Employee Benefits Guide





JEFFERSON UNION HIGH SCHOOL DISTRICT
EDUCATING OUR YOUTH AND ADULTS
ESTABLISHED 1922

contents

If you (and/or your dependents) have Medicare or you will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please see page 24 for more details.

This document summarizes the benefits program. Full details of the benefit plans are contained in the official documents, which will govern in the case of any discrepancies.

our commitment

Our greatest asset and the key to our success, is our employees. You make the difference for the people we care for and the community we serve. Jefferson Union High School District is pleased to provide health and compensation benefits for your peace of mind, financial stability and good health.

introduction

What's Inside

Health insurance is one of the most critical benefits offered by the District. A major illness or injury could be financially devastating without adequate insurance. Even the cost of treatment of minor conditions can be prohibitive. With this in mind, your program has been designed to include comprehensive medical benefits with broad-based provider networks to best meet your needs.

Depending on where you live, your personal preference regarding physician choice and type of health care environment you prefer, you may choose the plan that is most suitable for you and your family members.

The benefit choices you make when you and your dependent(s) enroll will remain in place unless you experience a change in family status (e.g., marriage, divorce or legal separation, birth, adoption, death or spousal change). If you need to change your coverage before the next enrollment period due to one of these occurrences, you need to contact the Payroll Department within 31 days of your family status change. Please note that there is an annual open enrollment period for some, but not all of your benefits.

eligibility

All full-time employees working no less than the minimum number of hours per week are eligible to enroll in the benefits program the first day of the month following your date of hire.

- Full-time Employees mean any person who is regularly scheduled to work for the Policyholder for at least 30 hours a week for Certificated Day School Members, 24 hours a week for Certificated Adult School Members, 20 hours a week for Classified Members, 37.5 hours a week for Management and Confidential Members and 15 hours a week averaged annually for Certificated Staff Members participating in the Reduced Workload Program. Teachers on a board approved sabbatical are also considered full-time employees.
- Those working less than full-time may have the option to buy-in to medical insurance pro-rata.

You may also enroll your eligible dependents in the medical and dental program, including:

- Your legal spouse
- Your registered domestic partner
- Your unmarried children to age 26
- Natural, adopted and stepchildren
- Any other children you support for whom you are the court-appointed guardian or for whom you are required to provide coverage as the result of a qualified medical child support order.
- A child who is a qualified IRS dependent (e.g., due to a mental or physical handicap that occurred prior to reaching age limit for dependents).

It is your responsibility to inform both the carrier and the Payroll Department if your dependent is no longer eligible for coverage. They can then be offered COBRA coverage.

Termination of Coverage

Your coverage ends on the last day of the month following your last day of employment. If your active full-time service ends for any reason, other than for disability, you may continue benefits during a family leave of absence and for a limited period of time after termination under your Federal and State COBRA rights.

When You Can Make Changes

I. New Hire Orientation

You have 31 days from becoming eligible for the benefits to elect or waive coverage.

II. Open Enrollment

You can make changes during Open Enrollment which occurs April 28 to May 23 for a July 1 effective date. If you wish to make a change, please obtain and complete the appropriate forms and submit them to the Payroll Department by May 23.

III. Family Status Change Event

Other than the above, you cannot make changes unless you have an IRS-approved "change of family status", such as:

- The addition of a dependent through birth, adoption, marriage or a registered domestic partner
- The loss of a dependent through divorce or death, or if your child reaches the maximum limit for coverage (age 26)
- A change in your or your spouse/registered domestic partner's employment status from full-time to part-time, or vice versa
- A substantial change in your benefits coverage or a spouse/registered domestic partner's coverage

eligibility (continued)

You must adjust your benefits election within 31 days of the qualified family status change event. It is your responsibility to contact the Payroll Department as soon as you are aware of this event. Keep in mind, the decisions you make will affect your benefits for the remainder of the benefits plan year.

Opting Out Provision

It is important to note that if you Opt Out of health and welfare coverage, you may not be able to enroll in the Jefferson Union High School District's medical plans unless you have a designated family status change event or during open enrollment.

Dental Coverage Addendum

If the employee declines enrollment at the time of eligibility, they are not eligible to enroll any time for the rest of their employment with the district.

If a dependent was dropped and wishes to be added back onto the employee's coverage that there is a three year waiting period.

Dependent is eligible and must enroll within 30 days of a qualifying event.

medical

Benefits at a Glance	Kaiser HMO (High Plan) You Pay	Anthem Blue Cross EPO You Pay
Annual Deductible	None	None
Office Visit / Exam	$20 copay	$30 copay
Maximum Copay Liability		
• Individual	$1,500	$2,000
• Two Party	$3,000	$4,000
• Family	$3,000	$4,000
Lifetime Plan Maximum	Unlimited	Unlimited
Preventive Services		
• Well-Child Care and Immunizations	No charge	No charge
• Adult Periodic Exams	No charge	No charge
Physician Services		
• Office Visit	$20 copay	$30 copay
• Diagnostic X-Ray and Lab Tests	No charge	No charge
• Pregnancy & Maternity Care	No charge	$30 copay
• Well-Baby Care *(Outpatient)*	No charge	No charge
• External Prosthetic and Orthotic Devices	20%	20% coinsurance
• Durable Medical Equipment	20% (Kaiser Formulary)	20% coinsurance
Inpatient Hospital Services		
• Pre-Authorization of Services Required	Yes	Yes
• Semi-Private Room & Board	No charge	$200 copay
Emergency Services		
• Emergency Room *(waived if admitted)*	$50 copay	$100 copay
• Urgent Care Center	$20 copay	$30 copay
• Ambulance	$50 per trip	$100
Mental or Nervous Disorders and Substance Abuse *(Proviso: AB 88 Mental Health Parity requires plans to cover specifics severe mental health diagnoses as any other medical condition. See booklet for details.)*		Provided by MHN
• Inpatient Hospitalization	No charge Substance Abuse inpatient care limited to Detoxification only	No charge; 30-day/cal year max
• Outpatient Care - Individual Therapy	$20 copay; 20 visit/cal year max	$15 copay; 20 visit/cal year max

This chart is a summary only. Plan document prevails.

medical (continued)

Benefits at a Glance	Kaiser HMO (High Plan) You Pay	Anthem Blue Cross EPO You Pay
Prescription Drugs		
• Generic	$10 copay	$7 copay
• Brand	$10 copay	$20 copay
• Non-Formulary	$10 copay	$35 copay
• Number of Days Supply	100-day supply or 3 cycles for oral contraceptives	30 days
• Mail-Order Prescription Drugs	$10 copay for 100 days	$0 / $40 / $70 for 90 days
Other Services		
• Home Health Care	No charge; 100 visits/cal year	$30 copay (100 days/year; on 31st day)
• Vision	$20 exam; $175 allowance towards purchase of eyewear at Kaiser optical center	$15 exam; $130 allowance towards frames / lenses $130 towards contact lenses (Blue Vision)
– Frequency	Exam every 12 months Eyewear every 24 months	Exam every 12 months Eyewear every 24 months
• Chiropractic Services	Not covered	$10 copay (in CHP Network only)
• Skilled Nursing Facility	No charge 100 days/benefit period max	No charge; 365 days/lifetime
• Hospice Care	No charge	No charge
• Physical, Occupational and Speech Therapy	$20 copay	No charge
• Highlights	Health education classes available at minimal cost relating to exercise and fitness, nutrition, cholesterol and weight reduction, smoking cessation and stress management. Call the Healthphone system at 800.33.ASK ME for information on more than 200 health topics. Care management programs mitigate risk and improve outcomes for members who are pregnant, asthmatic, diabetic or suffer from a chronic medical condition.	Take advantage of the plans' preventive care benefits, as well as MCSIG's wellness programs and resources. To learn more visit www.mcsig.com and click on the wellness button. The MCSIG Health Promotion Coordinator is Neil Hertsch and can be reached at 831.755.0161 or nhertsch@monterey.k12.ca.us.

Reimbursement of District Cost of Medical Plan

If an employee has medical coverage provided and paid for by the employer of a spouse or registered domestics partner equivalent to that offered by the district and provides evidence of such a plan, the employee may elect to withdraw from the district health plan, and receive at the end of the school year, one annual stipend of $2,500 minus the mandatory employer contribution to STRS pursuant to AB 2700 if applicable (Confidential and Administrative employees receive $2,200).

This chart is a summary only. Plan document prevails.

medical (continued)

Benefits at a Glance	Kaiser HMO (Low High Plan) You Pay
Annual Out-of-Pocket Maximum	
• Individual	$6,000
• Two Party	$6,000
• Family	$12,000
Annual Deductible	
• Individual	$3,000
• Two Party	$3,000
• Family	$6,000
Lifetime Maximum	None
Professional Services	
• Primary and Specialty Care Consultations/Exams	$40/visit (deductible N/A)
• Routine Physical Maintenance Exams	No charge (deductible N/A)
• Well-Child Preventive Exams *(through 23 months)*	No charge (deductible N/A)
• Family Planning Counseling	No charge (deductible N/A)
• Prenatal Care Exams and First Post-Partum Follow-Up Consultation and Exam	No charge (deductible N/A)
• Eye Exams for Refraction	No charge (deductible N/A)
• Hearing Exams	No charge (deductible N/A)
• Urgent Care Consultations and Exams	$40/visit (deductible N/A)
• Physical, Occupational and Speech Therapy	$40/visit (deductible N/A)
Outpatient Services	
• Outpatient Surgery and Certain Other Outpatient Procedures	30% coinsurance after deductible
• Allergy Injections *(including Allergy Serum)*	No charge (deductible N/A)
• Most Immunizations *(including Vaccines)*	No charge (deductible N/A)
• Most X-Rays and Lab Tests	$10/encounter (deductible N/A)
• Preventive X-Rays, Screenings, and Lab Tests as described in the EOC	No charge (deductible N/A)
• MRI, most CT, and PET Scans	$50/procedure (deductible N/A)
• Health Education	
– Covered Individual Health Education Counseling and Programs	No charge (deductible N/A)
– Covered Group Educational Programs	No charge (deductible N/A)

This chart is a summary only. Plan document prevails.

medical (continued)

Benefits at a Glance	Kaiser HMO (Low High Plan) You Pay
Hospitalization Services (*Room and Board, Surgery, Anesthesia, X-Rays,* Lab Tests, and Drugs)	30% coinsurance after deductible
Emergency Health Coverage *(Emergency Department Visits)*	30% coinsurance after deductible
Ambulance Services	$150/trip (deductible N/A)
Prescription Drugs	
• Generic Items from a Plan Pharmacy	$10/30-day supply $20/31- 60-day supply $30/61- 100-day supply
• Generic Refills from Mail-Order Service	$10/30-day supply $20/31- 100-day supply (deductible N/A)
• Brand-Name Items from a Plan Pharmacy	$30/30-day supply $60/31- 60-day supply $90/61- 100-day supply (deductible N/A)
• Brand-Name Refills from Mail-Order Service	$30/30-day supply $60/31- 100-day supply (deductible N/A)
Durable Medical Equipment *(Most Covered Durable Medical Equipment for Home Use in Accordance with our Durable Medical Equipment Formulary Guidelines)*	20% coinsurance (deductible N/A)
Mental Health Services	
• Inpatient Psychiatric Hospitalization and Intensive Psychiatric Treatment Programs	30% coinsurance after deductible
• Outpatient Mental Health Evaluation and Treatment	$40/individual visit (deductible N/A) $20/group visit (deductible N/A)
Chemical Dependency Services	
• Inpatient Detoxification	30% coinsurance after deductible
• Individual Outpatient Chemical Dependency Consultations and Treatment	$40/visit (deductible N/A)
• Group Outpatient Chemical Dependency Treatment	$5/visit (deductible N/A)
Home Health Services *(Home Health Care; up to 100 visits/cal year)*	No charge
Other	
• Skilled Nursing Facility Care *(up to 100 days/benefit period)*	30% coinsurance (deductible N/A)
• All Covered Services Related to Infertility Treatment	50% coinsurance (deductible N/A)
• Hospice Care	No charge (deductible N/A)

This chart is a summary only. Plan document prevails.

dental

Cost per Month – Full Time Employees

The District currently pays 100% of the monthly insurance premium for you and your family.

Delta Dental	Premier Network	Non-Premier Network
• Annual Deductible *(Individual / Family)*	None	
• Annual Plan Maximum	$1,700	$1,500
• Maximum Accident Benefit/Cal Year	$1,000	
• Reasonable & Customary	Member is responsible for charges above Usual, Customary & Reasonable (UCR)	
• Waiting Period	None	
• Progressive Service Benefit	** Delta pays 70% of the Covered Fees during the first cal year you are eligible. This percentage increases 10% each year, to a max of 100%, PROVIDED you visit a dentist at least once a cal year. If you do not use the program during a cal year, the percentage remains at the level you reached the previous year.	
Diagnostic and Preventive Services		
• Oral Exams	70% - 100% **	70% - 100% of UCR
• Bitewing and Full Mouth X-Rays	70% - 100% **	70% - 100% of UCR
• Cleaning and Scaling *(three/cal year)*	70% - 100% **	70% - 100% of UCR
• Fluoride Treatments	70% - 100% **	70% - 100% of UCR
• Space Maintainers	70% - 100% **	70% - 100% of UCR
• Emergency Treatment	70% - 100% **	70% - 100% of UCR
Basic Services		
• Oral Surgery: Extractions and Certain Other Surgical Procedures	70% - 100% **	70% - 100% of UCR
• Restorative: Amalgam, Synthetic Porcelain and Plastic Restorations *(Fillings)*	70% - 100% **	70% - 100% of UCR
• Endodontic and Periodontic Treatment	70% - 100% **	70% - 100% of UCR
• General Services: General Anesthesia, Office Visit, Post Surgical Complications	70% - 100% **	70% - 100% of UCR
Major Services		
• Crowns, Jackets, and Cast Restoration Inlays, Onlays*	70% - 100% **	70% - 100% of UCR
Prosthodontic Benefits		
• Construction or repair of fixed bridges	50%	50% of UCR
• Partial and Complete Dentures	50%	50% of UCR
Dental Accidents *(Services required for conditions caused by external, violent and accidental means)*	100%	100% of UCR

Note: Orthodontia Services are not covered.

Footnote: The annual plan maximum is $1,500. However, if you or a covered family member incur dental charges which exceed $1,500, the District will reimburse you to a combined maximum of $2,500 ($1,500 through the dental plan and $1,000 through the District). You will need to submit those claims which exceed $1,500 directly to the District for payment. Please note that expenses which would not have been covered by the dental plan will not be eligible for reimbursement from the District (such as cosmetic dentistry procedures).

This chart is a summary only. Plan document prevails.

life and ad&d

Overview

Basic Life insurance would help your family or beneficiary cover costs in your absence. AD&D insurance provides additional protection for your beneficiaries in the event of your accidental death or loss of limb or eyesight.

Cost per Month - Full Time Employees

The District currently pays 100% of your monthly insurance premium.

	Principal Financial Group
Benefits at a Glance	
• Eligible Member	All full-time employees
• Benefit Amount	$50,000
• Guarantee Issue	$50,000
General Plan Information	
• Accelerated Death Benefit	75% of benefit
• Waiver of Premium	If you become totally disabled while active and insured before your 60th birthday, premium is waived
• Conversion	Yes

This chart is a summary only. Plan document prevails.

long term disability

Overview

Long Term Disability benefits are paid to employees who become injured or suffer an illness and cannot perform the duties of their job. Long Term Disability benefits are considered taxable income by the IRS and will be offset by income from other sources including , but not limited to, income from other sources and wages earned upon a partial return to work.

Cost per Month – Full Time Employees

The District currently pays 100% of your monthly insurance premium.

	Principal Financial Group
Benefits at a Glance	
• Maximum Benefit *(Payable)*	$10,000 monthly
• Elimination Period	3 months *
• Benefit Percentage	66 2/3%
• Benefit Duration	To SSNRA (Age 67 - Social Security Normal Retirement Age)
• Integration	Other Sources
Definition of Disability	Inability to perform the majority of the material duties of your normal occupation for the first two years after becoming disabled. After the two-year period, inability to perform the majority of the material duties of any occupation for which you are or may reasonably become qualified based on education, training or experience.
• Income Loss Required	20%
• Survivor Benefit	3 months
• Mental Disorders and Substance Abuse	24 months
• Pre-Existing Condition Limitation	3/12
• Return to Work Incentive	Included

* Benefits begin after 90 days or sick leave and vacation days are exhausted, whichever is longer.

This chart is a summary only. Plan document prevails.

flexible spending accounts

Flexible Spending Accounts are a great way for you to save money on your out-of-pocket health and dependent care expenses. When you sign up for the Flexible Spending Accounts, your contributions are taken from your paycheck before taxes are calculated. This makes budgeting easier, and saves you money. There are two ways that you can save.

Health Care Spending Account

Allows you to set aside a maximum of $2,500 per Annual Plan Year to help pay for expected out-of-pocket medical, dental, vision, prescription drug and other expenses related to you and your dependent's health care such as:

- Plan deductible
- Copays
- Orthodontia expenses
- Vision care expenses (exams, glasses, contact lenses)
- Prescription drug co-payments

A complete list of acceptable expenses is available in IRS Publication 502 (www.irs.gov).

Dependent Daycare Spending Account

Allows you to use before-tax dollars to pay for dependent child or elderly care. It is a great way to reduce the bite that this expense takes out of your family's income. If you are single or married and filing jointly, you can set aside a maximum of $5,000 for one or more dependents. If you are married filing separately, you can set aside up to $2,500 per year.

If you use a Dependent Care Reimbursement Account, the IRS will not allow you to take a dependent care credit on your tax return for reimbursed expenses. For some people, the tax credit may be greater than the savings from a Dependent Care Reimbursement Account. If you are married, but file a separate tax return, your annual maximum contribution is $2,500. In addition, if you or your spouse earns less than $5,000 per year, the maximum contribution is equal to that person's earned income. If you are married and file a joint tax return, the maximum combined amount that you and your spouse can contribute to a Dependent Care Reimbursement Account is $5,000. If you are in doubt about which is best for you, consult a professional tax advisor.

Eligibility

Any employee shall be eligible to participate as of his date of employment (or the effective date of the Plan, if later) and

- Certificated Day School unit member working at least 15 hours per week
- Certificated Adult School unit member working at least 12 hours per week
- Management, Confidential, Cafeteria, BISS, and OSS unit employees working at least 18.75 hours per week

flexible spending accounts (continued)

Before Enrolling, Points To Consider

Before you enroll in your Flexible Spending Accounts (FSA), there are some things you should know about the plans. There are specific rules and regulations surrounding FSAs that affect the way they operate. Keep these in mind as you do your budgeting.

- The regulations require that you decide at the beginning of the plan year how much you want to set aside for your contributions to your health and dependent daycare spending accounts.
- Once you have made your election for the year, you can change it only if you have a change in family status. For example, marriage, divorce or legal separation, birth, adoption or change in custody status of a child, death of a dependent, or a spouse losing a job or starting a new one.
- You should budget carefully. The IRS mandates that any money left in your account at the end of the plan year cannot be refunded. You will have a 90-day grace period after the end of the plan year to get reimbursed for any expenses you incurred during the plan year.

You must re-enroll in the FSA plans each year that you wish to participate.

How The Plan Works

1. You sign up for the plan during Open Enrollment to make your annual election.
2. You incur your health expense (or dependent daycare expense).
3. Submit a claim form with receipts by the March 31 filing deadline for services incurred during calendar year. Review your account activity online through Payflex, www.mypayflex.com.

A Tax-Saving Way to Pay Your Contribution

Every April, you will be given an opportunity to enroll (effective July 1st) in the FSAs. These accounts enable employees to use pre-tax earnings to pay for out-of-pocket medical expenses or daycare for dependent children and disabled adults (i.e., spouse and parent) who require care when the employee works. If you are contributing to the cost of your coverage, your payroll deductions can be made on a pretax basis. This means that your contributions come out of your pay before federal, state, and Social Security taxes. The result is lower taxable income, which means you pay less tax.

Important

Be sure to save your receipts!

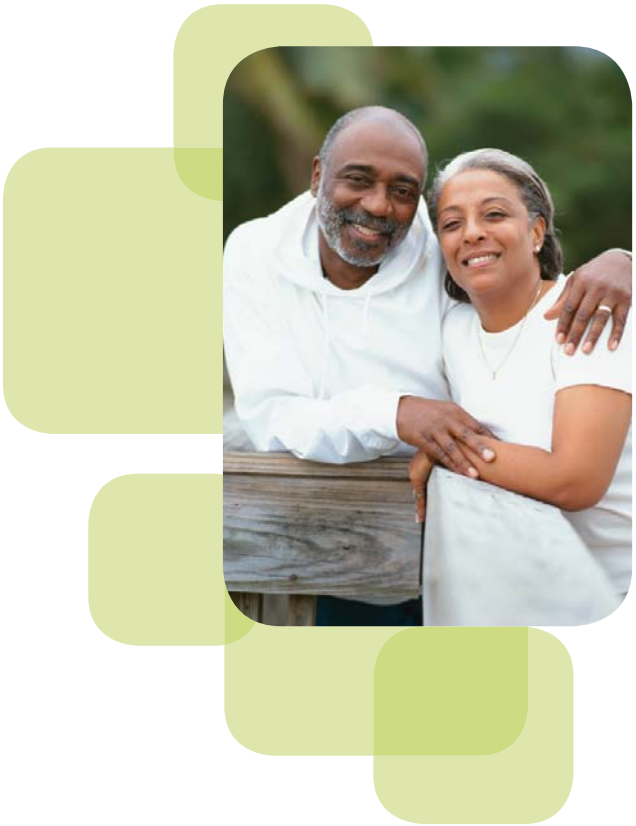
retirement plans

403(b) and 457(b) Retirement Plans

As an employee of a public school system, you are eligible to participate in a 403(b) and/or 457(b) retirement plan. Participation in these plans is voluntary and may be done at the employee's discretion. Please review this letter to understand the retirement plan savings options available to you.

403(b) Tax Sheltered Annuities

A tax-sheltered plan permits you to defer taxes voluntarily through salary reduction contributions. Though commonly referred to as Tax Sheltered Annuities (TSAs), investment options for public education employees include fixed and variable annuities as well as custodial mutual fund accounts. You may not make direct contributions to individual stocks or bonds. Please find the complete list of available 403(b) vendors at the CalSTRS Web site, www.403bcompare.com. Information packets and forms are available from Payroll Department or on the District web site at www.juhsd.net.



457(b) Deferred Compensation

A tax-sheltered plan permits you to defer taxes voluntarily through salary reduction contributions. Employer contributions (non-salary reduction contributions) are also permitted in this plan. This option is commonly referred to simply as a "457 plan". The available investment options in this plan differ from those offered under a 403(b) and are provided by:

- Hartford Life Insurance Company (Hartford Life) Ben Yohanan
  Investment and Enrollment Representative
  650.573.9960

- CalPERS 457 Deferred Compensation Program
  Henry Tran
  Account Manager
  916.795.9167
  henry_tran@calpers.ca.gov

- The TDS Group
  Tax Deferred Services/CSBA
  866.446.1072
  E-mail: planadministrator@tds.org
  Web site: www.tdsgroup.org

general retirement information

As you near retirement age, it is a good idea to review your current financial status and plan for your retirement. If you are age 50 or older or within a few years of your projected retirement, you may want to contact the appropriate agencies to verify your retiree benefits, ask questions and ensure all paperwork has been processed.

PERS and STRS

For Web site address, please see Contact Information in the back of this Guide.

Social Security

Social Security currently pays a normal retirement benefit at age 65, or a reduced retirement benefit at age 62. Full benefits begin slightly later for younger workers. Social Security sends statements out annually to let you know the "balance" in your account. For more information please refer to the Contact Information in the back of this Guide.

Section 419(c) of Public law 108-203, the Social Security Protection Act of 2004, requires State and local government employers, including school districts, to provide a statement to employees hired January 1, 2006 or later in a job not covered under Social Security. The statement explains how a pension from that job could affect future Social Security benefits to which they may become entitled.

Form SSA-1945, Statement Concerning Your Employment in a Job Not Covered by Social Security, is the document that the District will use to meet the requirements of the law. The SSA-1945 explains the potential effects of two provisions in the Social Security law for workers who also receive a pension based on their work in a job not covered by Social Security. The Windfall Elimination Provision can affect the amount of a worker's Social Security retirement or disability benefit.

The Government Pension Offset Provision can affect any possible Social Security benefit entitlement as a spouse or an ex-spouse. Districts must comply with the following requirements:

- Give the statement to the employee prior to the start of employment;
- Get the employee's signature and social security number in the employee ID section of the form;
- Ensure the employee has been established at CalSTRS as a Defined Benefit (DB) member or Cash Balance (CB) participant;
- Keep a copy of the signed form in the employee's personnel file;
- Submit a copy of the signed form to CalSTRS;
- Do not send if the employee has not been established as a member or participant of a CALSTRS retirement program.

California State Teachers' Retirement System
Member Account Service MS 81
P.O. Box 15275
Sacramento, CA 95851-0275

If the employee's service is going to be covered by an alternative retirement system, the District will send a copy of the form signed by the employee to the plan administrator of the alternative retirement system.

Human Resources and the Payroll Department are located at the District Office at:

699 Serramonte Boulevard, Suite 100
Daly City, CA 94015

glossary of terms

AD&D – Accidental Death & Dismemberment

Coverage that pays benefits in the event an individual dies or is dismembered as a result of an accident.

COB – Coordination of Benefits

Process whereby insurance carrier must determine claim liability when an individual has coverage under more than one plan.

COBRA – Consolidated Omnibus Budget Reconciliation Act

Legislation enacted in 1986 designed to extend coverage to terminated employees and their families, as well as for dependents losing coverage due to death of employee, divorce, etc.

Copay

A fixed amount that the member or covered insured must pay out-of-pocket.

Deductible

The annual amount of medical expense that must be incurred before benefits are payable

Formulary

A panel of preferred drugs chosen by a Managed Care Organization to treat patients. Drugs outside the formulary are rarely used unless medically necessary.

HMO – Health Maintenance Organization

Network of physicians/ hospitals that provide services on a prepaid basis. Patient usually pays a small co-payment for office visits and nothing for hospitalization. All services, treatment and referrals must be coordinated through the Primary Care Physician or there are no benefits.

Member

Any individual or dependent who is enrolled in, and covered by, a managed health care plan.

Open Enrollment

The annual period during which employees are allowed to enroll and/or transfer between employer-sponsored plans.

SNF – Skilled Nursing Facility

A facility that provides inpatient services for persons requiring skilled nursing care.

SPD – Summary Plan Description

Booklet or certificate that explains benefits and employee rights.

UCR – Usual, Customary and Reasonable

The level whereby a claim charge is based upon historical fee patterns deemed to be in line with normal charges for the same procedure performed in the same area.

federal earned income tax credit

Effective January 1, 2008, all employers are required to notify all of their employees of the Federal Earned Income Tax Credit (EITC).

Assembly Bill 650, Stats. 2007, Ch. 606 (Lieu and Jones), requires any employer, who is subject to, and is required to provide unemployment insurance to employees, to notify all employees that they may be eligible for the EITC. Employers shall give notification within one week before or after, or at the same time, they provide employees with an annual wage summary (IRS Form W-2, 1099). This new law also requires the employer to process the IRS Form W-5 for advance payments of the EITC, if requested by the employee.

Notice to Employees

Based on your annual earnings, you may be eligible to receive the earned income tax credit from the federal government. The earned income tax credit is a refundable federal income tax credit for low-income working individuals and families. The earned income tax credit has no effect on certain welfare benefits. In most cases, earned income tax credit payments will not be used to determine eligibility for Medicaid, supplemental security income, food stamps, low-income housing or most temporary assistance for needy families payments. Even if you do not owe federal taxes, you must file a tax return to receive the earned income tax credit. Be sure to fill out the earned income tax credit form in the federal income tax return booklet. For information regarding your eligibility to receive the earned income tax credit, including information on how to obtain the IRS Notice 797 or Form W-5, or any other necessary forms and instructions, contact the Internal Revenue Service at 800.829.3676 or through its Web site at www.irs.gov.

For additional information, the following IRS links are provided for your convenience:

- Employers
  www.irs.gov/individuals/article/0,,id=129062,00.html
- Employees
  www.irs.gov/individuals/article/0,,id=150557,00.html
- Tax Professionals
  www.irs.gov/individuals/article/0,,id=150528,00.html
- IRS Notice 797
  www.irs.gov/pub/irs-pdf/n797.pdf
- IRS Notice 1015
  www.irs.gov/pub/irs-pdf/n1015.pdf
- Form W-5
  www.irs.gov/pub/irs-pdf/fw5.pdf
- Internal Revenue Service
  www.irs.gov

important notices

Change in Annual Limits

Although overall lifetime limits have been eliminated, there may be an overall annual dollar limit added. Please be sure to check your summary of benefits. Limits on the number of visits with respect to some conditions and financial restrictions will remain largely unchanged.

Pre-Existing Condition Exclusions for Children

A plan cannot deny coverage or eligibility for benefits for a condition that a child had prior to enrolling in the plan. In this case, the child must be under the age of 26 and the benefits must have been otherwise available under the plan.

Termination of Coverage for Fraud and Misrepresentation

Health Care Reform permits us to terminate your coverage, retroactively, in cases of fraud or intentional misrepresentation. Please make sure that the individuals you are enrolling in our plans are eligible for coverage and be prepared to show proof of that eligibility.

Over-the-Counter Drugs and Health Reimbursement Accounts

Effective January 1, 2011, over-the-counter drugs will not be reimbursable expenses unless purchased under a doctor's prescription or is for insulin. Purchases of over-the-counter drugs made on or before December 31, 2010 will be reimbursable even if the expense is submitted after that date but no later than March 31, 2011. Any over-the-counter drug purchased on or after January 1, 2011 without a physician's prescription will be rejected.

Newborns and Mothers Health Protection Act (NMHPA)

A health plan which provides benefits for pregnancy delivery generally may not restrict benefits for a covered pregnancy Hospital stay (for delivery) for a mother and her newborn to less than 48 hours following a vaginal delivery or 96 hours following a Cesarean section. Also, any utilization review requirements for Inpatient Hospital admissions will not apply for this minimum length of stay and early discharge is only permitted if the attending health care provider, in consultation with the mother, decides an earlier discharge is appropriate.

Women's Health and Cancer Rights Act (WHCRA)

The health benefits of most plans must include coverage for the following post-mastectomy services and supplies when provided in a manner determined in consultation between the attending Physician and the patient:

1. Reconstruction of the breast on which a mastectomy has been performed;
2. Surgery and reconstruction of the other breast to produce symmetrical appearance;
3. Breast prostheses; and
4. Physical complications of all stages of mastectomy, including lymphedemas.

COBRA Continuation Coverage

In order to comply with the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), the Plan includes a continuation of coverage option, which is available to certain Covered Persons whose health care coverage(s) under the Plan would otherwise terminate. This provision is intended to comply with that law, and if it is found to be incomplete or in conflict in any way with the law or changes to the law, the law will prevail.

Life insurance, accidental death and dismemberment benefits and weekly income or long-term disability benefits (if part of the Employer's Plan) are not eligible for continuation under COBRA.

QUALIFIED BENEFICIARY

Any individual who meets one of the following requirements:

1. An individual who, on the day before a Qualifying Event, is covered under the Plan as either a Covered Employee, or the Covered Dependent spouse or child of a Covered Employee.
2. Any child who is born to or placed for adoption with a Covered Employee during a period of COBRA continuation coverage. Such child has the right to immediately elect under COBRA the same coverages that the Covered Employee has at the time of the child's birth or placement for adoption, or the same coverage that a Dependent child of any Employee in Active Service would receive. The Employee's Qualifying Event date and continuation coverage period also apply to the child.

3. If an individual is not covered under the Plan on the day before a Qualifying Event because he was denied Plan coverage or was not offered Plan coverage and such denial or failure to offer constitutes a violation of applicable law, the individual will be considered to have had the Plan coverage and will be a "Qualified Beneficiary" if that individual experiences a Qualifying Event.

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a Qualifying Event. After a Qualifying Event, COBRA continuation coverage must be offered to all Qualified Beneficiaries. Under the Plan, Qualified Beneficiaries who elect COBRA continuation coverage must pay for the cost for COBRA continuation coverage as outlined in the section COST OF CONTINUATION COVERAGE, located in this section.

Exception: An individual is not a Qualified Beneficiary if the individual's status as a Covered Employee is attributable to a period in which he was a nonresident alien who received no earned income from the Employer that constituted income from sources within the United States. If such an Employee is not a Qualified Beneficiary, then a spouse or Dependent child of the Employee is not a Qualified Beneficiary by virtue of the relationship to the Employee.

QUALIFYING EVENT

Any of the following events, which would result in the loss of health coverage under the Plan in the absence of COBRA continuation coverage:

1. Voluntary or involuntary termination of Employee's employment for any reason other than Employee's gross misconduct;

2. Reduction in an Employee's hours of employment to non-eligible status. In this regard, a Qualifying Event occurs whether or not the Employee actually works and may include absence from work due to a disability, temporary layoff or leave of absence where Plan coverage terminates, but termination of employment does not occur. If a Covered Employee is on FMLA unpaid leave, a Qualifying Event occurs at the time the Employee fails to return to work at the expiration of the leave, even if the Employee fails to pay his portion of the cost of Plan coverage during the FMLA Leave;

3. For an Employee's spouse or child, Employee's entitlement to Medicare. For COBRA purposes, "entitlement" means that the Medicare enrollment process has been completed with the Social Security Administration and the Employee has been notified that his Medicare coverage is in effect;

4. For an Employee's spouse or child, the divorce, annulment or legal separation of the Employee and spouse;

5. For an Employee's spouse or child, the death of the Covered Employee;

6. For an Employee's child, the child's loss of Dependent status (e.g., a Dependent child reaching the maximum age limit).

NON-COBRA BENEFICIARY

An individual who is covered under the Plan on an "active" basis (e.g., an individual to whom a Qualifying Event has not occurred).

NOTIFICATION

The Plan Administrator shall furnish written notice of the rights provided by this COBRA Continuation Coverage Section to each Covered Employee and his spouse not later than the earlier of (1) ninety days after the date on which such individual's coverage under the Plan commences, or (2) the first date on which the Plan Administrator is required to furnish the Qualified Beneficiary with notice of the right to elect Continuation Coverage pursuant to the following paragraphs (the "initial notice"). The requirements of this paragraph may be satisfied by furnishing a single notice addressed to both the Covered Employee and his spouse if, on the basis of the most recent information available to the Plan, the Covered Employee's spouse resides at the same location as the Covered Employee, and the spouse's coverage under the Plan commences on or after the date on which the Covered Employee's coverage commences, but not later than the date on which the notice required by this paragraph is required to be provided to the Covered Employee.

The Plan Administrator will provide Qualified Beneficiaries with notification of their COBRA continuation coverage rights within 14 days of receipt of notice of a Qualifying Event. Notice to Qualified Beneficiaries will be delivered by first-class mail.

Each Qualified Beneficiary, including a child who is born to or placed for adoption with an Employee during a period of COBRA continuation coverage, has a separate right to receive a written election notice when a Qualifying Event occurs that permits him to exercise COBRA coverage continuation rights. However, where more than one Qualified Beneficiary resides at the same address, the notification requirement will be met with regard to all such Qualified Beneficiaries if one election notice is sent to that address, by first-class mail, with clear identification of those beneficiaries who have separate and independent rights to COBRA continuation coverage.

An Employee or Qualified Beneficiary is responsible for notifying the Employer or Plan Administrator of a Qualifying Event that is: (1) a Dependent child losing eligibility under the requirements of the Plan, or (2) the divorce, annulment or legal separation of the Employee from their spouse. The notification must be provided in writing to the Plan Administrator. Such notice must comply with the Notice and Election Procedures Section and must be furnished to the Plan Administrator not later than sixty (60) days following the latest of the date of the Qualifying Event, the date on which the Qualified Beneficiary loses (or would lose) coverage under the Plan as a result of the Qualifying Event, or the date on which the Qualified Beneficiary is informed, through the furnishing of the Plan's Summary Plan Description or the initial notice described above, of both the responsibility to provide the notice and the Plan's procedures for providing such notice to the Plan Administrator.

The Plan will offer COBRA continuation coverage to Qualified Beneficiaries only after the Plan Administrator has been notified that a Qualifying Event has occurred. When the Qualifying Event is the end of employment or the reduction of hours of employment, death of the Employee or the loss of group coverage due to Employee becoming entitled to Medicare benefits (under Part A, Part B or both), the Plan Administrator must notify the Claim Administrator of the Qualifying Event within 30 days of the Qualifying Event.

If the Plan Sponsor or representative receives a notice of Qualifying Event from a potential beneficiary not eligible to receive COBRA benefits under this Plan, the Plan Sponsor or representative will provide notice to the potential beneficiary explaining why he is not entitled to COBRA coverage. This ineligibility notice will be provided within 14 days after the receipt of the notice of the Qualifying Event from the potential beneficiary. Notice to potential beneficiaries or Qualified Beneficiaries must be provided by first class mail.

In order to receive extended Continuation Coverage following a second Qualifying Event, as described in "Maximum Coverage Periods," the Qualified Beneficiary or the related Covered Employee must provide written notice to the Plan Administrator of a second Qualifying Event that occurs after the Qualified Beneficiary has become entitled to Continuation Coverage due to a Covered Employee's termination or reduction in hours of employment. Such notice must comply with the Notice and Election Procedures Section and must be furnished to the Plan Administrator not later than sixty (60) days following the latest of the date of the Qualifying Event, the date on which the Qualified Beneficiary loses (or would lose) coverage under the Plan as a result of the Qualifying Event, or the date on which the Qualified Beneficiary is informed, through the furnishing of the Plan's Summary Plan Description or the initial notice described above, of both the responsibility to provide the notice and the Plan's procedures for providing such notice to the Plan Administrator.

NOTICE AND ELECTION PROCEDURES

Each type of notice or election to be provided by a Covered Employee or a Qualified Beneficiary under this COBRA Continuation Coverage Section must be in writing, must be signed and dated, and must be furnished by U.S. mail, registered or certified, postage prepaid and properly addressed to the Plan Administrator.

Each notice must include all of the following items: the covered employee's full name, address, phone number and Social Security number; the full name, address, phone number and Social Security number of each affected Dependent, as well as the Dependent's relationship to the covered employee; a description of the Qualifying Event or disability determination that has occurred; the date the Qualifying Event or disability determination occurred on; a copy of the Social Security Administration's written disability determination, if applicable; and the name of this Plan. The Plan Administrator may establish specific forms that must be used to provide a notice or election.

ELECTION AND ELECTION PERIOD

COBRA continuation coverage may be elected during the period beginning on the date Plan coverage would otherwise terminate due to a Qualifying Event and ending on the later of the following: (1) 60 days after coverage ends due to a Qualifying Event, or (2) 60 days after the notice of the COBRA continuation coverage rights is provided to the Qualified Beneficiary.

If the COBRA election of a Covered Employee or spouse does not specify "self-only" coverage, the election is deemed to include an election on behalf of all other Qualified Beneficiaries with respect to the Qualifying Event. However, each Qualified Beneficiary who would otherwise lose coverage is entitled to choose COBRA

continuation coverage, even if others in the same family have declined. A parent or legal guardian may elect or decline for minor Dependent children.

An election of an incapacitated or deceased Qualified Beneficiary can be made by the legal representative of the Qualifying Beneficiary or the Qualified Beneficiary's estate, as determined under applicable state law, or by the spouse of the Qualified Beneficiary.

If, during the election period, a Qualified Beneficiary waives COBRA continuation coverage rights, the waiver can be revoked at any time before the end of the election period. Revocation of the waiver will be an election of COBRA continuation coverage. However, if a waiver is revoked, coverage need not be provided retroactively (that is, from the date of the loss of coverage until the waiver is revoked). Waivers and revocations of waivers are considered to be made on the date they are sent to the Employer or Plan Administrator.

Open Enrollment rights, which allow non-COBRA Beneficiaries to choose among any available coverage options, are also applicable to each Qualified Beneficiary. Similarly, the "Special Enrollment Rights" of the Health Insurance Portability and Accountability Act (HIPAA) extend to Qualified Beneficiaries. However, if a former Qualified Beneficiary did not elect COBRA, he does not have Special Enrollment Rights, even though Employees in Active Service not participating in the Plan have such rights under HIPAA.

The Plan is required to make a complete response to any inquiry from a health care provider regarding a Qualified Beneficiary's right to coverage during the election period.

EFFECTIVE DATE OF COVERAGE

COBRA continuation coverage, if elected within the period allowed for such election, is effective retroactively to the date coverage would otherwise have terminated due to the Qualifying Event, and the Qualified Beneficiary will be charged for coverage in this retroactive period.

See "Election and Election Period" for an exception to the above when a Qualified Beneficiary initially waives COBRA continuation coverage and then revokes his waiver. In that instance, COBRA continuation coverage is effective on the date the waiver is revoked.

LEVEL OF BENEFITS

COBRA continuation coverage will be equivalent to coverage provided to similarly situated non-COBRA Beneficiaries to whom a Qualifying Event has not occurred. If coverage is modified for similarly situated non-COBRA Beneficiaries, the same modification will apply to Qualified Beneficiaries.

If the Plan includes a deductible requirement, a Qualified Beneficiary's Deductible Amount at the beginning of the COBRA continuation period must be equal to his Deductible Amount immediately before that date. If the deductible is computed on a family basis, only the expenses of those family members electing COBRA continuation coverage are carried forward to the COBRA continuation coverage. If more than one family unit results from a Qualifying Event, the family deductibles are computed separately based on the members in each unit. Other plan limits are treated in the same manner as deductibles.

If a Qualified Beneficiary is participating in a region-specific health plan that will not be available if the Qualified Beneficiary relocates, any other coverage that the Plan Sponsor makes available to Employees in Active Service and that provides service in the relocation area must be offered to the Qualified Beneficiary.

COST OF CONTINUATION COVERAGE

The cost of COBRA continuation coverage will not exceed 102% of the Plan's full cost of coverage during the same period for similarly situated non-COBRA Beneficiaries to whom a Qualifying Event has not occurred. The "full cost" includes any part of the cost which is paid by the Employer for non-COBRA Beneficiaries.

The initial payment must be made within 45 days after the date of the COBRA election by the Qualified Beneficiary. Payment must cover the period of coverage from the date of the COBRA election retroactive to the date of loss of coverage due to the Qualifying Event (or date a COBRA waiver was revoked, if applicable). The first and subsequent payments must be submitted and made payable to the Plan Administrator or COBRA Administrator. Payments for successive periods of coverage are due on the first of each month thereafter, with a 30-day grace period allowed for payment. Where an Employee organization or any other entity that provides Plan benefits on behalf of the Plan Administrator permits a billing grace period later than the 30 days stated above, such period shall apply in lieu of the 30 days. Payment is considered to be made on the date it is sent to the Plan or Plan Administrator.

The Plan will allow the payment for COBRA continuation coverage to be made in monthly installments but the Plan can also allow for payment at other intervals. The Plan is not obligated to send monthly premium notices.

The cost of COBRA continuation coverage can only increase if:

1. The cost previously charged was less than the maximum permitted by law;
2. The increase occurs due to a disability extension (i.e., the 11-month disability extension) and does not exceed the maximum permitted by law which is 150% of the Plan's total cost of coverage; or
3. The Qualified Beneficiary changes his coverage option(s), which results in a different coverage cost.

Timely payments, which are not significantly less than the required amount, are deemed to satisfy the Plan's payment requirement, unless the Plan notifies the Qualified Beneficiary of the deficiency and grants a reasonable period of time (at least 30 days) to make full payment.

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

MAXIMUM COVERAGE PERIODS

The maximum coverage periods for COBRA continuation coverage are based on the type of Qualifying Event and the status of the Qualified Beneficiary and are as follows:

1. If the Qualifying Event is a voluntary or involuntary termination of employment or reduction of hours of employment, the maximum coverage period is 18 months after the Qualifying Event. With a disability extension (see "Disability Extension" information below), the maximum coverage period is extended to 29 months;
2. If the Qualifying Event occurs to a Dependent due to Employee's loss of coverage under this Plan due to entitlement in the Medicare program, the maximum coverage period for the Dependent is 36 months from the date the Employee loses group coverage due to entitlement in Medicare. A Dependent of a Qualified Beneficiary who loses COBRA coverage due to entitlement to Medicare can also extend COBRA coverage up to 36 months from the original Qualifying Event;
3. For any other Qualifying Event, the maximum coverage period ends 36 months after the Qualifying Event.

If a Qualifying Event which provides an 18-month or 29-month maximum coverage period is followed by a second Qualifying Event that allows a 36-month maximum coverage period, the coverage period will be expanded to 36 months, but only for individuals who are Qualified Beneficiaries at the time of both Qualifying Events and provide notice of the second Qualifying Event as described in the Notification section. Thus, a termination of employment following a Qualifying Event that is a reduction of hours of employment or a bankruptcy of the Plan Sponsor following any Qualifying Event will not expand the maximum COBRA continuation period. In no circumstance can the COBRA maximum coverage period be more than 36 months after the date of the first Qualifying Event, except in the case of a bankruptcy Qualifying Event with regard to a retiree where the maximum coverage period is to the date of the retired Employee's death.

Medical continuation of coverage under The Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) does not extend the COBRA continuation period but any such Employee and any of his covered Dependents shall be treated as any other Qualified Beneficiary for purposes of COBRA.

DISABILITY EXTENSION

An 11-month disability extension (an extension from a maximum 18 months of COBRA continuation coverage to a maximum 29 months) will be granted if a Qualified Beneficiary is determined under Title II or XVI of the Social Security Act to have been disabled at the time of the Qualifying Event or at any time during the first 60 days thereafter.

To qualify for the disability extension, the Plan Administrator must be provided with a copy of the notice of the Social Security Administration's disability determination no later than 60 days after the latest of: (1) the date of the Social Security Administration's disability determination; (2) the date on which the Qualifying Event occurred; (3) the date the Qualified Beneficiary loses coverage; or (4) the date on which the Qualified Beneficiary is informed, through the furnishing of the Summary Plan Description of the Plan or the initial notice described above, of both the responsibility to provide the notice and the Plan's procedures for providing such notice to the Plan Administrator.

Notwithstanding the above, such notice must be furnished to the Plan Administrator before the end of the first eighteen (18) months of continuation coverage. The Qualified Beneficiary must also be disabled at the end of the 18-month period to be eligible for the 11-month extension. The disabled Qualified Beneficiary or any Qualified Beneficiaries in his family may notify the Plan Administrator of the determination. If the Qualified Beneficiary is later determined by Social Security to be no longer disabled, a copy of the Social Security Administration notice must be provided to the Employer or Plan Administrator. The notification must be provided no later than 30 days after the Social Security Administration's determination that the Qualified Beneficiary is no longer disabled or, if later, the date on which the Qualified Beneficiary is informed, through the furnishing of the Summary Plan Description of the Plan or the initial notice described above, of both the responsibility to provide the notice and the Plan's procedures for providing such notice to the Plan Administrator.

Under the Disability extension, the Qualified Beneficiary's cost for continuation coverage for the 19th through 29th month of continued coverage shall increase to 150% of the Plan's cost for similarly situated non-COBRA Beneficiaries.

If the individual who is eligible for the 11-month disability extension also has family members who are entitled to COBRA continuation coverage, those family members are also entitled to the 29-month COBRA continuation coverage period.

TERMINATION OF CONTINUATION COVERAGE

Except for an initial interruption of Plan coverage in connection with a waiver (see "Election and Election Period" above), COBRA continuation coverage that has been elected by or for a Qualified Beneficiary will extend for the period beginning on the date of the Qualifying Event and ending on the earliest of the following dates:

1. The last day of the applicable maximum coverage period – see "Maximum Coverage Periods" above;
2. The date on which the Employer ceases to provide any group health plan to any Employee;
3. The date, after the date of the COBRA election, that the Qualified Beneficiary first becomes covered under any other plan that does not contain any exclusion or limitation with respect to any pre-existing condition that would reduce or exclude benefits for such condition in the Qualified Beneficiary. (Note: there are limitations on plans' imposing a preexisting condition exclusion and such exclusions will become prohibited beginning January 1, 2014 under the Affordable Care Act);
4. The date, after the date of the COBRA election, that the Qualified Beneficiary first becomes entitled to Medicare benefits. For COBRA purposes, "entitled" means that the Medicare enrollment process has been completed with the Social Security Administration and the individual has been notified that his Medicare coverage is in effect;
5. In the case of a Qualified Beneficiary entitled to a disability extension, the later of:
    a) 29 months after the date of the Qualifying Event, or the first day of the month that is more than 30 days after the date of a final determination under Title XVIII of the Social Security Act that the disabled Qualified Beneficiary whose disability resulted in the Qualified Beneficiary's entitlement to the disability extension is no longer disabled, whichever is earlier; or
    b) The end of the maximum coverage period that applies to the Qualified Beneficiary without regard to the disability extension;
6. The end of the last period for which the cost of continuation coverage is paid, if payment is not received in a timely manner (e.g., coverage may be terminated if the Qualified Beneficiary is more than 30 days delinquent in paying the applicable premium). The Plan is required to make a complete response to any inquiry from a health care provider regarding a Qualified Beneficiary's right to coverage during any period the Plan has not received payment.

The Plan Sponsor can terminate, for cause, the coverage of any Qualified Beneficiary on the same basis that the Plan may terminate the coverage of similarly situated non-COBRA Beneficiaries for cause (e.g., for the submission of a fraudulent claim).

If an individual is receiving COBRA continuation coverage solely because of the person's relationship to a Qualified Beneficiary (e.g., a newborn or adopted child acquired during an Employee's COBRA coverage period), the Plan's obligation to make COBRA continuation coverage available will cease when the Plan is no longer obligated to make COBRA continuation coverage available to the Qualified Beneficiary.

The Plan will notify the Qualified Beneficiary in writing, or any termination of COBRA coverage based on the criteria stated in this subsection that occurs prior to the end of the Qualified Beneficiary's applicable maximum coverage period. Notice will be given within 30 days of the Plan's decision to terminate. Such notice shall include the reason that Continuation Coverage has terminated earlier than the end of the maximum coverage period for such Qualifying Event, the date of termination of Continuation Coverage, and any rights the Qualified Beneficiary may have under the Plan or under applicable law to elect an alternative group or individual coverage, such as a conversion right.

Special Enrollment Rights Notice

LOSS OF OTHER COVERAGE

If you have declined or will be declining enrollment for yourself and/or your dependents because of other in-force health plan coverage, you may be able to enroll yourself and/or your dependents in this plan in the future. If you or your dependents lose eligibility for that other coverage, or if the employer stops contributing towards other group health plan coverage, it may trigger a special enrollment right.

You must request enrollment in this plan within 30 days after the other coverage ends. You may be required to submit a Certificate of Creditable Coverage, as described below.

NEW DEPENDENT

If you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and/or your dependents. This triggers a special enrollment right. However, you must request enrollment within 30 days after the marriage, birth, adoption or placement for adoption.

TERMINATION OF MEDICAID OR CHIP COVERAGE

If you and/or your dependents are covered under a Medicaid plan or a state child health insurance plan (CHIP), and coverage under such a plan is terminated as a result of loss of eligibility, you may be able to enroll yourself and/or your dependents in this plan, as it may trigger a special enrollment right.

To be eligible for this special enrollment opportunity you must request coverage under the group health plan within 60 days after the date Medicaid or state-sponsored CHIP coverage ends.

ELIGIBILITY FOR PREMIUM ASSISTANCE UNDER MEDICAID OR CHIP

If you and/or your dependents become eligible for premium assistance under Medicaid or a state CHIP, including under any waiver or demonstration project conducted under or in relation to such a plan, you may be able to enroll yourself and/or your dependents in this plan, as it may trigger a special enrollment right. This is usually a program where the state provides employed individuals with premium payment assistance for their employer's group health plan, rather than direct enrollment in a state Medicaid program.

To be eligible for this special enrollment opportunity you must request coverage under the group health plan within 60 days after the date you and/or your dependents become eligible for premium assistance under Medicaid or a state CHIP.

CERTIFICATE OF CREDITABLE COVERAGE

A Certificate of Creditable Coverage (also known as a HIPAA Certificate) will provide information to our health plan about your prior coverage. Prior creditable coverage is used to reduce the Pre-existing Condition Limitation, if applicable, to this plan. You may request a Certificate of Creditable Coverage from a previous employer, insurance company or HMO. Creditable coverage includes coverage under the following:

- another group health plan;
- an individual health policy;
- Parts A or B of Medicare;
- Medicaid;
- CHAMPUS;
- a medical health care program of the Indian Health Service or tribal organization;
- a state health benefits risk pool;

- any public health plan, including state child health insurance plan (CHIP);
- a health plan issued under the Peace Corps Act;
- a foreign government plan.

Medicare Part D – Important Notice About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Jefferson Union High 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. Jefferson Union High School District has determined that the prescription drug coverage offered by Jefferson Union High School District Medical Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

WHEN CAN YOU JOIN A MEDICARE DRUG PLAN?

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

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

WHAT HAPPENS TO YOUR CURRENT COVERAGE IF YOU DECIDE TO JOIN A MEDICARE DRUG PLAN?

If you decide to join a Medicare drug plan, your current Jefferson Union High School District coverage may be affected.

If you do decide to join a Medicare drug plan and drop your current Jefferson Union High School District coverage, be aware that you and your dependents may not be able to get this coverage back.

WHEN WILL YOU PAY A HIGHER PREMIUM (PENALTY) TO JOIN A MEDICARE DRUG PLAN?

You should also know that if you drop or lose your current coverage with Jefferson Union High School District and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

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

FOR MORE INFORMATION ABOUT THIS NOTICE OR YOUR CURRENT PRESCRIPTION DRUG COVERAGE

Contact the person listed below for further information. NOTE: You will 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 Jefferson Union High School District changes. You also may request a copy of this notice at any time.

important notices (continued)

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 will 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 your copy of the Medicare & You handbook for their telephone number) for personalized help.
- Call 800.MEDICARE (800.633.4227). TTY users should call 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 800.772.1213 (TTY 800.325.0778).

REMEMBER

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

Date:	October 2014
Name of Entity/Sender:	Jefferson Union High School District
Contact:	Assistant to Associate Superintendent
Address: Daly City, CA 94015	699 Serramonte Blvd., Suite 100
Phone:	650.550.7955

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 1-31-2017)

PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

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

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.[1]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution, as well as your employee contribution to employer-offered coverage, is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact Pat Ramos in Business Services.

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

1 An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

PART B: Information About Health Coverage Offered by Your Employer

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

3. Employer name Jefferson Union High School District	4. Employer Identification Number (EIN) 94-3083772	
5. Employer address 699 Seramonte Blvd,. #100	6. Employer phone number 650.550.7955	
7. City Daly City	8. State CA	9. ZIP code 94015
10. Who can we contact about employee health coverage at this job? Patricia Ramos		
11. Phone number (if different from above)	12. Email address patramos@juhsd.net	

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

- As your employer, we offer a health plan to:
  - ☐ All employees.
  - ☒ Some employees. Eligible employees are:
    - Regular employees working more than .50 FTE.
- With respect to dependents:
  - ☒ We do offer coverage. Eligible dependents are:
    - Spouse / Registered Domestic Partner
    - Dependents under the age of 26.
  - ☐ We do not offer coverage.

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

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

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

Health Insurance Portability and Accountability Act (HIPAA) Notice of Privacy Practices

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.

This Notice of Privacy Practices ("Notice") is made in compliance with the Standards for Privacy of Individually Identifiable Health Information (the "Privacy Standards") set forth by the U.S. Department of Health and Human Services ("HHS") pursuant to the Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA"). The Jefferson Union High School District Employee Medical Plan (the "Plan") is required by law to take reasonable steps to ensure the privacy of your Protected Health Information ("PHI"), as defined below, and to inform you about:

- The Plan's uses and disclosures of PHI;
- Your privacy rights with respect to your PHI;
- The Plan's duties with respect to your PHI;
- Your right to file a complaint with the Plan and with the Secretary of HHS; and
- The person or office to contact for further information about the Plan's privacy practices.

The term **"Protected Health Information"** (PHI) includes all "Individually Identifiable Health Information" transmitted or maintained by the Plan, regardless of form (oral, written or electronic).

The term **"Individually Identifiable Health Information"** means information that:

- Is created or received by a health care provider, health plan, Employer or health care clearinghouse;
- Relates to the past, present or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present or future payment for the provision of health care to an individual; and
- Identifies the individual, or with respect to which there is a reasonable basis to believe the information can be used to identify the individual.

SECTION 1. NOTICE OF PHI USES AND DISCLOSURES

1.1 Required PHI Disclosures

Upon your request, the Plan is required to give you access to certain PHI to inspect and copy it and to provide you with an accounting of disclosures of PHI made by the Plan. For further information pertaining to your rights in this regard, see Section 2 of this Notice.

The Plan must disclose your PHI when required by the Secretary of HHS to investigate or determine the Plan's compliance with the Privacy Standards.

1.2 Permitted uses and disclosures to carry out treatment, payment and health care operations

The Plan, its business associates, and their agents/subcontractors, if any, will use or disclose PHI without your consent, authorization or opportunity to agree or object, to carry out treatment, payment and health care operations. The Plan will disclose PHI to a business associate only if the Plan receives satisfactory assurance that the business associate will appropriately safeguard the information.

In addition, the Plan may contact you to provide information about treatment alternatives or other health-related benefits and services that may be of interest to you. The Plan will disclose PHI to Jefferson Union High School District ("Plan Sponsor") for purposes related to treatment, payment and health care operations. The Plan Sponsor has amended its plan documents to protect your PHI as required by the Privacy Standards. The Plan Sponsor will obtain an authorization from you if it intends to use or disclose your PHI for purposes unrelated to treatment, payment and health care operations.

Treatment is the provision, coordination or management of health care and related services by one or more health care providers. It also includes, but is not limited to, consultations and referrals between one or more of your providers.

For example, the Plan may disclose to a treating Specialist the name of your treating Physician so that the Specialist may ask for your X-rays from the treating Physician.

Payment means activities undertaken by the Plan to obtain premiums or to determine or fulfill its responsibility for coverage and provision of benefits under the Plan, or to obtain or provide reimbursement for the provision of health care. Payment includes,

but is not limited to, actions to make eligibility or coverage determinations, billing, claims management, collection activities, subrogation, reviews for medical necessity and appropriateness of care, utilization review and pre-authorizations.

For example, the Plan may tell a doctor whether you are eligible for coverage or what percentage of the bill might be paid by the Plan.

Health Care Operations means conducting quality assessment and improvement activities, population-based activities relating to improving health or reducing health care costs, contacting health care providers and patients with information about treatment alternatives, reviewing the competence or qualifications of health care professionals, evaluating health plan performance, underwriting, premium rating and other insurance activities relating to creating, renewing or replacing health insurance contracts or health benefits. It also includes disease management, case management, conducting or arranging for medical review, legal services and auditing functions including fraud and abuse detection and compliance programs, business planning and development, business management and general administrative activities. However, the Plan will not use your genetic information for underwriting purposes.

For example, the Plan may use information about your claims to refer you to a disease management program, project future benefit costs or audit the accuracy of its claims processing functions.

1.3 Uses and disclosures that require your written authorization

Your written authorization generally will be obtained before the Plan will use or disclose psychotherapy notes about you from your psychotherapist. Psychotherapy notes are separately filed notes about your conversations with your mental health professional during a counseling session. They do not include summary information about your mental health treatment. The Plan may use and disclose such notes without authorization when needed by the Plan to defend against litigation filed by you.

The Plan will not use or disclose your protected health information for marketing and will not sell your protected health information, unless you give us a written authorization.

Any other use or disclosure not described in this Notice will require your written authorization.

1.4 Disclosures that require that you be given an opportunity to agree or disagree prior to the disclosure

The Plan may disclose to a family member, other relative, close personal friend of yours or any other person identified by you PHI directly relevant to such person's involvement with your care or payment for your health care when you are present for, or otherwise available prior to, a disclosure and you are able to make health care decisions, if:

- The Plan obtains your agreement;
- The Plan provides you with the opportunity to object to the disclosure and you fail to do so; or
- The Plan infers from the circumstances, based upon professional judgment that you do not object to the disclosure.

The Plan may obtain your oral agreement or disagreement to a disclosure.

However, if you are not present, or the opportunity to agree or object to the disclosure cannot practicably be provided because of your incapacity or an Emergency Services circumstance, the Plan may, in the exercise of professional judgment, determine whether the disclosure is in your best interests, and, if so, disclose only PHI that is directly relevant to the person's involvement with your health care.

1.5 Uses and disclosures for which authorization or opportunity to agree or object is not required

Use and disclosure of your PHI is allowed without your authorization or opportunity to agree or object under the following circumstances:

a) When required by law, provided that the use or disclosure complies with and is limited to the relevant requirements of such law.

b) When permitted for purposes of public health activities, including disclosures to (i) a public health authority or other appropriate government authority authorized by law to receive reports of child abuse or neglect and (ii) a person subject to the jurisdiction of the Food and Drug Administration (FDA) regarding an FDA-regulated product or activity for the purpose of activities related to the quality, safety or effectiveness of such FDA-regulated product or activity, including to report product defects,

to permit product recalls and to conduct post-marketing surveillance. PHI also may be disclosed to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading a disease or condition, if authorized by law.

c) Except for reports of child abuse or neglect permitted by part (b) above, when required or authorized by law, or with your agreement, the Plan may disclose PHI about you to a government authority, including a social service or protective services agency, if the Plan reasonably believes you to be a victim of abuse, neglect, or domestic violence. In such case, the Plan will promptly inform you that such a disclosure has been or will be made unless (i) the Plan believes that informing you would place you at risk of serious harm or (ii) the Plan would be informing your personal representative, and the Plan believes that your personal representative is responsible for the abuse, neglect or other injury, and that informing such person would not be in your best interests. For the purposes of reporting child abuse or neglect, it is not necessary to inform the minor that such a disclosure has been or will be made. Disclosure generally may be made to the minor's parents or other representatives although there may be circumstances under Federal or state law when the parents or other representatives may not be given access to the minor's PHI.

d) The Plan may disclose your PHI to a health oversight agency for oversight activities authorized by law. This includes civil, administrative or criminal investigations; inspections; licensure or disciplinary actions (for example, to investigate complaints against providers); and other activities necessary for appropriate oversight of: (i) the health care system, (ii) government benefit programs for which health information is relevant to beneficiary eligibility, (iii) entities subject to government regulatory programs for which health information is needed to determine compliance with program standards, or (iv) entities subject to civil rights laws for which health information is needed to determine compliance.

e) The Plan may disclose your PHI in the course of a judicial or administrative proceeding in response to an order of a court or administrative tribunal, provided that the Plan discloses only the PHI expressly authorized by such order, or in response to a subpoena, discovery request, or other lawful process, that is not accompanied by an order of a court or administrative tribunal if certain conditions are met. One of those conditions is that satisfactory assurances must be given to the Plan that the requesting party has made a good faith attempt to provide written notice to you, and the notice provided sufficient information about the proceeding to permit you to raise an objection, and the time to object has expired and either no objections were raised or any objections were resolved in favor of disclosure by the court or tribunal.

f) The Plan may disclose your PHI to a law enforcement official when required for law enforcement purposes. The Plan may disclose PHI as required by law, including laws that require the reporting of certain types of wounds. Also, the Plan may disclose PHI in compliance with (i) a court order, court-ordered warrant, or a subpoena or summons issued by a judicial officer, (ii) a grand jury subpoena, or (iii) an administrative request, including an administrative subpoena or summons, a civil or authorized investigative demand, provided certain conditions are satisfied. PHI may be disclosed for law enforcement purposes, including for the purpose of identifying or locating a suspect, fugitive, material witness or missing person. Under certain circumstances, the Plan may disclose your PHI in response to a law enforcement official's request if you are, or are suspected to be, a victim of a crime. Further, the Plan may disclose your PHI if it believes in good faith that the PHI constitutes evidence of criminal conduct that occurred on the Plan's premises.

g) The Plan may disclose PHI to a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death or other duties as authorized by law. Also, disclosure is permitted to funeral directors, consistent with applicable law, as necessary to carry out their duties with respect to the decedent.

h) The Plan may use or disclose PHI for research, subject to certain conditions.

i) When consistent with applicable law and standards of ethical conduct, the Plan may use or disclose PHI if the Plan, in good faith, believes the use or disclosure: (i) is necessary to prevent or lessen a serious and imminent threat to health or safety of a person or the public and is to person(s) able to prevent or lessen the threat, including the target of the threat, or (ii) is needed for

law enforcement authorities to identify or apprehend an individual, provided certain requirements are met.

j) When authorized by and to the extent necessary to comply with Workers' Compensation or other similar programs established by law.

Except as otherwise indicated in this Notice, uses and disclosures will be made only with your written authorization, subject to your right to revoke such authorization. You may revoke an authorization at any time, provided your revocation is done in writing, except to the extent that the Plan has taken action in reliance upon the authorization, or if the authorization was obtained as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy or the policy itself.

SECTION 2: RIGHTS OF INDIVIDUALS

2.1 Right to Request Restrictions on PHI Uses and Disclosures

You may request the Plan to restrict uses and disclosures of your PHI to carry out treatment, payment or health care operations, or to restrict disclosures to family members, relatives, friends or other persons identified by you who are involved in your care or payment for your care. However, the Plan is not required to agree to your requested restriction.

If the Plan agrees to a requested restriction, the Plan may not use or disclose PHI in violation of such restriction, except that, if you requested a restriction and later are in need of Emergency Services and the restricted PHI is needed to provide the Emergency Services, the Plan may use the restricted PHI, or it may disclose such information to a health care provider, to provide such treatment to you. If restricted PHI is disclosed to a health care provider for Emergency Services, the Plan must request that such health care provider not further use or disclose the information.

A restriction agreed to by the Plan is not effective to prevent uses or disclosures when required by the Secretary of HHS to investigate or determine the Plan's compliance with the Privacy Standards or uses or disclosures that are otherwise required by law.

The Plan will comply with any restriction request if (1) except as otherwise required by law, the disclosure is to a health plan for purposes of carrying out payment or health care operations (and is not for purposes of carrying out treatment); and (2) the protected health information pertains solely to a health care item or service for which the health care provider involved has been paid in full out of pocket by you or another person.

The Plan may terminate its agreement to a restriction, if:

- You agree to or request the termination in writing;
- you orally agree to the termination and the oral agreement is documented; or
- The Plan informs you that it is terminating its agreement to a restriction, except that such termination is only effective with respect to PHI created or received after the Plan has informed you of the termination.

If the Plan agrees to a restriction, it will document the restriction by maintaining a written or electronic record of the restriction. The record of the restriction will be retained for six (6) years from the date of its creation or the date when it last was in effect, whichever is later.

You or your personal representative will be required to request restrictions on uses and disclosures of your PHI in writing. Such requests should be addressed to the following individual:

Jefferson Union High School District
Business Services
699 Seramonte Boulevard, #100, Daly City, CA 94015
650.550.7955

2.2 Right to Request Confidential Communications of PHI

You may request to receive communications of PHI from the Plan by alternative means or at alternative locations if you clearly state that the disclosure of all or part of the information to which the request pertains could endanger you. The Plan will accommodate all such reasonable requests. However, the Plan may condition the provision of a reasonable accommodation on:

- When appropriate, information as to how payment, if any, will be handled; and
- Specification by you of an alternative address or other method of contact.

You or your personal representative will be required to request confidential communications of your PHI in writing. Such requests should be addressed to the following individual:

Jefferson Union High School District
Business Services
699 Seramonte Boulevard, #100, Daly City, CA 94015
650.550.7955

2.3 Right to Inspect and Copy PHI

You have a right to inspect and obtain a copy of your PHI contained in a "designated record set," for as long as the Plan maintains PHI in the designated record set.

"Designated Record Set" is defined as a group of records maintained for a covered entity. They include medical information and records about the individual maintained by or for a covered provider; the enrollment, payment, claims and adjudication, and case or medical management record systems maintained by or for a health plan; and used in whole or in part, by or for the covered entity to make decisions about individuals. Record means any item, collection or grouping of information that includes PHI and is maintained by, collected, used, or disseminated by or for a covered entity.

The Plan will act on a request for access no later than 30 days after receipt of the request. However, if the request for access is for PHI that is not maintained or accessible to the Plan on-site, the Plan must take action no later than 60 days from the receipt of such request. The Plan must take action as follows: if the Plan grants the request, in whole or in part, the Plan must inform you of the acceptance and provide the access requested. However, if the Plan denies the request, in whole or in part, the Plan must provide you with a written denial. If the Plan cannot take action within the required time, the Plan may extend the time for such action by no more than 30 days if the Plan, within the applicable time limit, provides you with a written statement of the reasons for the delay and the date by which it will complete its action on the request.

If the Plan provides access to PHI, it will provide the access requested, including inspection or obtaining a copy, or both, of your PHI in a designated record set. The Plan will provide you with access to the PHI in the form or format requested if it is readily producible in such form or format; or, if it is not, in a readable hard copy form or such other form or format as agreed to between you and the Plan. The Plan may provide you with a summary of the PHI requested, in lieu of providing access to the PHI or may provide an explanation of the PHI to which access has been provided in certain circumstances. The Plan will arrange with you for a convenient time and place to inspect or obtain a copy of the PHI, or mail a copy of the PHI at your request. If you request a copy of PHI or agree to a summary or explanation of PHI, the Plan may impose a reasonable, cost-based fee.

If the Plan denies access to PHI in whole or in part, the Plan will, to the extent possible, give you access to any other PHI requested, after excluding PHI as to which the Plan has grounds to deny access. If access is denied, you or your personal representative will be provided with a written denial setting forth the basis for the denial, if applicable, a statement of your review rights, including a description of how you may exercise those review rights and a description of how you may complain to the Plan or to the Secretary of the HHS. If you request review of a decision to deny access, the Plan will refer the request to a designated licensed health care professional for review. The reviewing official will determine, within a reasonable period of time, whether to deny the access requested. The Plan will promptly provide you with written notice of that determination.

If the Plan does not maintain the PHI that is the subject of your request for access, and the Plan knows where the requested information is maintained, the Plan will inform you where to direct the request for access.

You or your personal representative will be required to request access to your PHI in writing. Such requests should be addressed to the following individual:

Jefferson Union High School District
Business Services
699 Seramonte Boulevard, #100, Daly City, CA 94015
650.550.7955

2.4 Right to Amend PHI

You have the right to request the Plan to amend your PHI or a record about you in a designated record set for as long as the PHI is maintained in the designated record set.

The Plan may deny your request for amendment if it determines that the PHI or record that is the subject of the request:

- Was not created by the Plan, unless you provide a reasonable basis to believe that the originator of PHI is no longer available to act on the requested amendment;
- Is not part of the designated record set;
- Would not be available for your inspection under the Privacy Standards; or
- Is accurate and complete.

The Plan has 60 days after the request is made to act on the request. A single 30-day extension is allowed if the Plan is unable to comply within that deadline provided that the Plan, within the original 60-day time period, gives you a written statement of the

reasons for the delay and the date by which it will complete its action on the request. If the Plan accepts the requested amendment, the Plan will make the appropriate amendment to the PHI or record that is the subject of the request by, at a minimum, identifying the records in the designated record set that are affected by the amendment and appending or otherwise providing a link to the location of the amendment. The Plan will timely inform you that the amendment is accepted and obtain your identification of and agreement to have the Plan notify the relevant persons with which the amendment needs to be shared as provided in the Privacy Standards.

If the request is denied in whole or part, the Plan must provide you with a written denial that (i) explains the basis for the denial, (ii) sets forth your right to submit a written statement disagreeing with the denial and how to file such a statement, (iii) states that, if you do not submit a statement of disagreement, you may request that the Plan provide your request for amendment and the denial with any future disclosures of the PHI that is the subject of the amendment, and (iv) includes a description of how you may complain to the Plan or to the Secretary of HHS. The Plan may reasonably limit the length of a statement of disagreement. Further, the Plan may prepare a written rebuttal to a statement of disagreement, which will be provided to you. The Plan must, as appropriate, identify the record or PHI in the designated record set that is the subject of the disputed amendment and append or otherwise link your request for an amendment, the Plan's denial of the request, your statement of disagreement, if any, and the Plan's rebuttal, if any, to the designated record set. If a statement of disagreement has been submitted, the Plan will include the above-referenced material, or, at the Plan's election, an accurate summary of such information, with any subsequent disclosure of the PHI to which the disagreement relates. If you do not submit a written statement of disagreement, the Plan must include your request for amendment and its denial, or an accurate summary of such information with any subsequent disclosure of the PHI only if requested by you.

You or your personal representative will be required to request an amendment to your PHI in a designated record set in writing. Such requests should be addressed to the following individual:

Jefferson Union High School District
Business Services
699 Seramonte Boulevard, #100, Daly City, CA 94015
650.550.7955

All requests for amendment of PHI must include a reason to support the requested amendment.

2.5 Right to Receive an Accounting of PHI Disclosures

At your request, the Plan will provide you with an accounting of disclosures by the Plan of your PHI during the six (6) years prior to the date on which the accounting is requested. However, such accounting need not include PHI disclosures made: (a) to carry out treatment, payment or health care operations; (b) to individuals about their own PHI; (c) incident to a use or disclosure otherwise permitted or required by the Privacy Standards; (d) pursuant to an authorization; (e) to certain persons involved in your care or payment for your care; (f) to notify certain persons of your location, general condition or death; (g) as part of a "Limited Data Set" (as defined in the Privacy Standards), which largely relates to research purposes; or (h) prior to the compliance date of April 14, 2003. You may request an accounting of disclosures for a period of time less than six (6) years from the date of the request.

The accounting will include disclosures of PHI that occurred during the six (6) years (or such shorter time period, if applicable) prior to the date of the request for an accounting, including disclosures to or by business associates of the Plan. Except as otherwise provided below, for each disclosure, the accounting will include:

- The date of the disclosure;
- The name of the entity or person who received the PHI and, if known, the address of such entity or person;
- A brief description of the PHI disclosed; and
- A brief statement of the purpose of the disclosure that reasonably informs you of the basis for the disclosure, or, in lieu of such statement, a copy of a written request for disclosure.

If during the period covered by the accounting, the Plan has made multiple disclosures of PHI to the same person or entity for a single purpose, the accounting may, with respect to such multiple disclosures, provide the above-referenced information for the first disclosure; the frequency, periodicity or number of the disclosures made during the accounting period; and the date of the last disclosure.

If during the period covered by the accounting, the Plan has made disclosures of PHI for a particular research purpose for 50 or more individuals, the accounting may, with respect to such disclosures for which your PHI may have been included, provide certain information as permitted by the Privacy Standards. If the Plan provides an accounting for such research disclosures, and if

it is reasonably likely that your PHI was disclosed for such research activity, the Plan shall, at your request, assist in contacting the entity that sponsored the research and the researcher.

If the accounting cannot be provided within 60 days after receipt of the request, an additional 30 days is allowed if the individual is given a written statement of the reasons for the delay and the date by which the accounting will be provided.

If you request more than one accounting within a 12-month period, the Plan will charge a reasonable, cost-based fee for each subsequent accounting unless you withdraw or modify the request for a subsequent accounting to avoid or reduce the fee.

You or your personal representative will be required to request an accounting of your PHI disclosures in writing. Such requests should be addressed to the following individual:

Jefferson Union High School District
Business Services
699 Seramonte Boulevard, #100, Daly City, CA 94015
650.550.7955

2.6 The Right To Receive a Paper Copy of This Notice Upon Request

You have a right to obtain a paper copy of this Notice upon request. To request a paper copy of this Notice, contact the following individual:

Jefferson Union High School District
Business Services
699 Seramonte Boulevard, #100, Daly City, CA 94015
650.550.7955

2.7 Right to Be Notified of a Breach

You have the right to be notified in the event that the Plan (or a Business Associate) discovers a breach of unsecured protected health information.

2.8 A Note About Personal Representatives

You may exercise your rights through a personal representative. Your personal representative will be required to produce evidence of his/her authority to act on your behalf before that person will be given access to your PHI or allowed to take any action for you. Proof of such authority may include, but is not limited to, the following:

- A power of attorney for health care purposes, notarized by a notary public;
- A court order of appointment of the person as the conservator or guardian of the individual; or
- An individual who is the parent of a minor child.

The Plan retains discretion to deny access to your PHI to a personal representative to provide protection to those vulnerable people who depend on others to exercise their rights under these rules and who may be subject to abuse or neglect. This also applies to personal representatives of minors.

SECTION 3: THE PLAN'S DUTIES

3.1 Notice

The Plan is required by law to maintain the privacy of PHI and to provide individuals (participants and beneficiaries) with notice of its legal duties and privacy practices with respect to PHI.

This Notice is effective September 23, 2013 and the Plan is required to comply with the terms of this Notice. However, the Plan reserves the right to change the terms of this Notice and to make the new revised notice provisions effective for all PHI that it maintains, including any PHI created, received or maintained by the Plan prior to the date of the revised notice. If a privacy practice is changed, a revised version of this Notice will be provided to all individuals then covered by the Plan. If agreed upon between the Plan and you, the Plan will provide you with a revised Notice electronically. Otherwise, the Plan will mail a paper copy of the revised Notice to your home address. In addition, the revised Notice will be maintained on any web site maintained by the Plan to provide information about its benefits.

Any revised version of this Notice will be distributed within 60 days of any material change to the uses or disclosures, the individual's rights, the duties of the Plan or other privacy practices stated in this Notice. Except when required by law, a material change to any term of this Notice may not be implemented prior to the effective date of the revised notice in which such material change is reflected.

3.2 Minimum Necessary Standard

When using or disclosing PHI or when requesting PHI from another covered entity, the Plan will make reasonable efforts not to use, disclose or request more than the minimum amount of

PHI necessary to accomplish the intended purpose of the use, disclosure or request, taking into consideration practical and technological limitations.

However, the minimum necessary standard will not apply in the following situations:

- Disclosures to or requests by a health care provider for treatment;
- Uses or disclosures made to the individual;
- Disclosures made to the Secretary of HHS.
- Uses or disclosures that are required by law;
- Uses or disclosures that are required for the Plan's compliance with the Privacy Standards; and
- Uses or disclosures made pursuant to an authorization.

This Notice does not apply to information that has been de-identified. De-identified information is health information that does not identify an individual and with respect to which there is no reasonable basis to believe that the information can be used to identify an individual. It is not individually identifiable health information.

In addition, the Plan may use or disclose "summary health information" to the Plan Sponsor for obtaining premium bids or modifying, amending or terminating the group health plan. Summary health information summarizes the claims history, claims expenses or type of claims experienced by individuals for whom a Plan Sponsor has provided health benefits under a group health plan, and from which identifying information has been deleted in accordance with the Privacy Standards.

SECTION 4: YOUR RIGHT TO FILE A COMPLAINT WITH THE PLAN OR THE HHS SECRETARY

If you believe that your privacy rights have been violated, you may complain to the Plan. Any complaint must be in writing and addressed to the following individual:

Jefferson Union High School District
Pat Ramos, Business Services
699 Seramonte Boulevard, #100, Daly City, CA 94015
650.550.7955

You also may file a complaint with the Secretary of the U.S. Department of Health and Human Services, by writing to him at the following address: The Hubert H. Humphrey Building, 200 Independence Avenue, S.W., Washington, D.C. 20201.

The Plan will not retaliate against you for filing a complaint.

SECTION 5: WHOM TO CONTACT AT THE PLAN FOR MORE INFORMATION

If you have any questions regarding this Notice or the subjects addressed in it, you may contact the following individual:

Jefferson Union High School District
699 Seramonte Boulevard, #100, Daly City, CA 94015
650.550.7955

CONCLUSION

PHI use and disclosure by the Plan is regulated by a Federal law known as HIPAA. You may find these rules at 45 **Code of Federal Regulations** Parts 160 and 164. This Notice attempts to summarize the Privacy Standards. The Privacy Standards will supersede any discrepancy between the information in this Notice and the Privacy Standard.

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 are eligible for health coverage from your employer, your State may have a premium assistance program that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for these programs, but also have access to health insurance through their employer. If you or your children are not eligible for Medicaid or CHIP, you will not be eligible for these premium assistance programs.

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

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, you can contact your State Medicaid or CHIP office, dial 877.KIDS.NOW, or visit www.insurekidsnow.gov to find out how to apply. If you qualify, you can ask the State if it has a program that might help you pay the premiums for an employer-sponsored plan.

important notices (continued)

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must permit you to enroll in your employer plan if you are not 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, you can contact the Department of Labor electronically at www.askebsa.dol.gov or by calling toll-free 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, 2014. You should contact your State for further information on eligibility.

- **Alabama - Medicaid**
  www.medicaid.alabama.gov
  855.692.5447

- **Alaska - Medicaid**
  http://health.hss.state.ak.us/dpa/programs/medicaid/
  Anchorage: 907.269.6529
  Outside of Anchorage: 888.318.8890

- **Arizona - CHIP**
  www.azahcccs.gov/applicants
  Maricopa County: 602.417.5437
  Outside of Maricopa County: 877.764.5437

- **Colorado - Medicaid**
  www.colorado.gov/
  800.866.3513
  Out-of-State: 800.221.3943

- **Florida - Medicaid**
  https://www.flmedicaidtplrecovery.com/
  877.357.3268

- **Georgia - Medicaid**
  http://dch.georgia.gov/
  Click on Programs, then Medicaid, then Health Insurance Premium Payment (HIPP)
  800.869.1150

- **Idaho - Medicaid**
  http://healthandwelfare.idaho.gov/medical/medicaid/PremiumAssistance/tabid/1510/Default.aspx
  800.926.2588

- **Indiana - Medicaid**
  www.in.gov/fssa
  800.889.9949

- **Iowa - Medicaid**
  www.dhs.state.ia.us/hipp/
  888.346.9562

- **Kansas - Medicaid**
  http://www.kdheks.gov/hcf/
  800.792.4884

- **Kentucky - Medicaid**
  http://chfs.ky.gov/dms/default.htm
  800.635.2570

- **Louisiana - Medicaid**
  www.lahipp.dhh.louisiana.gov
  888.695.2447

- **Maine - Medicaid**
  www.maine.gov/dhhs/ofi/public-assistance/index.html
  800.977.6740
  TTY: 800.977.6741

- **Massachusetts - Medicaid and CHIP**
  www.mass.gov/MassHealth
  800.462.1120

- **Minnesota - Medicaid**
  www.dhs.state.mn.us/
  Click on Health Care, then Medical Assistance
  800.657.3629

- **Missouri - Medicaid**
  www.dss.mo.gov/mhd/participants/pages/hipp.htm
  573.751.2005

- **Montana - Medicaid**
  http://medicaidprovider.hhs.mt.gov/clientpages/clientindex.shtml
  800.694.3084

- **Nebraska - Medicaid**
  www.ACCESSNebraska.ne.gov
  800.383.4278

- **Nevada - Medicaid**
  http://dwss.nv.gov/
  800.992.0900

important notices (continued)

- New Hampshire - Medicaid
  www.dhhs.nh.gov/oii/documents/hippapp.pdf
  603.271.5218

- New Jersey - Medicaid and CHIP
  Medicaid
  www.state.nj.us/humanservices/dmahs/clients/medicaid/
  609.631.2392
  CHIP
  www.njfamilycare.org/index.html
  800.701.0710

- New York - Medicaid
  www.nyhealth.gov/health_care/medicaid/
  800.541.2831

- North Carolina - Medicaid
  www.ncdhhs.gov/dma
  919.855.4100

- North Dakota - Medicaid
  www.nd.gov/dhs/services/medicalserv/medicaid/
  800.755.2604

- Oklahoma - Medicaid and CHIP
  www.insureoklahoma.org
  888.365.3742

- Oregon - Medicaid and CHIP
  www.oregonhealthykids.gov
  www.hijossaludablesoregon.gov
  800.699.9075

- Pennsylvania - Medicaid
  www.dpw.state.pa.us/hipp
  800.692.7462

- Rhode Island - Medicaid
  www.ohhs.ri.gov
  401.462.5300

- South Carolina - Medicaid
  www.scdhhs.gov
  888.549.0820

- South Dakota - Medicaid
  http://dss.sd.gov
  888.828.0059

- Texas - Medicaid
  www.gethipptexas.com/
  800.440.0493

- Utah - Medicaid and CHIP
  http://health.utah.gov/upp
  866.435.7414

- Vermont - Medicaid
  www.greenmountaincare.org
  800.250.8427

- Virginia - Medicaid and CHIP
  Medicaid
  www.dmas.virginia.gov/rcp-HIPP.htm
  800.432.5924
  CHIP
  www.famis.org
  866.873.2647

- Washington - Medicaid
  http://hca.wa.gov/medicaid/premiumpymt/pages/index.aspx
  800.562.3022, ext. 15473

- West Virginia - Medicaid
  www.dhhr.wv.gov/bms/
  877.598.5820, HMS Third Party Liability

- Wisconsin - Medicaid
  www.badgercareplus.org/pubs/p-10095.htm
  800.362.3002

- Wyoming - Medicaid
  http://health.wyo.gov/healthcarefin/equalitycare
  307.777.7531

To see if any more States have added a premium assistance program since January 31, 2014, or for more information on special enrollment rights, you can contact either:

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

- U.S. Department of Health and Human Services
  Centers for Medicare and Medicaid Services
  www.cms.hhs.gov
  877.267.2323, ext. 61565

contact information

Plan	Phone Number	Web Site
Medical		
• Kaiser – Group #38320		
– Member Services	800.464.4000 - English 800.788.0616 - Spanish	www.kp.org
• Monterey County Schools Insurance Group		
– Anthem Group #18548 – Member Services	800.287.1442	www.mcsig.com
Dental		
• Delta Dental – Group #15997-000		
– Member Services	888.335.8227	www.deltadentalca.org
Life and AD&D		
• Principal Financial – Group #H01607-00001		
– Service and Claims	800.245.1522	www.principal.com
Long Term Disability (LTD)		
• Principal Financial – Group #H01607-00001		
– Service and Claims	800.245.1522	www.principal.com
Flexible Spending Account (FSA)		
• Payflex Systems USA, Inc.		
– Member Services	800.284.4885	www.mypayflex.com
Retirement		
• PERS	800.284.4885	www.calpers.ca.gov
• STRS		www.strs.ca.gov www.calstrs.ca.gov/members/active/retireplanning.htm
• Social Security	800.772.1213	www.ssa.gov
Payroll and Human Resources		
• Certificated	650.550.7967	
• Classified	650.550.7966	
• Personnel	650.550.7965	

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