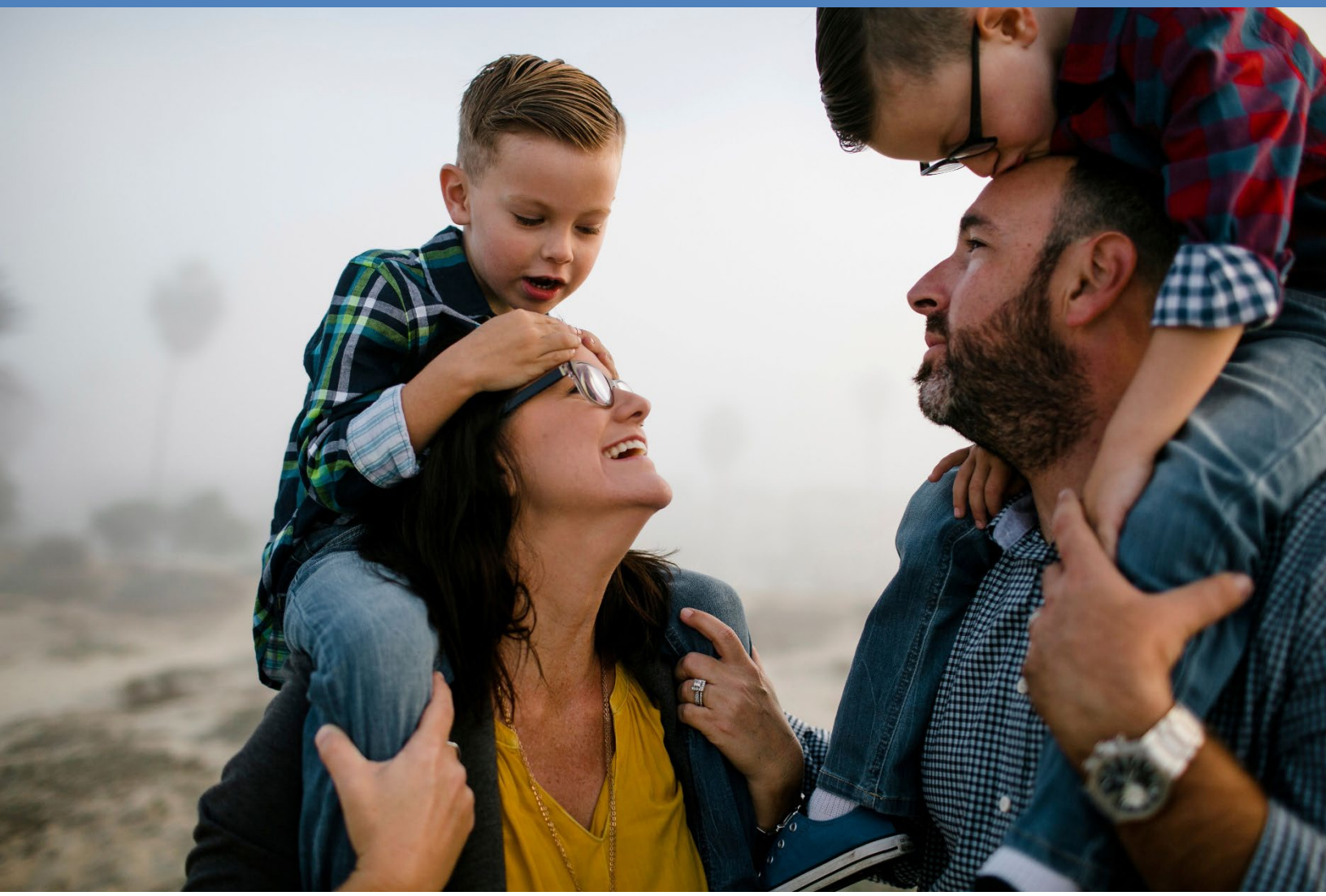
Enrollment & Eligibility Guide



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ELIGIBILITY INFORMATION

ELIGIBILITY – Active Employees

All regular full-time and part-time employees working at least .5 FTE, or 20 hours or more per week, are eligible to enroll in San Ramon Valley Unified School District's benefit plans. You and your eligible dependents may enroll in the medical, dental and vision programs. Your eligible dependents include your legal spouse, domestic partner, natural and adopted children, stepchildren, and any other children you support for whom you are the legal guardian or for whom you are required to provide coverage as the result of a qualified medical child support order. You must elect coverage when first eligible. If you do not enroll when you are first eligible, you must wait until the next annual Open Enrollment period to enroll or until you have a qualified change in status/HIPAA qualifying event outside of annual Open Enrollment.

When can you enroll:

Eligible employees may enroll at the following times:

- **As a new hire** or an employee who is newly eligible for benefits. You have 30 calendar days to enroll.
- **During annual Open Enrollment (typically October-November of each year)** This is when you have the opportunity to make changes to your benefit elections. These changes include adding or dropping coverage for yourself or your eligible dependents, and/or changing health carriers and/or plans, including cash-in-lieu.
- **When you experience a qualified change-in-status** event, such as marriage or the birth of a child, or a HIPAA special enrollment event. You must report these events within 30 days in order to make any allowable changes to your benefits. See pages 5 & 6 for more details about reporting qualified change-in-status events and HIPAA special enrollment events.

Enrolling your dependents:

You may enroll your dependents when you are first eligible. If you do not enroll when you are first eligible, you must wait until the next Open Enrollment period or until you have a change in family status/ HIPAA qualifying event.

ELIGIBILITY – Retirees

When you retire, you have 30 days to enroll yourself and your eligible dependents in the San Ramon Valley Unified School District's medical, dental, and vision plans.

Your eligible dependents include your legal spouse, domestic partner, natural and adopted children, stepchildren, and any other children you support for whom you are the legal guardian or for whom you are required to provide coverage as the result of a qualified medical child support order.

If you do not elect coverage when first eligible, you will not be permitted to join the plans at a later date. If you enrolled when initially eligible, Open Enrollment is your one chance each year to make changes to your elections. However, please note, if you drop your coverage for any reason, you will not be allowed to re-enroll in any of the plans.

ELIGIBLE DEPENDENTS

Your eligible dependents include:

- Your spouse (as defined by applicable State law)
  Note: Legally separated or divorced spouses are ineligible
- Your same-sex or opposite sex domestic partner who meets certain criteria (see below)
- Children (as described below) from birth up to the age of 26 for medical (regardless of marital status), Unmarried children up to age 26 for life insurance, and Unmarried Children up to age 19 (or age 25 if a full time student) for dental and vision coverage.
  a. You or your domestic partner's biological or adopted children
  b. Your stepchildren whom you support and who live with you in a parent-child relationship
  c. Children placed in your home for adoption
  d. Any other children you support for whom you are the legal guardian or for whom you are required to provide coverage as the result of a qualified medical child support order

Unmarried Dependent children over the age of 19 through age 25 must be a full-time student (12 semester units undergrad/ 6 semester units grad) to be eligible to continue participating in Dental and Vision plans. It is the employee's responsibility to inform the benefits department when they are no longer eligible. Dependent children can continue coverage for medical until the month they turn 26 without school verification.

IMPORTANT: Failure to delete ineligible dependents within 30 days of a change in status may result in a loss of continuation coverage (COBRA) rights for your dependent(s), AND you may also become financially responsible for the cost of premiums and any services received by your dependent(s) after the loss of eligibility.

ELIGIBILITY INFORMATION

Domestic Partner Eligibility Criteria:

If you are enrolling a domestic partner, same sex or opposite sex, you are required to meet all eligibility requirements listed below for the previous 6 months.

- You are both eighteen (18) years of age or older
- You share a close personal relationship and are responsible for each other's basic living expenses in the event that either of you is unable to provide such expenses for himself or herself
- Neither of you is married or legally separated from anyone else
- You are not related by blood to such a degree that you would be prevented for marrying in the State in which you reside
- You cohabit and reside together in the same residence and intend to do so indefinitely
- You must complete the Domestic Partnership Affidavit provided by the District

If your domestic partner status changes in the future, i.e. you are no longer meet the above eligibility criteria or you get married, you must notify the Benefits Office within 30 days of the change.

Imputed Income for Domestic Partners

The Federal Government and IRS do not recognize domestic partnerships and require that premiums paid for benefits of domestic partners or children of domestic partners be paid with post-tax dollars. Due to the District contribution for medical, dental and vision insurance, the value of the medical, dental and vision benefit results in imputed income to the employee. This means you will be taxed on the value of the coverage.

The State of California also applies imputed income unless you have filed a Declaration of Domestic Partnership with the California Secretary of State. Your domestic partnership does not need to be filed with the State for your dependents to be eligible for coverage. Registration simply allows the benefit to NOT be considered imputed income and subject to tax under the State tax laws. However, even if registered, the benefit will still be subject to tax under Federal tax law.

Note: It is recommended you consult with your tax advisor for more information on how this affects you. COBRA Continuation Rights do not apply to a same-sex or opposite sex Domestic Partnership as defined by the law or any child of such partner.

ELIGIBILITY INFORMATION

EFFECTIVE DATE OF COVERAGE

An employee's coverage under the district-sponsored medical, dental, vision, and basic life insurance plans becomes effective as follows:

- Employees hired or newly eligible that have a start date between the 1st and 15th of the month — Benefits will become effective on the first day of the following month. EXAMPLE: An employee starting on August 10th would become eligible for benefits on September 1st.
- Employees hired or newly eligible that have a start date after the 15th of the month — Benefits will become effective the first day of the second month. EXAMPLE: An employee starting on August 26th would become eligible for benefits on October 1st.
- Changes made during the annual Open Enrollment period take place on January 1st of each year.

Coverage for Eligible Dependents who are included on an employee's enrollment form becomes effective the same date as the employee's coverage. All enrollment forms must be received in the Benefits Office no later than 30 days from the date the employee becomes eligible.

IF YOU LEAVE EMPLOYMENT OR ARE NO LONGER ELIGIBLE FOR BENEFITS

Medical, Dental, Vision and EAP plan coverage ends following your date of separation or loss of eligibility as follows:

a. If your separation date is between the 1st and 15th of the month — your benefits stop at the end of the month.

b. If you separation date is between the 16th and 31st of the month — your benefits stop at the end of the following month.

c. If you separate after a full school year of service, your active benefits will run through July 31st.

Your life and disability coverage ends on the date you separate employment. You and any dependents you have covered under your medical, dental and vision coverage have the right to continue participation in group health coverage as allowed under the Consolidated Omnibus Budget Reconciliation Act (commonly referred to as "COBRA"). COBRA generally allows you to continue coverage for up to 18 months by paying the monthly premiums yourself. In some cases, longer extensions and/or premium assistance may apply. Detailed information about COBRA rights is given to you when you join the Company or become eligible for health coverage. You may request another copy of your COBRA rights notice at any time. For more information, contact the Benefits Office at (925) 552-5014. You can convert life insurance coverage to an individual policy or port (take with you) your current term coverage within 31 days of your termination date.

ENROLLMENT INFORMATION

HOW TO ENROLL

Please note, the Universal Enrollment Form (UEF) can now be completed online by going to: https://srvusd.sharepoint.com/DistrictFormsandFiles/FormsOnline/SitePages/Home.aspx

This interactive form will track your progress and notify the Benefits Office of any missing information or documentation.

In order to enroll you must complete the online UEF and submit required documentation as follows:

1. If you are a **new employee**, enrolling a spouse, domestic partner or dependent child (ren) in the benefit plans for the first time, you must complete the Universal Enrollment Form and attach a copy of the applicable documentation:
    a. Your Marriage License
    b. Birth Certificate(s) for your children
    c. Affidavit of Domestic Partnership form (available in the Benefits Office) and California's Domestic Partnership papers, if applicable
    d. Student Certification Form and document from the school registrar's office indicating number of units enrolled in for any dependent children between the ages of 19 and 24 who you want to enrolled in dental and/or vision. This form can be obtained from the Benefits Office.
2. If you were previously enrolled and want to **add or remove** a dependent, please complete the online Universal Enrollment Form indicating the change and attach appropriate documentation:
    a. Your Marriage License, Domestic Partnership papers and/or Birth Certificate(s) for your child(ren)
    b. Your Divorce or Legal Separation court documents
3. If you are changing a health plan during the annual **Open Enrollment** period but not adding or deleting dependents, complete and submit the online Universal Enrollment Form indicating the change.

Please complete the online Universal Enrollment Form and provide all necessary documents to the Benefits Office within 30 days of becoming eligible or no later than 4:00 pm on the day of the Open Enrollment deadline for all Open Enrollment changes. If you have any questions, please contact us at (925) 552-5014.

WHAT HAPPENS IF YOU DON'T ENROLL OR CANCEL COVERAGE

If You Don't Enroll

New eligible employees who don't enroll in District-sponsored benefits within the 30-day period will not be able to enroll in the medical plan until the next annual Open Enrollment period or until you experience a qualified change-in-status event or HIPAA special enrollment event. See page 7 for the criteria on qualified change in status or HIPPA events.

If You Cancel Coverage

Employees on an unpaid approved Leave of Absence may cancel coverage. If you cancel coverage, you may not re-enroll until you physically return to work from the approved Leave of Absence or during the next Open Enrollment Period.

Retirees

The benefit choices you make during Open Enrollment (or upon initial retirement) will remain in place until the next Open Enrollment period unless you move out of the service area and are no longer eligible to continue coverage under the plan you are currently on (per carrier rules).

If you did not elect coverage when first eligible, you will not be permitted to join the plans at a later date. If you enrolled when initially eligible, Open Enrollment is your one chance each year to make changes to your elections. However, please note, if you drop your coverage for any reason, you will not be allowed to re-enroll in any of the plans.

MAKING CHANGES DURING THE YEAR

You can enroll in benefits as a new hire or during the annual open enrollment period. When you elect coverage under the medical, dental and vision plans, coverage stays in effect for the entire plan year (January 1 through December 31). You cannot change your coverage, start or stop coverage, or add or drop any family members to or from your coverage, during the plan year unless you have a qualified change-in-status event or a HIPAA special enrollment event.

QUALIFIED CHANGE-IN-STATUS EVENTS

Examples of a qualified change-in-status events include:

- Change in marital or domestic partner status (marriage, divorce or legal separation)
- Change in number of dependents (birth, adoption or placement for adoption of a child; death of spouse or child)
- Change in dependent eligibility (dependent child loses eligibility due to age, student status or marriage)
- Change in other coverage (spouse or child gains or loses eligibility for coverage under another plan, such as through a spouse's employer)
- Change in residence resulting in loss of eligibility (such as moving out of HMO area)

If you experience a qualified change-in-status event, **you have 30 days to report the event and request an enrollment change that is consistent with the type of event.** For instance, if the event is marriage, you may request an enrollment change to add your new spouse to your coverage. Enrollment changes due to qualified change-in-status events generally are effective the first of the month following the event, provided that you requested the enrollment change by the 30-day deadline. Coverage for a new child due to birth or adoption is generally effective on the date of the event.

The plan's official documents govern how and when you can make enrollment changes during the plan year and may allow qualified change-in-status events in addition to those listed above. The Benefits Office can provide complete details.

It is the employee's responsibility to delete a dependent that loses eligibility for coverage due to divorce/end of a domestic partnership, and/or for children due to exceeding age limitations. If you need to delete dependents, contact the Benefits Office. **IMPORTANT: Failure to delete ineligible dependents within 30 days of a change in status may result in a loss of continuation coverage (COBRA) rights for your dependent(s), AND you may also become financially responsible for the cost of premiums and any services received by your dependent(s) after the loss of eligibility.**

Examples of Life Changes:

1. If you and your domestic partner get married, please inform the Benefits Department right away so we can stop the imputed income tax on the value of your benefits.
2. If you are adding a child to your family, you must complete an enrollment form and provide a copy of the live birth certificate within 30 days. *(Please note: if you are participating in the UHC HMO plan, the newborn child's pediatrician must be in the same group as the mother for the pediatrician expenses to be covered. You can switch to another group the following month if you choose. Please contact UHC customer service for additional information.)*
3. If your spouse loses coverage, make sure to enroll them and/or yourself on our plans within 30 days.
4. Voluntarily dropping COBRA coverage is not a qualified status change. You must experience a life changing event as outlined above AND enroll a qualified dependent within 30 days of their loss of coverage.
5. Dependent children over the age of 19 through age 25 who drop below full-time status. It is the employee's responsibility to inform the benefits department when they are no longer eligible for Dental or Vision coverage. (Dependent children can continue coverage for medical until the month they turn 26 without school verification.)

MAKING CHANGES DURING THE YEAR

HIPAA Special Enrollment Rights

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), if you decline company-sponsored medical, dental or vision coverage for yourself or your dependents because you have other health insurance coverage (for example, through your spouse's employer), you may be able to enroll yourself and your dependents in our company's health care plan during the plan year if:

- You or your dependents lose eligibility for the other coverage
- The other employer stops contributing toward the other coverage
- You or your dependents lose eligibility for Medicaid or Children's Health Insurance Program (CHIP) coverage
- You or your dependents become eligible for a State's premium assistance program under Medicaid or CHIP

For any HIPAA special enrollment event, you must request enrollment within **30 days** after you or your dependent's other coverage ends (or after the other employer stops making a contribution toward the other coverage) or you acquire the new dependent. If the event is gaining or losing eligibility for coverage or premium assistance under Medicaid or CHIP, you have up to **60 days** to request a change. For more information or to request special enrollment, contact the Benefits Office at (925) 552-5014.

IF YOU PLAN TO RETIRE

Certain employees, depending upon your hire date, status and your bargaining unit, may receive a monthly monetary amount towards paying for medical, dental, vision or life insurance if you retire from the District and CalPERS or CalSTRS. You may only continue the existing benefit plans you were enrolled in at the time of retirement. Make sure to plan ahead and make changes at the Open Enrollment period prior to your retirement date to ensure the coverage you want into retirement is accessible. Employees planning to retire within the year, should consider carefully whether to enroll in a Medical Expense Flexible Spending Account (FSA). These plans are administered on a calendar year basis, January through December.

Please refer to your bargaining unit agreement for information on eligibility. Management, Confidential, CSEA III, and most CSEA II represented employees are no longer eligible for this benefit. Please refer to board policy or your bargaining unit agreement for more information. If you have any questions please contact the Benefits Department at (925) 552-2913.

CASH-IN-LIEU OF MEDICAL

Employees, who have **alternative medical coverage through a group plan**, may opt to waive their medical benefit. The cash value of this option varies from year to year and is pro-rated for part-time employees. The cash-in-lieu amount can be found in the benefit booklet.

Employees must provide proof of group medical insurance in the form of a letter from the employer providing alternative group coverage within 30 days of enrollment. Privately purchased insurance, Medicare and Medi-Cal will not serve as proof of alternative coverage.

The amount received from Cash-In-Lieu is taxable income and does NOT count towards retirement credit under STRS/PERS.

Employees enrolling in Cash-In-Lieu may purchase Dental and Vision insurance, but must pay the full cost of the monthly premium.

There is a 2-year commitment for both Dental and Vision elections. Employees who enroll in Dental and Vision coverage may not cancel during this time period, unless there has been a qualified change-in-status event.

Important facts if you waive coverage:

- Employees who have previously elected to waive medical, dental or vision coverage and would like to enroll in coverage may do so only during Open Enrollment unless there has been a qualified change-in-status event.
- Enrollment in Cash-In-Lieu may only occur at the time of initial hire/eligibility or during the Open Enrollment period. There is no mid-year enrollment for Cash-In-Lieu however, you are permitted to make all appropriate enrollment changes if you have a qualified change in status.

If you have questions you can contact the plan carriers below or call the the District Benefits Office at (925) 552-5014.

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