Health and Welfare Benefits Board

SJUSD / Signatory Unions

2024-2025 Benefit Guide

San José Unified School District

Welfare Benefits Board
SJUSD / Signatory Unions

WELCOME!

At **San José Unified School District**, we recognize the important role our employees play in preparing today's students to be the thinkers, leaders, and creators of tomorrow. San José Unified provides benefits-eligible employees with a competitive and comprehensive benefits package designed to meet your needs and those of your family.

To that end, San José Unified created the Health and Welfare Benefits Board (HWBB). The HWBB meets with insurers and third parties to review and monitor the Plan, and continues to make improvements to the Plan when possible.

This guide provides an overview of San José Unified's benefits program, including a summary of each type of coverage. Because the selection of your benefits is important, we encourage you to carefully review the information in this guide.

If you have any other questions about your benefits, please contact the vendors or the Human Resources department. Contact information is listed on page 19.

You can review benefit plan information anytime at the HWBB Benefits website at **https://c2mb.ajg.com/SJUSD/home**.

Table of Contents

This document is an outline of the coverage provided under your employer's benefit plans based on information provided by your company. It does not include all the terms, coverage, exclusions, limitations, and conditions contained in the official Plan Document, applicable insurance policies and contracts (collectively, the "plan documents"). The plan documents themselves must be read for those details. The intent of this document is to provide you with general information about your employer's benefit plans. It does not necessarily address all the specific issues which may be applicable to you. It should not be construed as, nor is it intended to provide, legal advice. To the extent that any of the information contained in this document is inconsistent with the plan documents, the provisions set forth in the plan documents will govern in all cases. If you wish to review the plan documents or you have questions regarding specific issues or plan provisions, you should contact your Human Resources/Benefits Department.

Open Enrollment

Message from the Health and Welfare Benefits Board

As Open Enrollment approaches, the Health and Welfare Benefits Board (HWBB) is excited to announce current employee contributions single coverage toward the San José Unified School District's (SJUSD) plans will remain unchanged for the 2024-2025 plan year.

Open Enrollment is May 1, 2024 through June 7, 2024

Open Enrollment is your once-a-year opportunity to make changes to your benefit elections, such as switching health plans, adding or dropping dependents, and enrolling or re-enrolling in the Section 125 Flexible Spending Arrangement (FSAs), both Healthcare and Dependent Care. It's also a perfect time to review and update your beneficiary information and increase your Voluntary Term Life insurance to meet your family's changing needs.

In order to provide employees ample time to enroll in their benefits for the coming plan year, San José Unified is providing an extended Open Enrollment period. This year Open Enrollment will begin Monday, May 1, 2024, and end Friday, June 7th.

Employees who work a minimum of 30 hours per week must enroll in medical and dental. Dependents who are covered must be enrolled in medical and dental. Eligible dependents include spouse, domestic partners, and children to age 26.

What You Need To Do

Review plan information in this booklet or at **https://c2mb.ajg.com/SJUSD/home** so you know your plan options.

Complete your Open Enrollment electronically at **my.sjusd.org** by June 7, 2024. Remember, changes are effective July 1, 2024. If you do not wish to make changes to your benefit election, no action is needed and your current election will roll over to 2024-2025 **with the exception of the FSA(s). We do recommend you check your current benefit elections for accuracy**.

Enroll in the Health Care or Dependent Care Flexible Spending Arrangement(s) (FSAs) if you wish to participate in the 2024-2025 plan year. Your current election will not roll over. Remember the "use-it-or-lose-it" rules.

Call American Fidelity to schedule a virtual appointment at **800.365.8306 x1**. Register online for an appointment at **https://enroll.americanfidelity.com/BD6C6AA2**.

What's Changing?

- The Healthcare Flexible Spending Arrangement (FSA) limit is increased to $3,200, the IRS limit.

What's New?

- Benefithub is transitioning to Connect2MyBenefits with a new URL. Please unsubscribe to Benefithub's promotional emails.
- Healthcomp is changing the look to your ID Cards. You will receive a new ID card with simpler refinements.
- Employee Contributions will be different for 7/1/24 plan year.

Voluntary Life Annual Enrollment:

This is a great opportunity to purchase additional Life insurance for yourself and possibly your dependents. Page 12 describes the program and the rates are listed on page 18.

A few things to remember:

- If you or your spouse were previously declined, you will need to submit Evidence of Insurability.
- If you initially purchased at least $10,000 of coverage, each subsequent year you have the ability to purchase some additional coverage but you must submit Evidence of Insurability.
- You can only insure your dependents, if you are insured.
- Remember to name a beneficiary.
- Coverage will commence once approved by underwriting. Once underwriting approves coverage, it will be effective the 1st of the month following underwriting approval.
- Married couples working at SJUSD may each apply as an employee, however no one can be covered twice.

Wellness Program

Wellness Program Moves Into Year Seven

The Health and Welfare Benefits Board (HWBB) aims to provide the best health benefits at a reasonable cost to you and your family. We also encourage improving your well-being by becoming more educated and responsible healthcare consumers.

To this end, HWBB partners with our vendors to makes it easy for employees to obtain health information and take action to improve their health.

Check out what Kaiser offers on its website as well as **https://c2mb.ajg.com/SJUSD/home**, where you can find helpful tips and discounts. Over time, improving your own health is really good for you, helps control avoidable costs, and keeps our benefit costs affordable.

Health screenings can identify unknown conditions, diseases, or risks for future diseases that can significantly influence your quality of life. San José Unified encourages you to take charge of your health. As always, we highly recommend you see a physician once a year and complete any necessary blood work or tests recommended by your physician.

There is no requirement to provide the health screening form to Human Resources and there are no additional fees for the 2024-2025 plan year.

Telemedicine Services

Members enrolled in the Foundation PPO plan have access to video visits with their personal physician at a $20 copay.

Call your doctor's office to make your appointment.

Employee Assistance Program (EAP)

Your employer has partnered with HealthAdvocate to offer you personalized support to find balance and gain control during life's challenges, all at no cost to you!

Your Employee Assistance Program (EAP) through HealthAdvocate offers confidential support from EAP Professionals, who can help you work through personal, family or work issues to feel more balanced and productive.

Six Counseling Sessions per member, per issue, per year

Services are available to employees, spouses, dependents, parents and parents-in-law at no cost to you.

Life has its challenges... Health Advocate is here to help

Identify emotional and mental health issues and strategies to cope

Develop a plan to help you feel more in control

Locate the right support resources such as childcare, eldercare and more

Research travel, plan events, make reservations and handle other time-consuming tasks through our concierge service

Quick Access via Phone, Email, Online or Mobile App

- Compassionate support over the phone when you need it most
- Participate in virtual counseling through phone, text, chat or video
- Work with a counselor in face-to-face sessions

866.799.2485

Email: **answers@HealthAdvocate.com**

Web: **HealthAdvocate.com/members**

Additional Services

- Explore webinars, online courses and articles on a variety of well-being topics
- Visit the Personalized Legal Center, Financial Fitness Center and Mindfulness page
- Watch the confidential orientation video on San José Unified School District's C2MB

Medical Benefits

San José Unified provides employees with two medical plans from which to choose:

- The Foundation Preferred Provider Organization (PPO) Plan
- The Kaiser Permanente Health Maintenance Organization (HMO) Plan

Both of San José Unified's medical plan options are designed to provide you with cost-effective, comprehensive coverage. While each plan covers most of the same services, the provider networks and your out-of-pocket medical expenses may vary due to the type of services you receive.

The self-funded Foundation PPO plan, administered by HealthComp, allows you to access covered medical services from any provider you wish.

You receive the highest level of coverage when you access services from Anthem Blue Cross Prudent Buyer providers.

The Kaiser Permanente HMO plan requires you to use their providers and facilities (except for emergencies).

The following tables provide a comparison of highlights between the two plans. For further details, please refer to the vendor plan descriptions or contact the vendor directly.

Note: You will be enrolled for single coverage in the Foundation PPO plan, unless you submit an enrollment form electing other coverage.

HMO vs. PPO

	PPO	HMO
	Preferred Provider Organization	Health Maintenance Organization
Do I need to designate a Primary Care Physician (PCP)?	**NO** A PPO plan does not require you to select a PCP. You can receive care from any doctor you choose, however you will save more money by choosing a doctor, specialist or hospital that is within the network.	**YES** At Kaiser, most of your healthcare services will be coordinated between you and your designated Primary Care Physician (PCP).
Is a referral needed?	**NO** Generally, PPO plans do not require you to get a referral in order to see a specialist.	**SOME** At Kaiser, most of your care does require a referral with a few exceptions. You may be asked to check with your PCP first, even if your plan doesn't require it.
If I have a doctor or specialist who is out-of-network, will I still be able to see them and have my care covered?	**YES** With a PPO, you have the flexibility to visit providers, hospitals and facilities outside of your network. You will be responsible for paying any applicable member deductibles or copayments, plus any amount in excess of the covered amount.	**NO** Kaiser doesn't provide coverage for care from an out-of-network physician, hospital or facility except in the case of a true medical emergency.
Will I have to file a claim?	**RARELY** In some cases with a PPO, you will have to pay a doctor for services directly and then file a claim to get reimbursed. This is most common when you seek a service from an out-of-network provider.	**RARELY** Since Kaiser only allows you to see providers in-network, it's likely you'll never have to file a claim, except in the case of an emergency.

Medical Benefits

Administered by HealthComp

	FOUNDATION PPO PLAN	
	In-Network[1]	Out-of-Network[1]
Plan Provisions		
Calendar Year Deductible[2]	$150 per individual; $300 per family	$750 per individual; $1,500 per family
Calendar Year Out-of-Pocket Maximum	$1,500 per individual; $3,000 per family	Unlimited
Life Maximum Benefit	Unlimited	
Medical Benefits		
Doctor's Office Visits/Specialist Office visit	$20/$40 copay; deductible waived	60%
Preventive Care	100%[3]	60%
Physical and/or Speech Therapy	$20 copay	60%
X-Ray and Lab	80%	60%
Chiropractic[4]	$15 copay; deductible waived	60%
Ambulance Benefit	100% covered for the first $5,000 per trip. Any remaining eligible charges subject to deductible and 80%	
Prescription Drug Benefits		
Retail Pharmacy (up to 30-day supply; up to 90-day supply maintenance medication)	Generic: $10 copay	Not covered
	Preferred Brand: $15 copay	
	Brand: $35 copay	
ElixirRx Mail Order (Up to 90-day supply)	Preferred Brand: $15 copay	
	Brand: $35 copay	
Hospital Benefits		
Hospitalization	80% after $250 copay	60% after $250 copay
Outpatient Surgery	60%	60%
Emergency Room	80% after $75 copay (waived if admitted or life-threatening)	
Mental Health and Substance Abuse Benefits		
Inpatient and Outpatient	Covered the same as any other illness in accordance with Healthcare Reform and Mental Health parity requirements	

[1] Subject to the deductible; Out-of-Network benefits are paid at Usual, Customary and Reasonable (UCR) rates; however, if no Anthem Blue Cross Prudent Buyer Network providers are available in the area where services are received, the plan will pay 80% rather than 60%

[2] Payments made to satisfy the In-Network deductible apply to the Out-of-Network deductible as well and vice versa

[3] In accordance with Healthcare Reform requirements

[4] Up to 40 visits are covered per calendar year

Access to Anthem's LiveHealth Online

With Anthem's LiveHealth Online, you can have face-to-face conversations with a doctor on your computer or mobile device, wherever you are.

LiveHealth Online uses two-way video to connect you with a U.S.-based board-certified doctors who can answer your questions, assess your condition, and even provide prescriptions* if needed.

*Prescription availability is based on physician judgment and state regulations.

Go to **www.livehealthonline.com** to get started or call **888.Livehealth (888.548.3432).**

Once you select a doctor, click Connect, and in just a few minutes, you'll be talking with him or her face–to–face!

There is no cost for a LiveHealth Online visit, and the deductible is waived.

Foundation PPO Plan Contact Information

- **800.442.7247** or **408.535.4736 x15042**
- HealthComp: **healthcomp.com**
  Email: **sjusdbenefithelp@healthcomp.com**
- Blue Cross Prudent Buyer Network: **anthem.com/ca**
- ElixirRx Prescription Drug Benefits:
  envisionrx.com
  800.361.4542

Medical Benefits
Administered by Kaiser Permanente

	KAISER HMO Kaiser Providers and Facilities Only
Plan Provisions	
Calendar Year Deductible	None
Calendar Year Out-of-Pocket Maximum[1]	$1,500 per individual; $3,000 per family
Life Maximum Benefit	Unlimited
Medical Benefits	
Doctor's Office Visits	$30 copay
Preventive Care	100%[1]
Physical and/or Speech Therapy	$20 copay
X-Ray and Lab	100%
Chiropractic	$15 copay; deductible waived; up to 40 visits
Prescription Drug Benefits	
Retail Pharmacy (Up to 30-day supply)	Generic: $10 copay; Brand: $25 copay
Kaiser Mail Order (Up to 100-day supply)	Generic: $20 copay; Brand: $50 copay
Hospital Benefits	
Hospitalization	$250 copay per admission
Outpatient Surgery	$20 copay
Emergency Room	$75 copay (waived if admitted)
Mental Health and Substance Abuse Benefits	
Inpatient and Outpatient	Covered the same as any other illness in accordance with Healthcare Reform and Mental Health parity requirements

[1]In accordance with Healthcare Reform requirements

Access to Kaiser's Video Visits

With Kaiser's video visits, you can meet with your doctor from the convenience of your home, office, or wherever works for you. You can securely connect with your doctor on the internet using your computer and webcam, your phone, or your tablet.

If you join your visit using your mobile device or tablet, you will need to have the Kaiser My Doctor Online app installed.

Video visits are secure and encrypted so only the participants of the visit can see and hear the meeting, and visits are not recorded by Kaiser Permanente. Kaiser video visits are offered at no charge.

To learn more about Kaiser's video visits, go to **mydoctor.kaiserpermanente.org/ncal/videovisit**.

Kaiser Permanente HMO Plan Contact Information

- **800.464.4000**
- **healthy.kaiserpermanente.org/northern-california**

Dental Benefits

Administered by Cigna

San José Unified provides employees with comprehensive dental coverage through Cigna Dental, offering both a DPPO (Dental Preferred Provider Organization) plan and a DHMO (Dental Health Maintenance Organization) plan.

With the DPPO plan, you may obtain dental care services from any dentist you wish. However, if you obtain services from a dentist in the Cigna Dental DPPO network, you will save money on your out-of- pocket expenses, and your benefits will be greater. All participating network dentists agree to provide services at discounted, negotiated fees.

If you use non-network dental providers, your charges will be based on the Reasonable and Customary (R&C) rates for your area, as determined by Cigna and you may be subject to balance billing which further increases your cost.

With the DHMO plan, benefits are paid only when you receive care from a participating provider. You pay a set copayment for each covered dental procedure, and there are no annual deductibles or maximums on general services. If a procedure is not listed as a covered expense, you are responsible for any and all charges.

Many services are covered at 100%. When you enroll in the DHMO, you will need to select your primary care provider from Cigna's participating dentists. For more information or to locate Cigna providers, call **800.244.6224** or visit their website at **www.cigna.com**. Go to "Find Providers" and for DPPO providers, select "Cigna Dental PPO" and for DHMO providers, select "Cigna Dental Care HMO."

Note: You will be enrolled for single coverage in the DPPO dental plan, unless you submit an enrollment form electing other coverage. If you have dependents enrolled in SJUSD's medical plan, they will also be enrolled in the dental plan you elected for yourself.

	DPPO PLAN		DHMO PLAN
	In-Network[1]	Out-of-Network[2]	In-Network Only
Plan Provisions			
Deductible	None		None
Calendar Year Maximum Benefits	$2,000 per individual		None
Diagnostic and Preventive Services			
Exams, X-Rays, Cleanings[4]	100% of negotiated fee	90% of R&C	100%[3]
Basic Services			
Fillings, Extractions	100% of negotiated fee	90% of R&C	100%[3]
Major Services			
Bridges, Dentures, Crowns	90% of negotiated fee	90% of R&C	100%[3]
Orthodontia			
Adults and Children	50% of negotiated fee	50% of R&C	100%[3]
Lifetime Maximum Benefits	$1,000		None

[1] All participating network dentists agree to provide services at discounted, negotiated fees

[2] Paid at Reasonable & Customary rates as determined by Cigna

[3] Almost all services are paid by the plan. See the schedule of benefits on **my.sjusd.org** to determine any copays you may be responsible for.

[4] Includes two cleanings per calendar year.

Voluntary Vision Benefits

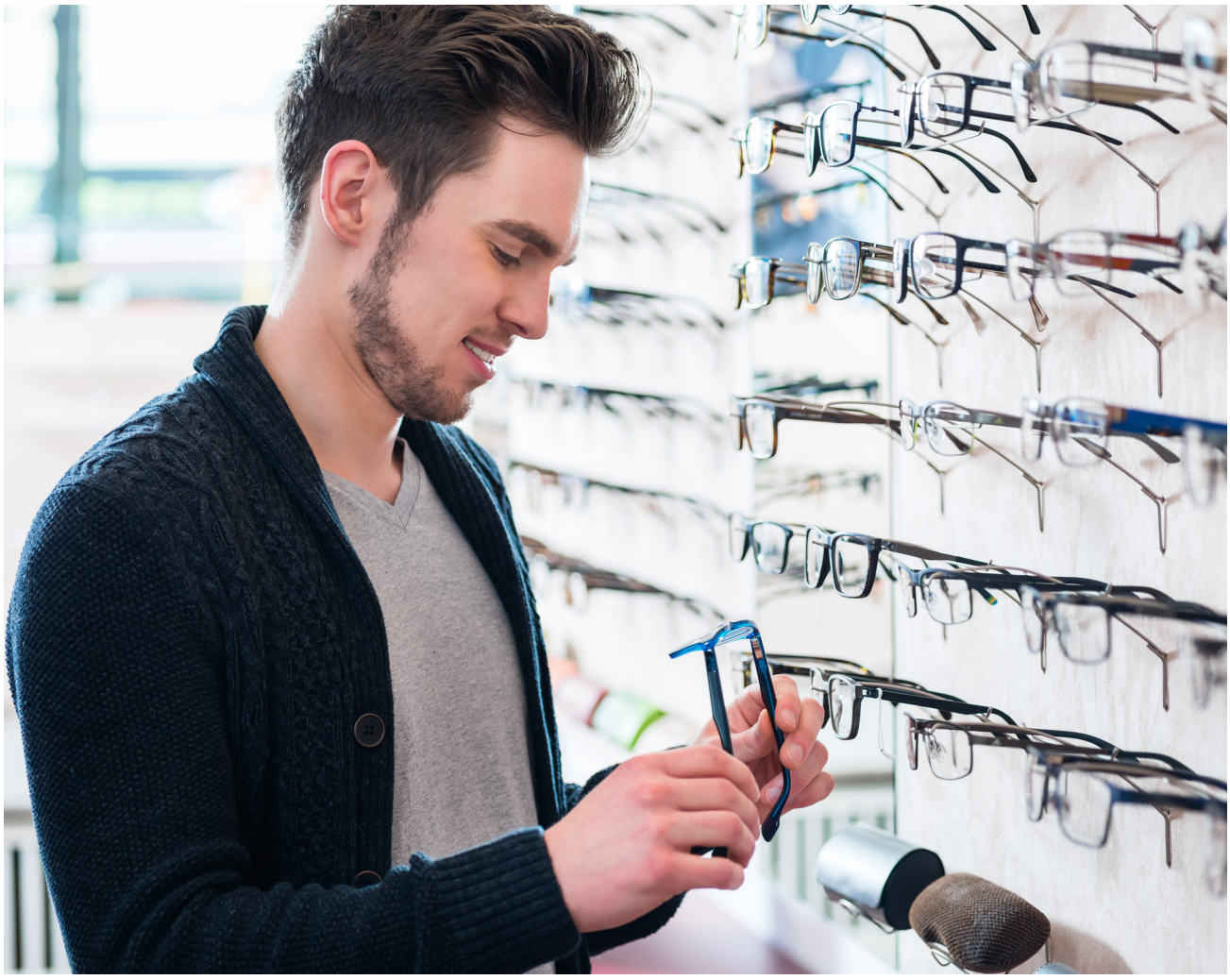
Administered by VSP

San José Unified recognizes vision care is an important part of overall health, and offers Voluntary Vision plans to all eligible employees through Vision Service Plan (VSP). This plan is paid for entirely by the employee. The plan covers vision exams, frames, lenses, and contacts each VSP plan year (July 1 through June 30).

You can see any provider you wish, but will receive greater discounts when using a VSP provider. See page 17 for annual premiums.

For more information or to locate VSP providers, call **800.877.7195** or visit their website at **vsp.com**.

	VISION PLAN	
	In-Network	Out-of-Network
Plan Provisions		
Well Vision Exams	$25 copay for exam and glasses	Up to $45
Frames (no copay)	$200 allowance + 20% discount	Up to $70
Lenses (no copay)	Single vision, lined bifocal and trifocal	Up to $30/$50/$65
Contacts ($60 copay)	$150 allowance in lieu of glasses	Up to $105
Medically Necessary	Covered in full	Up to $250



Continuation of Coverage – COBRA (Consolidated Omnibus Budget Reconciliation Act)

In compliance with federal law, San José Unified offers eligible employees and their families the opportunity to elect a temporary extension of health coverage (referred to as COBRA) in certain instances where coverage would otherwise end. The circumstances which permit this special election privilege are called "qualifying or life events". It is important for you to become familiar with these events so you can exercise your COBRA rights when eligible.

For some qualifying events, it is your (or a family member's) responsibility to inform Human Resources in writing or by email of these events so your COBRA rights can be initiated. Please refer to your plan descriptions or carrier materials which explain the provisions of COBRA in greater detail. Human Resources is also available to answer your questions.

If you are planning to elect retiree coverage under San José Unified plans, then you waive your rights for COBRA coverage by electing retiree coverage. San José Unified also provides coverage in compliance with other federal and state laws, such as the Family Medical Leave Act and conversion privileges, i.e., the ability to convert some benefits to an individual policy when leaving San José Unified.

Life Insurance

San José Unified provides active, eligible employees with Life Insurance coverage. Your Basic Life and Dependent Life Insurance is provided through Unum Insurance Company.

There is no cost to you for Basic and Dependent Life Insurance if you work at least 30 hours per week (at least 0.75 FTE). Retirees pay 100% of the cost of Basic Life and Dependent Life insurance, and must enroll within 31 days after retirement. Be sure to check whether your beneficiary designation on file is appropriate.

Basic Life Insurance

If your death occurs while you are an active employee covered under San José Unified's Basic Life Insurance plan, your beneficiary will receive a benefit of $50,000, adjusted for age reductions commencing at age 70. Retiree coverage terminates at age 70.

Dependent Life Insurance

Eligible dependents of active and retired employees are eligible for $2,000 of Life Insurance coverage per dependent.

Voluntary Term Life Insurance

San José Unified School District has partnered with Unum to make Voluntary Term Life and Accidental Death & Dismemberment Insurance available to active employees working at least 30 hours per week (at least 0.75 FTE). When initially hired, you may elect anywhere from $10,000 up to the lesser of five times your salary or $500,000 in $10,000 increments. Elections above $200,000 require the completion of a medical questionnaire. There are no medical questions if you apply for less than $200,000. You can also elect coverage for your dependents if you elected coverage yourself:

- Spouses are entitled to up to $25,000 of guaranteed issued coverage, and up to $500,000 with medical underwriting (in increments of $5,000).
- Dependent children (up to age 26) are entitled to up to $10,000 of coverage (in increments of $2,000).

When you enroll in Life Insurance, you need to designate one or more beneficiaries. You can change your beneficiaries at any time. If you have a spouse/domestic partner and choose not to name that person as your beneficiary, we suggest you contact an attorney to understand any potential consequences.

Unum's Voluntary Life Insurance is portable (meaning you take the policy with you, should you leave San José Unified), includes Survivor Support, and offers resources for Financial and Legal Planning.

Important: If you initially purchase $10,000 of coverage, you preserve your right to buy up to $200,000 of coverage during future Open Enrollments—with no medical questions. See page 17 for rates.

Income Protection Benefits

San José Unified provides eligible employees with Income Protection coverage. Your level of coverage is based on your employee classification. The income Protection Plan is designed to provide income replacement in the event you suffer a loss of income because you are disabled from an injury or illness. San José Unified pays 100% of the Income Protection Plan cost and you are automatically enrolled.

Short-Term Disability Coverage for Administrators and Classified Employees Working at Least 20 Hours Per Week

You are eligible for Short-Term Disability coverage on your date of hire. You are considered disabled if you are unable to perform each and every duty of your occupation while under the care of a qualified physician.

- You may replace up to 75% of your earnings.[1]
- Your benefit payments will be offset by any income you received, or are entitled to receive, from Workers' Compensation, Disability, or Retirement Social Security Benefits, and any Disability, Retirement, or other income benefits provided by or through San José Unified.
- Short-Term Disability benefits begin on the first day when hospitalized or on the eighth day of your disability, or the expiration of your accrued sick leave benefits, whichever occurs later.
- Your benefit payments may continue for up to twelve (12) months or until you are eligible to receive PERS or STRS disability benefits through the retirement systems, whichever occurs first.
- In the event you die while receiving benefits, your surviving spouse, or legal dependent(s), will receive the same monthly benefits for a period of three months from the date of death.

[1] Earnings means your annual salary divided by twelve, or in the case of twelve-month employees, your regular monthly salary. Earnings for hourly employees will be based upon the hourly base rate of pay (times normal hours you would have worked had you not been disabled) at the time of your disability.

Short-Term Disability Coverage for Certificated Employees Working at Least 20 Hours Per Week

All certificated employees working at least 20 hours per week are eligible for Short-Term Disability coverage on the first of the month coincident with or next following the date you become eligible. You are considered disabled while you are unable to perform the material duties of your own occupation and while you are not engaged in any other occupation.

- You may receive a benefit of up to $200 per regular work month while receiving fully paid sick leave.
- Once you have exhausted your sick leave, you may receive up to 75% of your monthly contract salary.
- You may receive a minimum monthly benefit of up to $400 during any period in which substitute differential pay is received.
- Short-Term Disability benefits begin following ten consecutive regular workdays of disability.
- Your benefit payments may continue for up to one year from expiration of fully paid sick leave.
- Your benefit payments will be offset by any income you received, or are entitled to receive, from Workers' Compensation, Disability, or Retirement Social Security Benefits, and any Disability, Retirement, or other income benefits provided by or through San José Unified.

Additional Benefits for Certificated Employees Working at Least 20 Hours Per Week

Income Protection Classes

Class 1: An employee with five or more years of service under California STRS or PERS, or who is not a participant in either system.

Class 2: An employee who participates in but has less than five years of service under California STRS or PERS.

Accidental Death & Dismemberment Benefit

If your accidental death occurs while covered under San José Unified's Income Protection Plan, your beneficiary will receive a benefit of $1,000. You will receive a percentage of the principal amount in the event of a qualifying accident which results in the loss of limbs or eyesight.

Survivorship Benefit

- Class 1: If you die while receiving benefits under San José Unified's Income Protection Plan, your spouse/domestic partner will receive a benefit equal to 75% of your contracted salary for up to three months.
- Class 2: If you die while receiving benefits under San José Unified's Income Protection Plan, your spouse/domestic partner will receive a benefit equal to 50% of your contracted salary for up to three months.

Long-Term Disability Coverage for Certificated Employees

- Long-Term Disability coverage for Class 1 Certificated employees is provided through STRS or PERS. Class 2 Certificated employees working at least 20 hours per week are eligible for Long-Term Disability coverage. This coverage provides financial assistance if you are not able to return to work after 360 calendar days or the exhaustion of accumulated sick leave, whichever is greater. Long-Term Disability Insurance is provided through Unum.
- You may replace up to 50% of your basic monthly earnings[1], up to $5,000 per month.
- You may receive a minimum monthly benefit of up to $100 or 10% of your gross monthly benefit, whichever is greater.
- Your benefit payments will be offset by any income you received, or are entitled to receive, from Workers' Compensation, Disability or Retirement Social Security Benefits, and any Disability, Retirement, or other income benefits.
- Your benefit payments may continue up to your Social Security Normal Retirement Age of five years (if after age 65). Mental Nervous disorders are generally limited to 24 months.
- How to Apply – Application and Plan Documents are in HR Box-Send to United Administrative Services (UAS).

[1]Earnings mean your basic monthly salary or rate of pay, as verified by San José Unified's pay records and by paid premiums. Basic monthly earnings do not include overtime, commissions, bonuses, or other additional pay.

Tax Savings Benefits

San José Unified offers employees two IRS Section 125 Flexible Spending Arrangement (FSAs) through American Fidelity Assurance Company—Healthcare and Dependent Care—that allow you to use pre-tax dollars to pay for certain health and dependent care expenses. You can participate in one or both of the accounts. Each year, you decide how much to contribute on a pre-tax basis. The annual amount you elect is deducted from your paycheck in equal amounts each pay period. As you incur eligible expenses during the year, you can request reimbursement with your untaxed money from the appropriate account.

To learn how much you can save by enrolling in one or both of the FSAs, call **800.325.0654** or visit **americanfidelity.com**. The website provides you with expense calculators, worksheets, and answers to frequently asked questions.

Flexible Spending Arrangement for Medical Expenses

The Flexible Spending Arrangement for Medical Expenses allows you to pay for certain healthcare expenses that are not covered or only partially covered by your healthcare plans (medical, dental, vision, and prescription drug). Examples of eligible expenses include, but are not limited to, copays for office visits and prescription drugs, coinsurance, deductibles, and fees for acupuncture, chiropractic care, laser eye surgery, and orthodontia.

Eligible expenses can be incurred by you or any of your eligible dependents. You can contribute up to $3,200 per year to the Flexible Spending Arrangement for Medical Expenses.

If you enroll in the Healthcare Flexible Spending Account through American Fidelity, you may opt to receive a debit card to use for eligible expenses. Simply swipe the debit card and funds are dispersed from your account! Remember to keep your receipts, as you may still need to provide substantiation to American Fidelity to verify the expense is eligible. You may still submit claims manually if you do not wish to use the debit card.

Under the Coronavirus Aid, Relief, and Economic Security (CARES) Act, signed into law on March 27, 2021, the following are now eligible expenses for reimbursement through your Health FSA:

- Over-the-counter (OTC) drugs and medicines without a doctor's prescription
- Menstrual care products

These OTC changes are effective for expenses incurred after December 31, 2020.

Flexible Spending Arrangement for Dependent Care

The Flexible Spending Arrangement for Dependent Care is designed for people who need dependent care so that they can work. You are eligible to participate if you are singled or married. However, if you are married, your spouse must either work, go to school full-time, or be unable to care for your eligible dependents due to a disability in order for you to use the Flexible Spending Arrangement for Dependent Care.

Dependent care can be for your children, spouse, or parents. Dependents must live with you and be claimed as a dependent on your federal income tax return. The most you can contribute per year to the Flexible Spending Arrangement for Dependent Care is $5,000 per IRS household.

Important IRS Rules

1. Plan carefully! Any FSA money that has not been used by September 30, 2024 will be forfeited. This is sometimes known as the "Use it or Lose it" rule.
2. You cannot change or stop your FSA contributions during the year unless you terminate employment or experience a qualifying status change.
3. Money cannot be transferred between accounts. For example, you cannot use your Dependent Care FSA to reimburse yourself for healthcare expenses and vice versa.

Other Benefits

Other Voluntary Benefits

In addition to ACSA, Standard (CTA), AFT Plus, CSEA, AFLAC, and Pacific Educators voluntary benefits, San José Unified also offers employees voluntary benefits underwritten by American Fidelity Assurance Company. You may supplement the coverage provided by San José Unified with Life Insurance, Accident Insurance, Annuities, Cancer Insurance, and/or Hospital Indemnity. Because you pay for these coverages, you own any policies you purchase, and you can take them with you when you retire or if you should leave San José Unified. For more information, contact American Fidelity Assurance Company as shown in the Benefit Contacts on page 19.

TSA Plan (403(b) and 457)

Employees have the option to voluntarily save for retirement in addition to PERS/STRS benefits and tax-defer a portion of their earnings. All contributions are made through payroll deductions. San José Unified does not match employee contributions. Employees can get more information by calling Tax Deferred Solutions at **866.466.1072.** You can also enroll (or make changes) online with a Salary Amendment Form at **tdsgroup.org**.

Commuter Benefits

Commuting to work each day can be expensive. The commuter benefit program will help you save money on your public transportation commuting costs and gives you the convenience of automated electronic fulfillment. My Commuter Check provides vouchers, debit cards, and electronic loading of select SmartCards for a number of transit authorities through an easy online enrollment and benefit management program.

Using the My Commuter Check website at **www.mycommutercheck.com**, employees can create an account and place orders for transit and/ or parking products. Using pre-tax dollars, the employee's transit order is deducted from the employee's pay warrant. Instructions on how to register to use this benefit are on the HR Box Notes page and on the HWBB Benefits website at **https://c2mb.ajg.com/SJUSD/home**. Employees can also contact Human Resources at **benefits@sjusd.org**.

Employee Cost Sharing

San José Unified pays 100% of the cost for some benefits and shares the cost of other benefits with employees. Active employees pay 100% for any other voluntary benefit elections.

Contributions by active employees for medical and dental coverage, and for flexible spending accounts, are deducted from paychecks on a pre-tax basis before federal income taxes, Social Security, and unemployment taxes are withheld.

Similar income tax treatment applies in California when permitted by law. Employees may not waive coverage which is fully paid for by San José Unified.

Double coverage is not permitted for married couples or domestic partners working at San José Unified. An employee can not be covered as an employee and a dependent at the same time, and dependent children can only be covered by one employee.

Employee contributions for all FTE groups (100, 87.5, and 75) are shown below and on the following page.

BENEFIT PLAN	ANNUAL AMOUNT
Medical PPO	
Single Only Rate	$0.00
Two Party Rate	$1,800.00
Family Rate	$3,000.00
Medical HMO	
Single Only Rate	$0.00
Two Party Rate	$1,800.00
Family Rate	$3,000.00
Dental DPPO	
Single Only Rate	$0.00
Two Party Rate	$0.00
Family Rate	$0.00
Dental DHMO	
Single Only Rate	$0.00
Two Party Rate	$0.00
Family Rate	$0.00
Voluntary Vision Plan	
Single Only Rate	$111.96
Two Party Rate	$224.52
Family Rate	$361.20

ANNUAL COST SHARING EMPLOYEE BASIC LIFE – $50,000 POLICY	
Group	Annual Employee Contribution
All FTEs	$0

ANNUAL COST SHARING DEPENDENT LIFE – $2,000 POLICY	
Group	Annual Employee Contribution
All FTEs	$0

In the 2024-2025 plan year, eligible employees will not be able to waive fully paid health insurance coverage. If a newly eligible employee does not elect benefits, they will be enrolled for single Foundation PPO medical coverage and single DPPO dental coverage.

If you have eligible dependents on your medical plan, they must also be enrolled on your dental PPO or dental HMO plan. Confirm your dependents are being covered at **my.sjusd.org**. You can update your dependents if you find any discrepancies.

VOLUNTARY AND LIFE AD&D COVERAGE MONTHLY RATES			
Age Group	Employee (Per $10,000)	Spouse/Domestic Partner (Per $5,000)	Child (Per $2,000)
To age 24	$0.80	$0.40	$0.40
25-29	$0.90	$0.45	Note: The premium paid for child coverage is based on the cost of coverage for one child, regardless of how many children you have.
30-34	$1.10	$0.55	
35-39	$1.20	$0.60	
40-44	$1.70	$0.85	
45-49	$2.40	$1.20	
50-54	$3.50	$1.75	
55-59	$4.60	$2.30	
60-64	$6.90	$3.45	
65-69	$13.00	$6.50	
70-74	$20.90	$10.45	
75+	$20.90	$10.45	

Maintaining Benefits During Summer

All employees enrolled in benefits will be covered for 12 months unless they voluntarily quit or resign. Benefits end on the last day of the month that the employee is in paid status. In order to maintain benefits during the summer months:

- Starting at the beginning of each school year, employees working less than 12 months will have a portion of their pay deferred to cover the cost of health and welfare benefits for the summer months.
- Many employees working 9.5, 10, 10.25 or 11 month cycles do not receive a regular paycheck in July. Therefore, if you have a credit union deduction, it is your responsibility to make any necessary arrangements to send your payments to your credit union. If you have a tax shelter deduction, contributions will continue again in the fall.

Benefit Contacts

If you have questions or require additional information about your San José Unified benefits, contact Human Resources or our benefit partners using the telephone numbers and websites provided below.

BENEFIT	ADMINISTRATOR	PHONE	WEBSITE/EMAIL
Foundation PPO Plan	SJUSD HealthComp Customer Service	408.535.4736	sjusdbenefithelp@healthcomp.com
	HealthComp	800.442.7247	https://healthcomp.com
	Care Advocate	800.755.7247	https://healthcomp.com/healthcare-advocate-team/
	Mommies2Be	800.442.7247 x2415	m2b@healthcomp.com
	Anthem Blue Cross Prudent buyer Network		https://anthem.com/ca
	ElixirRx Prescription Drugs	800.361.4542	https://envisionrx.com
	LiveHealth	888.LiveHealth	https://livehealthonline.com/
Kaiser Permanente HMO Plan	Kaiser Video Visits	800.464.4000	https://healthy.kaiserpermanente.org/northern-california https://mydoctor.kaiserpermanente.org/ncal/videovisit
Dental Plan	Cigna DPPO and DHMO	800.244.6224	https://www.cigna.com
Voluntary Vision Plan	VSP	800.877.7195	https://vsp.com
Flexible Spending Arrangements	American Fidelity Assurance Company	800.325.0654	https://americanfidelity.com
Life and Long-Term Disability Insurance	Unum	800.421.0344	https://www.unum.com
Employee Assistance Program	Health Advocate	800.854.1446	https://www.unum.com/lifebalance
Voluntary Benefits	American Fidelity Assurance Company Life, Accident, and/or Cancer Insurance, Annuities, Hospital Indemnity	800.365.8306	https://americanfidelity.com
	TSA Plan (403(b) and 457)	866.446.1072	https://www.tsacg.com/
	My Commuter Check Commuter Benefits	800.235.9223	https://www.mycommutercheck.com
San José Unified's Human Resources Department	Employee Support Team	A - L: 408.535.6139, ext. 15020 M - Z: 408.535.6139, ext. 15041	benefits@sjusd.org
SJUSD Benefits Website	https://c2mb.ajg.com/SJUSD/home		
SJUSD Box Account	https://sjusd.app.box.com		

Additional Information

Your Payment Responsibility – Non-PPO Providers

The amount the plan pays for covered services provided by non-network providers is based on a maximum allowable amount for the specific service rendered. Although your plan stipulates an out-of-pocket maximum for out-of-network services, please note the maximum allowed amount for an eligible procedure may not be equal to amount charged by your out-of-network provider. Your out-of-network provider may bill you for the difference between the amount charged and the maximum allowed amount. This is called balance billing and the amount billed to you can be substantial. The out-of-pocket maximum outlined in your policy will not include amounts in excess of the allowable charge and other non-covered expenses as defined by your plan. The maximum reimbursable amount for non-network providers can be based on a number of schedules such as a percentage of reasonable and customary or a percentage of Medicare.

Contact your claims payer or insurer for more information. The plan document or carrier's master policy is the controlling document, and this Benefit Highlight does not include all of the terms, coverage, exclusions, limitations, and conditions of the actual plan language.

Notice of Special Enrollment Rights

If you work less than 75% FTE and are not eligible for benefits, you may be able to enroll yourself and your dependents if your FTE increases. You must request enrollment within 31 days of your FTE change. In addition, if you are enrolled and you have a qualifying or life event (new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll your dependent within 31 days of the event.

However, you must request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption. We urge you to notify us as soon as possible, including before the effective date of the event. To request special enrollment or obtain more information, contact the Human Resources Department.

Notice Regarding the Newborns' 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, please visit **www.dol.gov/EBSA**.

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

Our medical plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including all states of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema.

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. Please review the plan option you elected to determine the actual deductible and coinsurance provisions. Contact the Human Resources Department for more information.

HIPAA Special Enrollment Notice

Our records show that you are eligible to participate in the Health Plan.

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

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

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

New Dependent by Marriage, Birth, Adoption, or Placement for Adoption. If you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll your new dependents. However, you must request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

Eligibility for Medicaid or a State Children's Health Insurance Program. If your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan, you may be able to enroll your dependents in this plan. However, you must request enrollment within 60 days after your dependents' determination of eligibility for such assistance. To request special enrollment or to obtain more information about the plan's special enrollment provisions, contact the Human Resources Department.

Summary of Benefits and Coverage

As an employee, the health benefits available to you represent a significant component of your compensation package. They also provide important protection for you and your family in the case of illness or injury. Choosing a health coverage option is an important decision. To help you make an informed choice, your plan makes available a Summary of Benefits and Coverage (SBC), which summarizes important information about any health coverage option in a standard format, to help you compare across plans. The SBCs are available from Human Resources and posted online at **https://c2mb.ajg.com/SJUSD/home**.

Continuation of Coverage Rights

Your group health plan may contain certain options to continue your and or your dependent's health benefits following termination of coverage. These continuation options may include federal COBRA rights, conversion rights, and/or state mandated continuation rights. Commencing January 1, 2014, State and Federal Marketplace exchanges can also provide medical coverage with no health questions plus you may be eligible to qualify for a subsidy to make the coverage affordable to you. Additionally, your group life insurance certificates or booklets may also include and describe certain continuation options that may be available to you. Please examine your options carefully before declining this coverage. You should be aware that companies selling individual health insurance typically require a review of your medical history that could result in a higher premium or you could be denied coverage entirely.

Notice of Availability of Privacy Practices

Our company provides healthcare benefits and related benefits to eligible employees and their eligible dependents. By so doing, it may create, receive, use, and maintain health information about plan participants which is protected by federal law (protected health information or PHI). The Health Insurance Portability and Accountability Act (HIPAA) requires health plan(s) to provide plan participants and others with a notice of the plan's privacy practices with regard to the health information it creates and maintains in the course of providing benefits (Notice of Privacy Practices). This Notice of Privacy Practices describes the ways the plan uses and discloses PHI. To obtain a copy of the plan's Notice of Privacy Practices, you should contact the member services department for your health coverage. Their contact information is located on your ID card the notice is generally available on their respective websites. Additionally, you may contact our Human Resources department.

More Information

More information about your rights can be found in your Summary Plan Description, insurance certificates or booklets, as well as any required notices that are sent to you separately regarding these rights. If you would like more information about any of these notices, please contact the Human Resources Department.

Personal Contact Information

An employee's personal contact information can easily be kept up to date through the Employee Self Service Portal. Home address, phone numbers and emergency contact information can be changed at any time by the employee using **my.sjusd.org**. Once logged in, click on Personal Information, then Contact and update your information. This ensures an employee receives important information from the District as well as the insurance carriers in a timely fashion.

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 January 31, 2024. Contact your state for more information on eligibility.

ALABAMA – Medicaid
http://myalhipp.com 855.692.5447
ALASKA – Medicaid
The AK Health Insurance Premium Payment Program http://myakhipp.com/ | 866.251.4861 CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid
http://myarhipp.com 855.MyARHIPP (855.692.7447)
CALIFORNIA – Medicaid
Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp 916.445.8322 | Fax: 916.440.5676| Email: hipp@dhcs.ca.gov
COLORADO – Medicaid and CHIP
Health First Colorado (Colorado's Medicaid Program) https://www.healthfirstcolorado.com Member Contact Center: 800.221.3943 | State Relay 711 Child Health Plan Plus (CHP+) https://www.colorado.gov/pacific/hcpf/child-health-plan-plus Customer Service: 800.359.1991 | State Relay 711 Health Insurance Buy-In Program (HIBI) https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program HIBI Customer Service: 855.692.6442
FLORIDA – Medicaid
www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html 877.357.3268
GEORGIA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp 678.564.1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra 678.564.1162, Press 2

INDIANA – Medicaid
Healthy Indiana Plan for low-income adults 19-64 http://www.in.gov/fssa/hip/ | 877.438.4479 All other Medicaid https://www.in.gov/medicaid/ | 800.457.4584
IOWA – Medicaid and CHIP (Hawki)
Medicaid: https://dhs.iowa.gov/ime/members | 800.338.8366 Hawki: http://dhs.iowa.gov/Hawki | 800.257.8563 HIPP: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp | 888.346.9562
KANSAS – Medicaid
https://www.kancare.ks.gov/ 800.792.4884 | HIPP Phone: 800.967.4660
KENTUCKY – Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP): https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx 855.459.6328 | KIHIPP.PROGRAM@ky.gov KCHIP: https://kynect.ky.gov | 877.524.4718 Medicaid: https://chfs.ky.gov/agencies/dms
LOUISIANA – Medicaid
www.medicaid.la.gov or www.ldh.la.gov/lahipp 888.342.6207 (Medicaid hotline) or 855.618.5488 (LaHIPP)
MAINE – Medicaid
Enrollment: https://www.mymaineconnection.gov/benefits/s/?language=en_US 800.442.6003 | TTY: Maine relay 711 Private Health Insurance Premium: https://www.maine.gov/dhhs/ofi/applications-forms 800.977.6740 | TTY: Maine relay 711
MASSACHUSETTS – Medicaid and CHIP
https://www.mass.gov/masshealth/pa 800.862.4840 | TTY: 711| Email: masspremassistance@accenture.com

MINNESOTA – Medicaid
https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp 800.657.3739
MISSOURI – Medicaid
http://www.dss.mo.gov/mhd/participants/pages/hipp.htm 573.751.2005
MONTANA – Medicaid
http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP 800.694.3084 | Email: HHSHIPPProgram@mt.gov
NEBRASKA – Medicaid
http://www.ACCESSNebraska.ne.gov Phone: 855.632.7633 | Lincoln: 402.473.7000 | Omaha: 402.595.1178
NEVADA – Medicaid
http://dhcfp.nv.gov 800.992.0900
NEW HAMPSHIRE – Medicaid
https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program 603.271.5218 | Toll free number for the HIPP program: 800.852.3345, ext. 5218
NEW JERSEY – Medicaid and CHIP
Medicaid: http://www.state.nj.us/humanservices/dmahs/clients/medicaid 609.631.2392 CHIP: http://www.njfamilycare.org/index.html 800.701.0710
NEW YORK – Medicaid
https://www.health.ny.gov/health_care/medicaid/ 800.541.2831
NORTH CAROLINA – Medicaid
https://dma.ncdhhs.gov 919.855.4100
NORTH DAKOTA – Medicaid
https://www.hhs.nd.gov/healthcare 844.854.4825
OKLAHOMA – Medicaid and CHIP
http://www.insureoklahoma.org 888.365.3742
OREGON – Medicaid and CHIP
http://healthcare.oregon.gov/Pages/index.aspx 800.699.9075

PENNSYLVANIA – Medicaid and CHIP
https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx 800.692.7462 CHIP Website: https://www.dhs.pa.gov/CHIP/Pages/CHIP.aspx CHIP Phone: 800.986.KIDS (5437)
RHODE ISLAND – Medicaid and CHIP
http://www.eohhs.ri.gov 855.697.4347 or 401.462.0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid
http://www.scdhhs.gov 888.549.0820
SOUTH DAKOTA – Medicaid
http://dss.sd.gov 888.828.0059
TEXAS – Medicaid
http://gethipptexas.com 800.440.0493
UTAH – Medicaid and CHIP
Medicaid: https://medicaid.utah.gov CHIP: http://health.utah.gov/chip 877.543.7669
VERMONT – Medicaid
Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access 800.250.8427
VIRGINIA – Medicaid and CHIP
https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid and Chip: 800.432.5924
WASHINGTON – Medicaid
https://www.hca.wa.gov/ 800.562.3022
WEST VIRGINIA – Medicaid
https://dhhr.wv.gov/bms/ or http://mywvhipp.com/ Medicaid: 304.558.1700 CHIP Toll-free: 855.MyWVHIPP (855.699.8447)
WISCONSIN – Medicaid and CHIP
https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm 800.362.3002
WYOMING – Medicaid
https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ 800.251.1269

To see if any other states have added a premium assistance program since January 31, 2024, 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. 61565

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

Paperwork Reduction Act Statement

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

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

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

Notes

Notes

This benefit summary prepared by

Gallagher

Insurance | Risk Management | Consulting

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