

San Juan Unified School District

San Juan Unified
SCHOOL DISTRICT
Benefits

2027

Benefit Summary

Welcome to San Juan Unified School District Benefits Guide!

San Juan Unified takes pride in offering a generous and comprehensive benefits program. This Guide is to help you better understand the plans and programs available to you and your family. Whether you are single, married, raising a family, or thinking ahead to retirement, our benefits program offers you and your family resources for financial and personal health through all of life's stages. It is your responsibility to make sure you understand your benefits. We encourage you to review this guide in its entirety and refer to it throughout the year so you can make benefit choices that help you and your family members get the most out of your benefits. This guide provides an overview of:

- Medical
- Dental
- Vision
- Flexible Spending Account (FSA)
- Employee Assistance Plan
- Life Insurance
- Supplemental Insurance
- Tax Shelter Annuities- 403(b)
- Deferred Compensation- 457
- Employee Wellness Program

Your benefits are subject to the schedule of covered services as described in the applicable Evidence of Coverage Booklet (EOC) which is available on the district's intranet benefit page or by contacting the Employee Benefits Office. The Plan summaries contained in this Guide are for comparison purposes only.

While all regular District employees receive a wide selection of benefits, employees may have different benefit packages that have been negotiated by their employee association. The benefit options offered to any given employee are determined through the collective bargaining process with the recognized employee association. For some benefits the District pays the entire cost of your coverage. For others, you may contribute a portion of the cost of coverage. Your premiums will vary according to the plan, your representation unit, and/or the level of coverage you select.

Questions concerning your benefits and the application of policies that pertain to your specific situation should be addressed to the employee benefits office staff by calling (916) 971-7662.

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DISCLAIMER

This Guide is only a summary of benefit options, responsibilities, and/or opportunities to change benefits that are available to you as a participant in the benefits program offered by the District. The District reserves the right to revise, supplement, or rescind any segment or portion of the information provided as it deems appropriate. District benefits and the policies governing them may change as legislation is revised or contract provisions are modified. Reasonable attempts will be made to inform you of those changes. However, it is your responsibility to read, understand, and comply with the District's policies, and stay informed of changes. Changes will take effect regardless of whether any notice is received. If there is a conflict between the laws, regulations, contracts, and policies governing our benefits program and this information, the applicable provision of law or policy will take precedence. This Guide is not intended to be a contract (expressed or implied), nor is it intended to otherwise create any legally enforceable obligation on part of the District.

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If you 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 page 26 for more details.

Eligibility

You are eligible for benefits if you meet one of the following criteria:

- You are an active certificated contracted employee.
- You are an active classified employee who works a regular position assignment 20 hours or more a week.

Your eligible family members include:

- Your legally married spouse or California registered domestic partner
- Your children up to age 26 for Kaiser, Western Health Advantage, Delta Dental PPO, DeltaCare, VSP and up to age 21 for Reliance Standard dependent life insurance unless full-time student then can be on coverage until 25 (includes biological, adopted, stepchildren or for whom you are required to provide coverage as the result of a qualified medical child support order)
- Children age 26 or older with a disabled condition that occurred before reaching the age limit for dependents for whom you or your spouse provides 50% or more of their support or maintenance. (Must be approved by carrier)
- An eligible child attending college out of the HMO service area may be offered coverage, but will only receive urgent and emergency care. All on-going care or follow up care will need to be provided by the child's primary care physician.



Dependent Eligibility Verification

Coverage for your dependents will not be effective until their eligibility is confirmed. If the Employee Benefits Office is unable to verify your dependent's eligibility, your dependent will not be covered and your next available opportunity to add your dependent(s) will be the next Open Enrollment period, unless you have a qualifying life event.

To ensure compliance with our plan documents, you are required to email copies of documents which prove dependent relationship as outlined in chart below within 7 days of enrolling dependents on coverage. All documentation must be translated to English if in another language. Please email to benefitshelpdesk@sanjuan.edu

Dependents	Documentation Required
Spouse	Marriage Certificate
State Registered Domestic Partner	Certificated of Domestic Partnership issued by the California Secretary of State and Affidavit of Tax Status for Domestic Partners Form
Biological Children	Government-issued Birth Certificate reflecting that the child is the Employee's child
Stepchild	Copy of child's Birth Certificate showing your spouse's or domestic partner's name and a copy of marriage certificate or documentation of domestic partnership (see above)
Adopted Child	Government-issued Adoption Order, AND government issued Birth Certificate, or foreign adoption approved by the INS or legal adoption documents from foreign country AND home government-issued Birth Certificate
Guardianship Child	Court Order of Legal Guardianship
Disabled Dependent Child	Notice of disability determination from medical carrier or Social Security Administration prior to attaining age 26 AND child documentation (biological/step/adopted/guardianship).

Benefit Costs

The District pays 100% of the employee only premiums for an employee eligible for full benefits. The District pays 75% of the dependent's medical premium cost for an employee eligible for full benefits (please refer to your bargaining unit agreement for specifications). The District pays a prorated share of the premium cost for a part-time employee based on the terms specified in the employee's collective bargaining agreement. Premiums are paid over 10 pay periods (September through June) for 12 months of coverage.

You may view your benefit cost sheet for your employee group on the District intranet. Contributions you make for you and your IRS dependents' medical, dental and vision plan coverage is automatically deducted from your paycheck on a pre-tax basis per the District's Section 125 plan provisions. As a new hire, your first deduction depends on the time of month you make your elections. Elections received after the 10th of the month may not be reflected in that month's paycheck, resulting in double deduction the following month.

Employees who have a spouse that work in the district may maximize their District contributions by electing an In- District Family-Dual coverage tier. Please contact the benefits office to arrange the setup of the In- District Family- Dual coverage tier. One of the employees will be designated as the primary subscriber and carry the entire family on his/her coverage.

Tax Implications for Domestic Partnerships and Covered Dependents

Employer paid premiums for registered domestic partners who do not meet the tax dependent definition of IRC Section 152 for the employee, may be considered taxable income for federal taxes, but not state taxes.

Employer paid premiums for children:

- Your and your spouse's children who are under age 26 are not taxable
- Your registered domestic partner's children are not taxable for state taxes but are taxable for federal taxes unless they are your tax dependents under IRC Section 152

Benefit Elections

- You must make your benefit elections on the American Fidelity "AFenroll" benefit platform within 30 days of starting your benefit eligible position. Schedule your virtual enrollment session with an American Fidelity representative through the following link: https://americanfidelity.com/SanJuan or call **1-800- 365-8306.**
- If you fail to make your online elections within 30 days of becoming eligible, you will NOT have medical, dental, vision coverages, or receive medical cash waiver payments. You will need to wait until the next Open Enrollment to elect benefits or until you have a qualifying life event.



Prepare for AFenroll Session

1. Review your plan options and costs. The Medical Plans section of this Guide provides a summary of what each plan covers. Does your plan choice adequately cover the services you use most or will need in the future?
2. Check with your doctors to find out which plans they participate in; verify plan service areas and provider availability; research available doctor offices within the plan.
3. If you take any prescription medications regularly, contact the new plan to find out how these drugs are covered. Call the prescription plan's member services or visit its website.
4. If you are waiving medical coverage, it is mandatory for you to re-certify your medical waiver each year during open enrollment. If you do not re-certify your benefit during open enrollment, you will not receive your Cash In Lieu benefit payment for the 2027 plan year.
5. Estimate your life insurance coverage needs for you and your family:
   - ✓ Determine who you will designate as your beneficiary for your term life insurance and obtain their address/ phone information
6. Learn about a Flexible Spending Account to see if you would benefit from establishing one. Estimate your out- of- pocket health care and dependent care expenses to decide how much you want to contribute to each account.
7. Have the right information handy. When you start the enrollment process, you'll need:
   - ✓ Your Social Security number; and
   - ✓ The names, birth dates, and Social Security numbers of any dependents you wish to enroll
   - ✓ Copies of the required documents to confirm dependent eligibility status (see chart on page 3) will need to be emailed the benefitshelpdesk@sanjuan.edu within 7 days of completing your enrollment

Selecting your Primary Care Physician for Western Health Advantage (WHA) Plan and DeltaCare HMO dental plan

If you enroll in WHA, you need to designate a Primary Care Physician (PCP) for yourself and your enrolled dependents which contracts within the same medical group. Here is a link to **the WHA provider network**.

If you enroll in DeltaCare, you need to select a contracted DeltaCare dentist at the time of enrollment. You may view the provider list at www.1.deltadentalins.com and designate the DeltaCare USA network.

If you do not select a doctor for WHA or a dentist for DeltaCare, these plans will assign one for you that is closest to your home. You may choose a different PCP/doctor office by calling member services to request that your PCP/office assignment be changed. Requests must be made by the 15th of the month for the upcoming month of coverage.

Cash-in-Lieu of Medical Coverage

You may waive District medical coverage and receive cash-in-lieu payments if you provide proof of other group medical coverage that is not purchased through the individual market, Covered California and Medicare. The cash-in-lieu amount is specified on the Benefit Cost Schedule for your employee group and is a taxable benefit.

Acceptable proof of other group coverage must include the following:

- Dated with in the last 30 days
- Your Name
- Effective Date
- Current Plan Status (Active/Terminated)

A benefit eligibility printout from your insurance provider or a letter from the employer who is carrying you on their coverage are usually the best kinds of proof. A copy of your insurance card is not acceptable proof of coverage. You can email your proof of coverage to benefitshelpdesk@sanjuan.edu

If you elect cash-in-lieu of medical coverage, you will need to renew this election for each new calendar year and will need to provide proof of other group medical insurance annually during the District's open enrollment period. If you are hired in the fall and waive your medical coverage, you will need to waive your coverage again during the open enrollment period for the upcoming calendar year since your waiver is only valid to the end of the current calendar year. If you do not re-certify your cash-in-lieu benefit you will loose the coverage for the 2027 plan year.

When Coverage Begins

If you enroll on time, coverage will take effect on the first day of the month following your start date in a benefit eligible position. Your enrollment elections will remain in effect for the entire plan year (January through December). You may only change your coverage if you have a qualified life event or a HIPAA special enrollment event. Please report a qualifying life event to the Benefits Office at benefitshelpdesk@sanjuan.edu within 30 days of the event.

What Happens After Enrollment

You will receive your medical ID card(s) for each covered family member within a few weeks after enrollment.

Dental and vision providers do not issue ID cards since a card is not needed to visit a dentist or VSP provider, but you can establish an online account with these insurance providers and print out a paper ID card if you desire.

Making Election Changes

Due to Internal Revenue Service (IRS) regulations, you can change your benefit elections only during the annual Open Enrollment period or within 30 days of a qualifying life event. Refer to page 6 for details regarding life events.

Open Enrollment

Open Enrollment occurs once per year and is your opportunity to make benefit elections for the upcoming plan year. Changes made during Open Enrollment are effective January 1st of the following year.

Qualifying Life Events

Benefit election changes outside of the open enrollment period must be made on the benefit enrollment platform within 30 days of qualifying life event. Submitting FMLA or Parental Leave paperwork to Human Resources for the birth of a newborn does not add your new baby to your coverage. **You must update your coverage on the AFenroll benefit platform to add your baby.**

Changes must be consistent with the qualifying life event. You must provide documentation to the benefits office to verify the event. Examples of supporting documents: HIPAA Certificate, COBRA notice, or employer letter indicating the date of the loss/gain of another group coverage.

Some examples of qualifying life events as defined by the IRS are:

- Birth or adoption of a child
- Marriage or new domestic partnership
- Divorce, legal separation, or dissolution of domestic partnership
- You or your spouse's / domestic partner's or dependent child's loss or gain of coverage
- Change in residence affecting eligibility or access to HMO health care services
- Change in coverage election made by your spouse/registered domestic partner during his/her employer's Open Enrollment

If your change is a result of the loss of eligibility or enrollment in Medi-Cal or Medicare insurance programs, you must submit the request for change within 60 days of the event.

Change in Dependent Eligibility

You are responsible for dis-enrolling any dependent who loses eligibility (e.g., divorce, termination of a domestic partnership, death, dependent reaching age limit) within 30 days of the dependent's eligibility status change. If family court orders continued benefits for an ex-spouse, you would need to elect COBRA continuation coverage or purchase private coverage; divorced spouses cannot stay on employee's coverage.

IMPORTANT: Regardless of the timing of notice to the District, coverage for an ineligible dependent will end on the last day of the month in which the dependent loses eligibility. Failure to delete ineligible dependents within 30 days of a change in status may result in a loss of continuation coverage (COBRA) rights for your dependent(s), and you may also become financially responsible for the cost of premiums and any services received by your dependent(s) after the loss of eligibility.

Benefit Coverages While on a Leave of Absence

Core Medical, Dental and Vision Coverage

District premium contributions will continue while you are on a paid leave of absence or an unpaid FMLA leave as long as the employee's required premium contributions are continued during the leave of absence.



Employees on a District-approved unpaid leave may continue their medical, dental, and vision benefits by paying the required insurance premiums to the District. Contact the Benefits Office to make payment arrangements.

Submitting FMLA or Parental Leave paperwork to Human Resources for the birth of a newborn does not add your new baby to your coverage. **You must update your coverage on the AFenroll benefit platform within 30 days of the birth of a child.**

Reliance Term Life Insurance

Your term life insurance coverage ends on the last day of the month in paid status. You may port or convert your life insurance coverage during an unpaid leave of absence if you have been covered for 12 months under the policy prior to the end of coverage. You will need to apply within 31 days from the date you are no longer eligible for coverage. Contact the Benefits office if you wish to apply to port or convert our life policy.

Voluntary Insurance Coverage

If you do not have enough earnings to cover your voluntary premium deductions, you will need to contact the insurance carrier to make payment arrangements to continue your policy if the carrier permits.

Flexible Spending Account Deferrals

If you are deferring to a Flexible Spending Account (FSA) and you are going to take an unpaid leave absence, you will need to contact American Fidelity at **-1-800-365-8306,** to arrange the funding arrangement for your FSA.

1. Prepay the contributions pre-tax, or
2. Continue the contributions on an after-tax basis (pre-tax contributions may resume when your return to work) or
3. Prorate the unpaid contributions over the remaining pay periods when you return to work.

Failure to make all elected contributions will result in termination of your account as of the date contributions ceased.

When Your Benefits End

Core Medical, Dental and Vision Coverage

Your medical, dental, and vision coverages end on the last day of the month in the month of termination or loss of eligibility. For example: if termination date is March 14, benefits will end on March 31. If termination date is March 31, benefits will end on March 31. Employees who terminate employment in the month of June, July, or August will have insurance coverages end on August 31 since premiums are paid “10thly” for 12 months of coverage. You and your covered family member may be eligible to continue coverage under COBRA law. Please refer to page 30 for COBRA provisions.

You may continue benefits during a family medical leave of absence according to federal guidelines and in conjunction with the District’s policy, or under your federal and state COBRA rights.

Employees **retiring** under the age of 65 *may* be eligible for continued District paid medical and dental premiums as specified by the employee’s collective bargaining agreement. The Benefits Office will email retirees a benefits processing packet prior to the employee’s retirement date. Please refer to the Retiree Health Benefits Guide for more information which is available on the District’s intranet Retirement page.

Reliance Term Life Insurance

Your Reliance term life insurance coverage ends on the last day of the month in paid status. If you have been covered under the policy for 12 months prior to the loss of coverage, you may apply to port or you may convert to an individual term life policy within 31 days of your loss of eligibility. Please contact the benefits office for plan provisions regarding porting and converting.

Eligibility to participate in the District’s employee assistance plan will terminate at the end of the month in the month of termination.

Flexible Spending Accounts

Your coverage ends on the date of your termination for your Flexible Spending Accounts (FSA), which you may extend under COBRA provisions by contacting American Fidelity at **1-800-365-8306.**

CalPERS: Termination status will be reported to CalPERS within 30 days of separation. Membership options may be found at https://www.calpers.ca.gov/docs/forms-publications/options-at-separation.pdf or call (888) 225-7377

CalSTRS: Termination status will be reported to CalSTRS within 30 days of separation. Membership options may be found: https://www.calstrs.com/refund-of-contributions or call 800-228-5453

Accumulation Program for Part-time and Limited Service Employees (APPLE) Retirement Account: If you have an APPLE Retirement account, you will need to complete an APPLE Distribution form to receive your contributions. Contact the Benefits office for this form.

Medical Plan Comparisons

Summary of benefits only. The deductibles, copays, and coinsurance percentages below indicate the amounts for which you are responsible. Evidence of Coverage is available on the District's Benefits webpage.

Benefits	Kaiser HMO	Western Health Advantage HMO
Annual Deductible	**None**	**None**
Maximum Out-of-Pocket (does not include pharmacy)	$1,500 individual/$3,000 family	$1,500 individual/$3,000 family
Maximum Lifetime Benefit	None	None
Hospital Inpatient	No charge	No charge
Office Visit	$25 per visit	$20 per visit
Routine Physical Exams	No charge	No charge
Well-child preventive care (23 months or younger)	No charge	No charge
Scheduled prenatal care and 1st postpartum visit	No charge	No charge
Outpatient surgery	$25 per procedure	$100 per procedure if performed in a facility $20 per procedure if performed in an office
Allergy Injections	$5 per visit	$5 per visit
Pediatric and Adult Immunizations	No charge	No charge
X-rays and lab tests	No charge	No charge
Ambulance services (medically necessary)	No charge	No charge
Emergency Room	$35 per visit (waived if admitted)	$100 per visit (waived if admitted)
Urgent Care Visits	$25 per visit	$35 per visit
Outpatient Prescription Drugs (pharmacy and mail order)	Retail: $10 generic/$20 brand Mail order: $20 generic/$40 brand	Retail: $10 generic/$25 preferred brand/$35 non-preferred drugs/ $100 specialty and other high cost drugs Mail order: $20 generic/$50 preferred $70 non-preferred drugs
Days Supply	Retail: 30 days/Mail: 100 days	Retail: 30 days/Mail: 90 days
Mental Health Services		
Inpatient psychiatric care	No charge	No charge
Outpatient therapy visits	$25 per individual visit $12 per group visit	$20 per visit
Chemical Dependency Services		
Impatient detoxification	No charge	No charge
Outpatient therapy visits	$25 per individual visit $ 5 per group visit	$20 per visit
Infertility Services		
Covered services related to the diagnosis and treatment of infertility	$25 per visit	50% copayment
Additional Benefits		
Durable Medical Equipment	No charge	20% copayment
Prosthetics and Orthotics	No charge	$20 per service
Skilled Nursing Facility	No charge, up to 100 days per year	No charge, up to 100 days per year
Home Care	No charge, up to 100 days per year	No charge, up to 100 days per year
Hospice Care	No charge	No charge
Hearing Aids	Amount exceeding $1,000 per aid every 36 months	Amount exceeding $1,000 per aid every 36 months
Chiropractic/Acupuncture	Not covered	$15 per visit, up to 20 visits per year

Dental Plan Options

The District offers two dental plans: **Delta Dental PPO** and **DeltaCare HMO**. Dependent children can be covered up to age 26 on both the Delta Dental PPO plan and DeltaCare HMO plan. You do not need an ID card when you visit the dentist. Just provide your name, birth date and enrollee ID or social security number. If you prefer to take a paper or electronic ID card with you, simply sign up for an Online Services account at **deltadenatlins.com**, where you can view or print your card.

What if I already have dental insurance?

Even if you have other group dental coverage, you may still enroll in the District PPO dental plan. "Coordination of Benefits" rules will be applied in determining how benefits will be paid. You may find that many dental services might be paid in full between your two dental plans. You will want to contact your current dental insurance carrier to determine how they would coordinate a claim.

What if both my spouse/domestic partner and I are District employees?

You are encouraged to evaluate the benefits of you both enrolling all members of your family in the District's dental plan since the plan will provide full coordination of benefits for married couples and domestic partners who are both District employees.

DeltaCare (DHMO)

When you enroll in DeltaCare USA plan, you will choose a primary care dentist from a network of private dentist by viewing the provider list at deltadentalins.com and selecting the DeltaCare USA option from the drop-down menu. You must visit your primary care dentist to receive benefits or be referred by your primary care dentist to a specialist. There are no deductibles or maximums for covered services. You pay your copayment at the time of treatment. Refer to the summary plan booklet and evidence of coverage booklet for plan details on the District's Benefits intranet website. Requests to change your dentist must be made to DeltaCare by the 15th of the month for it to become effective the first day of the following month.

Deductibles	None
Lifetime Maximums	None
Professional Services	An Enrollee may be required to pay a copayment amount for each procedure as shown in the description of benefits and copayments, subject to the limitations and exclusions. Copayments range by category of service. Examples is as follows: Diagnostic Services: No Cost Preventative Services: No Cost - $15.00 Restorative Services: No Cost - $75.00 Endodontic Services: No Cost - $135.00 Periodontic Services: $8.00 - $200.00 Prosthodontic Services: No Cost - $160.00 Oral & Maxillofacial Surgery: No Cost -$40.00 Orthodontic Services: No Cost - $1800.00 Adjunctive General Services: No Cost - $20.00 Note: Some services may not be covered. Certain services may be covered only if provided by specified dentists or may be subject to an additional charge.



This matrix is to be used to help you compare coverage benefits and is a summary only. The combined evidence of coverage and disclosure form and the plan contract should be consulted for a detailed description of coverage benefits and limitations.

Delta Dental (PPO) Incentive Dental Plan

The Delta Dental (PPO) provides you and your eligible dependents with the flexibility to choose any licensed dentist or specialist. If you choose a PPO dentist, you'll receive the highest level of benefit versus an out of network dentist who has not agreed to provide services at the negotiated rate. The PPO provider network may be viewed at www.deltadentalins.com

This incentive plan pays 70% of the PPO contract allowance for covered diagnostic, preventive and basic services and 70% of the PPO contract allowance for major services during the first year of eligibility. The coinsurance percentage will increase by 10% each year (to a maximum of 100%) for each enrollee if that person visits the dentist at least once during the year. If an enrollee does not use the plan during the calendar year, the percentage remains at the level attained the previous year. If an enrollee becomes ineligible for benefits and later regains eligibility, the percentage will drop back to 70%. There is no orthodontics coverage under this plan.

Benefits and Covered Services*	Delta Dental PPO Network dentists**	Out- of -PPO Network Delta Dental Premier Dentists & Non-Delta Dental Dentists
Calendar Year Maximum Coverage	$1,600 per person	$1,500 per person
Calendar Year Deductible	None	None
Diagnostic & Preventive Services (D&P) Exams, cleanings, and x-rays	70-100%	70-100%
Basic Services Fillings and posterior composites	70-100%	70-100%
Endodontics (root canals) Covered Under Basic Services	70-100%	70-100%
Periodontics (gum treatment) Covered Under Basic Services	70-100%	70-100%
Oral Surgery Covered Under Basic Services	70-100%	70-100%
Major Services Crowns, inlays, on lays, and cast restorations	70-100%	70-100%
Prosthodontics Bridges and dentures	50%	50%
Dental Accident Benefits	100% (Separate $1,000 maximum per person each calendar year)	

*Limitations or waiting periods may apply for some benefits; some services may be excluded from your plan.

Reimbursement is based on Delta Dental contract allowances and not necessarily each dentist's actual fees.

**Reimbursement is based on PPO contracted fees for PPO dentists, Premier contracted fees for Premier dentists and the program allowance for non-Delta Dental dentists.

Differences Between PPO Network/Delta Dental Premier/ Non-Delta Dental Dentists

IN – PPO Network Delta Dental PPO Dentist	Out-of-PPO Network Delta Dental Premier Dentists & Non-Delta Dental Dentists
You will usually pay the lowest amount for services when you visit a Delta Dental PPO Dentist.	You are responsible for the difference between the amount Delta Dental pays and the amount your non-Delta Dental dentist bills. You will usually have the highest out-of-pocket costs when you visit a non-Delta Dental dentist.
PPO dentists agree to accept a reduced fee for PPO patients.	Delta Premier dentists may not balance bill above Delta Dental's approved amount, so your out-of-pocket costs may be lower than with non-Delta Dental dentists' charges.
You are charged only the patient's share at the time of treatment. Delta Dental pays its portion directly to the dentist.	Non-Delta Dental dentists may require you to pay the entire amount of the bill in advance and wait for reimbursement. Delta Premier dentists charge you only the patient's share at the time of treatment.

Vision Plan Options:

The District offers two vision plans to choose from through Vision Service Plan: Basic Employee Only Plan and an Enhanced Plan with dependent coverage option. Dependent children are eligible up to age 26.

As a VSP member, you'll receive access to care from great eye doctors, quality eyewear, and the affordability you deserve, all at low out-of-pocket costs. A provider directory may be viewed at vsp.com Please refer to the Evidence of Coverage booklet available on the District's benefit webpage. There are no ID cards necessary to access services, but if you'd like a card as a reference, you can print one on vsp.com

Basic Employee Only Plan			Enhanced Plan with Dependent Coverage Option		
Benefit	**Description**	**Copay**	**Benefit**	**Description**	**Copay**
WellVision Exam	• Focuses on your eyes and overall wellness • Every calendar year	$0 for exam and glasses	**WellVision Exam**	• Focuses on your eyes and overall wellness • Every calendar year	$0 for exam and glasses
Prescription Glasses			**Prescription Glasses**		
Frame	• $120 allowance for a wide selection of frames • $140 allowance for featured frame brands • 20% savings on the amount over your allowance • $65 Costco/ Walmart/ Sam's Club frame allowance • Every other calendar year	Combined with exam	**Frame**	• **$200 allowance for a wide selection of frames** • $220 allowance for featured frame brands • 20% savings on the amount over your allowance • $110 Costco/ Walmart/ Sam's Club frame allowance • Every calendar year	Combined with exam
Lenses	• Single vision, lined bifocal, and lined trifocal lenses • Every calendar year	Combined with exam	**Lenses**	• Single vision, lined bifocal, and lined trifocal lenses • Polycarbonate lenses for dependent children • Every calendar year	Combined with exam
Lens Enhancements	• Standard progressive lenses • Premium progressive lenses • Custom progressive lenses • Average savings of 35-40% on other lens enhancements • Every calendar year	$0 $80 - $90 $120 - $160	**Lens Enhancements**	• Standard progressive lenses • Premium progressive lenses • Custom progressive lenses • Average savings of 35-40% on other lens enhancements • Every calendar year	$0 $80 - $90 $120 - $160
Contacts (instead of Glasses)	• $120 allowance for contacts and contact lens exam (fitting and evaluation) • Contact lens exam (fitting and not apply evaluation • Every calendar year	Up to $60	**Contacts (instead of Glasses)**	• $200 allowance for contacts and contact lens exam (fitting and evaluation) • Contact lens exam (fitting and not apply evaluation) • Every calendar year	Up to $60
Diabetic Eyecare Plus Program	• Services related to diabetic eye disease, glaucoma, and age-related macular degeneration (AMD), Retinal screening for eligible members with diabetes. Limitations and coordination with medical coverage may apply. Ask your VSP doctor for details. • As needed	$20	Diabetic Eyecare Plus Program	• Services related to diabetic eye disease, glaucoma, and age-related macular degeneration (AMD), Retinal screening for eligible members with diabetes. Limitations and coordination with medical coverage may apply. Ask your VSP doctor for details. • As needed	$20

Extra Savings	**Glasses and Sunglasses** • Extra $20 to spend on featured frame brands. Got to vsp.com offers for details. • 30% savings on additional glasses and sunglasses, including lens enhancements, form the same VSP provider on the same day as your WellVision Exam. Or get 20% from any VSP provider within 12 months of your last WellVision Exam. **Retinal Screening** • No more than a $39 copay on routine retinal screening as an enhancement to a WellVision Exam • Average 15% off the regular price of 5% of the promotional price; discount only available from contracted facilities.

Hearing Aids VSP members receive exclusive hearing aid benefits through TruHearing Hearing Aid Discount Program

The cost of a pair of quality hearing aids usually costs more than $5,000. TruHearing is making hearing aids more affordable by providing exclusive savings to all VSP Vision Care members. VSP members can save up to $2,400 on a pair of digital hearing aids. Dependents and even extended family members are eligible for exclusive savings too.

In addition to great pricing, TruHearing provides VSP members with:

- Three visits for an exam, fitting, adjustments and cleanings with a TruHearing-participating licensed hearing aid professional. The provider may charge up to $75 for the exam.
- 45-day money back guarantee
- Three-year manufacturer's warranty for repairs and for one-time loss and damage
- 48 free batteries per hearing aid
- Deep discounts on replacement batteries shipped directly to your home

How do you get started?

1. Call TruHearing at 1.877.396.7194. You and family members MUST mention VSP when you call.
2. TruHearing will answer your questions and schedule a hearing exam with a local, participating provider.
3. The provider will make a recommendation, order the hearing aids through TruHearing, and fit them for you.

Learn more about this VSP Exclusive Member Extra or call TruHearing at 1.877.396.7194.
The relationship between VSP and TruHearing is that of independent contractors. VSP makes no endorsement, representations or warranties regarding any products or services offered by TruHearing, a third-party vendor. The vendor is solely responsible for the products or services offered by them. If you have any questions regarding the services offered here, you should contact the vendor directly.

Amplifon Hearing Health Care

Delta Dental members now have access to discounts on hearing aids through Amplifon. There's no sign-up fee for the program, and you'll enjoy 62% average savings off retail pricing. If you find a lower price at another local provider, Amplifon will beat it by 5%. No-interest financing is also available. Amplifon offers access to the nation's leading hearing aid brands featuring the latest technology. And all products are backed by a 60-day no-risk trial. Your purchase comes with one year of free follow-up care, two years of free batteries and a three-year product warranty for all hearing aid purchases. Visit **amplifonusa.com/deltadentalins** to take advantage of your value-added feature.

Call Amplifon at **888-779-1429**. A Patient Care Advocate will help you find a hearing care provider near you. Your advocate will explain the discount process, ask you a few simple questions, then help you make an appointment. Amplifon will send you and your selected provider the necessary information to activate your hearing aid discounts.

Qualsight LASIK

Thought you'd never be able to afford LASIK eye surgery? Now it may be within reach. Delta Dental has selected Qualsight to offer members access to discounts on LASIK services. Through Qualsight, you can save 40% to 50% off the national average price of Traditional LASIK along with big savings on custom and custom bladeless LASIK procedures. To learn more about the LASIK discounts, visit **qualsight.com/-delta-dental** or call **855-248-2020**.

Group Basic Term Life Insurance

RELIANCE STANDARD
A MEMBER OF THE TOKIO MARINE GROUP

The District provides term Life insurance through Reliance Standard to active employees working the minimum hours per week specified in the chart below (pro-rated based off FTE); policy excludes any person working on a temporary or seasonal basis. If you should pass away while you are covered under the plan, your beneficiary will receive the amount allowed based on your employee group as specified on the chart.

Reliance Standard Eligibility Coverage Chart

Employee Group	Minimum Hours Worked Per Week	Basic Term Life Insurance Coverage
Transportation	20 hours	$25,000
Classified	20 hours	$50,000
Unrepresented	20 hours	$100,000*
Certificated, Management, Confidential, & Supervisors	15 hours	$100,000*

Imputed Income for Excessive Insurance

An insurance policy over $50,000 that is paid by the employer is considered a fringe benefit to the employee. The District is required to report the value of this fringe benefit to the IRS based on IRS formulas. This taxable value will be reflected on the employees pay stub, but is not actually deducted from the employee's pay.

The Employee Basic Term Life Insurance is subject to age reductions. Benefit amounts reduced to 65% of the original amount at age 75, 45% of the original amount at age 80, 30% of the original amount at age 85.

IMPORTANT: Naming your Beneficiary

You may name anyone you wish as your beneficiary. This is the individual who will receive your insurance proceeds in the case of your death. You may change your beneficiary(ies) as often as you wish by updating your beneficiary information on the AFenroll benefit platform.



Group Supplemental Term Life Insurance

In addition to District paid basic coverage, you may purchase additional coverage for yourself in the amount of $25,000, $50,000, $75,000 or $100,000. This is a term policy with no cash value. At time of hire, you can purchase supplemental life insurance up to an additional $50,000 without having to complete a Statement of Health form. The additional post-tax insurance premium amount is specified on the premium cost sheet by employee group. If you are interested in purchasing supplemental life insurance above $50,000, you will need to submit a completed Statement of Health directly to Reliance Standard for approval. The Statement of Health Form for your employee group is available on benefits intranet website.

The Employee Supplemental Term Life Insurance is subject to age reductions. Benefit amounts reduced to 65% of the original amount at age 75, 45% of the original amount at age 80, 30% of the original amount at age 85.

Supplemental Dependent Life Insurance

San Juan Unified offers Supplemental Dependent Life Insurance policies with a value of $1,500 or $10,000 ($500 for newborns to 6 months) which you may elect during your first 30 days of eligibility. Supplemental Dependent Life Insurance is a "family unit" policy which is one rate regardless of how many children the employee covers. Premium rate is noted on Employee's Group Cost Schedule. Supplemental Dependent Life Insurance is payable to the employee as the beneficiary. Dependents are:

- your legal spouse not legally separated or divorced from you or your domestic partner
- unmarried financially dependent child(ren) from birth to age 21, to age 25 if full-time student, unmarried financially dependent
- child(ren) from age 21 if handicapped
- natural and adopted children; stepchildren and foster children in your custody.

A person may not have coverage as both an Employee and Dependent. Only one insured spouse may cover dependent children.

Living Benefit

The life insurance program includes an accelerated death benefit that allows terminally ill participants with a life expectancy of less than 12 months to withdraw up to 75% of their total benefit amount. Contact the Employee Benefits Office for more information or to apply.

Waiver of Premium

If you become disabled while under age 70 and are covered under this plan, you may apply for a waiver of premium. The policy remains in force, and you do not have to pay the premiums upon approval for as long as you remain disabled. Contact the Employee Benefits Office for more information or to apply.

Conversion/Portability

Your life insurance coverage will terminate at the end of the month in which you terminate employment. You may apply for a conversion policy within 31 days of loss of coverage. Employees taking unpaid leave of absence may continue to pay their group premium (port their life insurance policy) to avoid loss of coverage.

Accidental Death & Dismemberment Insurance

Certificated, Management, Supervisors, Confidential, and Unrepresented employees who are covered under the Basic Term Life Insurance policy with Reliance Standard are also covered for Accidental Death & Dismemberment Insurance (AD&D). If death results from an accident, the designated beneficiary will receive an additional payment equal to the Basic Term Life Insurance benefit amount. In addition to the Accidental Death benefit, AD&D Insurance also provides partial payment to the insured for accidental loss as outlined in chart below:

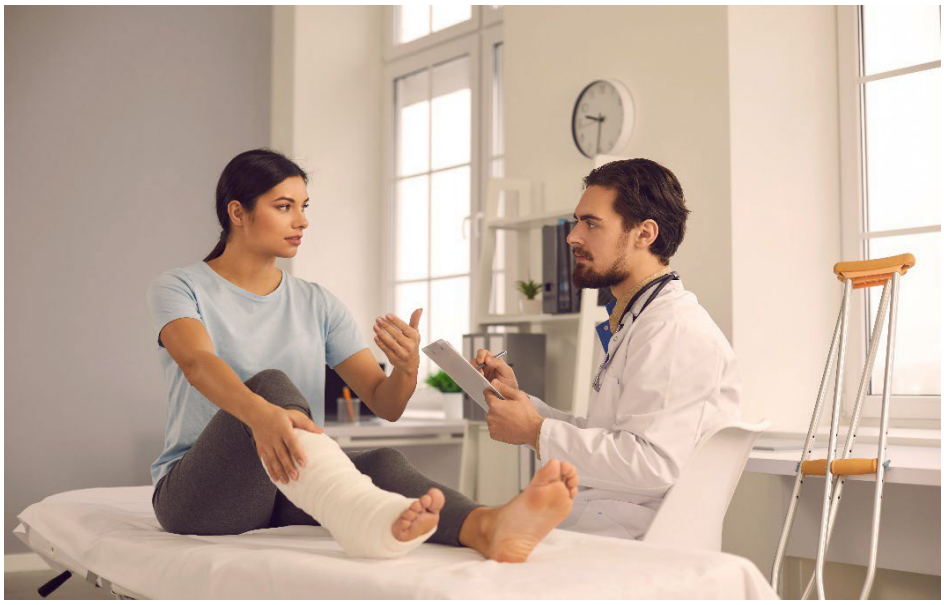
For Accidental Loss of:	Amount Payable
Life	100% of benefit
Both hands or both feet	100% of benefit
Sight of both eyes	100% of benefit
One hand and one foot	100% of benefit
One hand and sight of one eye	100% of benefit
One foot and sight of one eye	100% of benefit
Speech and hearing	100% of benefit
One hand or One foot	50% of benefit
Sight of one eye	50% of benefit
Speech or Hearing	50% of benefit



The AD&D Insurance is subject to age reductions. Benefit amounts reduced to 65% of the original amount at age 75, 45% of the original amount at age 80, 30% of the original amount at age 85.

Voluntary Insurance Policies

The District does not pay into the State Disability Program, and therefore, you will need to purchase an outside policy if you seek insurance for disability coverage. The District does not prevent employees from enrolling for two disability policies, but advises that there are limited benefits when carrying two disability policies. The District permits voluntary payroll deductions for two insurance providers: American Fidelity and CTA Standard Life Insurance Company. Payroll premium deductions are taken 10 months a year (September through June).



American Fidelity policies are available to all employee groups. American Fidelity offers a variety of insurance coverages to protect your financial health: Accident, Cancer, Critical Illness, Disability, Term Life, Whole Life and Youth Life.

An employee's initial eligibility enrollment period is the first 30 days of employment. Employees may also enroll during open enrollment. Schedule an appointment with an American Fidelity representative by calling **1-800-365-8306.**

CTA Standard Life Insurance policies are available for CTA members. Standard Life offers disability and life insurance policies. Standard Life's initial enrollment period is the first 180 days of employment.

CTA Standard offers their own open enrollment period which is communicated to eligible employees by the SJTA association. Employees may enroll by applying directly to CTA Standard Life.

Questions regarding CTA insurance products need to be directed The Standard's dedicated CTA Customer Service Department at 800-522-0406 7:00 a.m. to 6:00 p.m. Pacific Time, Monday through Friday
Learn more at CTAMemberBenefits.org/Disability and CTA MemberBenefits.org/Life

Leaves of Absence: If you take a leave of absence from work and do not have enough earnings to cover your voluntary premium deductions, you will need to contact the insurance carrier to make payment arrangements to continue your policy if the carrier permits.

Canceling Policy: If you wish to cancel your voluntary insurance payroll deductions, you will need to contact the insurance provider. The Benefits Office is not able to cancel the deduction without the payroll cancellation form provided by the insurance carrier.

Flexible Spending Accounts

The District offers tax advantaged plans called Flexible Spending Accounts (FSAs) which allow you to save money when paying for certain out-of-pocket health and dependent care expenses incurred during the current plan year (January through December). FSA accounts allow you to redirect a portion of your salary on a pre-tax basis into one or both of the reimbursement accounts. You designate an annual deferral amount which is deducted equally over your paychecks through the year and deposited into your account(s).

You may establish your account on the benefit platform. If you have questions regarding these accounts you may call the District's Section 125 Plan Administrator – American Fidelity at 800-365-8306. New employees have 30 days from eligibility to enroll for the current calendar year. Your election is for the entire year. You will need to re-enroll in the accounts each subsequent year during the District's open enrollment period which occurs in the fall.



Dependent Day Care (FSA) allows you to set aside up to $7,500 per year for day care expenses for your dependent children under the age of 13, and dependents of any age who are incapable of self-care, live with you at least eight hours per day, and are claimed as dependents on your income tax return. However, if your spouse has access to a Dependent Care Spending Account, your total combined contribution may not exceed $7,500. If you are married and file separate tax returns, each spouse may contribute $3,750. To be eligible, care must be provided while you (and your spouse, if you are married) work, look for work or attend school full-time. Eligible expenses include care in your home by an eligible provider or at a licensed facility. You will not be reimbursed for residential or "sleep- away" care, nursing home care, or for babysitting when you are not at work.

Health Care Spending Account (FSA) allows you to set aside up to $3,400 pre-tax dollars for unreimbursed medical expenses such as medical deductibles, co-payments, prescriptions, balances that remain after your benefit plan has made a payment, dental and orthodontia, and even some services not covered by your benefit plans (e.g., LASIK eye surgery or adult hearing aids). Eligible expenses that can be reimbursed through a Health Care FSA are determined by the IRS.

Reimbursement Process:

As you incur an expense, you submit the appropriate claim paperwork to American Fidelity for reimbursement of your expenses. You can either have your reimbursement directly deposited into your checking account or receive a check in the mail. Debit cards are also issued and can be used in lieu of submitting claim forms. You have a 70 days "grace period" (Jan 1 –March 15 of the following year) to incur expenses and be reimbursed if you still have funds in your account at the end of the plan year. You have 90 days from the end of the plan year to submit your claims for expenses you had during the current plan year; otherwise, any money left in your account will be forfeited.

It's important to carefully estimate your upcoming expenses since the plan has a "Use It or Lose it" provision which means you will only be reimbursed for actual expenses and any unused funds are forfeited per IRS rules.

Leaves of Absence: If you take a leave of absence, you may:

- Prepay the contributions pre-tax, or
- Continue the contributions on an after-tax basis (pre-tax contributions may resume when your return to work) or
- Prorate the unpaid contributions over the remaining pay periods when you return to work. Failure to make all elected contributions will result in termination of your account as of the date contributions ceased.

Employment Separation: If you have a positive FSA balance at the time you separate, you may elect to continue participation with after tax contributions through COBRA which allows you to claim expenses incurred after your separation date. Please contact American Fidelity to discuss your options at (800) 365-8306.

SCHOOLSFIRST
PLAN ADMINISTRATION

SchoolsFirst Plan Administration is the third-party administrator of your 403(b) and/or 457(b) retirement plan. These plans are designed to assist you in building and growing your savings for retirement by complimenting your pension income at retirement.

What is a 403(b) / 457(b) plan?
The IRS created retirement savings plans for various groups to encourage retirement savings by offering tax benefits. They developed the 403(b) for non-profit organizations and the 457(b) for state employees. Contributions to these plans are made directly from your paycheck before taxes are taken out - reducing your tax bill while saving for retirement.

What if I already have a 403(b)/ 457(b)?
Great News! You always have the opportunity to increase your contributions to the 403(b) and/or 457(b) plan any time during the year, contact us and we will be happy to assist you.

How much may I contribute?
You may contribute up to the 2027 current calendar year IRS contribution limits to each plan and may also qualify for additional catch-up contributions. We would be happy to review these options with you and answer any questions you may have related to your retirement.

Get Started
If you would like to start contributions to a 403(b) and/or 457(b) plan, you must first establish an account with an approved investment provider. If you are already working with a financial advisor or agent, please feel free to continue to do so. If you do not have a financial advisor or agent, we are here to help!

Our goal as your district's third-party administrator is to provide you with the very best personal service. If you have questions regarding the administration of your retirement plans, please contact SchoolsFirst Plan Administration at 800.462.8328, x4727 or at rpa@schoolsfirstfcu.org. If you would like to schedule an appointment to meet with an advisor, please contact our Retirement Planning Department at 800.462.8328, x 4116, Option 1.

SchoolsFirst Plan Administration, LLC is a wholly-owned affiliate of SchoolsFirst Federal Credit Union

24-Hour Travel Assistance Services

Through your group coverage with Reliance Standard, you automatically receive travel assistance services provided by **On Call International** (On Call), pursuant to an agreement between RSL and On Call. On Call is a 24-hour, toll-free service that provides a comprehensive range of information, referral, coordination and arrangement services designed to respond to most medical care situations and many other emergencies you may encounter when you travel more than 100 miles from home or in a foreign country. At any time before or during a trip, you may contact On Call for emergency assistance services at **(800) 456-3893.**

Pre-Trip Assistance:* Passport/Visa requirements *Currency exchange rates *Consulate/embassy referral

Emergency Personal Services: *Interpretation/translation services *Emergency travel arrangements* Recovery of lost or stolen luggage *Legal assistance and/or bail bond

Medical Services Include: Referrals for local physicians/dentists *Prescription assistance and eyeglasses replacement

Emergency Medical Transportation:

Services listed below are subject to a maximum combined single limit of $250,000. Return of vehicle is subject to $2,500 maximum limit.

- Emergency evacuation
- Medically necessary repatriation
- Visit by family member or friend
- Return of traveling companion
- Return of dependent children
- Return of vehicle
- Return of mortal remains

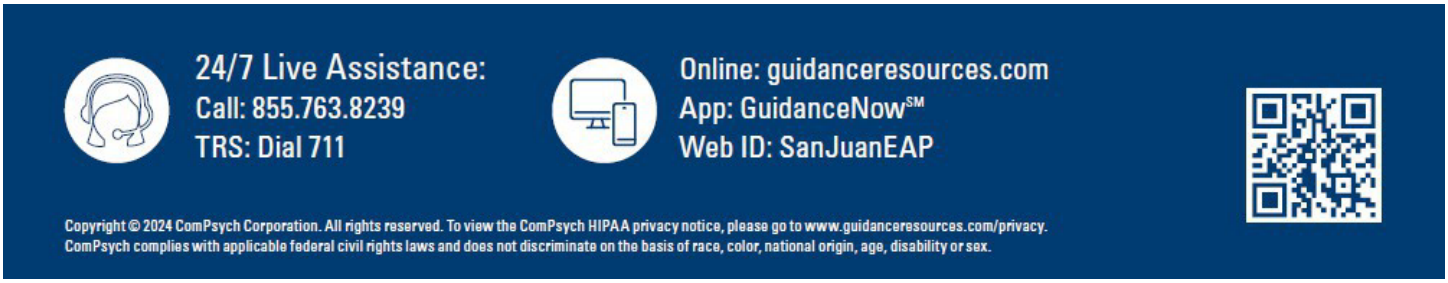
Employee Assistance Program

ComPsych administers the employee assistance program (EAP) which is available free of charge to all employees and their family members regardless of location, and easily accessible through ComPsych's 24/7 live-answer, **toll-free number 855-763-8239** and online at guidanceresources.com. Wed ID number is SanJuanEAP.

ComPsych's unlimited professional and confidential telephonic services consists of assessment and referral services to help employees and family members address a variety of personal, family, life, and work-related issues. Services include:

- Confidential Emotional Support: 5 in-person sessions per issue, per year
- Work and Lifestyle Support
- Legal Guidance
- Financial Resources
- Digital Support
- Wellness Support and Coaching

COMPSYCH®
GuidanceResources® Worldwide



"Live Healthy. Live Well."

San Juan Unified School District Employee Wellness Program

The Employee Wellness Program is designed to promote your health and well-being through a variety of health, fitness and educational programs, services and activities. A sampling of the Employee Wellness Program Services includes:, discount gym memberships, stress management webinars, well-being fitness challenges. Look for upcoming Wellness events announced in the weekly Behind the Scenes Employee Newsletter.

Kaiser - Mental Health Care - Kaiser patients can call their local mental health care team at (916) 973-5300 to request an appointment to be seen. If Kaiser patients have concerns about mental health care, please call the new patient assistance line 1-800-390-3503 to escalate and resolve issues involving mental health care.

Kaiser Podcasts!
No prior registration is required and you **do not need to be a Kaiser member**.

- Kaiser Health Talks Online are 12-15-minute audio programs featuring a moderated discussion intended to inspire healthy living and adoption of healthy lifestyle habits by applying the principles of behavior change science.
- **Healthy Living To Go Audio Library (Kaiser)**
- Rediscover the fun in walking and download the free mobile app (Every Body Walk) for the iPhone and Android Market. This app allows you to track your walks and so much more! **Everybodywalk.org**

WHA Members - Health Wellness Overview
WHA members can access the WHA "Healthy Living" portion of their website for online resources addressing topics such as smoking cessation, healthy recipes, preventative health and more. Please see **www.mywha.org** for a complete list of available topics.

Improve your health and get rewarded with **Western Health Advantage + Vitality**! Complete the personalized Vitality Health Assessment to learn your Vitality Age, receive insights into your health habits, and discover actionable steps to improve your well-being. You can earn Vitality Points for completing the assessment and continue earning points by making healthy choices. As you participate, you may unlock a higher status and bigger rewards. To get started, log in to your myWHA account at **mywha.org**, visit **powerofvitality.com**, or download the **Power of Vitality app** using your WHA member ID number.

Healthy Living with WHA - Are Your Goals Smart?
WHA Gym Discount Information

In-Shape Fitness- Corporate membership rates are available to all San Juan Unified School District employees.

Provider Contact Information		
Information Regarding		**Contact Information**
Enrollment & Eligibility		
SAN JUAN UNIFIED Benefits Office	**916-971-7662**	Email: benefitshelpdesk@sanjuan.edu www.sanjuan.edu/benefits
Health Plans		
Kaiser Permanente HMO • Group # 205-EU0000	1-800-464-4000	www.kp.org
Western Health Advantage HMO • Group # 104910	1-888-563-2250	www.westernhealth.com
Dental Plans		
DeltaCare USA HMO • 701103-0001	1-800-422-4234	www.deltadentalins.com
Delta Dental PPO • Group #6689-0011	1-866-499-3001	www.deltadentalins.com
Vision Plans		
Vision Service Plan • Group # 00798301	1-800-877-7195	www.vsp.com
Life Insurance		
Reliance Standard	1-800-351-7500	www.customercare.rsli.com
Voluntary Accident, Cancer, Disability, Life, & Policies		
American Fidelity	1-800-365-8306	www.afadvantage.com
CTA Standard Life Insurance	1-800-522-0406	CTAMemberBenefits.org/TheStandard
Flexible Spending Accounts		
American Fidelity	1-800-365-8306	www.afadvantage.com Email: flex@americanfidelity.com
403(B) Tax Shelter Annuities and 457 Deferred Compensation Plans		
Schools First	800-462-8328, x 4727	https://www.schoolsfirstfcu.org/products/just-for-school-employees/participant-center/

Important Plan Notices and Documents

Women's Health & Cancer Rights Act

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 the plan. Therefore, the following deductibles and coinsurance apply:

Plan 1: Kaiser HMO (Individual: 0% coinsurance and None deductible; Family: 0% coinsurance and None deductible)

Plan 2: Western Health Advantage HMO (Individual: 0% coinsurance and None deductible; Family: 0% coinsurance and None deductible)

If you would like more information on WHCRA benefits, please call your Plan Administrator at 916-971-7662 or Benefitshelpdesk@sanjuan.edu.

Newborns' and Mothers' Health Protection Act

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 insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

HIPAA Special Enrollment Rights

San Juan Unified School District Health Plan Notice of Your HIPAA Special Enrollment Rights

Our records show that you are eligible to participate in the San Juan Unified School District Health Plan (to actually participate, you must complete an enrollment form and pay part of the premium through payroll deduction).

A federal law called HIPAA requires that we notify you about an important provision in the plan - your right to enroll in the plan under its "special enrollment provision" if you acquire a new dependent, or if you decline coverage under this plan for yourself or an eligible dependent while other coverage is in effect and later lose that other coverage for certain qualifying reasons.

Loss of Other Coverage (Excluding Medicaid or a State Children's Health Insurance Program). If you decline enrollment for yourself or for an eligible dependent (including your spouse) while other health insurance or group health plan coverage is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

Loss of Coverage for Medicaid or a State Children's Health Insurance Program. If you decline enrollment for yourself or for an eligible dependent (including your spouse) while Medicaid coverage or coverage under a state children's health insurance program is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within 60 days after your or your dependents' coverage ends under Medicaid or a state children's health insurance program.

New Dependent by Marriage, Birth, Adoption, or Placement for Adoption. If you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your new dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Eligibility for Premium Assistance Under Medicaid or a State Children's Health Insurance Program – If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan, you may be able to enroll yourself and your dependents in this plan. However, you must request enrollment within 60 days after your or your dependents' determination of eligibility for such assistance.

To request special enrollment or to obtain more information about the plan's special enrollment provisions, contact Nicole Buvert - Employee Benefits and Processing Specialist at Benefitshelpdesk@sanjuan.edu.

Important Warning

If you decline enrollment for yourself or for an eligible dependent, you must complete our form to decline coverage. On the form, you are required to state that coverage under another group health plan or other health insurance coverage (including Medicaid or a state children's health insurance program) is the reason for declining enrollment, and you are asked to identify that coverage. If you do not complete the form, you and your dependents will not be entitled to special enrollment rights upon a loss of other coverage as described above, but you will still have special enrollment rights when you have a new dependent by marriage, birth, adoption, or placement for adoption, or by virtue of gaining eligibility for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan, as described above. If you do not gain special enrollment rights upon a loss of other coverage, you cannot enroll yourself or your dependents in the plan at any time other than the plan's annual open enrollment period, unless special enrollment rights apply because of a new dependent by marriage, birth, adoption, or placement for adoption, or by virtue of gaining eligibility for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan.

NOTICE OF CHOICE OF PROVIDERS

Health Maintenance Organization (HMO) plans generally require the designation of a primary care provider. You have the right to designate any primary care provider who participates in the network and who is available to accept you or your family members. Until you make this designation, your carrier designates one for you. For information on how to select a primary care provider, and for a list of the participating primary care provider, contact your insurance carrier directly. The plan may not require authorization or referral for OB/GYN care.

HIPAA Notice of Privacy Practices Reminder

Protecting Your Health Information Privacy Rights
San Juan Unified School District is committed to the privacy of your health information. The administrators of the San Juan Unified School District Health Plan (the “Plan”) use strict privacy standards to protect your health information from unauthorized use or disclosure.

The Plan’s policies protecting your privacy rights and your rights under the law are described in the Plan’s Notice of Privacy Practices. You may receive a copy of the Notice of Privacy Practices by contacting Nicole Buvert - Employee Benefits and Processing Specialist at Benefitshelpdesk@sanjuan.edu.

Notice of Creditable Coverage

Important Notice from San Juan Unified 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 San Juan Unified 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.**
2. **San Juan Unified School District has determined that the prescription drug coverage offered by the medical plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.**

When Can You Join a Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens to Your Current Coverage if You Decide to Join a Medicare Drug Plan?

Individuals who are eligible for Medicare should compare their current coverage, including which drugs are covered, with the coverage and costs of the plans offering Medicare prescription drug coverage in their area. Your medical benefits brochure contains a description of your current prescription drug benefits.

If you decide to join a Medicare drug plan, your current San Juan Unified School District coverage will be affected. If you do decide to join a Medicare drug plan and drop your current San Juan Unified School District Plan, be aware that you and your dependents will 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 San Juan Unified 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. In addition, you may have to wait until the following October to join.

For More Information About This Notice or Your Current Prescription Drug Coverage…

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

For More Information About Your Options Under Medicare Prescription Drug Coverage…

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

For more information about Medicare prescription drug coverage:

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

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

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

Date:	**January 01, 2027**
Name of Entity/Sender:	**San Juan Unified School District**
Contact—Position/Office:	**Nicole Buvert - Employee Benefits and Processing Specialist.**
Office Address:	**3738 Walnut Avenue** **Carmichael, California – 95608 - 3054** **United States**
Phone Number:	**916-971-7662**

COBRA General Notice

Model General Notice of COBRA Continuation Coverage Rights
(For use by single-employer group health plans)

**** Continuation Coverage Rights Under COBRA****

Introduction

You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

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

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

What is COBRA continuation coverage?

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

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

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

When is COBRA continuation coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

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

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

How is COBRA continuation coverage provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage

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

Second qualifying event extension of 18-month period of continuation coverage

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

Are there other coverage options besides COBRA Continuation Coverage?

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

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?

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

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

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

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

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

If you have questions

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

Keep your Plan informed of address changes

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

Plan contact information

San Juan Unified School District
Nicole Buvert - Employee Benefits and Processing Specialist.
3738 Walnut Avenue
Carmichael, California - 95608 - 3054
United States
916-971-7662

[1] https://www.medicare.gov/basics/get-started-with-medicare/sign-up/when-does-medicare-coverage-start

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 July 31, 2025. 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)	Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (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	Health Insurance Premium Payment Program All other Medicaid Website: https://www.in.gov/medicaid/ http://www.in.gov/fssa/dfr/ Family and Social Services Administration Phone: 1-800-403-0864 Member Services Phone: 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	**KANSAS – Medicaid**
Medicaid Website: Iowa Medicaid | Health & Human Services Medicaid Phone: 1-800-338-8366 Hawki Website: Hawki - Healthy and Well Kids in Iowa | Health & Human Services Hawki Phone: 1-800-257-8563 HIPP Website: Health Insurance Premium Payment (HIPP) | Health & Human Services (iowa.gov) HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
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://kynect.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	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=en_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: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid	**MISSOURI – Medicaid**
Website: https://mn.gov/dhs/health-care-coverage/ Phone: 1-800-657-3672	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

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. 15218 Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov
NEW JERSEY – Medicaid and CHIP	**NEW YORK – Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Phone: 1-800-356-1561 CHIP Premium Assistance Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710 (TTY: 711)	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: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**OREGON – Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	**RHODE ISLAND – Medicaid and CHIP**
Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html 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: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493	Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/ Email: upp@utah.gov Phone: 1-888-222-2542 Adult Expansion Website: https://medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/ CHIP Website: https://chip.utah.gov/

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://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs 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
Illinois- Medicaid	
Illinois Medicaid Premium Assistance Information Medicaid application website: https://abe.illinois.gov HIPP Hotline Number: 217-524-8268 HIPP Email: mhfs.boc.hipp@illinois.gov	

To see if any other states have added a premium assistance program since July 31, 2025, 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

Marketplace Notice

Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: General Information

Even if you are offered health coverage through your employment, you may have other coverage options through the Health Insurance Marketplace (“Marketplace”). To assist you as you evaluate options for you and your family, this notice provides some basic information about the Health Insurance Marketplace and health coverage offered through your employment.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options in your geographic area.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium and other out-of-pocket costs, but only if your employer does not offer coverage, or offers coverage that is not considered affordable for you and doesn’t meet certain minimum value standards (discussed below). The savings that you're eligible for depends on your household income. You may also be eligible for a tax credit that lowers your costs.

Does Employment-Based Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that is considered affordable for you and meets certain minimum value standards, you will not be eligible for a tax credit, or advance payment of the tax credit, for your Marketplace coverage and may wish to enroll in your employment-based health plan. However, you may be eligible for a tax credit, and advance payments of the credit that lowers your monthly premium, or a reduction in certain cost-sharing, if your employer does not offer coverage to you at all or does not offer coverage that is considered affordable for you or meet minimum value standards. If your share of the premium cost of all plans offered to you through your employment is more than 9.12%[1] of your annual household income, or if the coverage through your employment does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit, and advance payment of the credit, if you do not enroll in the employment-based health coverage. For family members of the employee, coverage is considered affordable if the employee’s cost of premiums for the lowest-cost plan that would cover all family members does not exceed 9.12% of the employee’s household income.[1] [2]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered through your employment, then you may lose access to whatever the employer contributes to the employment-based coverage. Also, this employer contribution -as well as your employee contribution to employment-based coverage- is generally excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis. In addition, note that if the health coverage offered through your employment does not meet the affordability or minimum value standards, but you accept that coverage anyway, you will not be eligible for a tax credit. You should consider all of these factors in determining whether to purchase a health plan through the Marketplace.

[1] Indexed annually; see https://www.irs.gov/pub/irs-drop/rp-22-34.pdf for 2023.

[2] An employer-sponsored or other employment-based health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs. For purposes of eligibility for the premium tax credit, to meet the “minimum value standard,” the health plan must also provide substantial coverage of both inpatient hospital services and physician services.

When Can I Enroll in Health Insurance Coverage through the Marketplace?

You can enroll in a Marketplace health insurance plan during the annual Marketplace Open Enrollment Period. Open Enrollment varies by state but generally starts November 1 and continues through at least December 15.

Outside the annual Open Enrollment Period, you can sign up for health insurance if you qualify for a Special Enrollment Period. In general, you qualify for a Special Enrollment Period if you've had certain qualifying life events, such as getting married, having a baby, adopting a child, or losing eligibility for other health coverage. Depending on your Special Enrollment Period type, you may have 60 days before or 60 days following the qualifying life event to enroll in a Marketplace plan.

There is also a Marketplace Special Enrollment Period for individuals and their families who lose eligibility for Medicaid or Children's Health Insurance Program (CHIP) coverage on or after March 31, 2023, through July 31, 2024. Since the onset of the nationwide COVID-19 public health emergency, state Medicaid and CHIP agencies generally have not terminated the enrollment of any Medicaid or CHIP beneficiary who was enrolled on or after March 18, 2020, through March 31, 2023. As state Medicaid and CHIP agencies resume regular eligibility and enrollment practices, many individuals may no longer be eligible for Medicaid or CHIP coverage starting as early as March 31, 2023. The U.S. Department of Health and Human Services **is offering a temporary Marketplace Special Enrollment period to allow these individuals to enroll in Marketplace coverage.**

Marketplace-eligible individuals who live in states served by HealthCare.gov and either- submit a new application or update an existing application on HealthCare.gov between March 31, 2023 and July 31, 2024, and attest to a termination date of Medicaid or CHIP coverage within the same time period, are eligible for a 60-day Special Enrollment Period. **That means that if you lose Medicaid or CHIP coverage between March 31, 2023, and July 31, 2024, you may be able to enroll in Marketplace coverage within 60 days of when you lost Medicaid or CHIP coverage.** In addition, if you or your family members are enrolled in Medicaid or CHIP coverage, it is important to make sure that your contact information is up to date to make sure you get any information about changes to your eligibility. To learn more, visit HealthCare.gov or call the Marketplace Call Center at 1-800-318-2596. TTY users can call 1-855-889-4325.

What about Alternatives to Marketplace Health Insurance Coverage?

If you or your family are eligible for coverage in an employment-based health plan (such as an employer-sponsored health plan), you or your family may also be eligible for a Special Enrollment Period to enroll in that health plan in certain circumstances, including if you or your dependents were enrolled in Medicaid or CHIP coverage and lost that coverage. Generally, you have 60 days after the loss of Medicaid or CHIP coverage to enroll in an employment-based health plan, but if you and your family lost eligibility for Medicaid or CHIP coverage between March 31, 2023 and July 10, 2023, you can request this special enrollment in the employment-based health plan through September 8, 2023. Confirm the deadline with your employer or your employment-based health plan.

Alternatively, you can enroll in Medicaid or CHIP coverage at any time by filling out an application through the Marketplace or applying directly through your state Medicaid agency. Visit https://www.healthcare.gov/medicaid-chip/getting-medicaid-chip/ for more details.

How Can I Get More Information?

For more information about your coverage offered through your employment, please check your health plan's summary plan description or contact Nicole Buvert.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit **HealthCare.gov** for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

PART B: Information About Health Coverage Offered by Your Employer

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

3. Employer name San Juan Unified School District		4. Employer Identification Number (EIN) 94-6002533
5. Employer address 3738 Walnut Avenue		6. Employer phone number 916-971-7662
7. City Carmichael	8. State California	9. ZIP code 95608 - 3054
10. Who can we contact about employee health coverage at this job? Nicole Buvert		
11. Phone number (if different from above)	12. Email address benefitshelpdesk@sanjuan.edu	

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

- As your employer, we offer a health plan to:

  ☐ All employees. Eligible employees are:

  ☐ Some employees. Eligible employees are:

- With respect to dependents:

  X We do offer coverage. Eligible dependents are:

  Spouse or state registered domestic partner; Employees' and domestic partner's children up to age 26 (includes biological, adopted, stepchildren, or for whom employee is required to provide coverage as the result of a qualified child support order; Children up to the age of 18 for whom the employee ore employee's spouse is the court appointed guardian.

  ☐ We do not offer coverage.

X If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, **HealthCare.gov** will guide you through the process. Here's the employer information you'll enter when you visit **HealthCare.gov** to find out if you can get a tax credit to lower your monthly premiums.

Notes

Notes

Notes

San Juan Unified
SCHOOL DISTRICT

Benefits

This benefit summary prepared by

Gallagher

Insurance | Risk Management | Consulting

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