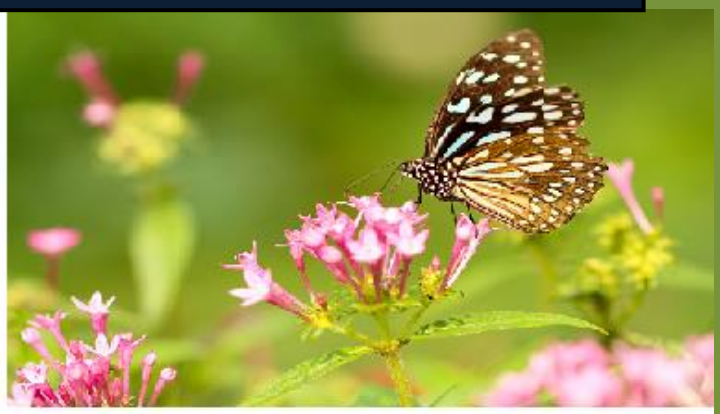
2021

San Juan Unified School District Benefits Guide



Welcome to San Juan Unified School District Benefits Guide!

SJUSD 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. In addition, we highly recommend that you read the weekly "Behind the Scenes Newsletter" emailed to you every Tuesday afternoon since this is our primary way to communicate upcoming changes to various benefit programs. This Guide provides an overview of:

- Medical
- Dental
- Vision
- Flexible Spending Accounts
- Employee Assistance Plan
- Life Insurance
- Supplemental Insurance
- Retirement (CalPERS/CalSTRS)
- 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 online or by contacting the Employee Benefits Office. The Plan summaries contained in this Guide are for comparison purposes only. Summary of Benefit Coverages (SBC) are also available online or by contacting the Employee Benefits Office.

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 and number of dependents you enroll, your representation unit, your hire date, and/or the level of coverage you select. Questions concerning your particular 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.

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 particular 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.

Contents of Guide:

When Coverage Begins

Coverage will begin the first of the month following the date you and eligible dependents meet benefit eligible status, and complete enrollment elections on the American Fidelity platform.

Eligibility for Benefits

You and eligible family members may enroll in the District's group medical, dental, vision, and life insurance plans once you meet one of the following employment statuses:

- You become an active certificated contracted employee.
- You become an active classified employee who works a regular position assignment 20 hours or more a week.
- You become an active classified employee who works a "limited term" position working 20 hours or more with a duration of six months or more.

Your eligible family members include:

- Your spouse or your domestic partner registered with the Secretary of State (see Imputed Income page 17)
- Your children up to age 26 for medical, DeltaCare HMO and vision; age 24 for Delta Dental; age 21 for dependent life insurance, or if full-time student up to 25 (includes biological, adopted, stepchildren and children for whom you or your spouse is the court appointed guardian (or was when the child reached age 18) or for whom you are required), 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)

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.

Initial Enrollment Period -How to Enroll

Newly benefit eligible employees must meet with an American Fidelity Benefit Advisor to either enroll or decline coverage within 30 days of becoming eligible. Individual virtual benefit sessions are held from 8:00 a.m. – 4:00 p.m. the 2nd and 4th Thursday of each month. You may schedule your session online at: https://americanfidelity.com/SanJuan or call **1-800-365-8306, ext. 1.** 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 (explained on page 5) or a HIPAA special enrollment event. Please report a change in status to the Benefits Office within 30 days of the event.

Fully benefited certificated and classified employees who do not complete a benefit election with required supporting documentation within 30 days of eligibility will be automatically enrolled in the Western Health Advantage Plan, "Employee Only". Employees who are automatically enrolled will only be allowed to change or drop coverage if they experience a Qualifying Life Event or during the next annual Open Enrollment.

Declining Medical Coverage

If you have other group health plan coverage, you may elect to opt out of the District's medical plan coverage on the AFenroll platform. Employees who waive coverage and provide proof of other group coverage that is not purchased through the individual market or Covered California are eligible to receive medical waiver cash payments in an amount specified on the Premium Cost Schedule for the respective employee group. You must sign a waiver form. Acceptable proof of other group coverage includes: a benefit eligibility printout from your insurance provider that lists your name on the coverage, or a letter from the employer who is carrying you on their coverage.

Employees opting out of medical coverage will need to complete a medical waiver form and provide proof of other group medical insurance annually during the District's open enrollment period. The medical waiver form for the upcoming plan year will be available on the District Benefit's website by November 1st.

Prepare for AFenroll Session

You will need to make choices on which plans to select for you and your family.

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, complete the medical waiver form and attach a copy of your proof of other group coverage.
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. 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:
   a. Your Social Security number; and
   b. The names, birth dates, and Social Security numbers of any dependents you wish to enroll.
   c. Copies of the required documents to confirm dependent eligibility status. (see chart)

Selecting Doctor Office for Western Health Advantage (WHA) Plan and Delta Care HMO dental plan

If you do not designate a Primary Care Physician (PCP) for WHA or a dental office number for DeltaCare at the time of enrollment, 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.

Required Proof of Dependent Eligibility

To ensure compliance with our plan documents, you are required to provide documentation to verify the eligibility of any dependent to be covered. Documentation must be submitted to the Employee Benefits Office within 30 days of initial benefit eligibility or within 30 days of a Qualifying Life Status Change event. All documentation must be translated to English if in another language.

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 Children	Notice of disability determination from medical carrier prior to attaining age 26 AND child documentation (biological/step/adopted/guardianship), or Notice of disability determination from the Social Security Administration prior to attaining age 26 AND child documentation (biological/step/adopted/guardianship)

If you are enrolling eligible dependents, you will need to provide copies of the required documents noted in the chart above. Please email proof to: benefitshelpdesk@sanjuan.edu

If additional information is needed, email benefitshelpdesk@sanjuan.edu or call our office at 916-971-7662. Walk-in office hours are Monday through Friday, from 8:30 a.m. to 3:30 p.m.

What Happens After Enrollment

You will receive an Evidence of Coverage packet and ID card(s) for each covered family member from the medical plan you select within a few weeks after enrollment. You **will not** receive ID card(s) for dental or vision coverage.

When you receive your ID card, confirm that all information is accurate. If not, contact the Benefits Office right away.

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 coverage privately; 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.

Open Enrollment

Each fall, the District provides an Open Enrollment opportunity to review and make changes to your benefits for the upcoming plan year, including:

- Transferring to a different insurance plan
- Adding or dis-enrolling eligible family members
- Enrolling in or opting out of medical, dental and vision plans
- Enrolling or re-enrolling in the Health and Dependent Care Flexible Spending Accounts.

Changes made during Open Enrollment are effective January 1 of the following year.

Qualifying Life Event Enrollment Changes

After your initial enrollment, you can only make changes to your coverage due to qualified "life events" and/or Open Enrollment. Changes due to a "life event" must be consistent with the event, and must be made within 30 days of the event. You must contact the benefits office to request a change to your coverage in the AFenroll platform and provide documentation to verify the event. Examples of supporting documents: HIPAA Certificate, COBRA notice, or employer letter indicating the date of the loss/gain of other group coverage. Failure to complete your enrollment within 30 days or provide supporting documentation will result in your inability to make changes until the next qualified status change event or Open Enrollment. If you do not have the supporting documentation, you still need to complete the enrollment within 30 days and request additional time for documents.

Qualifying Life Events as defined by the IRS are:

- Marriage, divorce or legal separation
- Birth or adoption of a child
- Death of a dependent
- You or your spouse's / domestic partner's loss or gain of coverage
- Change in residence affecting eligibility or access to HMO health care services.

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.

Coverage While on a Leave of Absence

District premium contributions will continue while an employee is on a paid leave of absence 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 coverage by paying the required insurance premiums to the District. Contact the Benefits Office to make payment arrangements.

Submitting FMLA or Parental Leave paperwork to HR 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.**

When Your Benefits End

Your medical, dental, and vision coverage ends 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 will have insurance end on August 31st since premiums are paid "10thly" for 12 months of coverage.

You may continue benefits during a family leave of absence according to federal guidelines and in conjunction with the District's policy, or under your federal and state COBRA rights. Your life insurance coverage ends on the last day of the month in paid status. Employees may port their Life Insurance coverage during unpaid leaves of absence. Upon termination or loss of eligibility, employees may convert to an individual term life policy.

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

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.

Benefits During Family and Medical Leave and California Family Rights Act

An employee taking family/medical leave will be allowed to continue participating in any health and welfare benefit plan in which he/she was enrolled before the first day of leave (for a maximum of 12 work-weeks) at the level and under the same conditions of coverage as if the employee had continued in employment for the duration of such leave. The District will continue to make the same premium contributions as if the employee had continued working. The continued participation in health benefits begins on the date leave first begins under the Family and Medical Leave Act (e.g. for pregnancy disability leaves) or under the Family and Medical Leave Act/CFRA (e.g. for all other family care and medical leaves). In some instances, the District may recover premiums it paid to maintain health coverage for you if you fail to return to work following pregnancy disability leave. Employees on family/medical leave who are not eligible for continued paid coverage may continue their group health insurance coverage at their own expense. Employees should contact the Human Resources department for further information. Under most circumstances, upon return from family/medical leave, an employee will be reinstated to his or her original job or to an equivalent pay, benefits, and other employment terms and conditions. However, an employee has no greater right to reinstatement than if he or she had been continuously employed rather than on leave. For example, if an employee on family/medical leave would have been laid off or terminated had he or she not gone on leave, or if the employee's job is eliminated during the leave and no equivalent or comparable job is available, then the employee would not be entitled to reinstatement. An employee's use of family/medical leave will not result in the loss of any employment benefit that the employee earned before using family/medical leave.

Medical Plan Options

The District offers two Health Maintenance Organization (HMO) plans to choose from. Please refer to the plan comparison chart on page seven to help you decide which plan best suits your needs. Evidence of Coverage is available on the District's Benefits webpage.

KAISER PERMANENTE®

As a member of the Kaiser Permanente Health Maintenance Organization (HMO) plan, you will receive your medical care from an integrated network of physicians and specialists at a Kaiser medical office, Kaiser medical center or affiliated hospital near you. Your care will be provided at Kaiser Permanente facilities which include all service under one roof including primary care, specialists, laboratory, radiology, and pharmacy. Additionally, you are covered for emergency care worldwide. With this Kaiser Permanente health plan, you get a wide range of care and support to help you stay healthy and get the most out of life. We make it simple for you to know what to expect and to get high-quality care for your needs.

- You may choose a primary care doctor for yourself or your family members by reviewing a physician's profile at kp.org/chooseyourdoctor, or receive assistance in selecting a physician and scheduling your first appointment by calling 1-800-464-4000 (for Northern CA)
- Initial referrals for most specialty care services will be coordinated by your Kaiser primary care physician. However, many departments such as OB/GYN, Optometry, Psychiatry and Addiction Medicine allow for self-referral
- There are no deductibles with the Kaiser Permanente HMO and no claim forms to submit unless you receive emergency services outside of a plan facility
- Preventive care is covered at 100%. An abbreviated schedule of covered services under the Kaiser Permanente HMO plan is listed on page nine. For a complete listing of covered services, please refer to your Kaiser Evidence of Coverage (EOC). Kaiser offers many ways to get care:
- Telephone appointments and after-hours care with primary care physicians and specialists: Call 1.866-454-8855 to make a telephone appointment
- 24/7 Nurse Advice Line to see what type of care you need: Call 1.866-454-8855
- Kaiser Telehealth – Schedule a Phone or Video Appointments on your mobile device or computer for primary care, pediatrics, OB/GYN, allergy or psychiatry; your regular office copay will apply. Download Kaiser's app at your device's app store. Type in KP or Kaiser Permanente. Visit: kp.org/getcare
- Email your physician for simple, direct communications securely through kp.org
- Travel Line when you are away from home and need medical care: call 1.951.268.3900 for assistance. Services outside of a Kaiser facility are not covered except if it is a life-threatening emergency.

To enroll in the plan, you must live or work within service area zip codes. If you live outside the service area, but plan to enroll using the District's address (live/work rule), you will receive an "out of area" letter from Kaiser. It does not mean that you don't have coverage with Kaiser; however, home health and durable medical equipment may not be available.

Headquartered in Sacramento, Western Health Advantage (WHA) is a non-profit HMO health plan founded in 1996. With the belief that decisions on health care should be made in hospitals and not corporate offices, WHA trusts their doctors to decide the best health care path for patients. The advantage of being based locally allows approvals and decisions to be made quickly without delays. The result is a health plan founded by doctors, not accountants.

The WHA provider network includes major hospitals and medical centers and thousands of local, trusted doctors and specialists from reputable medical groups including, here in the Sacramento region: Hill Physicians, Mercy Medical Group, Woodland Clinic Medical Group and expanding toward the North Bay Area: North Bay Healthcare, Meritage Medical Network and St. Joseph Health Medical Network. With WHA, members choose a primary care physician to coordinate care. You may review an available physician here. You have choices for specialist referrals beyond the PCP's medical group. Visit mywha.org/referral for additional information.

Members enjoy the peace-of-mind that comes with 13 major hospitals and medical centers in Northern California, including five in the Sacramento region (Mercy San Juan, Mercy Folsom, Mercy General Downtown, Methodist in Elk Grove and Woodland Hospital). Members will also find conveniently located full-service care centers that offer a wide array of services under one roof — providing access to quality care in a neighborhood near you.

In addition to your traditional medical benefits, your membership with WHA provides you with these value-added benefits:

- Nurse24, around the clock nurse advice
- Assist America, worldwide travel assistance
- CommunityFIT, community-based fitness program
- Fitness center discounts
- Complementary Alternative Medicine: acupuncture and chiropractic services
- Mental health and substance abuse services
- MyWHA Wellness, online health and wellness tools, and condition management services.

To learn more about Western Health Advantage, visit us at chooseWHA.com or call (916) 563-2250.

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*(see note below)	Western Health Advantage
Annual Deductible	**None**	**None**
Maximum Out-of-Pocket (does not include pharmacy)	$1,500 individual/$3,000 family	$1,500 individual/$2,500 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 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 $1000 per aid every 36 months
Chiropractic/Acupuncture	Not covered	$15 per visit, up to 20 visits per year

Medicare while Working

If you are eligible to participate in the District medical plans as an active employee and wish to continue working after reaching age 65, you may be able to delay enrollment in some parts of Medicare without incurring a late enrollment penalty at a later date. Your District active medical plan remains primary to Medicare while you are working. That is, the District plan will pay claims first. If you decline Part B when first eligible and you do not remain covered under a group medical plan sponsored by an employer or union, you may incur a late enrollment penalty.

Medicare coverage consists of the following options:

Part A - Hospital Insurance - covers inpatient hospital stays and related services, skilled nursing facilities, home health care, and hospice services. Part A entitlement is based on age, disability or End Stage Renal Disease (ESRD). For most people entitlement based on age occurs at age 65. Entitlement is automatic if you have reached age 65 and are receiving Social Security benefits. There is usually no premium cost for Part A. However, if you are not receiving Social Security benefits you may apply for Part A benefits separately. It is recommended that you contact your local Social Security office at least three (3) months before age 65 for more information. You generally cannot delay enrollment in Part A penalty free.

Part B - Medical Insurance - covers medically necessary physician services such as office visits, lab and X-ray services, outpatient surgical procedures, and wide variety of other benefits. Part B entitlement generally occurs at the same time as Part A. However, because there is a premium cost to Part B, you may decline coverage. As long as you are covered under a District employee medical plan as an active employee, you can delay enrollment in Part B without incurring a late enrollment penalty when your employment ends. Once your active District medical coverage ends, you have a Medicare Special Enrollment opportunity to sign up for Part B benefits.

Part C - Medicare Advantage Plans - Advantage plans are approved by Medicare and are administered by private companies to provide all of your Part A and Part B benefits. These plans are generally not available until you are no longer covered under a District sponsored plan.

Part D - Prescription Drug Coverage - Individual separate prescription drug plans are usually administered by insurance companies approved by Medicare. Each plan can vary in cost and drugs covered. Part D entitlement generally occurs at the same time as Part A. However, because there is a premium cost to Part D, you may decline coverage. As long as you are covered under a District employee medical plan, you can delay enrollment in Part D without incurring a late enrollment penalty. The prescription coverage for every District sponsored medical plan is considered “creditable” which means that it expects to pay as much as or more than the standard Medicare drug coverage. Once your active District coverage ends, you have a Medicare Special Enrollment opportunity to sign up for Part D benefits, with no late enrollment penalty. For details of what’s covered under Medicare, how to enroll, and your options regarding Medicare coverage, contact your local Social Security office or visit www.medicare.gov on the web.

Dental Plan Options

The District offers two dental plans: **DeltaCare DHMO** and **Delta Dental PPO**. Evidence of coverage booklets which define limitations or exclusions of the plans are available on the District's Benefits website. Dependent children can be covered up to age 24 on the Delta Dental plan and age 26 on DeltaCare 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 your family members are covered under your plan, they will need your information. If you prefer to take a paper or electronic ID card with you, simply sign up for an Online Services account at **deltadentalins.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 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.

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 practice dentists at the time you complete your enrollment form. You must visit your primary care dentist to receive benefits. 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 website. You may request a change in dentist by logging in at deltadentalins.com. Change requests received by the 15th of the month will become effective the first day of the following month. Plan offers some orthodontics coverage for children and adults.

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.
Outpatient Services	Not Covered
Hospitalization Services	Not Covered
Emergency Dental Coverage	The Enrollee may receive a maximum benefit of up to $100 per emergency for out of area emergency services.
Ambulance Services	Not Covered
Prescription Drug	Not Covered
Durable Medical Equipment	Not Covered
Mental Health Services	Not Covered
Chemical Dependency Services	Not Covered
Home Health Services	Not Covered
Other	Not Covered

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 detail description of coverage benefits and limitations.

Delta Dental (PPO) Incentive Dental Plan

Our preferred provider organization, Delta Dental (PPO), provides access to the largest PPO Dentist network in the U.S. With this plan, you can access dentists in both the PPO and Premier Networks for the lowest out-of-pocket costs.

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, onlays, 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 VPS 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 frame allowance • Every other calendar year	Combined with exam	**Frame**	• $150 allowance for a wide selection of frames • $170 allowance for featured frame brands • 20% savings on the amount over your allowance • $80 Costco frame allowance • 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) • 15% savings on a contact lens exam (fitting and evaluation) • Every calendar year	$0	**Contacts (instead of Glasses)**	• $150 allowance for contacts and contact lens exam (fitting and evaluation) • 15% savings on a contact lens exam (fitting and evaluation) • Every calendar year	$0
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 Exclusive Member Extra Benefit – 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 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

The District provides term Life insurance through Reliance Standard at no cost to active employees working the minimum hours per week specified in the chart below; 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

The Employee Basic Term Life Insurance is subject to age reductions. Benefit amounts reduced to 65% of the original amount at age 70, 45% of the original amount at age 80, 30% of the original amount at age 80.

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 Insurance Coverage

In addition to District paid basic coverage, you can 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 have the ability to 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 Schedule 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 district's website.

Supplemental Dependent Life Insurance

SJUSD 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. The 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. The 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. Benefit amounts reduced to 65% of the original amount at age 70, 45% of the original amount at age 75, 30% of the original amount at age 80.

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. That is, 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 conversion policy within 31 days of loss of coverage. Employees taking an 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 70, 45% of the original amount at age 75, 30% of the original amount at age 80.

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

On Call Travel Assistance (Continued)

Emergency Personal Services

- Urgent message relay
- Interpretation/translation services
- Emergency travel arrangements
- Recovery of lost or stolen luggage
- Legal assistance and/or bail bond

Medical Services Include:

- Medical referrals for local physicians/dentists
- Medical case monitoring
- Prescription assistance and eyeglasses replacement
- Convalescence arrangements

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

Insurance Premiums

SJUSD pays 100% of the employee only coverage for medical, dental, basic vision and term life insurance for employees with full benefits. The District pays 75% of the dependent's medical only premium cost for an employee with full benefits. The District pays a pro-rated share of the premium cost for part-time employees based on the terms specified in the employee's collective bargaining agreement.

Insurance Premiums Cost Schedules are posted on the District's Benefits website for each employee group. Any 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 IRS guidelines under Section 125. Premiums are paid over 10 pay periods (September through June) for 12 months of coverage. Employees who will not earn sufficient earnings in June to cover their share of their dependents' premium costs will have the June premium amount evenly deducted over April and May payrolls to prevent a loss of coverage. You will be notified by the Benefits office in early April if this applies to you.

"Imputed" Income

The IRS requires the District to "impute" the value of the district premiums paid for domestic partners and their children (unless they qualify as dependents under Section 152) and report that value as taxable income to the employee. The applicable amount will be added back into the employee's paycheck as taxable income. Employees who enroll a domestic partner onto their medical coverage are required to complete an "Affidavit of Tax Status for Domestic Partners" form.

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 permits voluntary payroll deductions for **American Fidelity** policies for all employee groups and **CTA Standard Life Insurance** policies for CTA members. Payroll deductions are taken September through June (10 months). These companies offer a variety of disability, cancer, critical illness, accident, and life insurance policies to protect your financial health.

Voluntary Insurance Policies (Continued)

American Fidelity's initial eligibility enrollment period is the first 30 days of employment. Standard Life's initial enrollment period is the first 180 days of employment.

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.

Employee Assistance Program

ACI Specialty Benefits 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 ACI's 24/7 live-answer, **toll-free number 855-RSL-HELP**. Multicultural and multilingual providers are available nationwide.

ACI'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:

- Clinical support for any Emotional Issue
- Child, Elder, and Pet Care Referrals
- Community based
- Legal and Financial Consultation
- Education Referrals and Resources
- Health and Wellness Resources
- Veteran-Specific Support
- Referral and Resources for any Personal Service
- Online Legal Resource Center

Employees have access to ACI's Affinity Online Work-Life Website and myACI App for Mobile Access

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). New employees have 30 days from eligibility to enroll for the current plan year. **You may establish your account by calling the District's Section 125 Plan Administrator – American Fidelity at 800-365-8306**. Your election is for the entire plan year. Only a qualifying event (marriage, divorce, birth/adoption, or death) will allow you to make a change to the amount you are contributing. A change in employment status is not a permissible qualifying event for the district's HealthCare FSA account.

You will need to re-enroll in the accounts each year.

How FSAs Work

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).

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 2 ½ month "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.

Health Care Spending Account (FSA) allows you to set aside up to **$2,750** 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 (Publication #502).

Dependent Day Care (FSA) allows you to deduct on a pre-tax basis up to **$5,000** 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 $5,000. If you are married and file separate tax returns, each spouse may contribute $2,500.

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.

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

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.

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.

Retirement Defined Benefit Plans: California State Teachers Retirement System (CalSTRS)

Certificated employees working in a regular position that requires a credential, certificate or permit are automatically enrolled in the California State Teacher's Retirement System (CalSTRS) defined benefit plan. Substitute teachers may elect optional membership.

As a CalSTRS member, you may access your information on myCalSTRS.com. Once you complete the one-time, five-step registration process, your myCalSTRS account will be active. With myCalSTRS, you can:

• Keep your mailing and email addresses and phone number current.
• Review your annual Retirement Progress Report, which includes your account balances and years of service credit.
• Name and update your beneficiary designations.
• Ask questions and receive prompt, secure answers.
• Obtain forms and view pension information videos
• Complete and submit your Service Retirement Application online.

Benefit Structures

The California Public Employees' Pension Reform Act of 2013 (Chapter 296, Statutes of 2012) made significant changes to the benefit structure that primarily affect members first hired to perform CalSTRS creditable activities on or after January 1, 2013. As a result, CalSTRS has two benefit structures:

CalSTRS 2% at 60

Members first hired on or before December 31, 2012, to perform CalSTRS creditable activities are under the 2% at 60 benefit structure. Members covered under this structure contribute 10.25% of creditable compensation per pay period to CalSTRS on a pre-tax basis.

The 2 percent at 60, also known as the age factor, refers to the percentage of your final compensation that you will receive as a retirement benefit for every year of service credit. The basic age factor for members under CalSTRS 2% at 60 is 2 percent at age 60 (the age factor gradually decreases to 1.1 percent at age 50 if you retire before age 60, and increases to a maximum 2.4 percent at age 63 if you retire after age 60).

CalSTRS 2% at 60 (Continued)

Your eligibility for retirement is either:

- Age 50 with at least 30 years of service credit.
- Age 55 with five years of service credit—or under special circumstances of concurrent retirement with certain other California public retirement systems.

CalSTRS 2% at 62

Members first hired on or after January 1, 2013, to perform CalSTRS creditable activities are under the 2% at 62 benefit structure. Members covered under this structure contribute 10.205% of creditable compensation per pay period to CalSTRS on a pre-tax basis.

The age factor for members under CalSTRS 2% at 62 is 2 percent at age 62 (the age factor gradually decreases to 1.16 percent at age 55 if you retire before age 62 and increases to a maximum 2.4 percent at age 65 if you retire after age 62).

To be eligible for retirement, you must be age 55 with at least five years of service, or under special circumstances of concurrent retirement with certain other California public retirement systems.

Other benefit differences for CalSTRS 2% at 62 include:

- A three-year final compensation period (based on the highest average annual compensation earnable for 36 consecutive months regardless of years of service credit).
- Lower compensation cap.
- No career factor.
- A higher retirement age (you cannot retire as early as age 50 with 30 years of service credit).

Learn more about the two benefit structures in the *Member Handbook*.

Refund of Contributions

Considering a career change? If you no longer work in a CalSTRS-covered position, you can leave your money in CalSTRS until you reach 70½ or request a refund.

Social Security, CalSTRS and You

As a California public school educator and a CalSTRS contributing member, you do not pay into Social Security, so you will not receive a Social Security benefit for your CalSTRS-covered employment.

If you expect to receive a Social Security benefit through other employment or your spouse, two federal rules—the Windfall Elimination Provision and the Government Pension Offset—may be used in the calculation of your Social Security benefit. Social Security is a federal program, and neither CalSTRS nor the State of California has control over eligibility requirements or Social Security benefit calculations. **Your CalSTRS retirement benefit will not be reduced by these rules.**

The Windfall Elimination Provision affects your Social Security benefit that is based on your earnings from other employment. The provision may reduce your Social Security benefit but will not eliminate it.
The Government Pension Offset affects your spousal, widow or widower Social Security benefit that is based on your spouse's earnings. Visit ssa.gov/gpo-wep to widower Social Security benefit that is based on your spouse's earnings. Visit ssa.gov/gpo-wep to learn more.

California Public Employees Retirement System (CalPERS)

Full-time classified employees (or part-time classified employees working at least halftime) are automatically enrolled in the CalPERS Retirement Plan. CalPERS is a defined benefit plan, which provides a retirement benefit based on the employee's applicable retirement formula, age at retirement, years of service credit and compensation. To be eligible, a full-time employee must be appointed for at least six months and one day, or a part-time employee must be appointed for one year or longer. Employees are required to contribute a 7% of their gross monthly salary per month. The contribution is not subject to federal and state taxes.

As a CalPERS member, you may access your information on www.calpers.ca.gov

• Review your annual Retirement Progress Report, which includes your account balances and years of service credit.
• Name and update your beneficiary designations.
• Ask questions and receive prompt, secure answers.
• Obtain forms and view pension information videos
•Complete and submit your Service Retirement Application online.

Address changes are updated to CalPERS through the Human Resources Office.

Service Retirement

To be eligible for service retirement, you must be at least age 50 and have a minimum of five years of CalPERS-credited service. If you became a member on or after January 1, 2013, you must be at least 52. If you are employed on a part-time basis, and have worked at least five years, contact CalPERS to find out if an exception will apply to you. There is no mandatory retirement age for school members. You may learn by viewing the What You Need to Know About Your CalPERS School Benefits.

Voluntary Retirement Savings Plans: 403(b) and 457 accounts

As an employee of San Juan Unified School District, you are eligible to participate in the District's 403(b) and/or 457 plans. These plans are administered by the District's third-party administrator National Benefit Services. Participation in these plans is voluntary and allows you to contribute a portion of your compensation as pre-tax dollars or post-tax (Roth) contribution in order to save for retirement.

Contributing to a 403(b) and/or 457 plan(s) helps you take control of your future retirement needs. Other sources of retirement income, including state pensions and Social Security, often do not adequately replace a person's salary in retirement. 403 (b) or 457 plan(s) can be a great way to supplement your income in retirement.

Benefits of a 403(b) or 457 plan?

- Pre-tax contributions may put you in a lower tax bracket reducing your overall tax rate.
- Interest and earnings on your investment will grow tax-free until the time of your withdrawal

Contribution Limits

Annual contribution limits are much higher than those of an IRA. You may elect to save:

- 100% of your income up to $19,500 (for 2021)
- Extra $6,500 if age 50+ (for 2021)

Rollovers

You also have the option of rolling retirement funds from previous employers to your District's plan thus simplifying retirement management.

Transfers

As a participant in the plan, you have the option to move funds, or "transfer" "exchange" tax-free between different investment providers within the same plan.

What are my investment choices?

There are several investment options for you. A list of approved investment providers is available on the District's Benefits website. Contact information for each provider is available at www.403bcompare.com

Investment vehicles include annuity contracts available through insurance companies as well as mutual fund options. We recommend that you seek the assistance of a financial investment advisor to help determine the best investment options for your investment goals.

Investment Advisors

You may choose any financial planner to assist you with your needs. The District has approved three firms to educate employees regarding the 403(b) & 457 (b) plans. These firms hold informational session throughout the school year and may advice you in your financial planning.

- Ameriprise Financial
- Plan Member Services, and
- Teacher's Pension

How to Enroll in the Plans

You will need to open up an account directly with the investment provider. Once your account is established you can begin investing by completing a Salary Reduction Agreement (SRA) 403(b) form or SRA 457 form. You may also complete an electronic salary reduction agreement through the District's third party administrator National Benefit Services (NBS) by following the online instructions.

Send your completed SRA form to NBS who will work with the District to begin contributions. The deadline to submit an SRA is the 5th of the month for the month in which you wish the deferral is to begin.

Distributions

Since both the 403(b) and the 457(b) Plans are long-term non-liquid retirement plans with IRS restrictions, distributions can only occur under limited circumstances. Distributions from pre-tax accounts will be taxed as normal income, as will growth earnings from the ROTH post-tax account if withdrawn within 5 tax years of establishing the ROTH. While distributions may be made after separation from service, both the 403(b) Plan and ROTH growth earnings have a 10% penalty if distribution takes place prior to age 59 ½.

"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: annual flu clinics, discount gym memberships, discount weight management program, stress management webinars, well-being fitness challenges. Look for upcoming Wellness events announced in the weekly Behind the Scenes Employee Newsletter.

SJUSD OFFERS WEIGHT WATCHERS MEMBERSHIP DISCOUNTS!

SJUSD will provide subsidized monthly Weight Watchers memberships available to all District employees (including substitutes). View information on Weight Watcher's Freestyle Program. To take advantage of this benefit, please visit enroll through the SJUSD/Weight Watchers web portal. **Please Note: Passcode 955834** If you have questions, please contact Risk Management at 971-7036.

There are two types of memberships to choose from:

Monthly Pass Membership - Allows access to monthly in-person meetings and unlimited access to all online tools. The discounted monthly fee is $36.50, of which 50% will be subsidized by SJUSD.*

Online Subscription - Provides unlimited access to online tools (no in-person meetings are included with this subscription). The discounted monthly fee is $16.10, of which 50% will be subsidized by SJUSD.*

* The 50% subsidy provided by SJUSD is made possible by funding provided by one of the District's health insurance providers. The monthly subsidy will continue until the allotted funding for this program is exhausted.

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.

Be sure to visit WHA's Healthyroads Online Wellness Portal - Track your fitness and nutrition, participate in challenges, and complete your personal health scorecard and receive valuable suggestions on how to improve your score and your health! Do you have an activity tracker such as a FitBit or a Pebble? Sync it to Healthyroads and seamlessly track your steps and other activities. Healthyroads offers over 100 wellness videos and interactive learning sessions. You can access Healthyroads through your myWHA.org account under the Healthy Living tab or register on Healthyroads.com.

Healthy Living with WHA - **Are Your Goals Smart**?

WHA Gym Discount Information

Tips for Succeeding in a Diverse Workplace

Today's workplace reflects the amazing diversity of our society. Diversity is good for business by providing a variety of perspectives. And it makes the workplace a lot more interesting. We can only learn from each other, though, in an environment where different views are respected. As an employee, you can help.

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

CUSTOMER SERVICE ADDRESS AND TELEPHONE NUMBERS

HEALTH PLANS

Kaiser Permanente
Customer Service: 1-800-464-4000
internet address: **www.kp.org**

Western Health Advantage
Customer Service: 1-888-563-2250
Internet address: **www.westernhealth.com**

DENTAL PLANS

DeltaCare USA
Customer Service: 1-800-422-4234

Delta Dental
Customer Service: 1-866-499-3001
P.O. Box 997330
Sacramento, CA 95899-7330
Group #6689-0011
Internet address: **www.deltadentalca.org**

VISION PLAN

Vision Service Plan (VSP)
Customer Service: 1-800-877-7195
3333 Quality Drive
Pre-Authorization 635-7373
Rancho Cordova, CA 95670
Internet address: **www.vsp.com**

LIFE INSURANCE

Reliance Standard
Customer Service: 1-800-351-7500
2001 Market St., Suite 1500
Fax: 267-256-3532
Philadelphia, PA 19103
Internet address: www.customercare.rsli.com

VOLUNTARY ACCIDENT, DISABILITY, LIFE, & CANCER POLICIES

American Fidelity
Customer Service: 1-800-365-8306
P.O. Box 1295
Local (916) 683-8306
9370 W. Stockton Blvd. Suite 130
Elk Grove, CA 95759-1295
Internet address: **www.afadvantage.com**

CTA Standard Life Insurance (CTA Members)
Customer Services: 1-800-522-0406
P.O. Box 4744
Fax: 1-888-414-0393
Portland, OR 97208
Internet address: CTAMemberBenefits.org/TheStandard

EMPLOYEE ASSISTANCE PROGRAM

ACI Specialty Benefits
(Reliance Standard)
Customer Service: 1-855-775-4357
Internet Address: **http://rsli.acieap.com**
rsli@acieap.com

FLEXIBLE SPENDING ACCOUNTS

American Fidelity Assurance Co.
Customer Service: 1-800-365-8306
P.O. Box 1295
Local (916) 683-8306
9370 W. Stockton Blvd. Suite 130
Elk Grove, CA 95759-1295
Internet address: **www.afadvantage.com**

RETIREMENT PLANS

CalPERS
400 Q Street
Sacramento, CA 95814
Mail: P.O. Box 942711
Sacramento, CA 94229-2711
1-888-225-7377
Internet address: **www.calpers.ca.gov**

CalSTRS
100 Waterfront Place
West Sacramento, CA 95605
P. O. Box 15275
Sacramento, CA 95851-0275
1-800-228-5453
Internet address: **www.calSTRS.com**

403(B) TAX SHELTER ANNUITIES AND 457 DEFERRED COMPENSATION PLANS

National Benefit Services
Customer Service: 1-800-274-0503 ext.5
8523 S. Redwood Rd.
Fax: 1-800-597-8206
West Jordan, UT 84088
Internet: nbsbenefits.com

Important Plan Notices and Documents

WOMEN'S HEALTH AND 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 this plan. Call your health plan's Member Services for more information.

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 the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). If you would like more information on maternity benefits, call your carrier directly at the number at the back of your medical card.

HIPAA NOTICE OF SPECIAL ENROLLMENT RIGHTS

If you decline enrollment in the San Juan Unified School District's health plan for you or your dependents (including your spouse) because of other health insurance or group health plan coverage, you or your dependents may be able to enroll in the San Juan Unified School District's health plan without waiting for the next open enrollment period if you:

• Lose other health insurance or group health plan coverage. You must request enrollment within 30 days after the loss of other coverage.

• Gain a new dependent as a result of marriage, birth, adoption, or placement for adoption. You must request health plan enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

• Lose Medicaid or Children's Health Insurance Program (CHIP) coverage because you are no longer eligible. You must request medical plan enrollment within 60 days after the loss of such coverage.

If you request a change due to a special enrollment event within the 30 day timeframe, coverage will be effective the date of birth, adoption or placement for adoption. For all other events, coverage will be effective the first of the month following your request for enrollment. In addition, you may enroll in the health plan if you become eligible for a state premium assistance program under Medicaid or CHIP. You must request enrollment within 60 days after you gain eligibility for medical plan coverage. If you request this change, coverage will be effective the first of the month following your request for enrollment. Specific restrictions may apply, depending on federal and state law.

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 providers, contact your carrier directly. For children, you may designate a pediatrician as the pri

HIPAA PRIVACY NOTICE SAN JUAN UNIFIED SCHOOL DISTRICT PRIVACY PRACTICES NOTICE

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR MEDICAL INFORMATION IS IMPORTANT TO US.

{The following summary section is optional, though suggested by HHS for a "layered notice" at 67 Fed. Reg. 53243

(Aug. 14. 2002) and 78 Fed. Reg. 5625 (Jan. 25, 2013).}

Summary of Our Privacy Practices

We may use and disclose your protected health information ("medical information"), without your permission, for treatment, payment, and health care operations activities. We may use and disclose your medical information, without your permission, when required or authorized by law for public health activities, law enforcement, judicial and administrative proceedings, research, and certain other public benefit functions.

We may disclose your medical information to your family members, friends, and others you involve in your care or payment for your health care. We may disclose your medical information to appropriate public and private agencies in disaster relief situations.

We may disclose to your employer whether you are enrolled or disenrolled in the health plans it sponsors. We may disclose summary health information to your employer for certain limited purposes. We may disclose your medical information to your employer to administer your group health plan if your employer explains the limitations on its use and disclosure of your medical information in the plan document for your group health plan.

Except for certain legally-approved uses and disclosures, we will not otherwise use or disclose your medical information without your written authorization.

You have the right to examine and receive a copy of your medical information. You have the right to receive an accounting of certain disclosures we may make of your medical information. You have the right to request that we amend, further restrict use and disclosure of, or communicate in confidence with you about your medical information.

You have the right to receive notice of breaches of your unsecured medical information.

Please review this entire notice for details about the uses and disclosures we may make of your medical information, about your rights and how to exercise them, and about complaints regarding or additional information about our privacy practices.

For more information about our privacy practices, to discuss questions or concerns, or to get additional copies of this notice contact:

Office: Benefits Division Telephone: (916)971-7662 E-mail: benefitshelpdesk@sanjuan.edu

Address: 3738 Walnut Avenue, Carmichael, CA 95608

CREDITABLE COVERAGE DISCLOSURE – MEDICARE PART D NOTICE

About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. If you have Medicare or will become eligible for Medicare in the next 12 months, you have more choices regarding prescription drug coverage. This notice explains your resulting choices. The following is a legal notice that San Juan Unified School District is required to send each year. It does not require any action or response on your part.

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 San Juan Unified Plans are on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is 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 through 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 November to join.

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

Contact the Department 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 whether or not you are required to pay a higher premium (a penalty).

Date:	September 21, 2020
Name of Entity/Sender:	San Juan Unified School District
Contact--Position/Office:	Employee Benefits Department
Address:	3738 Walnut Ave., Carmichael, CA 95608
Phone Number:	916-971-7662

San Juan Unified School District

General Notice of COBRA Continuation Coverage Rights
**** Continuation Coverage Rights Under COBRA****

Introduction

You are receiving this notice because you may be eligible for coverage under a San Juan Unified School District group health plan. This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under a San Juan Unified School District health plan. **This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.**

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 when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under a San Juan Unified School District health plan when they would otherwise lose their group health coverage.

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of group plan coverage when coverage would otherwise end because of a life event known as 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 a San Juan Unified School District health plan is lost because of the qualifying event. Under a San Juan Unified School District health plan, qualified beneficiaries who elect COBRA continuation coverage *must* pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you lose your coverage under a San Juan Unified School District health plan because either one of the following qualifying events happens:

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

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under a San Juan Unified School District health plan because any of the following qualifying events happens:

- 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 a San Juan Unified School District health plan because any of the following qualifying events happens:

- 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 a San Juan Unified School District health plan, the retired employee will become a qualified beneficiary with respect to the bankruptcy. 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 a San Juan Unified School District health plan.

When is COBRA Coverage Available?

The San Juan Unified School District will offer COBRA continuation coverage to qualified beneficiaries only after notification that a qualifying event has occurred such as the end of employment or reduction of hours of employment, death of the employee, or commencement of a proceeding in bankruptcy with respect to San Juan Unified School District.

You Must Give Notice of Some Qualifying Events

For the 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 San Juan Unified School District Employee Benefits Department within 60 days after the qualifying event occurs.

How is COBRA Coverage Provided?

Once the San Juan Unified School District Employee Benefits Department 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. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability extension of 18-month period of continuation coverage

If you or anyone in your family covered under a San Juan Unified School District health plan is determined by the Social Security Administration to be disabled and you notify the San Juan Unified School District Employee Benefits Department in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total 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 continuation coverage.

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

If your family experiences another qualifying event while receiving 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 notice of the second qualifying event is properly given to the San Juan Unified School District Employee Benefits Department. This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under a San Juan Unified School District health plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under a San Juan Unified School District health plan had the first qualifying event not occurred.

State Continuation of Coverage Rights – Cal-COBRA Extension

California law requires insured medical plans and HMOs in the state to offer qualified beneficiaries who exhaust their 18- or 29-months of federal COBRA an additional period of continuation coverage, for up to a total of 36 months from the date federal COBRA began. This extension became available for qualified beneficiaries who began federal COBRA coverage on or after January 1, 2003; making the earliest date a qualified beneficiary could have taken advantage of this right to be July 1, 2004. Your medical plan will notify you of the availability of Cal-COBRA coverage in the notice of pending termination of COBRA coverage that is required to be provided to COBRA beneficiaries.

If You Have Questions

Questions concerning your San Juan Unified School District health plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), 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 the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep the San Juan Unified School District informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the San Juan Unified School District.

Plan Contact Information

San Juan Unified School District
Employee Benefits Department
3738 Walnut Ave
Carmichael, CA 95608
916-971-7662

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

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your State may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs, but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**. If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available. If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial 877.KIDS.NOW or www.insurekidsnow.gov to find out how to apply. If you qualify, ask your State if it has a program that might help you pay the premiums for an employer sponsored plan. If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call 866.444.EBSA (3272). If you live in one of the following States, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2019. Contact your State for more information on eligibility.

ALABAMA – Medicaid Website: http://myalhipp.com/ Phone: 855.692.5447

ALASKA – Medicaid The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 866.251.4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx

ARKANSAS – Medicaid Website: http://myarhipp.com/ Phone: 855.MyARHIPP (855.692.7447)

COLORADO – Health First Colorado Colorado's Medicaid Program & Child Health Plan Plus (CHIP+) Healthy First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 800.221.3943 TTY: Colorado relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-planplus CHP+ Customer Service: 800.359.1991 TTY: Colorado relay 711

FLORIDA – Medicaid Website: http://flmedicaidtplrecovery.com/hipp/ Phone: 877.357.3268

GEORGIA – Medicaid Website: http://medicaid.georgia.gov/health-insurance-premiumpayment-program-hipp/ Phone: 678.564.1162, ext. 2131

INDIANA – Medicaid Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 877.438.4479 All other Medicaid Website: http://www.indianamedicaid.com Phone: 800.403.0864

IOWA – Medicaid Website: http://dhs.iowa.gov/hawki Phone: 800.257.8563 KANSAS – Medicaid Website: http://www.kdheks.gov/hcf/ Phone: 785.296.3512

KENTUCKY – Medicaid Website: http://chfs.ky.gov/agencies/dms Phone: 800.635.2570

LOUISIANA – Medicaid Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 888.695.2447

MAINE – Medicaid Website: http://www.maine.gov/dhhs/ofi/publicassistance/index.html Phone: 800.442.6003 TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 800.862.4840

MINNESOTA – Medicaid Website: http://mn.gov/dhs/people-we-serve/seniors/healthcare/health-care-programs/programs-and-services/medicalassistance.jsp | Phone: 800.657.3739

MISSOURI – Medicaid Website: https://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573.751.2005 38

MONTANA – Medicaid Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 800.694.3084

NEBRASKA – Medicaid Website: http://www.ACCESSNebraska.ne.gov Phone: 855.632.7633 Lincoln: 402.473.7000 Omaha: 402.595.1178

NEVADA – Medicaid Medicaid Website: https://dhcfp.nv.gov/ Medicaid Phone: 800.992.0900

NEW HAMPSHIRE – Medicaid Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf Phone: 603.271.5218 Toll-Free for the HIPP program: 800.852.3345, ext. 5218

NEW JERSEY – Medicaid and CHIP Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609.631.2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 800.701.0710

NEW YORK – Medicaid Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 800.541.2831

NORTH CAROLINA – Medicaid Website: https://medicaid.ncdhhs.gov/ Phone: 919.855.4100

NORTH DAKOTA – Medicaid Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 844.854.4825

OKLAHOMA – Medicaid and CHIP Website: http://www.insureoklahoma.org Phone: 888.365.3742

OREGON – Medicaid Websites: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 800.699.9075

PENNSYLVANIA – Medicaid Website: http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm Phone: 800.692.7462

RHODE ISLAND – Medicaid Website: http://www.eohhs.ri.gov/ Phone: 855.697.4347, or 401-462-0311 (Direct RIte Share Line)

SOUTH CAROLINA – Medicaid Website: https://www.scdhhs.gov Phone: 888.549.0820

SOUTH DAKOTA - Medicaid Website: http://dss.sd.gov Phone: 888.828.0059

TEXAS – Medicaid Website: http://gethipptexas.com/ Phone: 800.440.0493 **UTAH – Medicaid and CHIP Medicaid Website:** https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 877.543.7669

VERMONT– Medicaid Website: http://www.greenmountaincare.org/ Phone: 800.250.8427
VIRGINIA – Medicaid and CHIP Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 800.432.5924 CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm CHIP Phone: 855.242.8282

WASHINGTON – Medicaid Website: https://www.hca.wa.gov/ Phone: 800.562.3022, ext. 15473

WEST VIRGINIA – Medicaid Website: http://mywvhipp.com/ Toll-free phone: 855.MyWVHIPP (855.699.8447) WISCONSIN – Medicaid and CHIP Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 800.362.3002

WYOMING – Medicaid Website: https://wyequalitycare.acs-inc.com/ Phone: 307.777.7531

To see if any other states have added a premium assistance program since July 31, 2019, or for more information on special enrollment rights, contact either:

U.S. Department of Labor Employee Benefits Security Administration www.dol.gov/agencies/ebsa 866.444.EBSA (3272)

U.S. Department of Health and Human Services Centers for Medicare & Medicaid Services www.cms.hhs.gov 877.267.2323, Menu Option 4, Ext. 6156