MORGAN HILL
UNIFIED SCHOOL DISTRICT

Employee Benefits Guide

2024

TABLE OF CONTENTS

Important Notice

Morgan Hill Unified School District has made every attempt to ensure the accuracy of the information described in this enrollment guide. Any discrepancy between this guide and the insurance contracts or other legal documents that govern the plans of benefits described in this enrollment guide will be resolved according to the insurance contracts and legal documents. Morgan Hill Unified School District reserves the right to amend or discontinue the benefits described in this enrollment guide in the future, as well as change how eligible employees and Morgan Hill Unified School District share plan costs at any time. This enrollment guide creates neither an employment agreement of any kind nor a guarantee of continued employment with Morgan Hill Unified School District.

WELCOME

At Morgan Hill Unified School District (MHUSD), we truly value the dedication that goes into your work every day. We're proud of our talented employees and understand that our success is because of you. That's why as a District employee, you have access to a comprehensive, quality benefits package that offers flexibility and security.

Your benefits are a valuable addition to your overall compensation. It is important to take the time to thoroughly review this guide, understand your options and select the best coverage for you and your family. Be sure to consider factors like plan costs and what type of services you anticipate needing before you make your elections.

Open Enrollment begins October 9h and will remain open through October 27th

This open enrollment is your one chance[1] to make sure you have the coverage you want for the new plan year which begins January 1, 2024, and runs through December 31, 2024.

You must also actively participate in Open Enrollment if you wish to do any or all the following:

- Newly enroll in one of the medical, dental, or vision plans
- Contribute to a Flexible Spending Account (FSA)
- Contribute to a Health Savings Account (HSA)
- Newly enroll in one of the Voluntary Benefit products

Open Enrollment Presentations

In-Person:
October 11th at 3:30 pm in the Board room at the District office

Virtual Presentations will be held via Zoom. To register, click on the meeting you plan to attend.

Friday, 10/6 from 10:00 am to 11:00 am
Friday, 10/6 from 4:00 pm to 5:00 pm
Tuesday, 10/17 from Noon to 1:00 pm

For More Information

Full benefit summaries and forms for all plans included in the guide can be found online in the Ease portal .
Click here to enroll.

If you have Questions

You can contact the Support Center at (800) 863-9019 or please visit Customer Service to schedule an appointment with a Benefits Counselor.

[1]You can change your coverage during the year if you experience a "Qualified Status Change," including but not limited to marriage, registered domestic partnership, divorce, birth or adoption of a child or death of spouse or child. You have up to 30 days from the date of the event to notify the District, request a change and submit the necessary paperwork. Failure to do so within the 30-day window will forfeit your right to make a mid-year change. You will need to wait until the District's next open enrolment period to make any enrollment changes.

2024 OVERVIEW

- **Medical -** MHUSD continues to offer multiple plans, allowing for flexibility in network and cost, through Aetna and Kaiser.
  - **Kaiser** offers three HMO plans, including a high-deductible HSA-compatible plan option
  - **Aetna** offers three HMO plans and three PPO plans, which also includes a high-deductible HSA-compatible plan option – the deductible for the 80/60 plan has increased from $500/$1000 to $1,000/$2,000
- **Delta Dental** – DPPO Premium, High, and Low Plans & Deltacare DHMO. You cannot add, drop or change dental plans after your Initial Enrollment window closes. Open enrollment—for Dental coverage--occurs every three (3) years thereafter. Therefore, if you do not elect dental coverage for January 1, 2024, your next opportunity to enroll in Dental coverage will be during Open Enrollment for a January 1, 2027, effective date. **Note: The Premium plan is only available during your Initial Enrollment window when becoming a benefits-eligible employee.**
- **Vision –** Coverage is available through Vision Service Plan (VSP). See pages 12 and 13 for more information
- **Health Savings Accounts (HSA) –** If you are enrolling in one of the High Deductible Health Plans (HDHP), you will have the opportunity to enroll in a Health Savings Account (HSA). See page 10 for more information
- **Limited Purpose Flexible Spending Account (FSA)** – If you contribute to an HSA, you can elect this account to pay for eligible out-of-pocket dental and vision expenses. See page 14 for more information
- **Flexible Spending Accounts (FSA)** – The current contribution limit is $3,050 and may be subject to change for 2024. Current and new enrollees will need to enroll/re-enroll in the Health Care and/or Dependent Care FSA, if you want coverage for the new plan year, January 1, 2024 – December 31, 2024. **Your current election will not rollover to the new plan year.**
- **Basic Life Insurance** – You are automatically enrolled in this $10,000 benefit.
- **Voluntary Life & Disability Benefits** – You are not required to participate in these benefits, but they are available to complement your District benefits.

Benefits highlights are included throughout this guide. Additional information can be found online in the Ease portal.

WHAT IS CHANGING

- **Aetna 80/60 PPO Plan -** the deductible for the 80/60 plan has increased to $1,000/$2,000 from $500/$1000
- **Kaiser HDHP HSA Plan** –IRS mandated deductible change - the deductible has increased to $3,200/$6,400 from $3,000/$6,000

ELIGIBILITY

Full-time and part-time employees (working a minimum of 20 hours per week) and their eligible dependents can participate in the District's benefits. Eligible dependents include your:

- Legal Spouse or California state-registered domestic partner[1]
- Child(ren) up to age 26 – your natural or adopted children, stepchildren and any other children you support for whom you are the legal guardian or for whom you are required to provide coverage as the result of a qualified medical child support order
- Child(ren) of any age if he or she is incapable of self-support due to mental or physical disability

PROOF OF DEPENDENT ELIGIBILITY

If you are adding dependents for the first time to your medical, dental or vision plans, you must provide proof of eligibility by providing supporting documentation as listed below:

1. If adding a spouse - marriage certificate
2. If adding a domestic partner – Registered Domestic Partnership Certificate from the State of California
3. If adding a child – birth certificate
4. Social Security Numbers are required for spouses/domestic partners and all dependent children

Documents can be uploaded into the enrollment system or sent to Human Resources. If your dependent becomes ineligible for coverage during the year, you must contact the District's Benefits Office within 30 days. Failure to provide notification may lead to forfeiture of any COBRA rights for your dependents. Any contributions taken for dependents who are no longer eligible may also be forfeited. If you do not take action within the 30-day window, you will have to wait until the District's next open enrollment period to make a change.

ESSENTIAL TERMS

Before reviewing your benefit choices for this year, here's a refresher on some key health insurance vocabulary that will help you better understand your options:

Premium	The amount of money that's paid for your health insurance every month. The District pays a portion of this amount, and you pay the rest.
Deductible	The amount of money you need to pay out-of-pocket before your insurance begins contributing money for your health care costs. The exception to this are preventive services. These services are covered at no charge and are not subject to the deductible. Deductibles are tracked on a calendar year (January 1 – December 31).
Network	A group of doctors, hospitals, labs, and other providers that your health insurance carrier contracts with so you can make visits at a pre-negotiated (and often discounted) rate.
Health Savings Account (HSA)	A personal bank account that can be used to pay for qualified health care expenses. You can only contribute money to this account if you are enrolled in one of the District's High Deductible Health Plans (HDHPs) and not enrolled in Medicare or any other non-HDHP plan including FSA.
Copayment (Copay)	A predetermined dollar amount you pay for visits to the doctor, prescriptions, and other health care (as specified by your plan).
Coinsurance	The percentage you pay for the cost of covered health care services. For example, if the coinsurance under your plan is 20%, you would pay 20% of the cost of the service and your insurance would pay the remaining 80%.
Out-of-Pocket Maximum	The cap on your out-of-pocket costs for the calendar year (January 1 – December 31). Once you've reached this amount, your plan will cover 100% of your qualified medical expenses for the remainder of the calendar year.

[1]Due to federal and state tax regulations, benefits provided to domestic partners are generally taxable and therefore deducted from your pay on an after-tax basis. Additionally, any premium contributions made by the District on behalf of your domestic partner are generally considered taxable income to you. Contact the District's Benefits Office if you believe your domestic partner is exempt from federal or state taxes.

ENROLLMENT

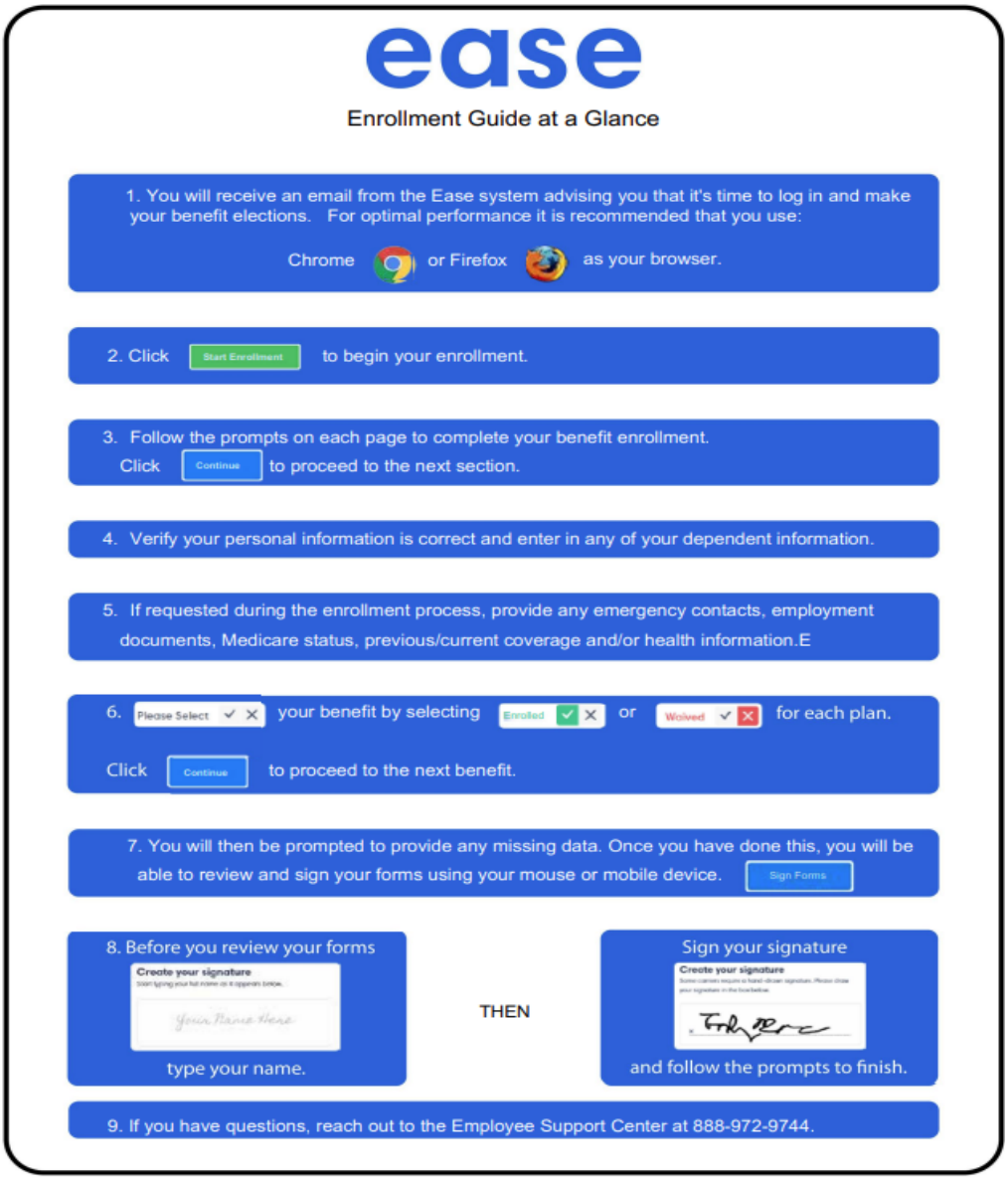
WHY IT'S IMPORTANT TO PARTICIPATE IN OPEN ENROLLMENT

All eligible employees are requested to actively participate in this open enrollment especially if you want medical or vision coverage for the new plan year. This is also a good opportunity to review your demographic information, current health benefit elections and dependent enrollments as well as understand any changes which may have occurred with the benefit plans and/or premium changes.

HOW TO PARTICIPATE / ENROLL

There are three ways to get started with your open enrollment:

1. You can self-enroll online. **Click here** and note username and password were sent separately to your work email address.
    a. Follow step-by-step instructions (sample site below)
2. Call the Employee Support Center at 800-863-9019 (Monday – Friday, 8 am to 8 pm and Saturday 8 am to 12 pm)
3. **Click here** to **Schedule an Appointment** time between October 9th and October 27th



BE SURE TO CLICK *FINISH* AT TOP RIGHT OF PAGE TO SUBMIT YOUR ENROLLMENT

DISTRICT CONTRIBUTIONS

DISTRICT CONTRIBUTIONS – As of January 1, 2024

Contributions are based on your bargaining unit. MHUSD contributes a specific amount based on hours worked. This contribution can be applied to medical, dental and vision coverage.

Classified (MHCEA)	1/1/2024	% of Contribution
3.5 but less than 5 hours	$525.00	50%
5 but less than 6 hours	$656.25	62.50%
6 but less than 7 hours	$787.50	75%
7 or more hours	$1,050.00	100%

Certificated (MHFT)	Employee	Employee + 1	Family
0.4 FTE	$320.00	$420.00	$520.00
0.5 FTE	$400.00	$525.00	$650.00
0.6 FTE	$480.00	$630.00	$780.00
0.7 FTE	$560.00	$735.00	$910.00
0.8 FTE	$640.00	$840.00	$1,040.00
0.9 FTE	$720.00	$945.00	$1,170.00
1.0 FTE	$800.00	$1,050.00	$1,300.00

Admin (MHELA)*	Employee	Employee + 1	Family
0.4 FTE	$420.00	$500.00	$600.00
0.5 FTE	$525.00	$625.00	$750.00
0.6 FTE	$630.00	$750.00	$900.00
0.7 FTE	$735.00	$875.00	$1,050.00
0.8 FTE	$840.00	$1,000.00	$1,200.00
0.9 FTE	$945.00	$1,125.00	$1,350.00
1.0 FTE	$1,050.00	$1,250.00	$1,500.00

Note: District contribution amount subject to change based on continued negotiations.

HMO MEDICAL & PRESCRIPTION DRUG BENEFITS

You have the choice of 6 HMO medical plans, and prescription coverage is included as part of the medical plan option you select. When choosing your medical plan, consider your budget, your preferences, your health and your covered dependents' health. The monthly premium rates for each plan are shown above the benefits. These are the full premiums before applying your applicable district contribution.

Please note the information below is a summary of coverage only. For more detailed benefit information, you may view each plan's full Benefit Summary and Summary of Benefits and Coverage (SBC) in the *Ease* portal.

KAISER and AETNA – HMO Plans

	High Options		Middle Options		Low Options	
Benefits	**Kaiser Traditional HMO**	**Aetna HMO Full $0 / $15**	**Kaiser HMO $500 Deductible**	**Aetna HMO AVN $1,000 Deductible**	**Kaiser HDHP**	**Aetna HMO AVN $3,000 Deductible**
Monthly Premium Rates 2024						
Employee	$926.58	$1,266.33	$826.48	$884.90	$571.83	$770.96
Employee + 1	$1,853.16	$2,532.66	$1,652.95	$1,769.80	$1,143.67	$1,541.91
Employee + 2 or More	$2,409.12	$3,292.46	$2,148.85	$2,300.75	$1,486.77	$2,004.49
Calendar Year Deductible[1] (Individual/Family)	None	None	$500 / $1,000	$1,000 / $2,000	$3,200 / $6,400	$3,000 / $6,000
Calendar Year Maximum (Individual/Family)	$1,500 / $3,000	$1,500 / $3,000	$3,000 / $6,000	$3,000 / $6,000	$5,250 / $10,500	$6,000 / $12,000
Preventive Care	No charge	No charge	No charge (deductible waived)	No charge (deductible waived)	No charge (deductible waived)	No charge (deductible waived)
Physician/Specialist Office Visits	$15	$15	$20 (deductible waived)	$10 / $35 (deductible waived)	$30 / $50	$50 / $75 (deductible waived)
Room & Board Hospital Inpatient (semi-private)	No charge	No charge	20%	20%	30%	No charge
Outpatient Surgery	$15	No charge	20%	20%	30%	No charge
X-Ray & Lab	No charge	No charge	$10	20% (deductible waived)	$10	X-ray: $15 copay Lab: No charge (deductible waived)
Diagnostic Imaging (PET, CT, MRI)	No charge	No charge	20% up to a max of $150	20% (deductible waived)	30% up to a max of $150	No charge (deductible waived)
Emergency Room	$50 (waived if admitted)	$50 (waived if admitted)	20%	20% (non-emergency not covered)	30%	$250 After Deductible (non-emergency not covered)
Urgent Care Visits	$15	$15 (non-urgent not covered)	$20 (deductible waived)	$35 (deductible waived) (non-urgent not covered)	$30	$50 (deductible waived) (non-urgent not covered)
Chiropractic Care	$15 up to 20 visits comb. w/ acupuncture	$15 up to 20 visits	$15 up to 20 visits comb. w/ acupuncture	$15 (deductible waived) up to 30 visits	Not Covered	Not Covered
Acupuncture	$15 up to 20 visits comb. w/ chiropractic	$15 up to 20 visits	$15 up to 20 visits comb. w/ chiropractic	$15 (deductible waived) up to 20 visits	$30 (only for treatment of nausea & pain mgt)	$75 up to 20 visits (deductible waived)
Retail Pharmacy (up to a 30-day supply)[2]	$5 G / $20 B	$5 G / $20 P / $50 NP	$10 G / $30 B (deductible waived)	$5 G / $20 P / $55 NP (deductible waived)	$15 G / $30 B	$5 G / $20 P / $55 NP (deductible waived)
Mail Order Pharmacy (up to a 90-day supply/100-day Kaiser)[2]	$10 G / $40 B	$10 G / $40 P / $100 NP	$20 G / $60 B (deductible waived)	$10 G / $40 P / $110 NP (deductible waived)	$30 G / $60 B	$10 G / $40 P / $110 NP (deductible waived)

[1] Deductible applies unless noted

[2] G = Generic, B=Brand Name, P = Preferred, NP = Non-Preferred

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

IMPORTANT: Enrolling in an Aetna HMO plan?

Before enrolling in an Aetna HMO plan, you must select a Primary Care Physician (PCP) for yourself and any enrolled dependents. The PCP will manage your care. If you do not select a PCP, Aetna will select one for you and for any enrolled dependents. You may change your PCP online after registering your account on www.aetna.com.

Click here to search for the Full HMO Network provider directory for the High Option plan

Click here to search the Value Network (AVN) provider directory for the Mid and Low Option plans

PPO MEDICAL & PRESCRIPTION DRUG BENEFITS

You have the choice of 3 PPO medical plans, and prescription coverage is included as part of the medical plan option you select. The monthly premium rates for each plan are shown above the benefits. These are the full premiums before applying your applicable district contribution.

Please note the information below is a summary of coverage only. For more detailed benefit information, you may view each plan's full Benefit Summary and Summary of Benefits and Coverage (SBC) in the *Ease* portal.

ÆTNA – PPO Plans

Benefits	Aetna PPO Open Access Managed Choice 80/60		Aetna POS Open Access Managed Choice POS 2500		Aetna POS Open Access Managed Choice HDHP	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Monthly Premium Rates 2024						
Employee	$1,371.68		$1,224.22		$1,132.54	
Employee + 1	$2,743.37		$2,448.43		$2,265.10	
Employee + 2 or More	$3,566.38		$3,182.96		$2,944.63	
Calendar Year Deductible (Individual/Family)	**$1,000 / $2,000**		$2,500 / $5,000		$3,000 / $6,000	
	Deductible applies unless noted		*Deductible applies unless noted*		*Deductible applies unless noted including Rx*	
Calendar Year Maximum (Individual/Family)	$3,000 / $6,000	No maximum	$4,000 / $8,000	No maximum	$4,000 / $8,000	No maximum
Preventive Care	No Charge (deductible waived)	40%	No Charge (deductible waived)	40% (some services not covered)	No Charge (deductible waived)	40%
Physician/Specialist Office Visits	$20 copay (deductible waived)	40%	$35 Copay (deductible waived)	40%	10%	40%
Room & Board Hospital Inpatient (semi-private)	20%	40%	20%	40%	10%	40%
Outpatient Surgery	20%	40%	20%	40%	10%	40%
X-Ray & Lab	20%	40%	20%	40%	10%	40%
Diagnostic Imaging (PET, CT, MRI)	20%	40%	20%	40%	10%	40%
Emergency Room Copay (waived if admitted)	$50 (deductible waived)		20% after $50 copay (deductible waived)		10%	
Emergency Room Non-Emergency Use	20%		Not Covered		Not Covered	
Urgent Care Visits (non-urgent not covered)	$35 copay (deductible waived)	40%	$35 (deductible waived)	40%	10%	40%
Chiropractic Care	$20 copay (deductible waived)	40%	$35 copay (deductible waived)	40%	10%	40%
	20 visits per year		20 visits per year		20 visits per year	
Acupuncture	$15 copay (deductible waived)	40%	$35 copay (deductible waived)	40%	10%	40%
	20 visits per year		20 visits per year		20 visits per year	
Retail Pharmacy (up to a 30-day supply)[1]	$5 G / $20 P / $50 NP (deductible waived)	40% up to max $250 (deductible waived)	$5 G / $20 P / $50 NP (deductible waived)	40% up to max $250 (deductible waived)	$5 G / $20 P / $50 NP	40% up to max $250
Mail Order Pharmacy (up to a 90-day supply)[1]	$10 G/ $40 P/ $100 NP (deductible waived)	Not covered	$10 G/ $40 P/ $100 NP (deductible waived)	Not covered	$10 G/ $40 P/ $100 NP	Not covered

[1] G = Generic, P = Preferred, NP = Non-Preferred

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

How to Find an In-Network Provider

With the HMO Medical plans, you can only see in-network providers. With the PPO plans, you'll save the most money when you stay in network. To find an in-network doctor near you, click here to search for providers in the Full PPO Network.

HEALTH SAVINGS ACCOUNT (HSA)

You are eligible to open and make contributions to an HSA if the following apply:

- You are covered under one of the qualifying "High Deductible Health Plan" (HDHP);
- You are **NOT** covered under another medical plan that is NOT a qualifying HDHP (including a full medical FSA even through your spouse)
- You are **NOT** enrolled in Medicare Parts A or B[1]; and,
- You are not claimed as a tax dependent by another taxpayer.

The TDS Group assists in administering the HSA accounts for participating employees. If you decide to participate, you will need to elect the HSA in the *Ease portal. You will then receive a Welcome Kit with additional information and forms directly from Avidia Bank.*

PLEASE NOTE: Your HSA election does not carry over to the following year. You must re-enroll during the annual Open Enrollment window if you would like contributions to continue.

An HSA is a bank account that can be used for qualified health care expenses.

- **Funds won't expire:** Your HSA balance is yours. If you don't spend your balance in a year, it'll roll over into the following year with the opportunity to earn interest along the way.
- **The account follows you:** You own your HSA account. Think of it as a personal checking account for qualified health care expenses. If you switch jobs or retire[1], you'll take it with you.
- **Triple tax advantages:** Once you've opened your HSA, you'll contribute pre-tax money[2], your account will grow tax-free, and you may pay for eligible health care expenses tax-free.

Each year, the IRS sets limits on how much you can contribute to an HSA. Maximum employee contributions for 2024 are as follows:

Single Coverage: $4,150 **Family Coverage (two or more enrolled):** $8,300

Age 55 or older: An additional contribution of $1,000

Full Contribution Rule: Generally, you can only contribute to an HSA during the months you are eligible, and IRS rules state that contribution limits must generally be prorated by the number of months you are eligible to contribute to an HSA. You may be eligible to use the last-month rule to make a full contribution even if you are not HSA-eligible for the whole year. See below.

Last Month Rule: Under this rule, if an individual is eligible on the first day of the last month of the tax year (December 1 for most taxpayers), he or she is considered an eligible individual for the entire year. HSA accountholders may utilize the Last Month Rule to make a full HSA contribution for that year.

HSAs involve very complex rules, including limitations on eligibility[1,2], contribution limits, and expense reimbursement. Federal and state tax penalties may be assessed upon you if these requirements are not met. You should talk to a tax advisor about your personal circumstances with respect to the HSA rules. Another helpful resource is IRS Publication 969 (https://www.irs.gov/publications/p969/ar02.html).

If you are interested in opening a Health Savings Account--and you will not be Medicare-eligible during the 2024 calendar year-- an educational presentation can be found here.

Debit Cards

If you enroll in the HSA, you will receive a debit card to pay for services directly out of your account if you choose.

---

[1]If you are Medicare eligible, once you enroll in Medicare, you will not be able to contribute to your HSA. You may delay your Medicare Part A and Part B enrollment until you retire which will allow you to continue to make contributions to your HSA. If you qualify for premium free Part A, your coverage will go back up to 6 months from when you sign up. You should stop making contributions to your HSA 6 months before you enroll in Part A and Part B. You must submit a change form to the District's Benefit Office in order to stop your contributions.

[2]Certain states do not treat HSA contributions or distributions as tax-free (e.g., Alabama, California, New Jersey). Consult your tax advisor to understand how HSA participation may impact you and your family members from a tax perspective.

DENTAL BENEFITS

The dental benefits are provided through Delta Dental. There is one Deltacare DHMO plan and three DPPO plans: Premium, High, and Low. Providers may be found at www.deltadentalins.com. You cannot add, drop or change dental plans after your Initial Enrollment window closes. Your next opportunity to enroll in Dental coverage will be during Open Enrollment for a January 1, 2027, effective date. Open enrollment—for Dental coverage--occurs every three (3) years thereafter. **Note: The Premium plan is only available during your Initial Enrollment window when becoming a benefits-eligible employee.**

DeltaCare DHMO

This plan is like a medical HMO in that you must select a contracting dentist or dental group who will provide all your dental care. You must initiate your dental care through your assigned dentist or dental group, or benefits will not be payable if you do not use your assigned dentist or dental group. You can search for an in-network dentist by visiting the DeltaCare USA network at www.deltadentalins.com .

Delta Dental PPO (Incentive Plan)

New members under this plan begin with a 70% benefit for most services. If a member has one claim in the calendar year, the benefit will increase 10% the following January 1 up to 100%. Each member within a family has their own incentive level and a member will maintain their benefit level if they remain on the PPO plan. This plan allows you to visit any licensed dentist; however, you receive advantages such as claims submission by the dentist and lower out-of-pocket expenses when choosing a network dentist. You can search for a provider by visiting www.deltadentalins.com. While you will receive discounts by seeing a **PPO** or **Premier** dentist, the discounts are best when utilizing in-network PPO dentists.

Delta Dental – DHMO and DPPO Plans

Key Features	DeltaCare DHMO Group #70870	Delta Dental Premium Plan Group #0710206431	Delta Dental High Plan Group #0710200649	Delta Dental Low Plan Group #0710206429
Monthly Premium Rates 2024				
Employee	$25.34	$61.48	$55.57	$47.87
Employee + 1	$41.87	$122.96	$111.11	$95.74
Employee + 2 or More	$61.65	$207.87	$187.87	$161.85
Annual Calendar Year Maximum	None	$3,200 In Network $3,000 Out of Network	$2,200 In Network $2,000 Out of Network	$1,200 In Network $1,000 Out of Network
Calendar Year Deductible	None	None	None	None
Diagnostic & Preventive *(Exams, cleanings, and x-rays)*	Various co-pays apply	70% - 100% three cleanings	70% - 100% two cleanings	70% - 100% two cleanings
Basic Services *(Fillings, simple tooth extractions)*	Various co-pays apply	70% - 100%	70% - 100%	70% - 100%
Endodontics *(Root canals)*	Various co-pays apply	70% - 100%	70% - 100%	70% - 100%
Periodontics *(Gum treatment)*	Various co-pays apply	70% - 100%	70% - 100%	70% - 100%
Major Services *(Crowns, inlays, onlays, and cast restorations)*	Various co-pays apply	50%	50%	50%
Prosthodontics *(Bridges and dentures)*	Various co-pays apply	50%	50%	50%
Implants	Not covered	50%	N/A	N/A
Orthodontics	Various co-pays apply adult & child	100% adult & child	100% child only	N/A
Orthodontic Lifetime Maximum Per Person	Adult: $1,800 / Child: $1,600	$3,000	$2,000	N/A

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

VISION BENEFITS

You and your dependents may choose from three vision plans through Vision Service Plan (VSP): Premium, High and Low. The main difference in the plans is the frequency of coverage for the lenses or contact lenses and frames. You can seek care through any vision provider; however, you receive discounts for seeking care through a contracted VSP provider. To find an in-network provider, visit **www.vsp.com**, select *FIND A DOCTOR*, *ADVANCED SEARCH* and choose the **Signature Network.**

Members are entitled to the following under VSP:

- WellVision Exam – Once every 12 months
- Materials – Once every 12 or 24 months, depending on chosen plan
- Essential Medical Eyecare – supplemental medical coverage for conditions related to the eye
- Discounts on Featured Frame Brands and additional pairs of glasses
- Copays for lens enhancements saving an average of 40%
- Discounts on Laser VisionCare Program and low-vision aids

VSP – Vision Plan Options

Monthly Premium Rates 2024	Premium (Plan C)		High (Plan B)		Low (Plan A)	
Employee	$9.42		$6.81		$5.71	
Employee + 1	$21.57		$15.62		$13.10	
Employee + 2 or More	$38.70		$27.99		$23.50	
Benefits	**Copay**		**Copay**		**Copay**	
Exam	$10		$10		$10	
Contact Lens Exam	up to $60		up to $60		up to $60	
Materials	$0		$0		$0	
	Benefit Frequency		**Benefit Frequency**		**Benefit Frequency**	
Exam	Once per calendar year		Once per calendar year		Once per calendar year	
Lenses	Once per calendar year		Once per calendar year		Once every other calendar year	
Frames	Once per calendar year		Once every other calendar year		Once every other calendar year	
Contact Lenses (in lieu of glasses)	Once per calendar year		Once per calendar year		Once every other calendar year	
Coverage	**In Network**	**Out of Network**	**In Network**	**Out of Network**	**In Network**	**Out of Network**
Single Lens	Covered in full	$50 allowance	Covered in full	$50 allowance	Covered in full	$50 allowance
Bi-Focal Lenses	Covered in full	$75 allowance	Covered in full	$75 allowance	Covered in full	$75 allowance
Tri-Focal Lenses	Covered in full	$100 allowance	Covered in full	$100 allowance	Covered in full	$100 allowance
Progressive Lenses						
Standard	Covered in full	$75 allowance	Covered in full	$75 allowance	Covered in full	$75 allowance
Premium	$80-$90 copay	$75 allowance	$80-$90 copay	$75 allowance	$80-$90 copay	$75 allowance
Custom	$120-$160 copay	$75 allowance	$120-$160 copay	$75 allowance	$120-$160 copay	$75 allowance
Frames Allowance	$130 allowance	$70 allowance	$130 allowance	$70 allowance	$130 allowance	$70 allowance
Costco	$70	N/A	$70	N/A	$70	N/A
Contact Lenses						
Medically Necessary	Covered in full	$210 allowance	Covered in full	$210 allowance	Covered in full	$210 allowance
Elective	$130 allowance	$105 allowance	$130 allowance	$105 allowance	$130 allowance	$105 allowance
Primary EyeCare	$20 copay	Not covered	$20 copay	Not covered	$20 copay	Not covered

Lens Enhancements - In Network	Premium (Plan C)			High (Plan B)			Low (Plan A)		
	Single Vision	Multifocal	Out of Network	Single Vision	Multifocal	Out of Network	Single Vision	Multifocal	Out of Network
Anti-Reflective Coating	$37.00	$37.00	Not covered	$37.00	$37.00	Not covered	$37.00	$37.00	Not covered
Polycarbonate - Adult	$23.00	$28.00	Not covered	$23.00	$28.00	Not covered	$23.00	$28.00	Not covered
Polycarbonate - Children	Covered		Not covered	Covered		Not covered	Covered		Not covered
Photochromic	Covered		Not covered	$70.00	$70.00	Not covered	$70.00	$70.00	Not covered
Scratch-resistant coating	$15.00	$15.00	Not covered	$15.00	$15.00	Not covered	$15.00	$15.00	Not covered

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

VISION BENEFITS – continued
VALUE ADDED VISION BENEFITS

Primary Eyecare Benefit ($20 copay)	The Primary Eyecare Benefit is designed for the detection, treatment and management of ocular conditions and/or systemic conditions that produce ocular or vision symptoms. A member can seek care from their VSP provider versus their medical primary care physician for: Symptoms –including but not limited to: • Ocular discomfort • Transient loss of vision • Flashes or floaters • Pain in or around the eyes • Red eyes • Swollen lids • Diplopia • Ocular trauma Conditions – including but not limited to: • Ocular hypertension • Glaucoma • Cataracts • Pink-eye • sty • Corneal abrasion • Corneal dystrophy • Macular degeneration • Retinal nevus blue • blepharitis
Glasses and Sunglasses	Get 20% off additional glasses and/or non-prescription sunglasses from any VSP doctor within 12 months of your last WellVision Exam. More information can be found at www.vsp.com.
Laser Vision Correction	Save up to $1,000 on LASIK at TLC laser Eye Centers and The LASIK Vision Institute. Visit www.vsp.com for more details.
Retinal Screening	Members pay no more than a $39 copay on routine retinal screenings as an enhancement to the WellVision Exam.
TruHearing	You can save up to 60% on a pair of digital hearing aids and savings on batteries for you and your extending family members. For more information, visit www.truhearing.com/vsp.

FLEXIBLE SPENDING ACCOUNTS

You may participate in FSAs to help pay for eligible medical and dependent care expenses with pre-tax dollars. B*enefit elections do not automatically roll over to the new plan year. You must actively elect to participate during each open enrollment window.*

- **General Health Care FSA projection, not yet finalized by IRS (up to $3,200 per year):** You may use the General Health Care FSA to be reimbursed for eligible medical, dental, and vision out-of-pocket expenses, like deductibles, copayments, coinsurance, and prescription drugs (except insulin, which is covered without a prescription) as well as other qualified medical expenses that aren't covered by your health plans. **Note:** While you're enrolled in a General Health Care FSA, you **cannot** make or receive Health Savings Account (HSA) contributions.
- **Limited Health Care FSA projection, not yet finalized by IRS (up to $3,200 per year):** You may use the Limited Health Care FSA to pay for eligible out-of-pocket dental and vision expenses. **Note:** You **can** make or receive HSA contributions when you're enrolled in a Limited Health Care FSA.
- **Dependent Care FSA (up to $5,000 per year):** You may use the Dependent Care FSA to be reimbursed for eligible dependent care expenses. Eligible dependent care is for dependent children under age 13 who live with you most of the time and do not provide more than on-half of their support or dependents of any age who are incapable of self-care.
    - ★ If your spouse has access to another dependent care FSA, your combined contribution may not exceed $5,000. If you're married and file separate tax returns, each spouse may contribute $2,500. You may not rollover any unused dependent care FSA funds remaining at the end of the plan year to the new plan year.

HOW FSAs WORK

FSAs work like a savings account. Here's how you save:

- ❑ A pretax payroll deduction amount of your choice (up to the IRS maximum) is deposited into your FSA
- ❑ The amount you contribute to any FSA is deducted from your paycheck before federal, state, local and Social Security taxes are withheld
- ❑ When you have an eligible expense, reimbursement from your account is tax free (receipts or documentation of expense may be required)
- ❑ You will have access to your full Healthcare FSA election amount at the very beginning of the plan year, regardless of the amount contributed to date (does not apply to Dependent Care accounts)

Health Care Carryover

If you have not spent all of your Health Care FSA dollars by the end of the plan year—December 31, 2023—you may carry over up to $610 to the new 2024 plan year. However, any balance in excess of $610, at the end of the current 2023 plan year, will be forfeited. The carryover for the 2024 plan year has not been finalized by the IRS – projected to be $640.

Dependent Care Grace Period

If you have not spent all of your Dependent Care dollars by the end of the plan year – December 31, 2023 – you may continue to incur expenses during the grace period. The grace period extends 2 ½ months after the end of the plan year (to March 15, 2024). Any dollars remaining at the end of the current 2023 grace period (March 31, 2024) will be forfeited.

Debit Cards

If you enroll in one of the Health Care FSAs, you will automatically receive a debit card to pay for services directly out of your account if you choose - you avoid out-of-pocket expenses.

You may also use your debit card for Dependent Care FSA expenses. Keep in mind the maximum amount you can use your debit card for is limited to your current Dependent Care FSA account balance. If there are not enough funds in your account to pay for your services up front, you will need to submit for reimbursement to TDS Group. See page 19 for contact details.

LIFE INSURANCE – DISTRICT PAID AND VOLUNTARY

In addition to health benefits, the District also offers eligible employees life benefits. These benefits are intended to provide financial assistance for you in the event of the death of a spouse or child or your beneficiaries in the event of your death.

BASIC LIFE

The District provides you with Basic Life insurance through Reliance Standard equal to $10,000 at no cost to you.

VOLUNTARY LIFE

You have the option to purchase additional life insurance through Reliance Standard for yourself, your spouse/domestic partner (under age 70) or your dependents (unmarried, financially dependent children age 14 days to 20 years or full-time students to age 26)

Eligibility: All active, full-time employees working 18 or more hours per week
A person may not have coverage as both an Employee and Dependent
Only one insured spouse may cover the Dependent Children

You can choose life insurance up to $500,000 in increments of $10,000 for you and your spouse/domestic partner. Newly eligible employees are guaranteed to be issued a policy for up to $200,000 (under age 60). Additional insurance will require evidence of insurability. If you do not enroll during your initial eligibility period, you will not be guaranteed to have this policy issued to you. You will need to provide evidence of insurability.

Dependent Child(ren): 14 days to 6 months: $1,000; age 6 months to 20 years of age (26 if full-time student) choice of: $2,500, $5,000, $7,500 or $10,000. Choose one benefit amount for all eligible children in the family.

Features:

- Accelerated Death Benefit
- Conversion Privilege at time of termination
- Portability at time of termination
- Waiver of Premium at time of total disability

Rates and limits are determined based on age.

NAMING YOUR BENEFICIARY

You may name anyone you which as your beneficiary(ies). They will receive your Life benefits in case of your death. Once you have selected your beneficiary(ies), your designation will remain unchanged until you submit a new beneficiary designation form. You may change your beneficiary(ies) as often as you wish.

VOLUNTARY DISABILITY INSURANCE

Reliance Standard Voluntary Short-Term Disability (STD)

Disability income protection provides a benefit for a "short term" disability resulting from a covered injury or sickness. After the initial 7-day elimination period, the benefits are paid to you and continue while you are disabled up to a maximum duration of 13 weeks. After that, long-term disability is payable for any additional coverage if you are enrolled.

Eligibility: All active, full-time employees working 18 or more hours per week and earning an annual salary of at least $15,000

Weekly payments up to 60% of your earnings with a maximum benefit of $1,250 per week. Pre-existing Condition Limitation – 3/12 (applies at initial enrollment and for any benefit increases)

Features

- Maternity covered as any other illness
- Non-occupational coverage
- Partial disability

Rates are based on your salary and age.

Reliance Standard Voluntary Long-Term Disability (LTD)

Disability income protection provides a benefit for a "long term" disability resulting from a covered injury or sickness by replacing a portion of your income. There is a 90-day elimination period before benefits are paid to you and continue to be disabled until you retire or to age 65 (if 61 or less at the time of benefit) or for a shorter period of time, 1 to 3 ½ years if age 62 or older at the time of benefit.

Eligibility: All active, full-time employees working 18 or more hours per week and earning an annual salary of at least $15,000

Weekly payments up to 60% of your earnings with a maximum benefit of $15,000 per week. Pre-existing Condition Limitation – 3/12 (applies at initial enrollment and for any benefit increases)

Rates are based on your salary and age

Offsets to the benefit are made based on any social security, workers compensation, or other disability benefits received so that the insured does not receive more than 100% of their pre disability compensation. For example, if the state insurance pays you 50%, you will only be entitled to 50% long term disability payments.

Features

- Own Occupation Coverage – 24 months
- Residual and Partial Disability
- Specific Indemnity Benefit
- Survivor Benefit – 3 months
- Work Incentive & Child-Care provisions
- Travel Assistance Service

OTHER VOLUNTARY BENEFITS

Reliance Standard Voluntary Hospital Indemnity

Hospital indemnity insurance provides a range of fixed, lump-sum daily benefits to help cover the costs associated with a hospital admission, including room and board. The benefits are paid directly to the insured. You can elect to insure your dependents as well, but they are only eligible if you, the employee, chooses the insurance coverage for yourself.

Eligibility: All active, full-time employees working 18 or more hours per week
Dependents include your spouse and children less than age 26

Features:

- Guarantee Issue: no medical questions
- No pre-existing conditions exclusions
- No deductibles
- Wellness Benefits
- Overlying Major medical plan is required for all California residents

Reliance Standard Voluntary Accident

Accident insurance provides a lump-sum payment of benefits for injuries resulting from a covered accident, or for accidental death or dismemberment. The benefits are paid directly to the insured and may be used for any reason. Coverage is guaranteed – no medical underwriting

Eligibility: All active, full-time employees working 18 or more hours per week (Employee must be under age 70 at date of application)
Dependents include spouse/domestic partner (under age 70) and children from birth to 26 years

Two plans to choose from, A and B. See separate schedule of benefits for each plan.

Features:

- Portability to employee age 70
- FMLA/MSLA Continuation
- Wellness benefit

Employee must be insured in order for dependents to be insured.

Allstate Cancer Coverage

With Allstate Cancer Insurance, you can protect your finances if faced with an unexpected cancer or specified disease diagnosis. Your coverage pays you a cash benefit to help with the costs associated with treatments, costs to pay for daily living expenses and empowers you to seek the care you need.

You choose the coverage that is right for you and your family. The benefit pays for 29 specified diseases. Benefits are paid directly to you unless you otherwise assign them. Coverage is available for you and your dependents.

Benefits include:

- Hospital confinement
- Radiation / Chemotherapy
- Surgery
- Miscellaneous benefits such as:
    - inpatient medicine and physician visit
    - ambulance
    - outpatient lodging
    - experimental treatments if approved
    - physical or speech therapy
    - prosthesis

OTHER VOLUNTARY BENEFITS - continued

Allstate Critical Illness and Cancer Coverage

Critical illness coverage helps provide financial support if you are diagnosed with a critical illness. You will receive a cash benefit based on the percentage payable for that condition.

Initial Critical illness Benefits available for:

- Heart attack
- Stroke
- Transient ischemic attack
- Major organ transplant
- End stage renal failure
- Coronary artery bypass surgery

Cancer Benefits under Critical illness policy available for:

- Invasive cancer
- Carcinoma in situ
- Second event- if you are given a second diagnosis more that 12 months after the first diagnoses you are covered separately for the second diagnosis.

Supplementary Critical illness Benefits available for:

- Benign brain tumor
- Coma
- Complete blindness
- Complete loss of hearing in both ears
- Paralysis

Additional option to purchase a Wellness Benefit – once per year for one of 23 exams. See brochure for list of wellness tests.

KEY CONTACTS

Contact	Phone Number	Website/Email
MHUSD Human Resources – Benefits Desk	(408) 201-6019	benefits@mhusd.org
Employee Support Center	(800) 863-9019	Click here to Schedule an Appointment
***Ease* Online Enrollment Portal**	**EASE Portal**	

Contact	Phone Number	Website/Email	Plan/Group ID
Kaiser – Medical	800-464-4000	www.kp.org	607208
Aetna - Medical	855-845-6557	www.aetna.com	176621
DeltaCare – Dental HMO	800-422-4234	www.deltadentalins.com	70870
Delta Dental – Dental PPO	800-765-6003	www.deltadentalins.com	Low Plan: 710206429 High Plan: 710200649 Premium: 710206431
VSP – Vision	800-877-7195	www.vsp.com	30106615
The TDS Group – FSA / HSA / Voluntary Benefits	866-446-1072	https://tds.wealthcareportal.com	N/A

MEDICARE PART D NOTICE

MEDICARE NOTICE OF CREDITABLE COVERAGE

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.

Important Notice About
Your Prescription Drug Coverage and Medicare

Notice of Creditable Coverage

This Notice applies only if you and/or your dependent(s) are enrolled in a Morgan Hill Unified School District medical plan, and you are eligible for Medicare. If this does not apply to you, you may ignore this notice.

Please read this notice carefully and keep it where you can find it. This notice has information about your prescription drug coverage with Morgan Hill Unified School District 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 employer 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 employer 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. **Morgan Hill Unified School District has determined that the prescription drug coverage offered under the Morgan Hill Unified School District health plans are, 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 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 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.

ANNUAL NOTICES

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

If you decide to join a Medicare drug plan, your employer coverage may be affected. Contact your employer to find out whether you can get your employer coverage back later if you or your dependents drop the coverage and join a Medicare drug plan.

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

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

For More Information About This Notice Or Your Employer Prescription Drug Coverage…

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

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

For More Information about Medicare prescription drug coverage:

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

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

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

October 1, 2023
Morgan Hill Unified School District
HR Specialist - Employee Benefits
15600 Concord Circle
Morgan Hill, CA 95037
408-201-6019

SUMMARY OF BENEFITS AND COVERAGE (SBC)

As an employee, the health benefits available to you represent a significant component of your compensation package. They also provide important protection for you and your family in the case of illness or injury. The District offers a variety of health coverage options and choosing a health coverage option is an important decision. To help you make an informed choice, a Summary of Benefits and Coverage (SBC) is available for your medical plan which summarizes important information about your health coverage options. The SBC and a Uniform Glossary are available on the District's benefits website. A paper copy is also available, free of charge, by emailing the District's Personnel Department.

NOTICE OF SPECIAL ENROLLMENT RIGHTS

If an eligible employee declines enrollment in a group health plan for the employee or the employee's spouse or dependents because of other health insurance or group health plan coverage, the eligible employee may be able to enroll him/herself and eligible dependents in this plan if eligibility is lost for the other coverage (or because the employer stops contributing toward this other coverage). However, the eligible employee must request enrollment within **30** days after the other coverage ends (or after the employer ceases contributions for the coverage).

In addition, if an eligible employee acquires a new dependent as a result of marriage, birth, adoption or placement for adoption, the eligible employee may be able to enroll him/herself and any eligible dependents, provided that the eligible employee requests enrollment within **30** days after the marriage, birth, adoption, or placement for adoption.

Furthermore, eligible employees and their eligible dependents who are eligible for coverage but not enrolled, shall be eligible to enroll for coverage within 60 days after becoming ineligible for coverage under a Medicaid or Children's Health Insurance Plan (CHIP) plan or being determined to be eligible for financial assistance under a Medicaid, CHIP, or state plan with respect to coverage under the plan. To request special enrollment or obtain more information, contact Meena Appleby at benefits@mhusd.org.

PATIENT PROTECTION NOTICE

Your health plan may require or allow for the designation of a primary care provider. If so, 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, including a pediatrician, as the primary care provider. Until you make this designation, the health plan may designate one for you.

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 our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan or procedures for making referrals.

For information on how to select a primary care provider, a list of participating primary care providers, or a list of health care professionals who specialize in obstetrics or gynecology, contact your health plan.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT NOTICE

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

WOMEN'S HEALTH AND CANCER RIGHTS ACT NOTICE

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

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

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

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **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)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2023. Contact your State for more information on eligibility –

ALABAMA Medicaid	**ALASKA Medicaid**
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS Medicaid	**CALIFORNIA Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
COLORADO Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**FLORIDA Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

GEORGIA Medicaid	INDIANA Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization- act-2009-chipra Phone: (678) 564-1162, Press 2	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone 1-800-457-4584
IOWA Medicaid and CHIP (Hawki)	**KANSAS Medicaid**
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid- a-to-z/hipp HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-766-9012
KENTUCKY Medicaid	**LOUISIANA Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov	Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE Medicaid	**MASSACHUSETTS Medicaid and CHIP**
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=e n_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: (617) 886-8102
MINNESOTA Medicaid	**MISSOURI Medicaid**
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
MONTANA Medicaid	**NEBRASKA Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178

ANNUAL NOTICES

NEVADA Medicaid	NEW HAMPSHIRE Medicaid
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 5218
NEW JERSEY Medicaid and CHIP	**NEW YORK Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA Medicaid	**NORTH DAKOTA Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
OKLAHOMA Medicaid and CHIP	**OREGON Medicaid**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
PENNSYLVANIA Medicaid and CHIP	**RHODE ISLAND Medicaid and CHIP**
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA Medicaid	**SOUTH DAKOTA Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS Medicaid	**UTAH Medicaid and CHIP**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
VERMONT Medicaid	**VIRGINIA Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://www.coverva.org/en/famis-select https://www.coverva.org/en/hipp Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON Medicaid	**WEST VIRGINIA Medicaid and CHIP**
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN Medicaid and CHIP	**WYOMING Medicaid**
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

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

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 1/31/2026)

Prepared By

EPIC®

Insurance Brokers &
Consultants