4. Click the type of care you are searching for (doctors, urgent cares, hospitals, etc.)

Remember: Provider contracts are always changing with the carrier. Please call your provider or Health Net to ensure that the provider's are still in-network before going to see them.

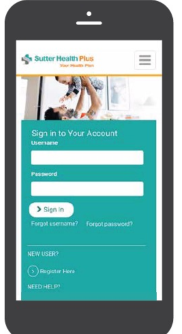
1. Please visit www.kp.org
2. Click on "Doctors & Locations"
3. Choose the region you are searching in and enter your zip code
4. Press "Search" you will see a listing of doctors

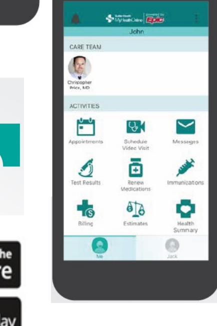
Remember: Choosing Kaiser means staying within the Kaiser network, with the limited exception for an approved referral for an outside provider from your PCP.

Looking for Chiropractic or Acupuncture Services?

- When you need chiropractic or acupuncture care under the Kaiser HMO plan, you can visit any participating provider in California from the ASH plan network without referral from your HMO PCP.
- Find an ASH Plan Participating Provider near you by calling the customer service line at 1-800-678-9133 weekdays from 5am to 6pm (PST) or visiting the website www.ashlink.com/ash/kp.

Member Tools





Sutter Member Portal & My Health Online

Sutter Health Plus offers a member portal for your convenience. Just visit https://shplus.org/memberportal, and after you register on the portal, you will have easy access from your smartphone, tablet or computer to:

- Renew prescriptions & view test results
- Pay bills and copays online
- Change your primary care physician
- Request or print member ID cards
- Access your summary of deductibles and out-of-pocket balances
- Review your benefit details and Evidence of Coverage (EOC)

You can also enroll in My Health Online (MHO), a convenient way to manage your health when and where you want. With MHO, it's easy to stay connected with your care team and have 24/7 access to your health information. Log in at https://mho.sutterhealth.org, and through the portal you can:

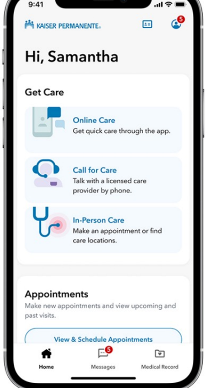
- Book a video visit & email your care team
- Make an appointment
- Sign up for text reminders

Health Net Mobile App

The Health Net Mobile app is the easiest way to connect to your www.healthnet.com online account.

Once you're a registered on the Health Net member site, you can use the member app to quickly get plan, co-pay and deductible information. You can also access Provider Search and a mobile version of your Health Net ID card.

Kaiser Mobile App & Member Portal



With the Kaiser app, keeping up with your care is quick, easy, and secure. Just download the mobile app at no cost from your preferred app site.

- Schedule or cancel routine appointments
- Email your doctor's office with non-urgent questions
- Refill most prescriptions & check most lab results
- Access a digital version of your member ID card
- View and pay bills

Register as a member through the Kaiser online portal by visiting kp.org/registernow.

Virtual Visits

When you need care — anytime, day or night — virtual visits can be a convenient option. Talk with a doctor 24/7 about mild conditions such as flus, fevers, colds, sore throats, migraines, rashes, allergies, stomach aches, pink eye, and more.

Sutter Video Visits – $25

You have access to video visits through your My Health Online (MHO) account, with same-day appointments for common and minor illnesses.

Download the MHO mobile app for the best experience using virtual care. You can also access virtual visits through your computer. Select "Schedule Video Visit" and pick a time for your visit. At the time of your appointment, log into MHO. Select your scheduled Video Visit and click "Begin Video Visit."

For more information visit, www.sutterhealth.org/video-visits.

Health Net Care with Babylon Health – $0 (HSA Plan: covered after deductible)

With the Babylon app you can make a video appointment to speak face-to-face with a health care provider for non-emergency issues at any time day or night, 24/7.

1. Search & download the Babylon Health app.
2. To sign-up, enter your information and the code **HNCOM**. You must be 18 or older to sign up. If you are a parent or guardian setting up an account for a child under 18, you must sign-up first and then add the child to your account. You will also need to be present during the child's Babylon video appointment.

Kaiser Virtual Care – $0

Kaiser offers phone and video appointments with your doctor, as well as 24/7 medical advice and guidance through their service team. You can even email your doctor through your Kaiser mobile app. These options are perfect for conditions such as colds, flus, allergies, sinus issues, and other mild medical needs.

E-visits

1. Log in at **www.kp.org/appointments** or go to Get Care on the KP mobile app
2. Answer questions online about your symptoms. Based on your answers, you'll receive treatment information or instructions.

Telephone Appointments

1. Log in at **www.kp.org** or the KP mobile app, or call (650) 358-7015, Monday through Friday, 7 a.m. to 7 p.m.

Video visits

1. Call (650) 358-7015, Monday through Friday, 7 a.m. to 7 p.m. and check if a video visit is appropriate for your condition and available.

Medical Preventive Services

The following are examples of Preventive Services covered by your policy. For a complete list of these services, please refer to your combined Evidence of Coverage and Disclosure Form. Preventive Services are covered 100%.

CHILD PREVENTIVE CARE	MEN & WOMEN'S PREVENTIVE CARE	ADULT PREVENTIVE CARE
Screening Tests ○ Behavioral counseling to promote a healthy diet ○ Blood pressure ○ Cervical dysplasia screening ○ Cholesterol and lipid level ○ Depression screening ○ Type 2 diabetes screening ○ Hearing screening ○ Height, weight and body mass index (BMI) ○ Hemoglobin (blood count) ○ HPV screening ○ Lead testing ○ Newborn screening ○ Screening and counseling for obesity ○ Oral (dental health) assessment ○ Screening and counseling for STIs ○ Vision screening **Immunizations** ○ Diphtheria, tetanus and pertussis (whooping cough) ○ Haemophilus influenza type b ○ Hepatitis A and Hepatitis B ○ Human papillomavirus (HPV) ○ Influenza ○ Measles, mumps and rubella ○ Meningococcal (meningitis) ○ Pneumococcal (pneumonia) ○ Polio ○ Rotavirus ○ Varicella (Chicken Pox)	**Men** ○ Aortic aneurysm screening (men who have smoked) ○ Prostate cancer **Women** ○ Well-woman visits ○ Breast cancer testing for BRCA 1 and BRCA 2 when certain criteria are met ○ Breastfeeding: primary care intervention to promote breastfeeding support, supplies and counseling ○ Contraceptive (birth control) counseling ○ FDA-approved contraceptive services provided by a doctor ○ Counseling related to chemoprevention for women with a high risk of breast cancer ○ Counseling related to genetic testing for women with a family history of ovarian or breast cancer ○ HPV screening ○ Screening and counseling for interpersonal and domestic violence ○ Pregnancy screenings: includes, but is not limited to, gestational diabetes, hepatitis, iron deficiency, anemia, and STDs ○ Pelvic exam and Pap test, including screening for cervical cancer	**Screening Tests** ○ Behavioral counseling to promote a healthy diet ○ Blood pressure ○ Bone density test to screen for osteoporosis ○ Cholesterol and lipid (fat) level ○ Colorectal cancer, including fecal occult blood test, barium enema, flexible sigmoidoscopy, screening colonoscopy and related prep kit and CT colonography (as appropriate) ○ Depression screening ○ Hepatitis C virus (HCV) for people at high risk for infection and a one-time screening for adults born between 1945 and 1965 ○ Type 2 diabetes screening ○ Eye chart test ○ Obesity ○ STIs ○ Tobacco use: related screening and behavioral counseling ○ Violence, interpersonal and domestic: related screening and counseling **Immunizations** ○ Diphtheria, tetanus and pertussis ○ Hepatitis A and Hepatitis B ○ HPV ○ Influenza ○ Meningitis ○ Measles, mumps and rubella ○ Pneumococcal ○ Varicella (Chicken pox) ○ Zoster (shingles)

Dental & Vision Plans

MetLife HMO Dental

Dental HMOs are designed to help you and your family maintain oral health and reduce your out-of-pocket costs, and they're simple to use. Just select a participating (network) dentist at enrollment and refer to your Schedule of Benefits to determine your benefits for each covered service.

This type of insurance requires some type of prepayment from you. In exchange, you get dental care from a network of dental care providers. If you want to use a dentist outside the approved network, you must pay your entire dentist's bill yourself.

MetLife PPO Dental

You may see any dentist, but you will have a higher benefit level and lower out-of-pocket costs if you visit a MetLife PPO network dentist. Savings are greater when you visit an In-Network provider because MetLife's contracted dentists have agreed to provide care at a negotiated rate.

Out of Network benefit amounts are subject to the MetLife contracted fee schedule. You will be responsible for the difference between the plan payment and the dentist's usual charge.

MetLife/VSP Vision Care

A vision plan is one of the most requested benefit options. We are pleased to provide an affordable vision plan. The plan utilizes the VSP Choice network.

VSP has one of the largest networks of private practicing optometrists, ophthalmologists, and opticians. In addition to the vision plan benefits provided through your benefits program, VSP offers a number of non-covered services at a discount.

Metlife Dental HMO Plan

	WHAT YOU PAY*
Plan Maximums	
Calendar Year Deductible	**None**
Calendar Year Maximum Benefit	**None**
Preventive Procedures	
Office Visit	**$5**
D1110/D1120 Cleaning Adult/Child	**$0**
D0210 – D0330 X-rays & Imaging	**$0**
Restorative Procedures	
D2391 White Filling (posterior)	**$25**
D3330 Molar Endodontics (root canal)	**$95**
D4261 Periodontal Osseous Surgery (gum disease)	**$198**
D4342 Periodontal Scaling & Root Planing (gum disease)	**$19**
Major Procedures	
D5110 – D5120 Complete Denture (maxillary or mandibular)	**$125**
D5211 – D5212 Partial Denture (maxillary or mandibular)	**$110**
D6241 Pontic (porcelain fused to a high noble metal)	**$100**
D6750 Crown (porcelain fused to a high noble metal)	**$100**
D7220 Surgery to remove impacted tooth (soft tissue)	**$20**
Orthodontia	
Comprehensive Orthodontic Treatment (child)	**$1,450**
Comprehensive Orthodontic Treatment (adult)	**$1,450**

* Please view the carrier's schedule of benefits for a more comprehensive outline.

Key Facts:

- No plan maximum, unlimited benefit coverage
- You must make all appointments with your assigned DHMO dentist
- You must contact MetLife before the 15th of the month to change your dentist
- Always request a treatment plan before you have services done!

Metlife Dental PPO Low Plan

	WHAT YOU PAY	
	In Network*	**Out Of Network***
Plan Maximums		
Calendar Year Deductible (single/family)	**$50/$150**	**$100/$300**
Calendar Year Maximum Benefit	**$2,000 per person per calendar year**	**$1,500 per person per calendar year**
Preventative Procedures		
Oral Examinations, Bitewing or Full Mouth X-rays, Cleanings	**0% (deductible waived)**	**0% (deductible waived)**
Basic Procedures		
Fillings, Endodontics (root canal therapy), Periodontics, Sealants, Simple Oral Surgery and Simple Extractions	**20%**	**20%**
Major Procedures		
Crowns, Inlays, Onlays and Cast Restorations, Bridges and Dentures	**50%**	**50%**
Orthodontic Procedures		
Orthodontia	**Not Covered**	

** Reimbursement is based on PPO contracted fees for PPO dentists, and maximum allowable charges for non-MetLife dentists.*

Key Facts:
- Free exams, cleanings, & x-rays
- Plan allowance (calendar year maximum benefit) resets every January 1
- Always request a treatment plan before you have services done!

Metlife Dental PPO High Plan

	WHAT YOU PAY In Network*	Out Of Network*
Plan Maximums		
Calendar Year Deductible (single/family)	**$0/$0**	**$100/$300**
Calendar Year Maximum Benefit	**$2,500 per person per calendar year**	**$2,000 per person per calendar year**
Preventative Procedures		
Oral Examinations, Bitewing or Full Mouth X-rays, Cleanings	**0% (deductible waived)**	**0% (deductible waived)**
Basic Procedures		
Fillings, Endodontics (root canal therapy), Periodontics, Sealants, Simple Oral Surgery and Simple Extractions	**20%**	**20%**
Major Procedures		
Crowns, Inlays, Onlays and Cast Restorations, Bridges and Dentures	**50%**	**50%**
Orthodontic Procedures		
Orthodontia	**$1,500 lifetime maximum benefit 50% (children & adults)**	

** Reimbursement is based on PPO contracted fees for PPO dentists, and maximum allowable charges for non-MetLife dentists.*

Key Facts:

- Free exams, cleanings, & x-rays
- Plan allowance (calendar year maximum benefit) resets every January 1
- Always request a treatment plan before you have services done!

Metlife/VSP Vision

	WHAT YOU PAY	
	In Network	**Out of Network**
Exams		
Vision Exam (every 12 months)	**$10**	**Reimbursement up to $45**
Lenses		
Single Bifocal Trifocal (every 12 months)	**$25**	**Reimbursement up to: $30 $50 $65**
Frames		
Frames (every 12 months)	**$150 allowance, then 20% off amount over frame allowance $85 allowance at Costco, Walmart, Sam's Club**	**Reimbursement up to $70**
Contacts (In Lieu of Glasses)		
Medically Necessary (every 12 months)	**$25**	**Reimbursement up to $210**
Elective (every 12 months)	**$150 allowance**	**Reimbursement up to $105**
Contact lens exam (fitting and evaluation)	**Not to exceed $60**	**Not Covered**

Key Facts:

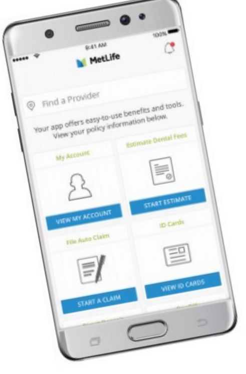
- Services are covered based on your **most recent service date**. You can have a new eye exam and purchase new lenses 12 months after your last eye exam or lens purchase. You can purchase new frames 12 months after your most recent purchase.
- Additional lens enhancements available at a co-pay or discount.
- Out of Network services may require you to make a full payment at the time or services, and submit a claim form for reimbursement.

Dental/Vision Provider Search

1. Visit www.metlife.com
2. Under the tab "Support", click on "Find a Dentist"
3. Enter your Zip Code or City & State. You may also search for a specific dentist or dental office.
4. Choose your plan:
    1. For **Dental HMO:** select "Dental HMO/Managed Care". After you click "Find", select "Met100" from the drop down list.
    2. For **Dental PPO:** select "PDP"
5. Click on the "Accepting new patients" box and a list of contracted providers that are accepting new patients will be generated

Remember: If you choose the Dental HMO plan, you will need to select a primary dental provider. If you choose the Dental PPO plan, you do not need to elect a primary dental provider, but we recommend requesting pre-determination for all proposed services prior to receiving treatment to determine what the plan will cover and what your out of pocket cost will be.

1. Visit www.metlife.com
2. Under the tab "Support", click on "Find a Vision Provider"
3. Enter your Zip Code or City & State, and a list of contracted providers will be generated



MetLife Mobile App

Find a MetLife Dental or Vision Provider and access your ID cards all in one easy-to-use app. One username and password gives you 24/7 access to your health plan information from your desktop, laptop and mobile device.

Download the mobile app today or visit www.metlife.com for more details and FAQs.

Flexible Spending Accounts

What is an FSA?

A Flexible Spending Account (FSA) is an account that allows you to set aside pre-tax dollars from your paycheck to use on eligible health care and dependent care expenses. You elect how much you want to contribute each year, and your employer deducts the amount from your paychecks for the plan year.

Health Care Reimbursement FSA

The annual maximum contribution to the Health Care Reimbursement FSA is $2,750
The Health Care Reimbursement FSA allows you to pay for certain health care services and items for you, spouse and dependents. These are items such as:

- Prescriptions
- Co-pays
- Dental & Vision care
- Certain over-the-counter items and medicines

For more information about eligible expenses, please refer to IRS Publication 502 available at www.irs.gov/publications/p502/index.html

Dependent Care Reimbursement FSA

The annual maximum contribution to the Dependent Care Reimbursement FSA is $5,000
The Dependent Care Reimbursement FSA allows you to use pre-tax dollars toward qualified dependent care. Care must be for a tax-dependent child under age 13 who lives with you, or a tax-dependent, spouse or child who lives with you and is incapable of caring for themselves. Also, the care must be needed so that you and your spouse (if applicable) can go to work. Care must be given during normal working hours and cannot be provided by another of your dependents. Typical expenses include:

- Before- and after-school care
- Day care, preschool, nursery school
- Adult day care

"Use-It-or-Lose-It" Rule

The Health Care and Dependent Care Reimbursement FSAs run on a plan year basis. The current plan year is from July 1, 2021 through June 30, 2022; claims can only be for services/expenses incurred during the plan period. Any funds left unclaimed will be forfeited. Your employer has elected to offer a $500 rollover option for Health Care Reimbursement, which will allow you to roll over up to $500 of unused contributions into the next plan year. Please refer to your plan documents for additional information.

The *MyFlex* Mobile App allows you to view FSA balances and submit claims and receipts.

FSA store

Have leftover funds at the end of the year?
Visit www.fsastore.com to purchase FSA-eligible items before the end of the plan year, and also review the updated FSA Eligibility list.

Life Insurance

All benefit eligible employees are provided with employer-paid Life and Accidental Death & Dismemberment (AD&D) coverage. All eligible employees are automatically enrolled in Life and AD&D plans. This benefit is paid for 100% by your employer.

Employee Basic Life Insurance & Accidental Death and Dismemberment (AD&D)

- Benefit amount of $50,000
- AD&D provides 100% of the Basic Life benefit
- In the event of death that occurs from a covered accident, both Life and AD&D benefit would be payable each in the amount of the basic life insurance.

Benefits After Age 70

Your life benefits will reduce after age 70, and the reduction schedule is as follows:

- Reduce to 70% at age 70, reduce to 40% at age 75

- Consider updating your Life Insurance beneficiary through the Ease enrollment portal.
- You may update your Life Insurance Beneficiary any time during the year as often as you would like.

As an added benefit, you may purchase Supplemental Life and Accidental Death & Dismemberment insurance for you and your dependents. This benefit is voluntary and paid for 100% by eligible employees through payroll deductions.

Supplemental Employee Life/AD&D

Employees may purchase additional coverage in $10,000 increments not to exceed $500,000 or 5 times their salary. The Guaranteed Issue* amount is $100,000.

Supplemental Spouse Life/AD&D

You may purchase additional coverage for your spouse in $5,000 increments to the lesser of $100,000 or 50% of employee coverage. The Guaranteed Issue* amount is $30,000.

Supplemental Child(ren) Life/AD&D

You may purchase additional coverage for your child(ren). For children age 6 months to 26 years (if full-time student), you may purchase additional coverage of $1,000 $2,000, $4,000, $5,000 or $10,000. For infants (birth to age 14 days), the benefit is $100, and from age 15 days to 6 months the benefit is $1,000.

Should you choose to elect coverage outside of your initial eligibility period, or you elect coverage above the Guaranteed Issue amount, you or your spouse will need to complete the Statement of Health Form for medical underwriting purposes

Employee Assistance Plan (EAP)

This benefit is paid for 100% by Sequoia Grove. There is no cost to you, the employee.
All members of your household can utilize the benefits of this program.

All benefit eligible employees are provided with employer paid Employee Assistance Plan (EAP) through MetLife. All eligible employees are automatically enrolled in the EAP. All members of your household can utilize the benefits of this program.

Life is full of challenges and sometimes balancing it is difficult. The EAP is there when you need it. MetLife offers the appropriate assistance for a wide range of issues and provides referrals to professional counselors or services that can help you resolve emotional health, family and work issues.

- Healthy Living
- Stress Management
- Mental Health
- Diet & fitness
- Overall wellness

- Parenting support
- Child & elder care
- Learning programs
- Special needs help

- Legal issues
- Will preparation
- Taxes
- Debt
- Financial planning

Along with unlimited telephonic access, the EAP also offers 5 face-to-face visits with a counselor per person per issue. Member Services Available 24/7!

Phone: 888-319-7819
Online: www.metlifeeap.lifeworks.com (username: metlifeeap Password: eap)

Voluntary Short Term Disability

This benefits is paid for 100% by the employee.

MetLife provides employees with Voluntary Short Term coverage for those unexpected situations that may keep you from performing the daily responsibilities of your job. Your disability plan is available to help supplement your income when you are not able to continue employment for a certain period of time. This benefit is voluntary and paid for 100% by eligible employees through payroll deductions.

Elimination Period

Benefits begin after the end of the elimination period. The elimination period begins on the day you become disabled and is the length of time you must wait, while disabled, before you are eligible to receive a benefit. For injury, accident, and pregnancy, the elimination period is 7 days.

Coverage Period

Benefits continue for as long as you are disabled up to a maximum duration of 12 weeks of Disability.

Benefit Amount

The Short Term Disability benefit replaces a portion of your pre-disability earnings. The benefit amount is 20% of your pre-disability weekly earnings up to $700 per week.

Pre-Existing Condition

Employees are subject to a pre-existing condition limitation. The pre-existing condition under this plan is 3/12 which means any condition that you receive medical attention, treatment, or medication for in the 3 months prior to your effective date of coverage that results in a disability during the first 12 months of coverage, would not be covered.

How do I submit a Short Term Disability Claim?

A completed Short Term Disability Claim is necessary for MetLife to review a claim. Please make a copy of the completed form for your records. Make sure you have provided all required information and answered all questions completely and accurately. You, your Employer, and your Attending Physician will need to provide information on this claim form.

Submit a claim online:
https://mybenefits.metlife.com

- Locate Sequoia Grove and then register online.

Start a claim over the phone:
1-800-438-6388

Submit a paper claim form:
MetLife Group STD Claims
P.O. Box 80826
Lincoln, NE 68501-0826
Phone: (800) 438-6388
Fax: (855) 306-7350

Voluntary Accident

This benefits is paid for 100% by the employee.

With the high cost of medical care today, a trip down the stairs can hurt your bank account as much as your body. Accident insurance can pay you money based on the injury and the treatment you receive, whether it's a simple sprain or something more serious, like an injury from a car accident.

Accident benefits pay in addition to other insurance, and can be used to help cover gaps in health insurance or other expenses if the unexpected happens. The money is paid directly to you and you decide how to spend it. This benefit is voluntary and paid for 100% by eligible employees through payroll deductions.

Benefits:

- Covers off-the-job accidents 24-hours per day
- Covers employee and spouses to age 65, covers children to age 26
- Family coverage is available
- Guarantee Issue: No Medical Questions asked
- Conversion Option available: you can take your policy with you if you leave your employer

Covered Conditions	24-Hour Off-Job Coverage Transamerica Accident Insurance Pays YOU
Fractures	$420 - $6,000
Dislocations	$180 - $4,800
Concussions	$140
Lacerations	$28 - $420
Ambulance	$210 - $1,050
Emergency Care	$150
CT/MRI/EEG Scan	$240
Physician Follow-Up	$50
Physical Therapy	$50
Hospital	$1,050 (ICU or non-ICU) per accident + Non-ICU $150/day (up to 365 days) ICU $450/day (up to 15 days)

Plus many other events!

Voluntary Critical Illness

This benefits is paid for 100% by the employee.

What's a critical illness? Some common examples are heart attack, stroke and cancer diagnosis. The medical treatment for these conditions can be very expensive.

Critical illness insurance with Transamerica can help by paying a lump sum payment directly to you at the first diagnosis of a covered condition. You decide how to spend it. You can use this coverage more than once for different conditions, but each condition is payable once per lifetime. This benefit is voluntary and paid for 100% by eligible employees through payroll deductions.

Plan Highlights

- Covers employee and spouses to age 65, covers children to age 26
- Employee benefit options: $10,000, $20,000 or $30,000
- Spouse benefit options: 100% of employee benefit
- Children benefit options: 100% of employee benefit
- Guarantee Issue: No Medical Questions asked
- Wellness Screening Benefit: pays $50 when a covered person undergoes a health screening test
- Conversion Option available: you can take your policy with you if you leave your employer
- Each illness is eligible for its own payout
- No pre-existing condition limitation
- No age reduction

Covered Conditions

- Heart Attack
- Stroke
- Major Organ Failure
- End Stage Renal Failure
- Loss of Speech
- Loss of Sight
- Coronary Artery Disease
- Cancer
- Plus many Other Conditions

Voluntary Hospital Indemnity

This benefits is paid for 100% by the employee.

Hospital indemnity (HI) insurance pays a cash benefit if you or an insured dependent (spouse or child) are confined in a hospital for a covered illness or injury. It also provides additional daily benefits for related services. Even with the best primary health insurance plan, out-of-pocket costs from a hospital stay can add up. This benefit is voluntary and paid for 100% by eligible employees through payroll deductions.

The benefits are paid in lump sum amounts to you, and can help offset expenses that primary health insurance doesn't cover (like deductibles, co-insurance amounts or co-pays), or benefits can be used for any non-medical expenses (like housing costs, groceries, car expenses, etc.).

Benefits:

- Covers on- and off-the-job injury or illness, 24-hours per day
- Covers employee and spouses to age 65, covers children to age 26
- Family coverage is available
- Guarantee Issue: No Medical Questions asked
- Conversion Option available: you can take your policy with you if you leave your employer
- No pre-existing condition limitations
- Pregnancy: excluded if occurring within the first 10 months of the Covered Person's effective date of coverage
- Wellness Screening Benefit: pays $50 when a covered person undergoes a health screening test

Covered Benefits	24-Hour On/Off-Job Coverage Transamerica Hospital Insurance Pays YOU
Hospital Coverage (Accident or Sickness)	
Admission Per member per calendar year	$1,000
Confinement	Non-ICU $100/day up to 31 days ICU $100/day up to 30 days
Pre-Existing Condition	None
Pregnancy	Covered after 10 months
Wellness Benefit	$50/person covered
Conversion	Included

Transamerica Claims Processing

Do you have what you need to file a claim?

Having all your documents together helps make submitting a claim a smoother process. Look below to see the documentation needed for each type of claim. Please include your name and Social Security number on all claims.

Wellness

- Date wellness services were provided
- Provider's contact information
- List of services provided

Accident, Critical Illness, and Hospital Indemnity Claim Filing Requirements

- Completed claim form
- Attending physician statement
- Itemized statement
- Discharge summary (if hospitalized)
- Police report (if applicable to the loss)

Online (cannot be utilized for wellness claims)

1. Log in at www.tebcs.com. If you're not registered, click "New User Registration" and use your contract (certificate or policy) number and personal information, including Social Security number, to register.
2. Click on the policy you're using to file a claim.
3. Once inside the policy's contract details, click on claims, then on the specific type of claim you want to file.
4. Complete all requested information. If your claim requires a specific form, it will be provided here.
5. Print a copy of your claim submission for your records.

Email

1. Email claim documents to: SelfAdminClaims@transamerica.com
2. Include the insured's name and policy/certificate number.
3. You will receive an email acknowledgment of receipt.

Phone

1. Contact the Transamerica Claims Customer Service Department at **855-244-8318**.
2. Be ready to provide all claim information.

Fax

- Fax claim documents to **855-604-5205**.
- Include the insured's name and policy/certificate number.
- All documents should be clear and readable.

Mail

- Mail completed claim documents to:
  Transamerica – Claims, PO BOX 869090, Plano, Texas, 75075
- Include the insured's name and policy/certificate number.

403b Savings Plan

We are committed to helping you save for retirement and encourage all eligible employees to take advantage of our 403(b) Retirement Savings Plan through Teacher's Pension Exchange (TPX).

Regardless of how far you may be from retirement, the sooner you start saving, the more time your money has to grow through compounding interest.

2021 IRS Maximum Allowed Contribution: $19,500 (If over age 50: $6,500 additional)

Your 403(b) contributions are all pretax, which can reduce your current-year taxable income, and you can make changes to your contribution amount at any time.

TPX offers a variety of resources to educate you about the benefits of retirement savings:

- Video Resources
- Easy to use retirement calculators
- Resource Articles
- Dedicated financial wellness consultants

Develop a retirement plan with the help of a financial professional!

https://tpensions.com/sequoiagrove

Phone: **888-498-6870**
Email: tpx@tpensions.com

Financial Wellness

Immediate

Immediate is a financial wellness solution designed to improve the quality of life by smoothing out income peaks and valleys. No more need to wait until the next payday to access your earnings.

How Immediate works

You will receive a registration email and registration code to use when downloading the app. Immediate will confirm your hours worked and wages earned and simply charge a small fee to access your wages early. You are able to access up to 50% of your earned wages, and those dollars are then deducted from your next paycheck.

Immediate is not a loan, nor does it have a payback period.

Immediate use – step by step

It's fast and easy to sign up and start using Immediate.

Sign up

1. Open the invitation email from: invite@joinimmediate.com
2. Download the **ImmediatePay** app to your mobile device
3. Enter the activation code from the invitation email
4. Verify your account with the verification code sent to your email address
5. Complete your password setup

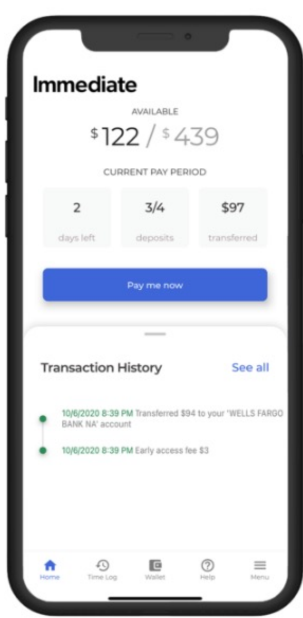
Set up your wallet

1. Open the Immediate app
2. Click "Wallet"
3. Click "+" to add your bank account

Make a transaction

1. Click "pay me now"
2. Select the amount you want and your account
3. Click confirm

Scan to download



Voluntary Pet Insurance

This benefit is paid for 100% by the employee.

ASPCA offers employees the ability to purchase discounted Pet Insurance. This benefit is voluntary and paid for 100% by eligible employees and paid directly to ASPCA.

What do the plans cover?

ASPCA plans provide nose-to-tail coverage for a wide range of injuries, illnesses, genetic conditions, and emergency care for dogs and cats. Coverage is provided with no claim limits and offers unlimited lifetime benefits with an annual deductible. Multiple discounts are applied at time of rate quote with actual dollar savings presented to the pet parent. The plan co-insurance can cover up to 90% of your veterinary bills.

How does the benefit schedule work?

Unlimited lifetime benefits are available with no caps on claims. There are some pre-existing conditions on the plans, and the plans do not cover routine care, office visits, or spay/neutering.

How to Enroll

Phone: call 877-343-5314 and tell the pet insurance specialist that you're an employee of Sequoia Grove.

Online: visit the link below to obtain personalized rates. The rates given will include your group discount.

Refer to the ASPCA website for a complete description of this plan.

Sign up for these plans any time during the year! Visit:
www.aspcapetinsurance.com/SequoiaGrove
Save with your priority code: **EB21SequoiaGrove**

Employee Support Center

Committed to YOU.

YOUR EMPLOYEE SUPPORT CENTER

Supporting You With...

- Benefits Inquiry
- Claims Assistance
- Eligibility
- Materials/Forms Request
- Plan Education
- Provider Network Inquiries
- Referral/Pre-authorization

...maximizing your benefits.

toll free
855.670.2222
local number
818.539.8804
email
LosAngeles.ESC@ajg.com

Insurance | Risk Management | Consulting

license #0D36879

Health Insurance Marketplace

Notice of Medical Coverage Options:

THE NEW HEALTH INSURANCE MARKETPLACE

Under federal law, beginning January 1, 2014, individuals will be required to have minimum essential health coverage, or else be subject to a penalty. This is referred to as the "individual mandate." The Health Insurance Marketplace is intended to help individuals meet the individual mandate requirement by providing another marketplace to purchase coverage, and possibly qualify for federal assistance. Individuals who have insurance through their employers (or who are eligible for insurance through their employers) may opt out of the employer plan during their renewal period and go to the Health Insurance Marketplace to purchase health insurance (note employers are not required to pass on their employer contribution towards an employee's coverage election in the Health Insurance Marketplace). Based upon your specific income level and household size, you may receive more affordable coverage for yourself and/or dependents through the Health Insurance Marketplace. Individuals who have insurance through their employers (or who are eligible for insurance through their employers) are not eligible for federal assistance through the individual mandate.

The Health Insurance Marketplace website will help people find out whether they qualify for federal financial assistance that will reduce their costs for medical coverage. Depending on your income and family size, you could be eligible for no-cost Medicare or for tax credits to help reduce your monthly premium costs. You do not need to purchase coverage through the Health Insurance Marketplace if you already have medical coverage. However, you have the option to do so if you wish.

If you have questions, please visit the Health Insurance Marketplace website at **www.Healthcare.gov**

Important Employee Notifications

Model General Notice Of COBRA Continuation Coverage Rights

Introduction: You're getting this notice because you recently gained coverage under a group health plan (the Plan). 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 a 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 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 doesn't 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're an employee, you'll become a qualified beneficiary if you lose your 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're the spouse of an employee, you'll 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 hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

Important Employee Notifications

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; or
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to your employer.

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 coverage on behalf of their 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 this 18-month period of COBRA continuation coverage can be extended:

1. Disability extension of 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. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.

2. Second qualifying event extension of 18-month period of continuation coverage: If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under 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 dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?: Yes. 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.

Important Employee Notifications

If you have questions: Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under 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 the Plan Administrator.

Women's Health and Cancer Rights Act of 1998 (WHCRA)

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

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan.

Contact your Benefits Administrator for more information.

Newborns' and Mothers' Health Protection Act of 1996

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

Extension of Dependent Coverage to Age 26

Individuals whose coverage ended, or who were denied coverage (or were not eligible for coverage), because the availability of dependent coverage of children ended before attainment of age 26 are eligible to enroll in Sutter Health Plus and Kaiser. Individuals may request enrollment for such children for 30 days from the date of notice. Enrollment will be effective retroactively to July 1, 2021.

For more information, contact Sutter Health Plus, Health Net, and Kaiser.

Notice of Special Enrollment Rights

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 you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage). In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days or any longer period that applies under the plan after the marriage, birth, adoption, or placement for adoption. To request special enrollment or obtain more information, contact your Benefits Administrator.

Important Employee Notifications

Lifetime Limit No Longer Applies and Enrollment Opportunity

The lifetime limit on the dollar value of benefits under Sutter Health Plus, Health Net, and Kaiser no longer applies. Individuals whose coverage ended by reason of reaching a lifetime limit under the plan are eligible to enroll in the plan. Individuals have 30 days from the date of this notice to request enrollment.

For more information, contact Sutter Health Plus, Health Net, and Kaiser.

Primary Protection

Sutter Health Plus and Health Nety generally 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, Sutter Health Plus designates one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact Sutter Health Plus and Health Net.

Medicaid and the Children's Health Insurance Program (CHIP) Offer Free Or Low-Cost Health Coverage To Children And Families

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, contact your State Medicaid or CHIP office to find out if premium assistance is available.
If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877- KIDS NOW** or www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.
If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call **1-866-444-EBSA (3272)**.

Out of Network Balance Billing

The amount the plan pays for covered services provided by non-network providers is based on a maximum allowable amount for the specific service rendered. Although your plan stipulates an out-of-pocket maximum for out of network services, please note the maximum allowed amount for an eligible procedure may not be equal to the amount charged by your out of network provider. Your out of network provider may bill you for the difference between the amount charged and the maximum allowed amount. This is called balance billing and the amount billed to you can be substantial. The out-of-pocket maximum outlined in your policy will not include amounts in excess of the allowable charge and other non-covered expenses as defined by your plan. The maximum reimbursable amount for non network providers can be based on a number of schedules such as a percentage of reasonable and customary or a percentage of Medicare. Contact your claims payer or insurer for more information. The plan document or carrier's master policy is the controlling document, and this Benefit Highlight does not include all of the terms, coverage, exclusions, limitations, and conditions of the actual plan language.

Important Employee Notifications

Prescription Drug Coverage and Medicare Part D

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Sequoia Grove 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. Sequoia Grove has determined that the prescription drug coverage offered by Sutter Health Plus, Health Net, and Kaiser 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 Sequoia Grove coverage may be affected.

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

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan? You should also know that if you drop or lose your current coverage with Sequoia Grove 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 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 the 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 Sequoia Grove changes. You may also request a copy of this notice at any time.

Important Employee Notifications

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 receive a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans. Additional resources: 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 **1-800-663-4227 (TTY 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)**.

Am I eligible for Medicare if I am under 65? There are three ways you can get Medicare coverage if you are under 65 years of age.

1. You are eligible for Medicare if you are a U.S. citizen or have your resident visa, have lived in the U.S. for five years in a row, and you have a disability and have been receiving Social Security Disability Insurance (SSDI) for more than 24 months. Your eligibility begins during the month you receive your 25th SSDI check. You do not need to contact anyone. Social Security should automatically mail you your Medicare card three months before you become eligible.
   Note: If you are receiving railroad disability annuity checks, whether you are eligible for Medicare and when you get it, depends on how your disability has been classified by the Railroad Retirement Board.

OR

2. You have been diagnosed with End-Stage Renal Disease (ESRD) and you are getting dialysis treatments or have had a kidney transplant; apply for Medicare benefits (up to 12 months retroactively); and you
   - are eligible to receive SSDI;
   - are eligible to receive railroad retirement benefits; or
   - are otherwise considered to be fully insured by Social Security, as defined by the length of time you have worked and the amount of money you have made (you need a certain amount of Social Security work credits depending on how long you have worked).

   Note: If you are a railroad worker with ESRD, you must contact Social Security, not the Railroad Retirement Board, to find out if you are eligible for Medicare because you have been diagnosed with ESRD. When your Medicare benefits begin depends on the circumstance.

OR

3. You have been diagnosed with Amyotrophic Lateral Sclerosis (ALS), commonly known as Lou Gehrig's Disease. You will automatically be enrolled in Medicare the first month you receive SSDI or, if you are a railroad worker, the first month you receive a railroad disability annuity check.
   Note: Because Social Security and Medicare eligibility rules are complex, you should call Social Security at **800-772-1213** to get the most accurate information regarding your particular situation.

Date:	**July 1, 2021**
Name of Entity/Sender:	**Human Resources**
Address:	**4305 South Meridian Road, Meridian CA 95957**
Phone Number:	**(530) 285-2578**

This proposal (analyses, report, etc.) is an outline of the coverages proposed by the carrier(s) based upon the information provided by your company. It does not include all the terms, coverages, exclusions, limitations, and conditions of the actual contract language. See the policies and contracts for actual language. This proposal (analyses, report, etc.) is not a contract and offers no contractual obligation on behalf of Gallagher Benefit Services (GBS). Policy forms for your reference will be made available upon request.

Notes

Benefit Plan Contact Information

Provider	Coverage Type	Phone and Web
Sutter Health Plus Your Health Plan	Medical	Sutter Health Plus 855-315-5800 **www.sutterhealthplus.org**
Health Net	Medical	Health Net 800-522-0088 **www.healthnet.com**
Kaiser Permanente	Medical	Kaiser 800-464-4000 **www.kp.org**
MetLife	Dental Vision Life/AD&D (Basic & Voluntary) Voluntary Short Term Disability	MetLife 800-438-6388 **www.metlife.com**
MetLife	Employee Assistance Plan (EAP)	MetLife 888-319-7819 **www.metlifeeap.lifeworks.com** Username: metlifeeap Password: eap
Transamerica	Voluntary Accident Voluntary Critical Illness Voluntary Hospital	Transamerica 855-244-8318 SelfAdminClaims@transamerica.com www.TEBCS.com
The Advantage Group	Flexible Spending Account (FSA)	The Advantage Group (TAG) 877-506-1660 **www.enrollwithtag.com**
ASPCA Pet Health Insurance — Pets are dependents, too.	Voluntary Pet Insurance	ASPCA 877-343-5314 **www.aspcapetinsurance.com/SequoiaGrove**

Employee Support Center
Call 855.670.2222
Monday - Friday | 8am - 4pm
LosAngeles.ESC@ajg.com

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