2026 Benefits Guide

Active Employees

Open Enrollment: October 17 – November 3, 2025
Effective January 1, 2026

SAN RAMON VALLEY UNIFIED SCHOOL DISTRICT
SRV USD

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PLEASE NOTE: All required Annual Notices, including the Medicare Part D Creditable Coverage Notice, are contained at the end of this Benefit Guide. Please refer to them and read them carefully. If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please see page 32 for more details.

Important Notice

San Ramon Valley Unified School District has made every attempt to ensure the accuracy of the information described in this enrollment guide. Any discrepancy between this guide and the insurance contracts or other legal documents that govern the plans of benefits described in this enrollment guide will be resolved according to the insurance contracts and legal documents. San Ramon Valley Unified School District reserves the right to amend or discontinue the benefits described in this enrollment guide in the future, as well as change how eligible employees and San Ramon Valley Unified School District share plan costs at any time. This enrollment guide creates neither an employment agreement of any kind nor a guarantee of continued employment with San Ramon Valley Unified School District.

OPEN ENROLLMENT is from October 17th to November 3rd

You play an important role in our success. That's why we strive to provide you with a benefits program that rewards you for the hard work and dedication you put forth every day.

Our comprehensive and competitive benefits program is an important component of your total compensation package. This guide provides valuable information to help you better manage your health and your financial security.

During open enrollment, you have the opportunity to review your coverage needs, consider the benefit plans available to you, and select benefits that will provide the most value to you.

Open Enrollment for 2026 coverage – **your one chance to make changes to your benefits**[1] – begins October 17, 2025 and will remain open until November 3, 2025. The benefits you choose will become effective on January 1, 2026 and will remain in place until December 31, 2026.

You must participate in Open Enrollment if you wish to do any or all of the following:

- Make changes to your medical, dental, or vision coverage for the upcoming plan year
- Contribute to a Health Care and/or Dependent Care Flexible Spending Account (FSA)

If you don't wish to make any changes, you may default into the same or comparable coverage that you elected last year, see page 7 for additional details. However, you won't be automatically enrolled in any FSAs – you need to make an election to participate each year. If you wish to enroll or make changes during Open Enrollment please **send the completed Universal Enrollment Form and supporting documents to the Benefits Office no later than November 3rd at 4:00 pm.**

Review this guide to choose which benefits are right for you. If after reading this guide you need more information, please contact the Benefits Office at (925) 552-5014, or go online to the TruHu benefits website, a mobile-friendly benefits portal. Visit the site using the link and login credentials below:

TruHu Benefits Portal

User ID: SRVUSD (case sensitive)

Password: Benefits1 (case sensitive)

[1] You can change your coverage during the year if you experience a "Qualified Status Change," including but not limited to marriage, domestic partnership, divorce, birth or adoption of a child or death of spouse or child.

2026 CHANGES

San Ramon Valley Unified School District consistently strives to offer an outstanding and comprehensive benefits package to their employees. Achieving this goal includes considering benefit modifications in order to better manage the rising costs of healthcare. Additionally, certain plan offerings have been discontinued, prompting The District to offer alternative plan options for the 2026 plan year. Please review the appropriate section for additional details on the following changes:

- **Medical** Plan costs have increased for all available options. There have been changes to the medical plans that are available in 2026.
    - The United Healthcare (UHC) Harmony HMO plan options will no longer be available in 2026. However, the District still has the **UHC Signature Value HMO** available and in addition you will have access to the same network of providers. Additionally, as a result of the changes to the partnership between Canopy Health and UHC the high-deductible plan option has transitioned to a **PPO** plan. PPO plans are typically more expensive than HMO offerings due to expanded in-network provider access and out-of-network coverage. Please review the full plan summaries to identify any benefit changes that will impact you and your dependents.
    - The District understands the challenges posed by these required network changes and in an effort to mitigate the cost impact to employees, you will find that there have been changes to all of the United Healthcare plans. Please carefully review the UHC plan summaries beginning on page 10 if you intend to continue participating in one of these plans
    - There have been no plan changes to the **Kaiser Traditional HMO** plan and The District continues to offer this coverage at no-cost to employees. Due to IRS mandated changes effective January 1st, there has been an increase to the deductible and out-of-pocket maximums for the **Kaiser High-Deductible HMO**.
- The IRS has announced an increase to the annual contribution limits for **Health Savings Accounts (HSA).** Those who are enrolled in a High-Deductible Health Plan and eligible to participate in an HSA can set aside up to $4,400 in 2026, or $8,750 if enrolled with dependents. The District will also continue to contribute to these accounts by providing $80 per month for an employee and $160 per month for anyone covering their eligible dependents. For more details, please see page 14.
- The annual contribution limit for **Flexible Spending Accounts** (FSA) has been increased by the IRS for the upcoming 2026 plan year. During Open Enrollment, you will be permitted to elect up to increased limit of $3,400 for the Health Care FSA. The contribution limits for the Dependent Care FSA will remain unchanged at $5,000 (or $2,500 if married and filing separate tax returns). Remember that these benefits require re-enrollment each year in order to participate. For additional details on how these accounts may benefit you or your household, please see page 17.
- Additional details on these changes can be found on the District's **TruHu benefits website**, a mobile-friendly benefits portal. You can access the TruHu Benefits Portal and login using the following credentials **(Username: SRVUSD | Password: Benefits1)**. Or simply scan the QR code on this page and login to get started!

User ID: SRVUSD (case sensitive)
Password: Benefits1 (case sensitive)

2026 CHANGES

The District is pleased to offer the same valuable Dental and Vision plans once again. Please review the plan details within this guide to better understand these coverage options.

- There are no changes to the benefits offered under the **Vision** coverage. The District continues to cover the full cost of this plan.
    - During Open Enrollment, anyone who has not previously enrolled in the Vision coverage will be eligible to enroll. Please be aware that there is a two-year commitment when enrolling in this plan. You cannot cancel during that time, unless you have a qualified status change. If you cancel for any reason, there is a 24-month waiting period to re-enroll.
- The same two Dental Plans are available once again for all employees. There has been an increase to the costs of the **Dental Buy-Up** plan.
    - During Open Enrollment, anyone who has not previously enrolled in the Dental coverage will be eligible to do so. Please note that there is a two-year commitment with this plan. You cannot cancel during that time, unless you have a qualified status change. If you cancel for any reason, there is also a 24-month waiting period to re-enroll and the benefit level is reset at 70%.

Additional information can also be found on the District's TruHu Benefits Portal (Username: SRVUSD | Password: Benefits1).

Full-time and Part-time employees (working a minimum of .5 FTE or 20 hours per week) and their eligible dependents can participate in San Ramon Valley Unified School District benefits. Eligible dependents include:

- Your spouse or domestic partner (see page 2 of Enrollment and Eligibility Guide)
- Child(ren) up to age 26 for medical, regardless of student or marital status
- Unmarried Child(ren) up to age 26 for dependent life insurance
- Unmarried Child(ren) up to age 19 (or age 25 if a full-time student) for dental and vision coverage
- Unmarried Child(ren) of any age if you support the child and he or she is incapable of self-support due to disability

Review the Enrollment and Eligibility Guide for additional details regarding eligibility, including the company's definition of domestic partner.

PROOF OF DEPENDENT ELIGIBILITY

You are required to provide proof of eligibility for your dependents. Note that attempting to enroll an ineligible dependent could lead to discipline and possible termination of employment. If your dependent becomes ineligible for coverage during the year, you must contact the Benefits Office at (925) 552-5014 within **30 days**. Failure to provide notification results 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.

Enrolling in Benefits

If you're eligible for San Ramon Valley Unified School District benefits, you can enroll and make changes by completing the Universal Enrollment Form and providing the appropriate documentation. Please refer to the Enrollment & Eligibility guide to determine what additional documents may be needed. If after reading this guide you have enrollment questions, please contact the Benefits Office at (925) 552-5014.

If you wish to enroll or make changes please **send the completed 2026 Universal Enrollment Form and supporting documents to the Benefits Office within 30 days of becoming eligible or no later than November 3rd at 4:00 pm for all Open Enrollment changes.**

UHC PPO

The District continues to offer a nationwide PPO medical plan through UHC.

- A PPO health insurance plan provides more choices when it comes to your healthcare, but there will also be higher out-of-pocket costs associated with these plans. Your monthly premiums will be higher, you'll be responsible for a portion of the plan costs (coinsurance) and there is also an annual deductible that must be met.
- No need to select a Primary Care Physician (PCP), you have access to any healthcare professional you wish to visit; inside or outside of the network.
- If you choose to go outside the Select Plus (West) network, you'll have higher out-of-pocket costs, and not all services may be covered.

EMPLOYEE CONTRIBUTIONS - Medical

The values below indicate how much you're responsible for contributing towards medical coverage. Amounts are taken directly from your paycheck each month.

Monthly rates are pro-rated for part-time employees based on your FTE. For example, if you are .80 FTE you would pay 20% of the district monthly contribution. Deductions for the medical, dental, and vision plans are taken on a pre–tax basis.[1]

Employees who work less than 12 months and pay a portion towards the cost of their benefit plans will have a double deduction taken from their June check to cover the July and August premium.

CONTRIBUTION SUMMARY (Monthly)

Benefit	2026 Total Premium	2026 District Share	2026 Employee Share	2025 Employee Share	2026 Cost Increase
Kaiser Permanente Traditional HMO					
Employee	$1,068.54	$1,068.54	**$0**	$0	$0
Employee + 1 Dependent	$2,137.08	$2,137.08	**$0**	$0	$0
Employee + Family	$3,023.97	$3,023.97	**$0**	$0	$0
Kaiser Permanente HDHP HMO - HSA Compatible (includes District HSA contribution, see below)					
Employee	$837.75	$837.75	**$0**	$0	$0
Employee + 1 Dependent	$1,675.50	$1,675.50	**$0**	$0	$0
Employee + Family	$2,370.83	$2,370.83	**$0**	$0	$0
United Healthcare Signature Value HMO					
Employee	$1,137.25	$1,068.54	**$68.71**	$117.32	-$48.61
Employee + 1 Dependent	$2,268.22	$2,137.08	**$131.14**	$228.92	-$97.78
Employee + Family	$3,206.86	$3,023.97	**$182.89**	$321.45	-$138.56
United Healthcare HDHP PPO - HSA Compatible (includes District HSA contribution, see below)					
Employee	$1,182.50	$1,068.54	**$113.96**	$0	$113.96
Employee + 1 Dependent	$2.358.48	$2,137.08	**$221.40**	$0	$221.40
Employee + Family	$3,334.45	$3,023.97	**$310.48**	$0	$310.48
United Healthcare Select Plus PPO					
Employee	$3,152.60	$1,068.54	**$2,084.06**	$1,863.32	$220.74
Employee + 1 Dependent	$6,287.82	$2,137.08	**$4,150.74**	$3,711.31	$439.43
Employee + Family	$9,219.63	$3,023.97	**$6,195.66**	$5,536.24	$659.42

HDHP HSA Compatible Plan – District Contribution

For employees that enroll in one of the HDHP options the District will contribute $80/month for individuals enrolled in employee only coverage, and $160/month for employees who have also enrolled at least 1 dependent. This contribution is based on full-time employment and will be pro-rated for part-time employees.

Additional information on HSAs can be found on page 14.

[1] Due to federal and state tax regulations, benefits provided to domestic partners are generally taxable and therefore deducted from your pay on an after-tax basis. Additionally, any premium contributions made by San Ramon Valley Unified School District on behalf of your domestic partner are generally considered taxable income to you. Contact the District if you believe your domestic partner is exempt from federal or state taxes.

EMPLOYEE CONTRIBUTIONS – Dental & vision

The values below indicate how much you're responsible for contributing towards dental and vision coverage. These amounts are taken directly from your paycheck each month.

Monthly rates are pro-rated for part-time employees based on your FTE. For example, if you are .80 FTE you would pay 20% of the district monthly contribution. Deductions for the medical, dental, and vision plans are taken on a pre–tax basis.[1]

Employees who work less than 12 months and pay a portion towards the cost of their benefit plans will have a double deduction taken from their June check to cover the July and August premium.

During this Open Enrollment period, anyone who has not previously enrolled in the Dental or Vision coverage through The District will be eligible to do so! Please note that there is a two-year commitment with enrolling in these plans. You cannot cancel during that time, unless you have a qualified status change. If you cancel for any reason, there is also a 24-month waiting period to re-enroll and the benefit level is reset at 70%. If you have any questions regarding these plans, please contact Human Resources.

CONTRIBUTION SUMMARY (Monthly)

Benefit	2026 Total Premium	2026 District Share	2026 Employee Share	2025 Employee Share	2026 Cost Increase
Delta Dental (Base Plan)					
Employee	$57.08	$57.08	**$0**	$0	$0
Employee + 1 Dependent	$114.20	$114.20	**$0**	$0	$0
Employee + Family	$165.54	$165.54	**$0**	$0	$0
Delta Dental (Buy-Up Plan)					
Employee	$71.69	$57.08	**$14.61**	$14.03	$0.58
Employee + 1 Dependent	$143.45	$114.20	**$29.25**	$28.09	$1.16
Employee + Family	$207.93	$165.54	**$42.39**	$40.71	$1.68
VSP Vision					
Employee	$8.12	$8.12	**$0**	$0	$0
Employee + 1 Dependent	$16.21	$16.21	**$0**	$0	$0
Employee + Family	$23.52	$23.52	**$0**	$0	$0

[1] Due to federal and state tax regulations, benefits provided to domestic partners are generally taxable and therefore deducted from your pay on an after-tax basis. Additionally, any premium contributions made by San Ramon Valley Unified School District on behalf of your domestic partner are generally considered taxable income to you. Contact the District if you believe your domestic partner is exempt from federal or state taxes.

CASH-IN-LIEU

Employees, who have **alternative medical coverage through a group plan**, may opt to waive their medical benefit. The cash value of this option is **$464** per month for full-time employees and is pro-rated for part-time employees. Employees enrolling in the Cash-in-Lieu option, may purchase Dental and Vision insurance, but must pay the full cost of the monthly premium.

If you waive dental and vision coverage, you must experience a Qualifying Status Change or wait until the next annual Open Enrollment period in order to re-enroll in dental or vision.

Review the Enrollment and Eligibility Guide for additional details regarding eligibility and important information if you waive coverage.

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.

MEDICAL & PRESCRIPTION DRUG BENEFITS

You have the opportunity to enroll in either the Kaiser Permanente Health Maintenance Organization (HMO) medical plan or the United Healthcare (UHC) HMO plan, provided that you **live or work inside the applicable service area**; this also applies to any dependents. Any services obtained outside of the HMO service area will be limited to Emergency coverage only. These medical plans are an HMO and offer in-network coverage only. If you do not select a primary care physician when you enroll, one will be assigned to you by the carrier. To review the service area, find a provider, or to obtain additional information about your plan visit www.kp.org or www.myuhc.com.

MEDICAL PLANS SUMMARY

Key Features	Kaiser HMO	UHC Signature Value HMO
	In-Network	In-Network
Calendar Year Deductible Individual / Family	None	$500 / $1,000
Out-of-Pocket Maximum *(includes deductible)* Individual / Family	$1,500 / $3,000	$3,000 / $6,000
Coinsurance (portion you pay)	None	None
Preventive Care	Covered 100%	Covered 100%
Physician Services Office Visit / Specialist Visit	$30 copay	$30 / $60 copay (deductible waived)
Urgent Care Copay	$30 copay	Within Service Area: $30 Outside Service Area: $50 (deductible waived)
Emergency Room Copay (waived if admitted)	$150 copay	$250 copay (deductible waived)
Inpatient Hospital	$250 copay/per admission	20% coinsurance
Lab and X-Ray Services	No charge	$25 copay (deductible waived)
Chiropractic	$15 copay, up to 30 visits/year	$15 copay, up to 40 visits/year (combined with acupuncture)
Prescription Drugs		
Calendar Year Prescription Drug Deductible	$100 (applies to all non-Generic drugs)	None
RETAIL PRESCRIPTIONS (30-DAY SUPPLY)		
Generic (Tier 1)	$15 copay	$10 copay
Preferred Brand (Tier 2)	$30 copay	$30 copay
Non-preferred Brand (Tier 3)	$30 copay	$50 copay
Specialty	20% up to $150 max copay	20% up to $100 max copay
MAIL-ORDER PRESCRIPTIONS	**100-DAY SUPPLY**	**90-DAY SUPPLY**
Generic (Tier 1)	$30 copay	$25 copay
Preferred Brand (Tier 2)	$60 copay	$75 copay
Non-preferred Brand (Tier 3)	$60 copay	$125 copay

The information above is a summary of coverage only. For more information, including the Summaries of Benefits and Coverage (SBC's), visit the *TruHu Benefits Portal (User ID: SRVUSD (case sensitive); Password: Benefits1 (case sensitive)).* For questions about a specific procedure, service or provider, please contact the medical plan directly at www.kp.org or www.myuhc.com. It is recommended that you register for an account after enrollment.

MEDICAL & PRESCRIPTION DRUG BENEFITS

You have the freedom to choose between two High-Deductible Health Plan (HDHP) options. By choosing to enroll in the Kaiser Permanente HDHP HMO you'll have access to a health savings account (HSA), which can be used to set aside money pre-tax to be used for qualified medical expenses. The Kaiser HDHP HMO offers in-network coverage and any services obtained outside of the HMO service area will be limited to Emergency coverage only. If you do not select a primary care physician when you enroll, one will be automatically assigned to you.

To review the service area, find a provider, or to obtain additional information about your plan visit www.kp.org or www.myuhc.com.

MEDICAL PLANS SUMMARY

Key Features	Kaiser High-Deductible HMO
	In-Network
Calendar Year Deductible Individual / Family	$1,700 / $3,400
All Services subject to the Calendar Year Deductible unless otherwise noted	
Out-of-Pocket Maximum *(includes deductible)* Individual / Family	$3,400 / $6,800
Coinsurance (portion you pay)	10%
Preventive Care	Covered 100% (deductible waived)
Physician Services Office Visit / Specialist Visit	10% coinsurance
Urgent Care Copay	10% coinsurance
Emergency Room Copay (waived if admitted)	10% coinsurance
Inpatient Hospital	10% coinsurance
Lab and X-Ray Services	10% coinsurance
Chiropractic	$15 copay, up to 30 visits/year
Prescription Drugs	
Calendar Year Prescription Drug Deductible Applies to all non-Generic drugs	Medical Deductible Applies
RETAIL PRESCRIPTIONS (30-DAY SUPPLY)	
Generic (Tier 1)	$10 copay
Preferred Brand (Tier 2)	$30 copay
Non-preferred Brand (Tier 3)	$30 copay
Specialty	20% up to $250 max copay
MAIL-ORDER PRESCRIPTIONS	**100-DAY SUPPLY**
Generic (Tier 1)	$20 copay
Preferred Brand (Tier 2)	$60 copay
Non-preferred Brand (Tier 3)	$60 copay

The information above is a summary of coverage only. For more information, including the Summaries of Benefits and Coverage (SBC's), visit the *TruHu Benefits Portal (User ID: SRVUSD (case sensitive); Password: Benefits1 (case sensitive)).* For questions about a specific procedure, service or provider, please contact the medical plan directly at www.kp.org or www.myuhc.com. It is recommended that you register for an account after enrollment.

MEDICAL & PRESCRIPTION DRUG BENEFITS

If you choose to enroll in the United Healthcare (UHC) HDHP PPO you'll also have access to a health savings account (HSA), which can be used to set aside money pre-tax to be used for qualified medical expenses. The UHC HDHP PPO offers both in-network and out-of-network coverage, but you will always maximize your benefits by visiting in-network providers. You do not need to select a primary care physician if enrolling in the UHC HDHP PPO plan. To find a provider, or to obtain additional information about your plan visit www.kp.org or www.myuhc.com.

MEDICAL PLANS SUMMARY

Key Features	UHC High Deductible PPO	
	In-Network	Out-of-Network
Calendar Year Deductible Individual / Family	$3,400 / $6,800	$7,000 / $14,000
All Services subject to the Calendar Year Deductible unless otherwise noted		
Out-of-Pocket Maximum *(includes deductible)* Individual / Family	$5,500 / $11,000	$11,000 / $22,000
Coinsurance (portion you pay)	20%	50%
Preventive Care	Covered 100% (deductible waived)	Not Covered
Physician Services Office Visit / Specialist Visit	20% coinsurance	50% coinsurance
Urgent Care Copay	20% coinsurance	50% coinsurance
Emergency Room Copay (waived if admitted)	20% coinsurance	
Inpatient Hospital	20% coinsurance	50% coinsurance
Lab and X-Ray Services	20% coinsurance	X-Ray: 50% coinsurance Lab: Not Covered
Chiropractic	20% coinsurance, up to 24 visits/year	Not Covered
Prescription Drugs		
Calendar Year Prescription Drug Deductible Applies to all non-Generic drugs	Medical Deductible Applies	
RETAIL PRESCRIPTIONS (30-DAY SUPPLY)		
Generic (Tier 1)	$5 copay	
Preferred Brand (Tier 2)	$35 copay	
Non-preferred Brand (Tier 3)	$75 copay	
Specialty	$250 copay	
MAIL-ORDER PRESCRIPTIONS	**90-DAY SUPPLY**	
Generic (Tier 1)	$12.50 copay	Not Covered
Preferred Brand (Tier 2)	$87.50 copay	Not Covered
Non-preferred Brand (Tier 3)	$187.50 copay	Not Covered

The information above is a summary of coverage only. For more information, including the Summaries of Benefits and Coverage (SBC's), visit the *TruHu Benefits Portal (User ID: SRVUSD (case sensitive); Password: Benefits1 (case sensitive)).* For questions about a specific procedure, service or provider, please contact the medical plan directly at www.kp.org or www.myuhc.com. It is recommended that you register for an account after enrollment.

MEDICAL & PRESCRIPTION DRUG BENEFITS

You have the opportunity to enroll in the United Healthcare (UHC) Preferred Provider Organization (PPO) plan, which offers both in- and out-of-network coverage, but you will pay less for services when you see in-network providers. To find a provider in the Select Plus Plan or to obtain additional information about your plan visit www.myuhc.com. If you do not select a primary care physician when you enroll, UHC will assign one to you.

MEDICAL PLAN SUMMARY

Key Features	UHC Select Plus PPO	
	In-Network	Out-of-Network
Calendar Year Deductible Individual / Family	$250 / $500	$500 / $1,000
Out-of-Pocket Maximum (includes deductible) Individual / Family	$2,250 / $4,500	$4,500 / $9,000
Coinsurance (portion you pay)	20%	40%
Preventive Care	Covered 100%	Not covered
Physician Services Office Visit / Specialist Visit	$15 copay (deductible waived)	40%, after deductible
Urgent Care Copay	$50 copay (deductible waived)	40%, after deductible
Emergency Room Copay (waived if admitted)	$100 copay (deductible waived)	
Inpatient Hospital (per admission)	20%, after deductible	40%, after deductible
Lab and X-Ray Services	No charge (deductible waived)	40%, after deductible
Chiropractic	$15 copay, up to 24 visits/year (deductible waived)	40%, after deductible
Prescription Drugs		
Calendar Year Prescription Drug Deductible Individual / Family	None	
RETAIL PRESCRIPTIONS (30-DAY SUPPLY)		
Generic (Tier 1)	$10 copay	$10 copay
Preferred Brand (Tier 2)	$30 copay	$30 copay
Non-preferred Brand (Tier 3)	$50 copay	$50 copay
MAIL-ORDER PRESCRIPTIONS (90-DAY SUPPLY)		
Generic	$25 copay	Not covered
Preferred Brand	$75 copay	Not covered
Non-preferred Brand	$125 copay	Not covered

The information above is a summary of coverage only. For more information, including the Summaries of Benefits and Coverage (SBC's), visit the *TruHu Benefits Portal (User ID: SRVUSD (case sensitive); Password: Benefits1 (case sensitive)).* For questions about a specific procedure, service or provider, after you are enrolled please contact the medical plan directly at www.myuhc.com. It is recommended that you register for an account after enrollment.

HEALTH SAVINGS ACCOUNT (HSA)

If you enroll in either of the Kaiser or UHC HMO HDHP options, you'll have access to a health savings account (HSA) through P&A Group. An HSA is a bank account which can be used to pay for qualified health care expenses, such as deductibles, coinsurance, prescriptions and dental/vision care using pre-tax deductions. For a complete list of eligible expenses, please visit https://www.irs.gov/pub/irs-pdf/p502.pdf.

HSA ELIGIBILITY

There are certain HSA eligibility requirements. You may not participate if you are:

- Covered as a dependent on another health plan
- Age 65 or older and enrolled in Medicare or Social Security
    - If you enroll in an HSA prior to retirement, you may continue to use saved HSA funds after you retire for qualified expenses, but you cannot contribute more money to the account)
- Enrolled in or covered by a flexible spending account (FSA) for health expenses (dependent care and limited purpose FSA are excluded)
- Covered by any other health coverage (e.g., under a military or college health plan)

HSA MAXIMUM CONTRIBUTIONS

Employees that choose to enroll in one of the HDHP options will receive the following contribution from the District:

- **Employee Only:** $80/month
- **Employee + 1 or more dependents:** $160/month

This contribution from the District is based on full-time employment and will be pro-rated for part-time employees.

Each year, the IRS sets limits on how much you can contribute to an HSA. This means that the combined total of your annual contributions and any contributions from the District can't exceed the following amounts in 2026:

- **Single:** $4,400
- **Family:** $8,750
- **Catch up Contribution (age 55 and older):** $1,000

HOW TO REGISTER FOR YOUR HSA

Employees enrolled in an HSA will be able to manage their account with P&A Group through the MyBenefits participant online portal. This portal gives you 24/7 access to manage your account with services that include:

- Checking your balance and account activity
- Making an HSA transaction
- Ordering additional debit cards

Participants will also be provided access to the P&A Group MyBenefits mobile app which can allow users to submit claims, check account balances and review eligible expenses.

To get a started with your HSA account through P&A Group, please visit www.padmin.com and select "Login/Register" to get started setting up your account. If you need additional support in getting your account setup, please contact P&A Group at (716) 852-2611 .

DENTAL BENEFITS

San Ramon Valley Unified School District offers dental coverage through Delta Dental. These plans are Preferred Provider Organizations (PPO) made up of general dentists and specialists who have agreed to provide dental care at discounted fees.

The Delta Dental PPO plan gives you the freedom to choose your own dentist and receive coverage from in-network and out-of-network providers. If you go to a dentist who participates in the PPO, you qualify for in-network coverage and benefit from discounted rates.

The District offers a Dental Buy-Up plan, in addition to the standard Dental Base plan. The Buy-Up is available at a slightly increased cost, this additional plan option includes an increased Calendar Year Maximum, allowing you to receive more covered services each year. You can find a participating provider at www.deltadentalins.com or by calling their Customer Service Department at (800) 765-6003.

DENTAL PLAN SUMMARIES

Key Features	DELTA DENTAL PPO (BASE PLAN)	
	In-Network	Out-of-Network
Annual Calendar Year Maximum (CYM)	$1,700	$1,500
Calendar Year Deductible (Individual / Family)	$25 / $75 (waived for Diagnostic, Preventive and Ortho)	
Diagnostic & Preventive Services	70% - 100% [1, 2]	
Basic Services	70% - 100% [1]	
Major Services	70% - 100% [1]	
Orthodontics (dependent children only)	50%	
Orthodontics Lifetime Maximum	$500	
Dental Accident Benefits	100% up to $1,000 per Calendar Year	

[1] Benefit percentage increases by 10% each year (to a maximum of 100%) provided the member visits the dentist at least once during the year. If the member does not use the plan during the year, the benefit level remains the same as the prior year.

[2] Diagnostic & Preventive services do not count toward the Annual Calendar Year Maximum

Key Features	DELTA DENTAL PPO (BUY-UP PLAN)	
	In-Network	Out-of-Network
Annual Calendar Year Maximum (CYM)	$2,500	$1,700
Calendar Year Deductible (Individual / Family)	$25 / $75 (waived for Diagnostic, Preventive and Ortho)	
Diagnostic & Preventive Services	70% - 100% [1, 2]	
Basic Services	70% - 100% [1]	
Major Services	70% - 100% [1]	
Orthodontics (dependent children only)	50%	
Orthodontics Lifetime Maximum	$1,500	
Dental Accident Benefits	100% up to $1,000 per Calendar Year	

[1] Benefit percentage increases by 10% each year (to a maximum of 100%) provided the member visits the dentist at least once during the year. If the member does not use the plan during the year, the benefit level remains the same as the prior year.

[2] Diagnostic & Preventive services do not count toward the Annual Calendar Year Maximum

The information above is a summary of coverage only. For more information, visit the *TruHu Benefits Portal (User ID: SRVUSD (case sensitive); Password: Benefits1 (case sensitive)).* For questions about a specific procedure, service or provider, please contact the dental plan directly at www.deltadentalins.com.

You and your dependents have access to vision coverage through VSP. The VSP Signature plan pays benefits for both in-network and out-of-network services. However, you will receive maximum value from your vision benefits when you choose in-network providers. If you see a network provider, you will pay copays for most services. If you receive care outside the network, you will need to pay the full cost and file a claim to be reimbursed for a portion of the costs.

VISION PLAN SUMMARY

Key Features	In-Network	Out-of-Network	Frequency
Exam	No charge after $10 copay	Up to $50 benefit allowance, after $10 copay	Once every 12 months
Lenses	No charge after $25 copay	Varies depending on lens type, after $25 copay	Once every 12 months
Frames [1]	Up to $150 benefit allowance, after $25 copay	Up to $70 benefit allowance, after $25 copay	Once every 24 months
Contact Lenses Instead of Glasses (elective)	Up to $130 benefit allowance, after $25 copay	Up to $105 benefit allowance, after $25 copay	Once every 12 months
Contact Lenses Instead of Glasses (medically necessary)	No charge after $25 copay	Up to $210 benefit allowance, after $25 copay	

[1] *Frames are available through Costco, with an $80 allowance, which is equivalent to $150 at other retail providers.*

The information above is a summary of coverage only. For more information, visit the *TruHu Benefits Portal (User ID: SRVUSD (case sensitive); Password: Benefits1 (case sensitive)).* For questions about a specific procedure, service or provider, please contact the vision plan directly at www.vsp.com.

Your VSP plan includes a $20 Essential Medical Eye Care benefit, which includes an exam for diabetes and other medically related services related to your eyes (i.e. pink eye, eye trauma).

VSP also offers a hearing aid discount program to all VSP members and their covered dependents through TruHearing. To take advantage of this free program and enjoy discounts of up to 50% on some of the most popular digital hearing aids on the market, simply sign up at www.vsp.com/offers/special-offers and then call (877) 396-7194 to make an appointment.

FLEXIBLE SPENDING ACCOUNTS

Flexible Spending Accounts (FSAs) allow you to set aside money from your paycheck to pay Health Care and Dependent Care expenses with tax-free dollars. When you contribute to FSAs, your pre-tax contributions reduce your taxable income.

The FSA maximum contribution limits are established each year by the IRS. For 2026, the Health FSA contribution limits have been increased to the amounts shown below.

These plans require re-enrollment each year if you wish to participate. For more information on how the Flexible Spending Accounts work, please contact P&A Group at (716) 852-2611 or visit www.padmin.com.

Account	What it can be used for:	Most you can contribute in 2026:
Health Care FSA	To pay medical, dental, vision, and hearing expenses not covered by your health care plans, such as deductibles, coinsurance and copayments. **NOTE:** If you contribute to an HSA, you are only eligible to participate in the Limited Purpose FSA.	$3,400
Limited Purpose FSA	To pay for qualified dental and vision expenses only. **NOTE:** Only available to individuals who are enrolled in an HSA	$3,400
Dependent Care FSA	Dependent care expenses such as day care and after school programs for children under age 13, or elder care expenses, so you and your spouse can work or attend school full time.	$5,000, or $2,500 if married and filing separate tax returns

HOW THE FSAs WORK:

- The total amount you choose to contribute to your Health Care FSA or Limited Purpose FSA is available immediately. You can spend the dollars in your Dependent Care FSA as they are deposited each pay period.
- Health Care, Limited Purpose and Dependent Care Accounts are all separate. The money in one account cannot be used to pay for expenses from the other account.
- If you enroll in the Health Care FSA, you will receive a debit card that you can use to pay for eligible health care expenses at the point of service. Otherwise, you can pay for services and submit a claim for reimbursement or request reimbursement online.
- If you enroll in the Dependent Care FSA, you will pay for services and submit a claim for reimbursement or request reimbursement online.
- If you are enrolled in an HSA, you are eligible to participate in a Limited Purpose FSA to pay for qualified dental and visions expenses.
- FSA elections do not automatically roll over from one year to the next. You must re-enroll each year to participate.
- For a complete list of eligible Health Care and Dependent Care FSA expenses, refer to IRS guidelines available online at www.irs.gov or go to the P&A Group website at www.padmin.com.

Use-It or Lose-It

- With the Health Care FSA or Limited Purpose FSA, you have an additional 2 1/2-month grace period next year to spend this year's funds, *which means that you have until March 15, 2027*.
- The Dependent Care FSA also offers you an additional grace period. This means that *you have until March 15, 2027 to spend funds from your account and until March 31, 2027 to submit expenses*.

BASIC LIFE AND AD&D

The District provides you with $50,000 in Basic Life and AD&D insurance, at no cost to you. Beginning January 1, 2026 these benefits will now be offered through SunLife Financial. Full and part-time employees may elect an additional $50,000 of Life and AD&D benefit for a total of $100,000* worth of coverage, when initially eligible for benefits.

Key Features	
Basic Life and AD&D Insurance	$50,000
Additional Life and AD&D Insurance	$50,000 (for a total of $100,000)*
Conversion and Portability	Included
Accelerated Death Benefit	Included at 75%

***Monthly Premium Cost for Part-Time Employees Electing Additional Life and AD&D**

$6.75 x % of FTE

Monthly premium rates are pro-rated for part-time employees based on your FTE. For example, if you are .80 FTE you would pay 20% of the premium cost or $1.35 per month.

Monthly Cost for any Employee Electing Dependent Life

$2.00 for $5,000 per dependent covered

Keep in mind: You and your eligible family members may only be covered once under Life and AD&D insurance. No one may be covered as both an employee and a dependent of the company. If you and your spouse or child work for the District, be sure to coordinate your Life insurance coverage so no one is covered more than once.

COST FOR ADDITIONAL LIFE AND AD&D*

- **Full-time** employees: The additional $50,000 in coverage is free
- **Part-time** employees: must pay the pro-rated share of the monthly premium for the additional $50,000

**Note: The value of any life insurance coverage in excess of $50,000 may be subject to imputed income taxes.*

ACCIDENTAL DEATH & DISMEMBERMENT (AD&D)

If your death is the result of an accident, you will receive an additional Accidental Death & Dismemberment (AD&D) benefit. If you lose a limb or your eyesight as the result of an accident, the AD&D plan will pay a percentage of your AD&D benefit amount.

Please note: the election you make upon initial benefits eligibility to take basic and/or additional life cannot be changed in the future, even if there is a change in family status.

NAMING YOUR BENEFICIARY

You may name anyone you wish as the beneficiary who will receive your Life and AD&D benefits in case of your death. Once you have selected your beneficiary(ies), your designation will remain unchanged until you submit a new beneficiary designation form. You may change your beneficiary(ies) as often as you wish. Please make sure your beneficiary information on file with the District is up to date. It is best to double check this information is up to date each year.

INCOME PROTECTION BENEFITS

LONG-TERM DISABILITY (LTD)

San Ramon Valley Unified School District offers Long-Term Disability (LTD) insurance through Sun Life Financial to Management and Confidential Employees. **You will automatically be enrolled when you become eligible.**

After you have been disabled for 150 days and/or have exhausted all of your sick leave (whichever is greater) LTD benefits begin and you receive 66.67% of your income, up to a maximum of $6,250 per month. Your LTD benefits will be offset by any other disability payments you may receive, such as Social Security or Workers' Compensation.

- Management Employees covered under CalPERS: Benefits continue until you are no longer disabled or for a duration between 12 months to 5 years, depending upon your age at the time you become disabled. The District pays for the cost of this coverage.
- Management Employees covered under CalSTRS: Benefits continue until you are no longer disabled or for a duration between 12 months to 2 years, depending upon your age at the time you become disabled. The District pays for the cost of this coverage.
- Confidential Employees: Benefits continue until you are no longer disabled or for a duration between 12 months to 5 years, depending upon your age at the time you become disabled. Confidential employees pay a monthly fee of 0.12% of base salary for this coverage.

The information above is a summary of coverage only. For more information, visit the *TruHu Benefits Portal (User ID: SRVUSD (case sensitive); Password: Benefits1 (case sensitive)).* For questions about a specific procedure, service or provider, please contact the disability plan directly.

EMPLOYEE ASSISTANCE PROGRAM (EAP)

The EAP, through Telus Health (formerly LifeWorks), is a confidential counseling and referral service available to you and your family members at no cost. The EAP provides three (3) free telephone or face-to-face consultations per issue, per person each year. The EAP offers 24/7 telephone access to licensed professionals who can help with concerns regarding:

- Marriage and relationships
- Depression, anxiety, stress, grief
- Substance abuse
- Work-related issues
- Childcare and elder care resources
- Financial and legal consultations and information
- Identity theft prevention and recovery
- And much more

EAP services are confidential. No information will be shared with your employer. To take advantage of the services and resources available through the EAP, call Telus Health at (888) 267-8126. You can also access valuable information online at https://one.telushealth.com (Username: srvusd; Password: eap)

COMMUTER BENEFIT

Save money on your work-related transportation costs by setting aside pre-tax dollars in our transit and parking spending accounts. You may choose to set aside up to $340 pre-tax per month for mass transit expenses and up to $340 pre-tax per month for parking expenses.

Each pay period, the appropriate amount will be deducted pre-tax from your paycheck and credited to your parking and transit accounts. You can then use the funds from these accounts to pay for your eligible transportation expenses. You may change the amount you are contributing or stop your contributions at any time during the year.

Transit expenses include ferry, subway, train and bus travel. Parking expenses include parking at a station to take another mode of transportation to work or parking at your workplace. Expenses that are not covered include mileage, tolls, parking at your residence and airport parking. This program is governed by the IRS and complies with the Bay Area Commuter Benefits Program adopted by the Bay Area Air Quality Management District and the Metropolitan Transportation Commission. You can view your balance and submit a claim by visiting www.padmin.com or by calling (716) 852-2611.

RETIREMENT PLAN INFORMATION

FOR CALSTRS MEMBERS

CalSTRS provides retirement benefits for eligible full-time and certain part-time California public school educators. Your retirement benefit is based on a formula set by law using your age, service credit and final compensation.

As a result of 2012 legislation, CalSTRS now has two benefit structures: Members first hired on or before December 31, 2012, are under "CalSTRS 2% at 60", and those first hired on or after January 1, 2013, are under "CalSTRS 2% at 62".

This is a very important benefit. Please take advantage of the workshops provided each year so you can plan appropriately for your retirement. Go to https://my.calstrs.com and register to view your account balances, calculate your retirement benefits and sign up for workshops/webinars. Additionally, the CalSTRS website is filled with information regarding retirement eligibility, planning, forms and publications. Go to www.calstrs.com or you can contact CalSTRS at (800) 228- 5453.

This is just a brief overview of benefits and coverage for CalSTRS. In the event of any conflict or discrepancy between this guide and the STRS plan documents, the plan documents will govern. You should refer to CalSTRS member publications, available online at www.calstrs.com.

FOR CALPERS MEMBERS

Classified employees who work at least 1,000 hours per fiscal year or work in a regular ongoing position for at least 4 hours per day become members of the California Public Employees Retirement System (CalPERS). Your retirement benefit is based on a formula set by law that includes your years of service credit, age at retirement, and final compensation.

As a result of 2012 legislation, CalPERS now has two benefit structures: Members first hired on or before December 31, 2012, are under "CalPERS 2% at 55", and those first hired on or after January 1, 2013, are under "CalPERS 2% at 62".

This is a very important benefit. Please take advantage by reading the plan material and attending workshops so you can plan appropriately for your retirement. The CalPERS website is filled with information regarding retirement eligibility, planning, forms and publications. Go to https://my.calpers.ca.gov and register to view your account balances, calculate and your future retirement benefits and sign up for workshops/webinars. You can also log onto CalPERS general website to obtain information at www.calpers.ca.gov or contact them at (888) 225-7377.

This is just a brief overview of benefits and coverage for CalPERS. In the event of any conflict or discrepancy between this guide and the plan documents, the PERS plan documents will govern. You should refer to CalPERS member publications, available online at www.calpers.ca.gov.

SUPPLEMENTAL RETIREMENT SAVING PLANS

You have the option of participating in a tax-deferred retirement savings program as authorized by Sections 403(b) and 457 of the Internal Revenue Code. Through these programs, you can shelter a portion of your compensation currently subject to Federal and State income tax to purchase supplemental retirement benefits. Your 403(b) and 457 contributions, with accumulated interest, are not subject to Federal or State income taxes until the funds are withdrawn (usually at retirement). A selection of ROTH plans have been added to the current approved vendor list. A ROTH is a type of individual retirement account that is funded with after-tax contributions.

403(b) Plan

SRVUSD has contracted with Envoy Plan Services to serve as the 403(b) Plan's Third-Party Administrator providing plan oversight and administration. Envoy is available to answer your questions and administer all plan related transactions and Salary Reduction Agreements.

The first step in the enrollment process is to establish an account with one of the approved companies/vendors. A list of participating vendors is available on the Client Resource Center of www.envoyplanservices.com. Once you have selected a company, call them to request literature on their 403(b) plan and account application. When the account is established, complete the Online Salary Reduction Agreement (SRA) at www.envoyplanservices.com. This form provides the necessary information for Envoy and SRVUSD to initiate your payroll deduction.

You may change or stop your deduction any time by submitting a new SRA form to Envoy. Changes are subject to month-to- month cutoff dates to meet payroll deadlines. Please keep or print copies of all completed forms for your records. Once you have established an account at Envoy you can make changes on-line at www.envoyplanservices.com using the ONLINE SRA tab. For questions or additional information please call Envoy at 1-800-248-8858 or visit their main website at www.envoyplanservices.com.

457 Plan

The 457 Plan is offered through CalPERS . Go to their website at https://calpers.voyaplans.com which provides detailed information on the plan and how to enroll. The enrollment kit is also available on SRVUSD website under: Employment/ Benefits. You may also contact the CalPERS Information Line at 1-800-260-0659. Participant Service Representatives are available from 6:00AM to 5:00PM Pacific Time, Monday through Friday (except on stock market holidays).

GLOSSARY

BENEFITS TERMS

As you review your benefit choices for this year, here's a refresher on some key health insurance vocabulary that will help you better understand your options.

Coinsurance	The percentage you pay for the cost of covered health care services **after** you've met your deductible. For example, if the coinsurance under your plan is 40%, you would pay 40% of the cost of the service and your insurance would pay the remaining 60%.
Copayment (Copay)	A fixed amount (for example, $30) you pay for a covered health care service, usually when you receive the service (as specified by your plan).
Deductible	The amount you pay in a plan year before your health plan begins to pay benefits.
Generic/ Tier 1 Drug	Your prescription drug copay depends on the class or group of your prescribed medication. A generic drug generally has the lowest copay level. A generic drug is one that is no longer produced only under a brand name. Once a drug's patent expires, many companies can begin to manufacture "generic" versions of a previously brand-name-only drug. Generic drugs are identical to brand-name drugs in chemical makeup ("active ingredients"), usage, strength and dosage. They are regulated and approved by the FDA just like brand-name drugs; however, they are much less expensive.
In-Network Provider	A provider who has contracted with a health care plan (a medical, dental or vision plan) and agreed to certain rates. In most cases, you pay less and receive a higher benefit when you use in-network providers. Check with your plan for coverage details.
Network	A group of doctors, hospitals, labs, and other providers that your health insurance contracts so you can make visits at a pre-negotiated (and often discounted) rate.
Non-preferred Brand/ Tier 3 Drug	Your prescription drug copay depends on the class or group of your prescribed medication. A non-preferred brand-name drug generally has the highest copay level because it is not on the plan's list of preferred drugs. You can find out how different drugs are classified by your plan by visiting the plan's Web site.
Out-of-Network Provider	A state-licensed health care provider who has not contracted with a health care plan (medical, dental or vision plan) and has not agreed to certain rates. In most cases, you pay more and receive a lower level of benefits when you use out-of-network providers. See your plan for coverage details.
Out-of-Pocket Maximum	The cap on your out-of-pocket costs for the plan year. Once you've reached this amount, your plan will cover 100% of your qualified medical expenses for the plan year.
Premium	The amount of money that's paid for your health insurance every month. The District pays a portion of this amount, and you pay the rest.

KEY CONTACTS

For Questions About	Carrier	Phone Number	Website/Email	Group ID
Medical & Prescription Drug	Kaiser Permanente	**800.464.4000** 24 Hour Nurse Line: **800.611.1811**	www.kp.org	568
Chiropractic (Kaiser)	American Specialty Health (ASH)		www.ashcompanies.com	568
Medical & Prescription Drug	United Healthcare (UHC)	HMO Members: **800.624.8822** PPO Members: **866.633.2446**	Before enrollment: https://uhc.welcometouhc.com/ After enrollment: www.myUHC.com	919045
Dental	Delta Dental	**866.499.3001**	www.deltadentalins.com	643
Vision	VSP	**800.877.7195**	www.vsp.com	00785000
Flexible Spending Account (FSA), Health Savings Account (HSA) & Commuter Benefits	P&A Group	**716.852.2611**	www.padmin.com	
Life and AD&D Insurance	SunLife Financial	**800.247.6875**	www.sunlife.com	972346
Long-Term Disability (LTD)	SunLife Financial	**800.247.6875**	www.sunlife.com	972346
Employee Assistance Program (EAP)	Telus Health (formerly LifeWorks)	**888.267.8126**	https://one.telushealth.com User ID: **srvusd** Password: **eap**	113728
Retirement Plans/Savings	CalSTRS CalPERS	**800.228-5453** **888.225-7377**	www.calstrs.com www.calpers.ca.gov	
403(b) Plan	Envoy Plan Services	**800.248.8858**	www.envoyplanservices.com	
457 Plan	CalPERS 457 Plan	**800.260.0659**	https://calpers.voya.com	
HR Department	Shannelle Sherrod Angelina Silva Shahnaz Babar	**925.552.2913** **925.552.2929** **925.552.5014**	ssherrod@srvusd.net asilva@srvusd.net sbabar@srvusd.net	
Benefits Portal	TruHu Benefits Portal		**User ID:** SRVUSD (case sensitive) **Password:** Benefits1 (case sensitive)	

Notice of HIPAA Special Enrollment Rights
If an eligible employee declines enrollment in a group health plan for the employee or the employee's spouse or dependents because of other health insurance or group health plan coverage, the eligible employee may be able to enroll him/herself and eligible dependents in this plan if eligibility is lost for the other coverage (or because the employer stops contributing toward this other coverage). However, the eligible employee must request enrollment within **30** days after the other coverage ends (or after the employer ceases contributions for the coverage).

In addition, if an eligible employee acquires a new dependent as a result of marriage, birth, adoption or placement for adoption, the eligible employee may be able to enroll him/herself and any eligible dependents, provided that the eligible employee requests enrollment within **30** days after the marriage, birth, adoption, or placement for adoption.

Furthermore, eligible employees and their eligible dependents who are eligible for coverage but not enrolled, shall be eligible to enroll for coverage within 60 days after becoming ineligible for coverage under a Medicaid or Children's Health Insurance Plan (CHIP) plan or being determined to be eligible for financial assistance under a Medicaid, CHIP, or state plan with respect to coverage under the plan.

To request special enrollment or obtain more information, contact your health plan.

Newborns' and Mothers' Health Protection Act Notice

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). If you would like more information on maternity benefits, contact your health plan.

Women's Health and Cancer Rights Act Notice
If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

All stages of reconstruction of the breast on which the mastectomy was performed;
Surgery and reconstruction of the other breast to produce a symmetrical appearance;
Prostheses; and
Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. If you would like more information on WHCRA benefits, contact your health plan.

Patient Protection Notice
Your health plan may require or allow for the designation of a primary care provider. If so, you have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members, including a pediatrician, as the primary care provider. Until you make this designation, the health plan may designate one for you.
You do not need prior authorization from the health plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan or procedures for making referrals.
For information on how to select a primary care provider, a list of participating primary care providers, or a list of health care professionals who specialize in obstetrics or gynecology, contact your health plan.

Notice of Privacy Practices

THIS NOTICE OF PRIVACY PRACTICES 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 (the "Notice") describes the legal obligations of San Ramon Valley Unified School District Health Plan (the "Plan") and your legal rights regarding your protected health information held by the Plan under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the Health Information Technology for Economic and Clinical Health Act (HITECH Act). Among other things, this Notice describes how your protected health information may be used or disclosed to carry out treatment, payment, or health care operations, or for any other purposes that are permitted or required by law.
We are required to provide this Notice of Privacy Practices to you pursuant to HIPAA.
The HIPAA Privacy Rule protects only certain medical information known as "protected health information." Generally, protected health information (PHI) is health information, including demographic information, collected from you or created or received by a health care provider, a health care clearinghouse, a health plan, or your employer on behalf of a group health plan, from which it is possible to individually identify you and that relates to:

a. Your past, present, or future physical or mental health or condition;

b. The provision of health care to you; or

c. The past, present, or future payment for the provision of health care to you.

Contact Information

If you have any questions about this Notice or about our privacy practices, and for any correspondence or requests related to the contents of this Notice, please contact the individual listed at the end of this notice.

Effective Date

This Notice is effective February 15th, 2026.

Our Responsibilities

We are required by law to:

a. maintain the privacy of your PHI;

b. provide you with certain rights with respect to your PHI;

c. provide you with a copy of this Notice of our legal duties and privacy practices with respect to your PHI; and

d. follow the terms of the Notice that is currently in effect.

We reserve the right to change the terms of this Notice and to make new provisions regarding your PHI that we maintain, as allowed or required by law. If we make any material change to this Notice, we will provide you with a copy of our revised Notice of Privacy Practices.

How We May Use and Disclose Your PHI

Under the law, we may use or disclose your PHI under certain circumstances without your permission. The following categories describe the different ways that we may use and disclose your PHI. For each category of uses or disclosures we will explain what we mean and present some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories. Note that we will use and disclose PHI as described below unless otherwise prohibited or restricted by applicable state or other law, and that information can lose its protected status as PHI once re-disclosed by a recipient.
For Treatment. When and as appropriate, we may use or disclose medical information about you to facilitate medical treatment or services by health care providers. We may disclose medical information about you to providers, including doctors, nurses, technicians, medical students, or other hospital personnel who are involved in taking care of you. For example, we might disclose information about you with physicians who are treating you.

For Payment. We may use or disclose your protected health information to determine your eligibility for Plan benefits, to facilitate payment for the treatment and services you receive from health care providers, to determine benefit responsibility under the Plan, or to coordinate Plan coverage. For example, we may tell your health care provider about your medical history to determine whether a particular treatment is experimental, investigational, or medically necessary, or to determine whether the Plan will cover the treatment. We may also share your protected health information with a utilization review or pre-certification service provider. Likewise, we may share your protected health information with another entity to assist with the adjudication or subrogation of health claims or to another health plan to coordinate benefit payments.

For Health Care Operations. We may use and disclose your protected health information for other Plan operations. These uses and disclosures are necessary to run the Plan. For example, we may use medical information in connection with conducting quality assessment and improvement activities; underwriting, premium rating, and other activities relating to Plan coverage; submitting claims for stop-loss (or excess-loss) coverage; conducting or arranging for medical review, legal services, audit services, and fraud and abuse detection programs; business planning and development such as cost management; and business management and general Plan administrative activities. However, we will not use your genetic information for underwriting purposes.

Substance Use Disorder (SUD) Treatment Information. Some of your health information may be part of a SUD patient record and subject to additional protections under federal law (42 CFR Part 2) governing confidentiality of SUD patient records. If we receive or maintain any information about you from a SUD treatment program that is covered by 42 CFR Part 2 (a "Part 2 Program") through a general consent you provide to the Part 2 Program to use and disclose the SUD patient record for purposes of treatment, payment or health care operations, we may use and disclose your SUD patient record for treatment, payment and health care operations purposes as described in this Notice. If we receive or maintain your SUD patient record through specific consent you provide to us or another third party, we will use and disclose your SUD patient record only as expressly permitted by you in your consent as provided to us. In no event will we use or disclose your SUD patient record, or testimony that describes the information contained in your SUD patient record, in any civil, criminal, administrative, or legislative proceedings by any Federal, State, or local authority, against you, unless authorized by your consent or the order of a court after it provides you notice of the court order.

To Business Associates. We may contract with individuals or entities known as Business Associates to perform various functions on our behalf or to provide certain types of services. In order to perform these functions or to provide these services, Business Associates will receive, create, maintain, transmit, use, and/or disclose your PHI, but only after they agree in writing with us to implement appropriate safeguards regarding your PHI. For example, we may disclose your PHI to a Business Associate to process your claims for Plan benefits or to provide support services, such as utilization management, pharmacy benefit management, or subrogation, but only after the Business Associate enters into a Business Associate contract with us.

Treatment Alternatives or Health-Related Benefits and Services. We may use and disclose your protected health information to send you information about treatment alternatives or other health-related benefits and services that might be of interest to you.

As Required by Law. We will disclose your PHI when required to do so by federal, state, or local law. For example, we may disclose your PHI when required by national security laws or public health disclosure laws.

To Avert a Serious Threat to Health or Safety. We may use and disclose your PHI when necessary to prevent a serious threat to your health and safety, or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat. For example, we may disclose your PHI in a proceeding regarding the licensure of a physician.

To Plan Sponsors. For the purpose of administering the plan, we may disclose PHI to certain employees of the Employer. However, those employees will only use or disclose that information as necessary to perform plan administration functions or as otherwise required by HIPAA, unless you have authorized further disclosures. Your PHI cannot be used for employment purposes without your specific authorization.

Special Situations

In addition to the above, the following categories describe other possible ways that we may use and disclose your PHI without your specific authorization. For each category of uses or disclosures, we will explain what we mean and present some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

Organ and Tissue Donation. If you are an organ donor, we may release your PHI after your death to organizations that handle organ procurement or organ, eye, or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

Military. If you are a member of the armed forces, we may release your PHI as required by military command authorities. We may also release PHI about foreign military personnel to the appropriate foreign military authority.

Workers' Compensation. We may release your PHI for workers' compensation or similar programs, but only as authorized by, and to the extent necessary to comply with, laws relating to workers' compensation and similar programs that provide benefits for work-related injuries or illness.

Public Health Risks. We may disclose your PHI for public health activities. These activities generally include the following:

a. to prevent or control disease, injury, or disability;
b. to report births and deaths;
c. to report child abuse or neglect;
d. to report reactions to medications or problems with products;
e. to notify people of recalls of products they may be using;
f. to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
g. to notify the appropriate government authority if we believe that a patient has been the victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree, or when required or authorized by law.

Health Oversight Activities. We may disclose your PHI to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose your PHI in response to a court or administrative order. We may also disclose your PHI in response to a subpoena, discovery request, or other lawful process by someone involved in a legal dispute, but only if efforts have been made to tell you about the request or to obtain a court or administrative order protecting the information requested.

Law Enforcement. We may disclose your PHI if asked to do so by a law-enforcement official.

a. in response to a court order, subpoena, warrant, summons, or similar process;
b. to identify or locate a suspect, fugitive, material witness, or missing person;
c. about the victim of a crime if, under certain limited circumstances, we are unable to obtain the victim's agreement;
d. about a death that we believe may be the result of criminal conduct; and
e. about criminal conduct.

Coroners, Medical Examiners, and Funeral Directors. We may release PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about patients to funeral directors, as necessary to carry out their duties.

National Security and Intelligence Activities. We may release your PHI to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

Inmates. If you are an inmate of a correctional institution or are in the custody of a law-enforcement official, we may disclose your PHI to the correctional institution or law-enforcement official if necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

Research. We may disclose your PHI to researchers when:

a. The individual identifiers have been removed; or

b. When an institutional review board or privacy board has reviewed the research proposal and established protocols to ensure the privacy of the requested information and approves the research.

Required Disclosures

The following is a description of disclosures of your PHI we are required to make.

Government Audits. We are required to disclose your PHI to the Secretary of the United States Department of Health and Human Services when the Secretary is investigating or determining our compliance with the HIPAA privacy rule.

Disclosures to You. When you request, we are required to disclose to you the portion of your PHI that contains medical records, billing records, and any other records used to make decisions regarding your health care benefits. We are also required, when requested, to provide you with an accounting of most disclosures of your PHI if the disclosure was for reasons other than for payment, treatment, or health care operations, and if the PHI was not disclosed pursuant to your individual authorization.

Other Disclosures

Personal Representatives. We will disclose your PHI to individuals authorized by you, or to an individual designated as your personal representative, attorney-in-fact, etc., so long as you provide us with a written notice/authorization and any supporting documents (i.e., power of attorney). Note: Under the HIPAA privacy rule, we do not have to disclose information to a personal representative if we have a reasonable belief that:

a. You have been, or may be, subject to domestic violence, abuse, or neglect by such person; or

b. Treating such person as your personal representative could endanger you; and

c. In the exercise of professional judgment, it is not in your best interest to treat the person as your personal representative.

Spouses and Other Family Members. With only limited exceptions, we will send all mail to the employee. This includes mail relating to the employee's spouse and other family members who are covered under the Plan and includes mail with information on the use of Plan benefits by the employee's spouse and other family members and information on the denial of any Plan benefits to the employee's spouse and other family members. If a person covered under the Plan has requested Restrictions or Confidential Communications (see below under "Your Rights"), and if we have agreed to the request, we will send mail as provided by the request for Restrictions or Confidential Communications.

Authorizations. Other uses or disclosures of your PHI not described above will only be made with your written authorization. For example, in general and subject to specific conditions, we will not use or disclose your psychiatric notes; we will not use or disclose your PHI for marketing; and we will not sell your PHI, unless you give us a written authorization. You may revoke written authorizations at any time, so long as the revocation is in writing. Once we receive your written revocation, it will only be effective for future uses and disclosures. It will not be effective for any information that may have been used or disclosed in reliance upon the written authorization and prior to receiving your written revocation.

Your Rights

You have the following rights with respect to your PHI:

Right to Inspect and Copy. You have the right to inspect and copy certain PHI that may be used to make decisions about your Plan benefits. If the information you request is maintained electronically, and you request an electronic copy, we will provide a copy in the electronic form and format you request, if the information can be readily produced in that form and format; if the information cannot be readily produced in that form and format, we will work with you to come to an agreement on form and format. If we cannot agree on an electronic form and format, we will provide you with a paper copy.

To inspect and copy your PHI, you must submit your request in writing. If you request a copy of the information, we may charge a reasonable fee for the costs of copying, mailing, or other supplies associated with your request.
We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to your medical information, you may request that the denial be reviewed by submitting a written request.

Right to Amend. If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the Plan.
To request an amendment, your request must be made in writing. In addition, you must provide a reason that supports your request.
We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

a. is not part of the medical information kept by or for the Plan;
b. was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
c. is not part of the information that you would be permitted to inspect and copy; or
d. is already accurate and complete.

If we deny your request, you have the right to file a statement of disagreement with us and any future disclosures of the disputed information will include your statement.

Right to an Accounting of Disclosures. You have the right to request an "accounting" of certain disclosures of your PHI. The accounting will not include (1) disclosures for purposes of treatment, payment, or health care operations; (2) disclosures made to you; (3) disclosures made pursuant to your authorization; (4) disclosures made to friends or family in your presence or because of an emergency; (5) disclosures for national security purposes; and (6) disclosures incidental to otherwise permissible disclosures.
To request this list or accounting of disclosures, you must submit your request in writing. Your request must state the time period you want the accounting to cover, which may not be longer than six years before the date of the request. Your request should indicate in what form you want the list (for example, paper or electronic). The first list you request within a 12-month period will be provided free of charge. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions. You have the right to request a restriction or limitation on your PHI that we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on your PHI that we disclose to someone who is involved in your care or the payment for your care, such as a family member or friend. For example, you could ask that we not use or disclose information about a surgery that you had.
Except as provided in the next paragraph, we are not required to agree to your request. However, if we do agree to the request, we will honor the restriction until you revoke it or we notify you.
We 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 PHI pertains solely to a health care item or service for which the health care provider involved has been paid in full by you or another person.
To request restrictions, you must make your request in writing. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure, or both; and (3) to whom you want the limits to apply-for example, disclosures to your spouse.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. To request confidential communications, you must make your request in writing. We will not ask you the reason for your request. Your request must specify how or where you wish to be contacted. We will accommodate all reasonable requests.

Right to Be Notified of a Breach. You have the right to be notified in the event that we (or a Business Associate) discover a breach of unsecured PHI.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice.

Complaints

If you believe that your privacy rights have been violated, you may file a complaint with the Plan or with the Office for Civil Rights of the United States Department of Health and Human Services. To file a complaint with the Plan, contact the person listed in the Contact Information section of this Notice. All complaints must be submitted in writing.

You will not be penalized, or in any other way retaliated against, for filing a complaint with the Office for Civil Rights or with us.

HIPAA Contact
San Ramon Valley Unified School District
Shannelle Sherrod / Personnel Analyst
699 Old Orchard Drive Danville, CA 94526
Phone: (925) 552-2913

Website: https://apps.truhu.com/Login.aspx

User ID: SRVUSD
Password: Benefits1
(login and password to website are case sensitive)

MEDICARE NOTICE OF CREDITABLE COVERAGE

Important Notice About
Your Prescription Drug Coverage and Medicare

Notice of Creditable Coverage

This Notice applies only if you and/or your dependent(s) are enrolled in a San Ramon Valley Unified School District medical plan and you are eligible for Medicare. If this does not apply to you, you may ignore this notice.

Please read this notice carefully and keep it where you can find it. This notice has information about your prescription drug coverage with San Ramon Valley Unified School District and 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 employer 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 employer coverage and Medicare's prescription drug coverage:

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.

San Ramon Valley Unified School District has determined that the prescription drug coverage offered under the San Ramon Valley Unified School District plan(s) 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 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 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 Employer Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your employer coverage may be affected. Contact your employer to find out whether you can get your employer coverage back later if you or your dependents drop the coverage and join a Medicare drug plan.

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 employer coverage and don't join a Medicare drug plan within 63 continuous days after the 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 Employer Prescription Drug Coverage…

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

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

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

For More Information about Medicare prescription drug coverage:

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

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

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

October 17, 2025

San Ramon Valley Unified School District
Shannelle Sherrod / Personnel Analyst
699 Old Orchard Drive Danville, CA 94526
Phone: (925) 552-2913

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

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

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

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2025. Contact your State for more information on eligibility –

ALABAMA-Medicaid	CALIFORNIA-Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
ALASKA-Medicaid	**COLORADO-Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx	Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program HIBI Customer Service: 1-855-692-6442
ARKANSAS-Medicaid	**FLORIDA-Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

GEORGIA-Medicaid	MASSACHUSETTS-Medicaid and CHIP
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: (678) 564-1162, Press 2	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
INDIANA-Medicaid	**MINNESOTA-Medicaid**
Health Insurance Premium Payment Program All other Medicaid Website: https://www.in.gov/medicaid/ http://www.in.gov/fssa/dfr/ Family and Social Services Administration Phone: 1-800-403-0864 Member Services Phone: 1-800-457-4584	Website: https://mn.gov/dhs/health-care-coverage/ Phone: 1-800-657-3672
IOWA-Medicaid and CHIP (Hawki)	**MISSOURI-Medicaid**
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
KANSAS-Medicaid	**MONTANA-Medicaid**
Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov
KENTUCKY-Medicaid	**NEBRASKA-Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kynect.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
LOUISIANA-Medicaid	**NEVADA-Medicaid**
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)	Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900
MAINE-Medicaid	**NEW HAMPSHIRE-Medicaid**
Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: -800-977-6740. TTY: Maine relay 711	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 15218 Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov

NEW JERSEY-Medicaid and CHIP	SOUTH DAKOTA-Medicaid
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Phone: 1-800-356-1561 CHIP Premium Assistance Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710 (TTY: 711)	Website: http://dss.sd.gov Phone: 1-888-828-0059
NEW YORK-Medicaid	**TEXAS-Medicaid**
Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831	Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493
NORTH CAROLINA-Medicaid	**UTAH-Medicaid and CHIP**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/ Email: upp@utah.gov Phone: 1-888-222-2542 Adult Expansion Website: https://medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/ CHIP Website: https://chip.utah.gov/
NORTH DAKOTA-Medicaid	**VERMONT-Medicaid**
Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825	Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427
OKLAHOMA-Medicaid and CHIP	**VIRGINIA-Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
OREGON-Medicaid and CHIP	**WASHINGTON-Medicaid**
Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
PENNSYLVANIA-Medicaid and CHIP	**WEST VIRGINIA-Medicaid and CHIP**
Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
RHODE ISLAND-Medicaid and CHIP	**WISCONSIN-Medicaid and CHIP**
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
SOUTH CAROLINA-Medicaid	**WYOMING-Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2024, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

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

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

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

NOTES

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Prepared by

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Insurance Brokers &
Consultants