Health and Welfare Benefit Plan
Summary Plan Description and Plan Document

Section 1: Document Overview

This document is a wrap-around Plan Document and Summary Plan Description. For purposes of the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), this document, when read together with the applicable Insurance Contracts, Certificates of Coverage or other benefit booklets of the Component Benefit Plans (as defined below), which are incorporated by this reference, serve as both the official Plan Document and as the Summary Plan Description for the benefits provided under this Santa Maria Bonita School District Health and Welfare Benefit Plan (the "Plan"). ***If there exists any discrepancy between this document and the applicable Insurance Contracts, Certificates of Coverage or other benefit booklets that govern the Component Benefit Plans (the "Governing Documents"), the provisions of the Governing Documents shall control and will govern.***

Through this Plan, Santa Maria Bonita School District (the "Employer") provides the employer-sponsored health and welfare benefits identified in Section 4 consisting of medical insurance (including prescription drug benefits), dental insurance, vision insurance , long-term disability insurance, basic group life and accidental death & dismemberment (AD&D) insurance, and health care flexible spending account (FSA) coverage. Each of the health and welfare benefits identified in Section 4 shall be referred to as a "Component Benefit Plan", and collectively as the "Component Benefit Plans".

The Employer established the Component Benefit Plans as of October 1, 1981. This document represents the official Plan Document for the Plan and its Component Benefit Plans, effective as of October 1, 2014

Section 2: Plan Information

ERISA establishes Federal controls over most employer-sponsored health and welfare benefit plans, which include the Component Benefit Plans identified in Section 4. The Component Benefit Plans have the following ERISA specifications in common.

Plan Name:	The Santa Maria Bonita Health & Welfare Benefits Plan (the "Plan")
Plan Number:	501
Employer/Plan Sponsor Name, Address and Phone Number:	Santa Maria Bonita School District 708 S. Miller Street Santa Maria, CA 93454 (805) 928-1783
Affiliated Employers/ Subsidiaries:	None
Employer ID #:	95-6000940
Effective Date:	October 1, 2015
Plan Year:	October 1 through September 30
Plan Administrator:	Santa Maria Bonita School District 708 S. Miller Street Santa Maria, CA 93454 (805) 928-1783 The Plan Administrator has authority to control and manage the operation and administration of the Plan.
Agent for Service of Legal Process:	Santa Maria Bonita School District 708 S. Miller Street Santa Maria, CA 93454 (805) 928-1783
Plan Changes or Termination:	The Employer may terminate, suspend, withdraw, amend or modify any element of this Plan, including any Component Benefit Plan, in whole or in part at any time.
HIPAA Covered Entity Status:	Hands-*On* PHI for HIPAA Privacy Hands-*On* PHI for HIPAA Security

Para assistance en espanol con este document, por favor llamada 805-684-5100 x112.

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please see Section 19 for more information.

Section 3: Table of Contents

Section 4: Component Benefit Plan Information

Plan Name:	The Santa Maria Bonita School District Health & Welfare Benefits Plan (the "Plan")		
Plan Number:	501	501	
Policy Number:	**69120**	**12223015**	
Type of Plan Benefit:	Health Insurance (PPO) Component Benefit	Vision Component Benefit	
Type of Plan Administration:	Contract administration with benefits provided in accordance with the self-funded benefit booklet.	Contract administration with benefits provided in accordance with the self-funded benefit booklet.	
Contract Administrator: *Responsible for plan administration and processing of claims.*	Self-Insured Schools of California (SISC) P.O. Box 1847 2000 "K" Street Bakersfield, CA 93303-1847	Vision Service Plan (VSP) 7400 Gaylord Parkway Frisco, TX 75034	
Contract Funding Agent: *Responsible for payment of claims and for financial risk of claims.*	Santa Maria Bonita School District 708 S. Miller Street Santa Maria, CA 93454	Santa Maria Bonita School District 708 S. Miller Street Santa Maria, CA 93454	
Claims Appeal Address:	SISC III P.O. Box 1847 Bakersfield, CA 93303-1847	Vision Service Plan Attn: Appeals Department P.O. Box 2350 Rancho Cordova, CA 95741	
Funding Arrangement:	Self-funded	Self-funded	
Plan Premiums/ Contributions:	This component benefit is paid by Employer contributions, including in some cases, those made at employee direction through a salary reduction agreement.	This component benefit is paid by Employer contributions, including in some cases, those made at employee direction through a salary reduction agreement.	
Medicare Part D:	Creditable; see Section 19 of this document.	N/A	
Grandfathered Plan:	No	N/A	
Special Notes:	This component benefit includes prescription drug coverage.	None	

The fully-insured benefits identified above are provided pursuant to an Insurance Contract and/or a Certificate of Coverage between the Employer and the Contract Administrator. If the terms of this document conflict with the terms of the Governing Documents of the Component Benefit Plans, the terms of the Governing Documents will control, unless superseded by applicable law. For further information about these Component Benefit Plans please refer to the Governing Documents for each separate benefit or contact the Plan Administrator.

Section 4: Component Benefit Plan Information (con't)

Plan Name:	The Santa Maria Bonita School District Health & Welfare Benefits Plan (the "Plan")		
Plan Number:	501	501	
Policy Number:	**432972**	**452215**	
Type of Plan Benefit:	Dental (DPPO) Insurance Component Benefit	Long-Term Disability (LTD) Component Benefit	
Type of Plan Administration:	Contract administration with benefits provided in accordance with the self-funded benefit booklet	Contract administration with benefits provided in accordance with the group policy.	
Contract Administrator: *Responsible for plan administration and processing of claims.*	The Guardian 7 Hanover Square New York, NY 10004	The Guardian 7 Hanover Square New York, NY 10004	
Contract Funding Agent: *Responsible for payment of claims and for financial risk of claims.*	Santa Maria Bonita School District 708 S. Miller Street Santa Maria, CA 93454	The Guardian 7 Hanover Square New York, NY 10004	
Claims Appeal Address:	The Guardian Sales Office 10880 Wilshire Blvd., Suite 800 Los Angeles, CA 90024	The Guardian Sales Office 10880 Wilshire Blvd., Suite 800 Los Angeles, CA 90024	
Funding Arrangement:	Self-Funded	Fully-Insured	
Plan Premiums/ Contributions:	This component benefit is paid by Employer contributions, including in some cases, those made at employee direction through a salary reduction agreement.	This component benefit is paid by Employer contributions, including in some cases, those made at employee direction through a salary reduction agreement	
Medicare Part D:	N/A	N/A	
Grandfathered Plan:	N/A	N/A	
Special Notes:	None	None	

The fully-insured benefits identified above are provided pursuant to an Insurance Contract and/or a Certificate of Coverage between the Employer and the Contract Administrator. If the terms of this document conflict with the terms of the Governing Documents of the Component Benefit Plans, the terms of the Governing Documents will control, unless superseded by applicable law. For further information about these Component Benefit Plans please refer to the Governing Documents for each separate benefit or contact the Plan Administrator.

Section 4: Component Benefit Plan Information

Plan Name:	The Santa Maria Bonita School District Health & Welfare Benefits Plan (the "Plan")		
Plan Number:	501	501	
Policy Number:	**503137**	**T5026**	
Type of Plan Benefit:	Basic Group Life and Accidental Death & Dismemberment (AD&D) Insurance Component Benefit	Health Care Flexible Spending Account (FSA) Component Benefit	
Type of Plan Administration:	Contract administration with benefits provided in accordance with the self-funded benefit booklet.	Contract administration with benefits provided in accordance with the FSA plan document.	
Contract Administrator: *Responsible for plan administration and processing of claims.*	Standard Insurance Company 1100 SW Sixth Avenue Portland, OR 97204	AFLAC 1932 Wynnton Road Columbus, GA 31999	
Contract Funding Agent: *Responsible for payment of claims and for financial risk of claims.*	Standard Insurance Company 1100 SW Sixth Avenue Portland, OR 97204	AFLAC 1932 Wynnton Road Columbus, GA 31999	
Claims Appeal Address:	Standard Insurance Company Life Benefits Department P.O. Box 2800 Portland, OR 97208	AFLAC ATTENTION: Claims Department 1932 Wynnton Road Columbus, GA 31999	
Funding Arrangement:	Fully-Insured	N/A	
Plan Premiums/ Contributions:	This component benefit is paid by Employer contributions, including in some cases, those made at employee direction through a salary reduction agreement.	This component benefit is paid solely by Employee contributions, including those made at employee direction through a salary reduction agreement.	
Medicare Part D:	N/A	N/A	
Grandfathered Plan:	N/A	N/A	
Special Notes:	None	None	

The fully-insured benefits identified above are provided pursuant to an Insurance Contract and/or a Certificate of Coverage between the Employer and the Contract Administrator. If the terms of this document conflict with the terms of the Governing Documents of the Component Benefit Plans, the terms of the Governing Documents will control, unless superseded by applicable law. For further information about these Component Benefit Plans please refer to the Governing Documents for each separate benefit or contact the Plan Administrator.

Health and Welfare Benefit Plan
Summary Plan Description and Plan Document

Section 5: Purpose

The Employer and its named subsidiaries and affiliates sponsor various Component Benefit Plans as identified in Section 4 for the exclusive benefit of the Participants. This Plan has been written and is intended to conform to the written plan document and other requirements of ERISA. Any assets of the Component Benefit Plans shall be held for the exclusive purposes of providing benefits to the Plan participants and their beneficiaries and for defraying reasonable costs of administration.

Section 6: Accompanying Documents

A. Certificates of Coverage. The term "Certificates of Coverage" refers to the plan documentation provided by the Contract Administrator, which describes the plan benefits in detail. Certificates of Coverage are sometimes also referred to as Certificates, Evidences of Coverage, or benefit booklets by the Contract Administrator that issues them. If you do not have a copy of your Certificate of Coverage you may obtain one from the Contract Administrator.

B. Insurance Contract. The term "Insurance Contract" refers to the plan documentation provided by the Contract Administrator, which outlines the important elements of the agreements/contracts between the Employer and the Contract Administrator. Insurance Contracts are sometimes also referred to as Insurance Policies, Contracts/Policies, or Service Agreements by the Contract Administrator that issues them.

C. Governing Documents. The term "Governing Documents" refers to the Certificates of Coverage, Insurance Contracts or benefit booklets that govern the Component Benefit Plans.

C. Wrap-around Document. This document is a wrap-around Plan Document and a wrap-around Summary Plan Description. When accompanied by the Governing Documents, this document, along with those Governing Documents, become the official Plan document and the Summary Plan Description for purposes of ERISA. Additional Plan information required by ERISA can be found in the Governing Documents for each Component Benefit Plan.

Section 7: Termination/Modification/Amendment of the Plan

A. Right to Terminate/Modify/Amend. The Employer has the right to amend or terminate the Plan or any Component Benefit Plan at any time. No consent of any participant is required to terminate, modify, amend or change the Plan or any of the Component Benefit Plans.

Your individual coverage terminates at the earliest of the following conditions:

1. When you leave your employment;
2. When you are no longer eligible;
3. When you cease to contribute, (if the Plan is contributory);
4. When the Plan terminates.

The Employer may enter into contracts with a Contract Administrator to provide coverage. The Employer has the right to amend, terminate, modify or change any Component Benefit Plan, or any relationship with a Contract Administrator at any time, subject to the terms of any service agreement with the Contract Administrator.

B. Other Provisions. If you cease active work, the Governing Document for the Component Benefit Plan in question will determine what arrangements, if any, may be made to continue your coverage beyond the date you cease active work. A Contract Administrator may terminate coverage if the Employer fails to pay the required premium in a timely manner as prescribed by the contract. A Contract Administrator may also terminate the Insurance Contract on any premium due date if the number of persons insured is less than the minimum number required, or if the Employer fails to meet any other criteria under the Insurance Contract.

Section 8: Participation, Eligibility, and Benefit Termination Specifications

A. Participation. The term "Participant" with respect to this Plan means any employee or beneficiary who meets the eligibility requirements of one of the Component Benefit Plans offered and participates in the Plan in accordance with the terms and conditions established for that specific Component Benefit Plan and has not for any reason become ineligible to participate. An employee, dependent, or beneficiary shall be a Participant in this Plan if he or she actively elects coverage under one or more of the Component Benefit Plans or if that employee becomes covered by one or more of the Component Benefit Plans by virtue of automatic administrative processing. Specific participation requirements for each Component Benefit Plan are outlined in the Governing Documents for each Component Benefit Plan.

B. Eligibility Requirements. This SPD and Plan Document is issued in conjunction with corresponding Governing Documents for each of the Component Benefit Plans identified in Section 4 and with federal and state guidelines. Information regarding eligibility requirements can be found in the Governing Documents in each separate Component Benefit Plan. Your eligible dependents include dependents who qualify under the Governing Documents currently in force under the Component Benefit Plans. A Plan participant or beneficiary may obtain a copy of the Plan's Qualified Medical Child Support Order (QMCSO) procedures from the Plan Administrator. Plan participants must complete an enrollment application (provided by the Plan Administrator) in a timely fashion in order to receive certain benefits under this Plan.

C. Effective Date of Benefits: All Component Benefit plans identified in Section 4 become effective upon the first of the month following the date of hire.

D. Benefit Termination. This SPD and Plan Document are issued in conjunction with corresponding Governing Documents for each of the Component Benefit Plans identified on the previous pages. Information regarding loss of benefits and when benefits terminate can be found in the Governing Documents describing each separate Component Benefit Plan.

Section 9: Description of Types of Funding Arrangements

A. Fully Insured Plan. In a fully-insured plan, benefits are provided under an Insurance Contract entered into between the Employer and the insurance company identified as the Contract Funding Agent. Claims for benefits are sent to the insurance company or Contract Administrator. The insurance company, not the Employer, is responsible for paying claims and for the financial risk of paying claims under the Plan. However, the insurance company and the Employer share the responsibilities for administering the plan. Insurance premiums for Plan participants as well as employee contributions (pre-tax and after-tax, as applicable) are paid by the Employer out of the general assets of the Employer. In no event, however, shall the Employer pay or otherwise be liable for any deductible, coinsurance or copayment amounts related to the applicable Component Benefit elected by Participants. Such amounts shall be the sole liability of the Participants. To the fullest extent permitted by law, any dividends, premium refunds, or like adjustments payable under or in connection with any Component Benefit shall remain the exclusive property of the Employer (shall any portion therein be required to be "refunded" to Participants, it shall be returned within 90 days of date of receipt by the Plan Administrator).

B. Self-Insured Plan. In a self-insured plan or a partially self-insured plan, the Employer hires the Contract Administrator to process claims under the Plan. The Contract Administrator does not serve as an insurer, but merely as a claims processor and administrator. Claims for benefits are sent to the Contract Administrator. The Contract Administrator processes the claims, then requests and receives funds from the Employer to pay the claims and make payment on the claims to health care providers. The Employer is ultimately responsible for providing Plan benefits, not the Contract Administrator. However, the insurance company and the Employer share responsibilities for administering the Plan. Plan benefits are paid by the Employer out of the general assets of the Employer. There is no special fund or trust or insurance from which benefits are paid. Employee contributions

Section 9: Description of Types of Funding Arrangements (con't)

(pre-tax and after-tax, as applicable) are also paid by the Employer out of the general assets of the Employer.

C. Pre-paid Plan. In a pre-paid plan, benefits are provided under a contract entered into between the Employer and the Contract Administrator. Premiums are due in advance of services being received. Providers are typically paid on a capitated basis for basic services and on a fee-for-service basis for other services. The Contract Administrator negotiates payment arrangements with providers. Insurance premiums for plan participants as well as employee contributions (pre-tax and after-tax, as applicable) are paid by the Employer out of the general assets of the Employer.

Section 10: Important Disclosures

A. Newborns and Mothers Health Protection Act of 1996. Group health plans and health insurance issuers offering group health insurance coverage 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 normal 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 or 96 hours, as applicable. Additionally, no group health plan or issuer may require that a provider obtain authorization from the plan or insurance issuer for prescribing a length of stay not in excess of the above periods.

B. Women's Health and Cancer Rights Act of 1998. The federal Women's Health and Cancer Rights Act of 1998 requires coverage of treatment related to mastectomy. If you are eligible for mastectomy benefits under your health coverage and you elect breast reconstruction in connection with such mastectomy, you are also covered for the following:

1. Reconstruction of the breast on which mastectomy has been performed;
2. Surgery and reconstruction on the other breast to produce a symmetrical appearance;
3. Prostheses;
4. Treatment of physical complications of all states of mastectomy, including lymphademas.

Coverage for reconstructive breast surgery may not be denied or reduced on the grounds that it is cosmetic in nature or that it otherwise does not meet the coverage definition of "medically necessary." Benefits will be provided on the same basis as for any other illness or injury under your medical plan. Coverage is subject to the standard applicable deductibles, copayments and coinsurance payments on your medical plan.

If you would like more information on WHCRA benefits, call your Plan Administrator at (805) 928-1783.

C. Mental Health Parity Act. When required by law, it is the intent of this Plan that health care benefit plans comply with the federal Mental Health Parity Act (MHPA). In general, the law requires parity of mental health benefits, meaning that annual or lifetime dollar limits on mental health benefits be no lower than any such dollar limits for medical and surgical benefits offered by a group health plan or health insurance issuer offering coverage in connection with a group health plan. In addition, the law provides that employers retain discretion regarding the extent and scope of mental health benefits offered to workers and their families (including cost sharing, limits on numbers of visits or days of coverage, and requirements relating to medical necessity). The law does not apply to benefits for substance abuse or chemical dependency. Small employers are exempt from this law; any group health plan of any employer who employed an average of between 2 and 50 employees on business days during the preceding calendar year and who employs at least 2 employees on the first day of the plan year is exempt.

D. Mental Health Parity and Addiction Equity Act. When required by law, this law requires that if a group health plan provides medical/surgical benefits and mental health benefits, the financial requirements (deductibles and co-payments) and any treatment limitations that apply to mental health benefits must be no more restrictive than the predominant financial requirements or treatment limitations that apply to substantially all medical/surgical benefits. Likewise, if the plan includes substance use disorder benefits, the financial requirements and treatment limitations for substance use disorders must also be equivalent to coverage for other conditions. Small employers are exempt from this law; any group health plan of any employer who employed an average of between 2 and 50 employees during the preceding calendar year is exempt.

E. Qualified Medical Child Support Orders (QMCSO) Provision. A dependent Child may become eligible for coverage by way of a QMCSO. If approved, coverage will become effective as of the date specified in a judgment, decree or order issued by a court of competent jurisdiction or through a state administrative process. The order must clearly identify all of the following:

- The name and last known mailing address of the participant;
- The name and last known mailing address of each alternate recipient (or official state or political designee for the alternate recipient);
- A reasonable description of the type of coverage to be provided to the Child or the manner in which such coverage is to be determined; and
- The period to which the order applies.

A Plan participant must submit a Medical Child Support Order to the Plan Administrator to determine whether it is qualified, and thus a QMSCO. A copy of the written procedures that the Plan uses when administering Qualified Medical Child Support Orders may be requested from Plan Administrator, at no charge.

F. Children's Health Insurance Program (CHIP) Reauthorization Act of 2009. As required by law, this plan complies with the applicable provisions of the Children's Health Insurance Program Reauthorization Act (CHIPRA). CHIPRA provisions apply to group health plans only, not all benefit plans offered under this plan.

If you are eligible for health coverage from your employer, but are unable to afford the premiums, some States have premium assistance programs that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for employer-sponsored health coverage, but need assistance in paying their health premiums.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, you can 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, you can 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, you can ask the State if it has a program that might help you pay the premiums for an employer-sponsored plan.

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, your employer's health plan is required to permit you and your dependents to enroll in the plan – as long as you and your dependents are eligible, but not already enrolled in the employer's plan. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**.

If you reside in the following State, you may be eligible for assistance paying your employer health plan premiums. You should contact your State for further information on eligibility.

CALIFORNIA: Please contact Medi-Cal (California's CHIP) via telephone at 1-800-541-5555 or via the Internet at http://www.medi-cal.ca.gov/contact.asp

G. Michelle's Law. *If and when* coverage for dependent children is contingent upon being a full time student (this is 'N/A' to any dependent who has not yet attained the age of 26), eligibility as a dependent will

Section 10: Important Disclosures (con't)

continue for up to 12 months of coverage in the event the dependent is not enrolled as a student due to a serious illness or injury. In the event that such a medically necessary leave of absence from school occurs, the coverage provider may request verification of the medical necessity of the leave.

H. Patient Protection and Affordable Care Act. Following is an outline of plan provisions implemented in accordance with PPACA. These provisions become effective for group health plans upon renewal after September 23, 2010. Where noted, some provisions may not apply to grandfathered plans. Please refer to Section 4 to determine the grandfathering status of your health plan.

1. Pre-Existing Conditions: This provision applies to all group health plans, regardless of grandfathered status. Health plans may not deny or exclude benefits for pre-existing conditions of children under age 19. *Upon the health plan's renewal in 2014, no limitation for a pre-existing condition will be applied to an enrollee on the Health Insurance Component Benefit plan.*

2. Lifetime Limits: The lifetime limit on the dollar value of benefits under the Anthem Blue Cross of California plan no longer applies. Individuals whose coverage ended by reason of reaching a lifetime limit under the plan are eligible to enroll in the Anthem Blue Cross of California component benefit plan. *Affected individuals have 30 days from the date he/she first receives this notice to request enrollment.*

3. Dependent Eligibility up to age 26 (Special Enrollment Opportunity): 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 now eligible to enroll in the Anthem Blue Cross of California component benefit plan. *Affected individuals have 30 days from the date he/she first receives this notice to request enrollment.*

4. Choice of Primary Care Provider: This provision does not apply to grandfathered plans. Plans and issuers that require or allow for the designation of primary care providers by participants or beneficiaries (such as an HMO plan) generally require the designation of a primary care provider. For any plan thus offered under this Plan, you have the right to designate any primary care provider who participates in that plan's network and who is available to accept you or your family members. Until you affirmatively make this designation, the health plan designates one for you. For children, you may designate a pediatrician as the primary care provider. You do not need prior authorization from the health plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in the plan's network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For information on how to select a primary care provider, and for a list of the participating primary care providers or participating health care professionals who specialize in obstetrics or gynecology, contact the applicable health plan (contact information is provided in Section 4).

5. External Claims Review: This provision does not apply to grandfathered plans. Plans and issuers are required to establish both internal and external review procedures in accordance with state or federal guidelines, as appropriate. Please refer to the Governing Document for the Component Benefit Plan in question for complete claim appeal and review procedures.

6. Rescission of Coverage: This provision applies to all group health plans, regardless of grandfathering status. Coverage may only be rescinded or cancelled if there is fraud or intentional misrepresentation of fact, as prohibited by plan terms of coverage. Plan must provide 30 days advance notice before coverage can be rescinded. Rescission of coverage will be treated as a claim denial, and may be appealed in accordance with the claim appeal procedures of the plan.

Section 11: Continuation Coverage (COBRA)

When required by law, our benefit program complies with the federal COBRA legislation (Public Law 99-272, Title X) which requires continuation rights for health expense coverage explained in this notice. If the Employer is subject to the law and you have health expense coverage under our benefit plan, and if that coverage would end for a reason listed below, you may be able to continue the coverage under the Employer's benefit plan for a specified period of time. Employers are subject to COBRA if they employed 20 or more persons for more than 50% of the business days during the prior calendar year. Employed persons are defined as any persons who appeared on the payroll for full or part time work.

It is important that you, your covered spouse, and any covered child(ren) over the age of 18 read this COBRA section carefully as it outlines both your rights and your responsibilities under the COBRA law.

You should be aware that there may be other coverage options for you and your family. When key parts of the health care law take effect, you'll be able to buy coverage through the Health Insurance Marketplace. In the Marketplace, you could be eligible for a new kind of tax credit that lowers your monthly premiums right away, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Being eligible for COBRA does not limit your eligibility for coverage for a tax credit through the Marketplace. Additionally, you may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a spouse's plan), even if the plan generally does not accept late enrollees, if you request enrollment within 30 days.

A. What is a Qualifying Event? A Qualifying Event is an event that causes you or your dependents to lose health benefits. The law defines qualifying events as a termination of employment (voluntary or involuntary except for gross misconduct), reduction in work hours, death of employee, divorce or legal separation, Medicare entitlement of the employee, or a child no longer satisfying eligibility requirements of a plan (for example a child no longer qualifying as a dependent because of age or student status).

B. When Continued Coverage Applies. Following is an outline of when continuation coverage applies based on the type of Qualifying Event.

If you are an *employee or the dependent of an employee* you may elect up to 18 months of continued health expense coverage for yourself if you lose coverage due to voluntary or involuntary termination of employment (except for gross misconduct) or reduction in work hours to less than the minimum needed to remain covered by the plan, or if an employee (or spouse or dependent child of an employee) is enrolled on the group health plan the day before the first day of a leave defined under the Family Medical Leave Act (FMLA), or becomes enrolled during the FMLA leave; and the employee does not return to employment at the end of the FMLA leave.

If you are an *employee's spouse or dependent child*, you may also elect up to 36 months of continued health expense coverage for yourself if you lose coverage due to the employee's death, or divorce or legal separation, or the employee's entitlement to Medicare, or no longer qualifying as a dependent child under the contract *(dependent children only).*

If you are a *covered retiree* and the Employer commences a bankruptcy proceeding, you and your dependents are entitled to a lifetime of continuation coverage. Upon the retiree's death, dependents are entitled to up to 36 months of coverage from the date of death.

If your plan covers *domestic partners* or *children of domestic partners*, those individuals are generally not eligible for COBRA continuation coverage unless they qualify as tax dependents under Internal

Section 11: Continuation Coverage (COBRA) (con't)

Revenue Code (IRC) Section 152(a). The Employer may have negotiated COBRA rights for your covered domestic partners; please check with the Employer for full details.

C. What Coverage is Continued. COBRA continuation rights apply only to health coverage as defined by the law (typically medical, dental, vision, employee assistance and health care spending accounts). Any other type of coverage provided by the employee benefit plan is not included in these continuation rights. Your continued health coverage will *at all times* be the *same* as the health coverage provided by the plan for similarly situated employees or dependents that have not had a Qualifying Event. Any future plan or rate changes affecting the group plan will affect your continued coverage as well. Continuation is available only for coverages that you or your dependents were enrolled in at the time of the Qualifying Event. However, you may enroll new dependents acquired while you are covered under COBRA in the same manner as similarly situated employees. A child born to or placed under adoption with an employee covered under COBRA is considered a qualified beneficiary, provided the child is enrolled under COBRA, and may have additional COBRA extension rights. The covered employee or family member must notify the plan administrator within 30 days of the birth or adoption, in order to enroll the child on COBRA.

D. How Long Can Coverage Continue. There are three different potential durations of COBRA coverage, depending on the type of Qualifying Event.

1. *18 Month Duration* - Coverage continued based on a Qualifying Event of termination of your employment or a reduction in your work hours is available for up to 18 months.

2. *36 Month Duration* - Coverage continued by virtue of a Qualifying Event of death of the employee, divorce or legal separation of the employee, loss of dependent eligibility, or Medicare entitlement for the employee is available for up to 36 months.

3. *Extensions Beyond 18 Months* - There are several additional circumstances when you can potentially continue COBRA beyond 18 months.

   (a) If you become entitled to Medicare and, within 18 months, experience a termination of employment or reduction in hours resulting in a loss of coverage, your covered dependents may elect to continue coverage for the period ending 36 months after the date you became entitled to Medicare.

   (b) If you or any family member are determined to have been disabled according to the Social Security Administration on the date of the original Qualifying Event (termination of employment or reduction of hours) or within the first 60 days of COBRA coverage, all qualified beneficiaries may extend COBRA coverage for up to 29 months total, from the date of the Qualifying Event. Non-disabled family members on COBRA coverage may also be eligible for this extension. To receive such an extension, you must notify the plan administrator of your disability determination before the end of the initial 18-month period and within 60 days of the Social Security determination date. If Social Security makes a determination of disability prior to the date of the qualifying event, then you must notify the plan administrator within 60 days of the date of the qualifying event.

   (c) The Cal-COBRA extension provides up to 36 months of medical coverage from the date federal COBRA coverage began. You may be eligible for this extension provided you are entitled to less than 36 months of continuation coverage under federal COBRA. The premium charged under this Cal-COBRA extension may be up to 110% of the total cost. Please contact your insurance carrier directly to inquire about the availability of this option. Please note, this extension applies to medical coverage only and self-funded plans are not subject to this extension.

   (d) If you are an eligible PBGC pension plan recipient or an eligible TAA recipient as defined in IRC Section 35(c)(1) and have received certification of such from the U.S. Department of Labor, you may be eligible for an extended COBRA election period. Please contact the Plan Administrator for more information.

E. When Does Coverage End? Within the limits described above, continuation coverage will terminate on the earliest of the following dates. COBRA coverage can be terminated before the maximum coverage period expires. In no event can coverage continue beyond 36 months from the original qualifying event date:

1. when no health coverage is provided by the Employer for any employees; or

2. when premium payment for your continued coverage is not made in the prescribed time limit; or

3. when, after electing COBRA Continuation Coverage, you become a covered employee and/or dependent under another group health plan. An exception to this rule applies if the new group plan contains an exclusion or limitation with respect to any pre-existing condition that applies to you or any covered dependents; or

4. when, after electing COBRA continuation coverage, you first become entitled to Medicare; or

5. when you or your dependents have extended coverage for up to 29 months due to a disability and there has been a final determination by the Social Security Administration that you or your dependent is no longer disabled. (You are required to notify the Plan Administrator within 60 days of the Social Security determination.)

In no event will COBRA continuation coverage last beyond 36 months from the original qualifying event date that enabled election of continuation coverage.

In the event a partial premium payment is made that results in a significant shortfall in the total premium due, coverage will be terminated retroactively with no opportunity for reinstatement, unless sufficient premium is received prior to expiration of the payment due grace period. If a partial premium payment is made that results in an insignificant shortfall in the total premium due, full premium must be made up within 30 days or coverage will be terminated retroactively. A premium shortfall is insignificant if it is not more than the lesser of $50 or 10% of the full premium due.

F. Continuation Beyond COBRA. In some instances, you may be eligible to continue health coverage beyond COBRA by conversion to an individual plan, a HIPAA Guaranteed Issue plan, or a conversion plan. A conversion privilege can be exercised, subject to all the rules that would apply to conversion privileges. However, coverages and costs will not be the same as your COBRA Coverage.

G. What Does It Cost? You are required to pay the entire cost of your continued health coverage. Where the plan benefits are provided by insurance, your cost would be the amount of the insurance premium (including any part formerly paid by the Employer) plus an administrative expense fee of 2% of the premium. (In the case of extended COBRA eligibility due to disability as specified above, the administrative fee increases to 50% of the premium after the 18th month through the 29th month.) You have 45 days from your election date to pay premiums that were incurred prior to your election. Thereafter, you have a grace period of 30 days for regularly scheduled premium payments. Where the plan pays its benefits directly (without insurance), your cost will not exceed the plan's actuarial estimate of its expense for the benefits of similarly situated employees, plus the administrative expense fee.

Section 11: Continuation Coverage (COBRA) (con't)

H. What You Have To Do. In the event of a divorce, legal separation or dependent child who no longer qualifies as an eligible dependent, you must formally advise the Employer. Our plan guidelines dictate that this notification *must* be received in writing on a COBRA Notification of Qualifying Event form as specified by the Plan Administrator. This form must be *received* by the Employer within 60 days of the date of the Qualifying Event or loss of coverage, whichever is later.

In the event of a termination of employment, reduction of hours or death, you need not take any action to request election materials. You should automatically receive COBRA election materials at your home via the U.S. Postal Service. The COBRA election materials will outline coverage costs and options available to you and your covered dependents. If you wish to elect coverage, you *must* follow the guidelines and timelines detailed in the COBRA election materials.

If you decide to elect continued coverage, you must notify the Plan Administrator within 60 days from the later of: (a) the Qualifying Event date; (b) the date your coverage would terminate due to the Qualifying Event; or (c) the date on which the qualified beneficiary receives the notice and election materials. You then have 45 days to pay all the retroactive and current premium amounts. Your coverage will be retroactively reinstated once the premium(s) and all required re-enrollment forms are received.

For more information about your rights under COBRA, visit the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) website at www.dol.gov/ebsa or call their toll-free number at 1-866-444-3272 For more information about health insurance options available through a Health Insurance Marketplace, visit www.healthcare.gov.

Section 12: Uniformed Services Employment and Reemployment Act (USERRA)

Congress enacted the USERRA legislation to protect the rights and benefits of employees who leave their civilian jobs to perform service in the military. In general, USERRA establishes employment and reemployment rights and benefits protections for returning military personnel and prohibits discrimination by employers against veterans, members of the military services and applicants for military service. USERRA applies to all employers, regardless of size, including foreign employers doing business in the United States, and covers full-time, part-time, seasonal and temporary employees. As required by law, our benefit program complies with the federal USERRA legislation, which requires continuation rights for health expense coverage.

Continuation coverage during a military leave under USERRA is available if you have health expense coverage under the benefit plan. If that coverage would otherwise end because of a military tour of duty, you and/or your dependents may be able to continue the coverage under the Employer's benefit plan for up to 24 months while you continue to be in military service. USERRA coverage is similar to COBRA Continuation coverage in that the employee must make an election for coverage and may be required to pay up to 102% of the full premium for the coverage elected during the leave. Even if you don't elect to continue coverage during your military service, you have the right to be reinstated to the benefit plan coverage when you are reemployed, generally without any waiting period or exclusions (for example, pre-existing condition exclusions) except for service connected illnesses or injuries. For military service of less than 31 days, health care coverage is provided as if the service member had remained continuously employed.

Section 13: HIPAA

As required by law, this Plan complies with the applicable provisions of the Health Insurance Portability and Accountability Act, as amended (HIPAA). HIPAA provisions apply to group health plans only, and not all Component Benefit Plans offered under this Plan.

A. Special Enrollment Rights. HIPAA also requires a group health plan to provide special mid-year enrollment opportunities to certain employees and/or their dependents in two circumstances: 1) loss of other coverage, or 2) acquisition of a new dependent. A participant enrollment under these special enrollment rules is not a late enrollee and thus would not be subject to the late enrollment penalties prescribed by HIPAA.

If you are covered under another group health plan and involuntarily lose that coverage (due to expiration of COBRA or loss of eligibility under the other group plan), you or your dependents may enter the plan under the special mid-year enrollment rights. You must request enrollment in writing within 30 days after the loss of other coverage or the Employer's cessation of contributions for such other coverage. Coverage will begin on the first day of the month after the plan receives the enrollment form.

If you as an employee acquire a new dependent, by marriage, birth, adoption, or placement for adoption, you have a right to enroll yourself and the new dependent in the group health plan. You must request enrollment in writing within 30 days of the marriage, birth, adoption, or placement for adoption. Coverage applied for as a result of one of these HIPAA special enrollment events will become effective as outlined in the Governing Document of the Component Benefit Plan. Please refer to the Governing Document for specifics.

B. Continuity of Coverage. HIPAA requires that your group health plan reduce or eliminate the exclusionary period of coverage for pre-existing conditions under your group health plans (not long term disability plans), if you have creditable coverage from another plan. Typically you should be provided with a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, or if you request it up to 24 months after losing coverage. Typically, without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion of 12 months (18 months for late enrollees) after your enrollment date in your coverage.

For further information regarding your rights and obligations under HIPAA, please contact the Plan Administrator at (805) 928-1783.

Section 14: Family Medical Leave Act (FMLA)

A. Compliance. When required by law, our benefit program will comply with the Family and Medical Leave Act (FMLA) of 1993 (and the additional provisions thereunder, such as the Qualifying Exigency Leave Act and Military Caregiver Leave Act) requiring continuation rights for health expense coverage assuming the Employer meets certain criteria during the preceding calendar year. If the Employer is subject to the law and you are covered under health benefit plans, you may be able to continue the coverage under our benefit plan for a certain period of time, provided you meet certain criteria during the previous 12 months.

B. Benefits. To the extent required under the FMLA, and the additional provisions thereunder, an employee on leave of absence under the FMLA may choose to continue coverage under the Plan by making the applicable contributions, on an after-tax basis, in accordance with procedures established by the Administrator that are consistent with the FMLA. In addition, to the extent required under and in accordance with the FMLA, and the regulations thereunder, any Employer contributions made under the terms of the Plan shall continue to be made on behalf of an employee on an FMLA leave. For further information on FMLA, please contact the Department of Labor at 1-866-487-9243.

Section 15: Conversion Privileges

Life insurance and disability benefits, if applicable, are not subject to the COBRA continuation provisions. However, in certain circumstances an existing life or disability insurance conversion privilege may be exercised within 31 days following the date of termination. If you wish to exercise this conversion, please refer to the Governing Document for the Component Benefit Plan in question for specific requirements.

Section 16: Claims Procedures

The determination of whether a claim falls under the procedures for health claims or under the procedures for disability and other non-health claims is based on the nature of the specific claim or benefit, not the characterization of the plan under which the claim is made or the benefit is offered.

A. Disability and Non-Health Claims. For a detailed description of the required procedures for filing claims and of the appeals procedures for any denied claims, please refer to the Governing Documents for each of the separate Component Benefit Plans. If you cannot locate the Governing Document that applies to the Component Benefit Plan in question, you may request a duplicate from the Plan Administrator identified on Page 1 of this Summary Plan Description

B. Health Claims. Under PPACA, DOL and ERISA regulations, claimants are entitled to full and fair review of any claims made under the Plan. For a detailed description of the required procedures for filing claims and of the appeals procedures for any denied claims, please refer to the Governing Document for each of the separate Component Benefit Plans. The Governing Documents of the Component Benefit Plans also describe the procedures for appealing an adverse benefit decision, for requesting internal review of an adverse benefit decision, and the procedures required to request an external review of any adverse benefit decision.

Section 17: Use and Disclosure of Protected Health Information (Privacy Rule)

This Section applies to Employers that are considered Hands-On PHI Covered Entities under the HIPAA Privacy Rule (Section 45 CFR § 164.530). Determination of Covered Entity status (whether the Employer is Hands-Off PHI or Hands-On PHI for the Privacy Rule) is identified in Section 4 of this document.

The Plan and any Contract Administrator, health insurance issuer or business associate servicing the Plan will disclose Protected Health Information to the Employer only to permit the Employer to carry out plan administrative functions for the Plan consistent with the requirements of 45 CFR §164.504(f)(2) (collectively referred to as the "Privacy Rule"). Any disclosure to and use by the Employer of Protected Health Information will be subject to and consistent with this Section 15.

A. Participant Disclosure. This Plan complies with the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA"). If you have questions about the privacy of your health information under the Plan, please contact the Plan Administrator or the Privacy Officer named in the Employer's Privacy Policy.

B. Employer's Obligations. Employer certifies compliance with the following.

1. Not use or further disclose the information other than as permitted or required by this Section, the Plan, or such other plan documents or as Required by Law, which shall have the same meaning as the term "required by law" under the Privacy Rule (45 CFR §164.501).

2. Ensure that any agents, including a subcontractor, to whom it provides Protected Health Information received from the Plan agree, by signing a Business Associate Agreement, that the agent agrees to implement reasonable and appropriate privacy and security measures to protect any Protected Health Information received or created to a level that is equivalent to the protections required by HIPAA of the Covered Entity.

3. Not use or disclose the information for employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the Employer.

4. Report to the Plan any use or disclosure of the information that is inconsistent with the uses and disclosures provided for in this Section or the Plan of which it becomes aware. Report to the Privacy Officer any security incident of which it becomes aware.

5. Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of Protected Health Information (including electronic Protected Health Information) created, received, maintained or transmitted.

6. Make available Protected Health Information (including electronic Protected Health Information) to Plan Participants upon their request of Protected Health Information or electronic Protected Health Information disclosures in accordance with the Privacy Rule (45 CFR §164.524).

7. Make available Protected Health Information for amendment and incorporate any amendments to Protected Health Information in accordance with the Privacy Rule (45 CFR §165.526).

8. Make available the information required to provide an accounting of disclosures in accordance with the Privacy Rule (45 CFR §164.528) and document such disclosures of Protected Health Information.

9. Make its internal practices, books, and records relating to the use and disclosure of Protected Health Information or electronic Protected Health Information received from the Plan available to the Secretary of the Department of Health and Human Services for purposes of determining compliance by the Plan with HIPAA.

10. If feasible, return or destroy all Protected Health Information received from the Plan that the Employer still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.

11. Ensure that adequate separation between the Plan and the Employer, is established pursuant to the Privacy Rule (45 CFR §164.504). Certain of employees, equivalently titled employees or classes of employees, or other workforce members under the control of the Employer may be given access to Protected Health Information received from the Plan or a health insurance issuer or business associate servicing the Plan. The specific classes of employees or workforce members who may have access to Protected Health Information are identified in the Employer's separate Privacy Policy. The Plan Administrator or the Privacy Official named in the Employer's Privacy Policy can provide information on the specific employees or classes of employees who have access to Protected Health Information. The list provided in the Privacy Policy shall include every class of employees or other workforce members under the control of the Employer who may receive Protected Health Information relating to payment under, health care operations of, or other matters pertaining to the Plan in the ordinary course of business. The classes of employees or other workforce members identified in the Employer's Privacy Policy will have access to Protected Health Information only to perform the plan administration functions that the Employer provides for the Plan.

12. The classes of employees or other workforce members identified in the Employer's Privacy Policy will be subject to disciplinary action and sanctions, including termination of employment or affiliation with the Employer, for any use or disclosure of Protected Health Information in breach or violation of or noncompliance with the provisions of this Section. The Employer will promptly report such breach, violation or noncompliance to the Plan, and will cooperate with the Plan to correct the breach, violation or noncompliance, to impose appropriate disciplinary action or sanctions on each employee or other workforce member causing the breach, violation or noncompliance, and to mitigate any deleterious effect of the breach, violation or noncompliance on any participant or beneficiary, the privacy of whose Protected Health Information

Section 17: Use and Disclosure of Protected Health Information (Privacy Rule) (con't)

may have been compromised by the breach, violation or noncompliance.

13. Provide participants in the Plan with such notice of privacy practices as required pursuant to the Privacy Rule (45 CFR §164.520).

C. Survival. The provisions of this Section shall survive the expiration or termination of the Plan or this Section for any reason.

D. Compliance with State and Federal Law. The Employer shall comply, and shall ensure that the Plan complies, with HIPAA and other applicable state and federal confidentiality, privacy, and security laws.

E. Interpretation. Any ambiguity in the Plan or this Section or in determining controlling provisions shall be resolved in favor of an interpretation that permits the parties to comply with HIPAA and other federal and state laws and that provides the greatest privacy protections for Protected Health Information. In the event of an inconsistency between the provisions of this Section and mandatory provisions of HIPAA, the HIPAA provisions shall control.

Section 18: Security of Protected Health Information (Security Rule)

This Section applies to Employers that are considered Hands-On PHI Covered Entities for the HIPAA Security Rule. Determination of Covered Entity status (whether the Employer is Hands-Off PHI or Hands-On PHI for Security Rule purposes) is identified in Section 4 of this document.

A. Participant Disclosure. This Plan complies with the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA"). If you have questions about the privacy of your health information under the Plan, please contact the Plan Administrator or the Privacy Officer named in the Employer's Privacy Policy.

B. Employer's Obligations. The Employer certifies compliance with the following.

1. The Employer shall develop, implement, and maintain administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of any Protected Health Information that it creates, receives, maintains, or transmits in an electronic format (with the exception of enrollment or disenrollment information and any Summary Health Information) on the Plan's behalf, and it will ensure that any of its agents or subcontractors to whom it may provide such electronic Protected Health Information agree to implement reasonable and appropriate security measures to protect such information. The Employer will report any "security incidents" (as defined in the Security Rule) of which it becomes aware. Report to the Plan any use or disclosure of the information that is inconsistent with the uses and disclosures provided for in this Section or the Plan of which it becomes aware. Report to the Security Official any security incident of which it becomes aware.

2. Follow the required notification procedures required by the Security Rule in the event of a breach of unsecured Protected Health Information which compromises the security of such information.

C. Survival. The provisions of this Section shall survive the expiration or termination of the Plan or this Section for any reason.

D. Interpretation. Any ambiguity in the Plan or this Section or in determining controlling provisions shall be resolved in favor of an interpretation that permits the parties to comply with HIPAA and other federal and state laws and that provides the greatest privacy protections for Protected Health Information. In the event of an inconsistency between the provisions of this Section and mandatory provisions of HIPAA, the HIPAA provisions shall control.

Section 19: Medicare Part D Disclosure Notice

Important Notice From Santa Maria Bonita School District 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 Santa Maria Bonita School 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.

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.

Section 19: Medicare Part D Disclosure Notice (con't)

2. Santa Maria Bonita School District has determined that the prescription drug coverage offered by the Anthem Blue Cross of California plans is, on average for the plan participants who are enrolled in the plan, 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 Santa Maria Bonita School District coverage may be affected. If you do decide to join a Medicare drug plan and drop your current Santa Maria Bonita School District 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 Santa Maria Bonita School 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 (a penalty) as long as you have Medicare prescription drug coverage. You *may* also need to wait until the following October to join a plan.

For More Information About This Notice Or Your Current Prescription Drug Coverage: Please contact your Plan Administrator (listed in Section 2 of this Document).

NOTE: You will get this notice each year. You will also get it before

Section 19: Medicare Part D Disclosure Notice (con't)

the next period you can join a Medicare drug plan and if this coverage through Santa Maria Bonita School District health plan provided by your applicable plan issuer (Anthem Blue Cross of California) changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage: More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans. For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov or call 1-800-633-4227 (TTY: 1-877-486-2048).
- 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

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

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

Section 20: Flexible Spending Account
This Plan offers a Flexible Spending Account option as identified in Section 4: Component Benefit Plan Information of this document. The Flexible Spending Account option offered under this Plan is governed according to the applicable rules and regulations of IRC Section 125, and administered with regards to eligibility, benefits, claims and appeals, and all other applicable elements in accordance with the terms and conditions detailed in the Flexible Spending Account plan document. Should you desire specific information regarding this Flexible Spending Account option pertaining to any of the aforementioned elements, please consult the Flexible Spending Account plan document.

Section 21: Genetic Nondiscrimination Act of 2008 (GINA)
The Genetic Information Nondiscrimination Act of 2008 enacted May 21, 2008, GINA), is designed to prohibit the use of genetic information in health insurance and employment. The Act prohibits group health plans and health insurers from denying coverage to a healthy individual or charging that person higher premiums based solely on a genetic predisposition to developing a disease in the future. The legislation also bars employers from using individuals' genetic information when making hiring, firing, job placement, or promotion decisions.

Section 22: Statement of Your Rights under ERISA
ERISA entitles you to certain rights and protections as a participant in The Plan. ERISA provides that all plan participants shall be entitled to the following rights.

Receive Information about the Plan. You have a right to examine, free of charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain Copies of Plan Documents. You have a right to obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The Plan Administrator may charge a reasonable charge for the copies. You are also entitled to receive a summary of a plan's annual financial reports.

Continue Group Health Plan Coverage. You have a right to continue health care coverage for yourself, spouse or dependents if there is loss of coverage under the plan as a result of a Qualifying Event. You or your dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the plan on the rules governing your COBRA Continuation rights. Additional information about COBRA may be found in Section 11 of this Summary Plan Description.

Obtain Certificate of Creditable Coverage. Should you lose coverage under the Plan, you may request a Certificate of Creditable Coverage that details the coverage and dates you were covered under the Plan.

Section 23: Protection of Your Rights under ERISA

A. Fiduciaries. In addition to creating rights of plan participants, ERISA imposes special obligations and duties upon the people (called fiduciaries) who are responsible for the operation of the Plan. The fiduciaries of the Plan have a duty to operate the Plan prudently and in the interest of you and other Plan participants and beneficiaries. The fiduciaries also have a duty to protect any Plan assets for the benefit of Plan participants. No one, including the Employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from receiving a welfare plan benefit or from exercising your rights under ERISA.

B. Claim Review. You have the right to have the Plan review and reconsider your claim. Under ERISA, there are steps you can take to enforce the above rights. ERISA gives you the right to file suit in a state or federal court if your claim for benefits under the Plan is denied or ignored. You can also file suit in a federal court if you request plan documents and do not receive them within 30 days. In such a situation, the court will require the Plan Administrator to give you the plan documents you requested. In some cases the court could also require the Plan Administrator to pay you up to $110 a day until you receive the requested materials, unless the materials were not sent because of reasons beyond the control of the administrator. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court.

C. Assertion of Rights. If it should happen that the fiduciaries have misused the Plan's money or assets, or that you have been discriminated against for asserting your rights, you can ask for help from the U.S. Department of Labor. You can also file suit in a federal court. If you file a suit, the court will decide who must pay those costs and legal fees. If you are successful, the court may order the person you have sued to pay those fees. If you lose, the court may order you to pay those costs and fees, if, for example, it finds your claim is frivolous.

Section 24: Not an Employment Contract

None of the Component Benefit Plans or benefits discussed on the preceding pages should be considered contracts for employment between the employee and the Employer. This Plan does not guarantee any employee or plan participant the right of continued employment nor do they limit the Employer's right to discharge any employee.

Section 25: Questions about the Plan or ERISA

A. Questions. If you have any questions about the Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration (EBSA), a division of the U.S. Department of Labor. Phone listings for the EBSA may be found in your local telephone directory. Alternatively, you may contact the national office of the EBSA. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

B. Contact Information. Contact information for the Los Angeles regional office and national offices of the EBSA are listed below:

Los Angeles Regional Office
EBSA
1055 East Colorado Boulevard, Ste. 200
Los Angeles, CA 91106-2357
Phone: (626) 229-1000

Division of Technical Assistance and Inquiries
EBSA
U.S. Department of Labor
200 Constitution Avenue, N.W.
Washington, DC 20210