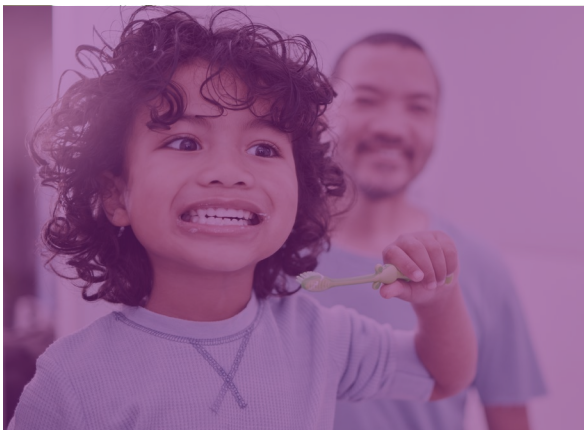
ELK GROVE UNIFIED
SCHOOL DISTRICT



Plan Year 2027
EMPLOYEE BENEFITS GUIDE

ABOUT THIS BENEFITS GUIDEBOOK

In the following pages, you will find a summary of our benefit plans for the **January 1, 2027 to December 31, 2027 Plan Year**. Please read this Guidebook carefully as you prepare to make your elections for the upcoming Plan Year.

This Benefits Guidebook describes EGUSD's benefits program in non-technical language. Your specific rights to benefits under the plan are governed solely, and in every respect, by the official plan documents and not the information in this guidebook. If there is any discrepancy between the description of the program elements as contained in this benefits guidebook and the official plan documents, the language in the official plan documents shall prevail as accurate. Please refer to the plan-specific documents published by each of the respective carriers for detailed plan information. Any and all elements of EGUSD's benefits program may be modified in the future, at any time, to meet Internal Revenue Service rules or otherwise as decided by EGUSD.

2027 PLAN YEAR
OPEN ENROLLMENT
9/28/26 - 10/16/26

For more information about your benefits, visit the Airbo Benefits Board at: ***https://app.airbo.com/ard/elk-grove-usd-2026*** or scan the QR code:

Elk Grove Unified School District Online Benefits Enrollment is easy with BenefitBridge!

Need Help?

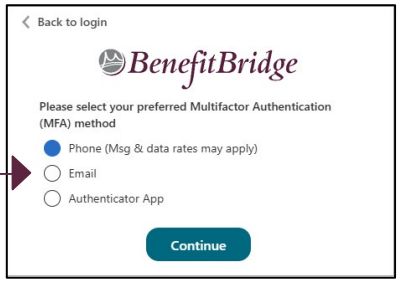
For all questions related to your benefits, please contact your employer's benefits administrator. For BenefitBridge technical assistance ***only***, please contact BenefitBridge Customer Care at 800-814-1862; Mon – Fri, 8:00 AM – 5:00 PM, PST or email benefitbridge@keenan.com.

A Multifactor Authentication (MFA) code is required to confirm your identity each time before you can log in to the system. Below are instructions to help you obtain your MFA code.

Registration and Login

Already have login credentials?

1. Login to BenefitBridge at www.benefitbridge.com/egusd
2. **For your first login only**, you will be asked to change your password.
   - If you have forgotten your password, click on **Forgot User Name/Password?** And follow the prompts.
3. The MFA selection popup will appear.
4. Select the MFA method you would like to use and select "Continue".
5. Different popup windows will appear, depending on your selection.



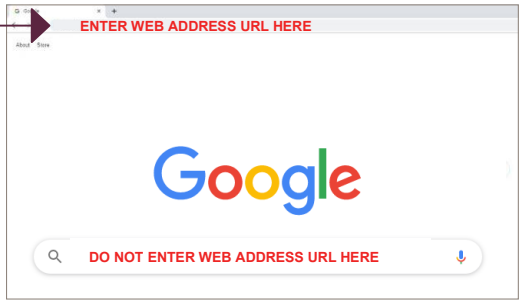
MFA Methods:

1. Select your preferred Multifactor Authentication Method: **Phone**, **Email or Authenticator App** and follow the prompts.
   Download the Authenticator App
   - Download the Microsoft Authenticator app (or the authenticator app of your choice) to your phone device using the Google Play Store or the Apple App Store.

NOTE: *If you do not have a phone number or email listed in BenefitBridge, those options* ***will not be available*** *to you as preferred methods. Please contact your Benefits department to have your phone number and email address updated in BenefitBridge.*

Need to create login credentials?

1. In the **address bar**, type www.benefitbridge.com/egusd
   (Not in the Bing, Google, Yahoo search engine field)
2. Click the **Enter** key, then follow the instructions below to register:
   - **STEP 1**: Select **Register** to Create an Account
     - You will need to create an account using your first and last names as they appear on your payroll statement.
   - **STEP 2**: Create a Username and Password
   - **STEP 3**: Select a picture, as instructed. You will be redirected to the User Login page to sign in.
   - **Step 4:** Follow instructions in the **MFA Methods** section above.



Enrolling in Benefits

Access your enrollment via the **Make Changes to My Benefits"** button

For BenefitBridge technical assistance only, please contact BenefitBridge Customer Care at

800-814-1862

Monday - Friday, 8:00 AM - 5:00 PM, PST or email benefitbridge@keenan.com

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ELIGIBILITY

EGUSD encourages the health and financial well-being of its employees by providing access to quality and affordable healthcare. Eligible employees have access to EGUSD's comprehensive benefits program. EGUSD may conduct an audit requesting supporting documentation on all eligible dependents at any time during the plan year.

Please thoroughly review this Benefits Guide to learn more about these options.

EMPLOYEE ELIGIBILITY

Full-time employees working 20+ hours per week (except for CSEA, which is 27.55 hours or greater) are eligible for our medical, dental, vision, and Basic Life/AD&D insurance benefits and are eligible to participate in our benefits program with an effective date of first of the month following date of hire. Please note you must make your election within 31 days after your hire date. Click here for important information on the different enrollment periods that affect you and your family.

Once your enrollment is completed, you may not make any changes to your elections unless you have a Qualifying Life Event or your hours worked per week drop below the minimum.

DEPENDENT ELIGIBILITY

You may also cover your eligible dependents, including:

- Legal Spouses
- Domestic Partners
- Eligible Children

QUALIFYING LIFE EVENTS

If you experience a Qualifying Life Event (QLE), such as getting married or having a baby, please contact the benefits department. Proof of the QLE must be submitted with your enrollment selection on BenefitBridge within 60 days to change current benefit election.

QLE EXAMPLES

- A change in the number of dependents (birth, adoption, death, guardianship);
- A change in marital status (marriage, divorce, death);
- A dependent's loss of eligibility (attainment of limiting age or change in student status);
- A change in employee's, spouse's, or dependents' work hours;
- A termination or commencement of employment of employee's spouse or eligible dependent with coverage;
- An entitlement to Medicare or Medicaid;
- Other events as the administrator determines to be permitted or any other applicable guidelines issued by the Internal Revenue Service.

MEDICAL

The medical programs available to you provide the framework for your health and well-being. To better meet the varying needs of our employees, EGUSD offers medical plans through Kaiser, Sutter Health Plan and Western Health Advantage.

Note: *EGUSD does not allow married EGUSD employees to be double covered on medical; one spouse must waive their medical.*

Medical Plan Summary	Kaiser Permanente	Sutter Health Plan	WHA
Deductible			
Individual	$0	$0	$0
Family	$0	$0	$0
Out of Pocket Max			
Individual	$1,500	$1,500	$1,500
Family	$3,000	$3,000	$3,000
Office Visits			
Preventive Services	No charge	No charge	No charge
Primary Care	$30 copay	$30 copay	$30 copay
Specialist	$30 copay	$30 copay	$30 copay
Urgent Care	$30 copay	$30 copay	$30 copay
Inpatient	No charge	No charge	No charge
Outpatient	$30 copay	Facility: $100 copay Physician: $30 copay	$100 copay
Diagnostic X-Ray and Lab Tests	$10 copay	No charge	No charge
Major Diagnostic (MRI, CT and PET scans)	$50 copay	No charge	No charge
Emergency Room	$100 copay (waived if admitted)	$100 copay (waived if admitted)	$100 copay (waived if admitted)
Prescription Copays			
Pharmacy Deductible	Not applicable	Not applicable	Not applicable
Retail (30-day)/Mail (100-day)			
Generic	$15 / $30	$15 / $30	$10 / $20
Preferred Brand Name	$35 / $70	$25 / $50	$30 / $60
Non-Preferred Brand Name	$35 / $70	$50/ $100	$50 / $100
Specialty	$100	10% up to $100	$100

Medical Monthly Cost*	Kaiser Permanente	Sutter Health Plan (includes TruHearing)**	WHA
Employee	$293.72	$389.71	$0.00
Employee + 1 Dependent	$587.48	$779.18	$0.00
Employee + 2(+) Dependents	$831.18	$1,102.53	$0.00

** Includes the Standard Plan for Dental and Vision. The District pays 100% for dental and vision coverage for employees and dependents.*

***See page 35 for TruHearing contact information.*

WELLNESS PLAN

NOTE: *2027 Wellness Rebate Forms will NOT be accepted before November 1, 2026. Employees have until 5 p.m. on October 1, 2027 to turn in 2027 Wellness Rebate Forms.*

The 2027 EGUSD Employee Wellness Rebate

EGUSD employees, who are primary subscribers of EGUSD health benefits, have the opportunity to earn an Employee Wellness Rebate consistent with each group's collective bargaining agreement and Board action for unrepresented employees. Each employee subscriber shall receive a Wellness Rebate equal to 5% of the average premium amount based on the District's low cost health plan and the subscriber's benefit level (single, 2 party, family) selected for that year on the condition that they submit to the District a Wellness Rebate Certification form that verifies the wellness requirements have been satisfied by the specified deadlines.

2027 Employee Wellness Rebate Certification Form

Benefitted employees must complete the Wellness Rebate Certification form with all required signatures to be eligible for the Wellness Rebate. Select the form below based on whether you are a member of Kaiser Permanente or Sutter Health Plan.

Kaiser Permanente – EGUSD 2027 Wellness Rebate Certification Form
Sutter Health Plan – EGUSD 2027 Wellness Rebate Certification Form

The timeline and payment schedule for 2027 is found at the District's website. Below is the link to the schedule: https://www.egusd.net/Employment/ResourcesSupports/Employee-Wellness/index.html

Employee Wellness Rebate Compensation Requirements

- A Glucose and Cholesterol Screening. Employees can complete the screening through their medical provider.
- Blood Pressure and Body Mass Index tests.
- An online Health Risk Assessment through either Kaiser Permanente or Sutter Health Plan.
- A Wellness Consultation with your primary/personal care provider that includes information regarding recommended age-appropriate screenings.

An email will be sent notifying employees that their completed form has been approved by Payroll and when to expect the rebate payments.

If you have questions, please email benefits@egusd.net.

DENTAL

Delta Dental gives you the freedom to choose whether you would like to visit a participating dentist or an out-of-network dentist. While your dental plan allows you to see any licensed dentist, using an in-network dentist may minimize your out-of-pocket expenses. If seeing an out-of-network dentist, keep in mind you may be responsible for the difference between your dentist's billed charges and the dental plan reimbursement level.

Dental Plan Summary	Standard Plan		Voluntary Reduced Plan	
	In-Network*	Out-of-Network*	In-Network*	Out-of-Network*
Calendar Year Deductible				
Individual	$0	$0	$100	$100
Family	$0	$0	$300	$300
Maximums	$2,700 per person each calendar year	$2,500 per person each calendar year	$1,200 per person each calendar year	$1,000 per person each calendar year
Diagnostic & Preventive				
Exams, (2) cleanings, x-rays and sealants	70-100%	70-100%	70-100%	70-100%
Basic Services				
Fillings, sealants, posterior composites, endodontics, periodontics and oral surgery	70-100%	70-100%	70-100%	70-100%
Major Services				
Crowns, inlays, onlays and cast restorations	70-100%	70-100%	70-100%	70-100%
Prosthodontics				
Bridges and dentures (implants under the Standard Plan only)	50%	50%	50%	50%
Orthodontic Benefits				
Adults and dependent children	50%	50%	N/A	N/A
Orthodontic Maximums	$2,500 Lifetime	$2,500 Lifetime	N/A	N/A
Dental Accident Benefits	100 % (Separate $1,000 maximum per person each calendar year)		100 % (Separate $1,000 maximum per person each calendar year)	

** Reimbursement is based on PPO contracted fees for PPO dentists, Premier contracted fees for Premier dentists and program allowance for non-Delta Dental dentists. Delta Dental will pay 70% of the Covered Fees for the Diagnostic, Preventive, Basic, Crowns and Restorative Benefits during the first calendar year of eligibility. This percentage increases 10% each consecutive year the dentist is visited to a maximum of 100%. If you do not use your plan, the percentage remains at the level you reached the previous year. It drops back to 70% if you lose eligibility and then become eligible again.*

Plans are 100% paid for by the District. Voluntary Reduced Plan is an option for AFSCME, PSWA, CSEA, NUHW, and EGTEAMS bargaining unit members enrolled in Kaiser and Sutter Health Plan only.

VISION

Your vision health is an important part of complete wellness. VSP is pleased to present to you vision benefits designed to give you and your covered family members the care, value, and service to help maintain good vision and overall health. This plan encourages yearly exams and offers a wide range of frames and lenses.

Standard Plan (VSP Choice)		Voluntary Reduced Plan (VSP Choice)	
Vision Plan Summary	Copay	Vision Plan Summary	Copay
WellVision Exam (Every calendar year) • Focuses on your eyes and overall wellness	$0 for exam and glasses	**WellVision Exam** (Every calendar year) • Focuses on your eyes and overall wellness	$30 for exam and glasses
Essential Medical Eye Care • Retinal screening for members with diabetes • Additional exams and services beyond routine care to treat immediate issues from pink eye to sudden changes in vision or to monitor ongoing conditions such as dry eye, diabetic eye disease, glaucoma, and more. • Coordination with your medical coverage may apply. Ask your VSP doctor for details.	$0 per screening $20 per exam	**Essential Medical Eye Care** • Retinal screening for members with diabetes • Additional exams and services beyond routine care to treat immediate issues from pink eye to sudden changes in vision or to monitor ongoing conditions such as dry eye, diabetic eye disease glaucoma, and more. • Coordination with your medical coverage may apply. Ask your VSP doctor for details.	$0 per screening $20 per exam
Prescription Glasses		**Prescription Glasses**	
Frames (Every calendar year) • $170 featured frame brands allowance • $150 frame allowance • 20% savings on the amount over your allowance • $80 Walmart®/Sam's Club®/Costco® frame allowance	$0	**Frames** (Every calendar year) • $95 featured frame brands allowance • $75 frame allowance • 20% savings on the amount over your allowance • $55 Walmart®/Sam's Club®/ Costco® frame allowance	Combined with exam
Lenses (Every calendar year) • Single vision, lined bifocal, & lined trifocal lenses • Impact-resistant lenses for dependent children	$0	**Lenses** (Every calendar year) • Single vision, lined bifocal, & lined trifocal lenses • Impact-resistant lenses for dependent children	Combined with exam
Lens Enhancements (Every calendar year) • Standard progressive lenses • Premium progressive lenses • Custom progressive lenses • Average savings of 30% on other lens enhancements	$0 $95 - $105 $95	**Lens Enhancements** (Every calendar year) • Standard progressive lenses • Premium progressive lenses • Custom progressive lenses • Average savings of 30% on other lens enhancements	$0 $95-$105 $150-$175
Contacts (Instead Of Glasses, Every calendar year) • $120 allowance for contacts and contact lens exam (fitting and evaluation) • 15% savings on a contact lens exam (fitting and evaluation)	$0	**Contacts** (Instead of Glasses, Every calendar year) • $100 allowance for contacts and contact lens exam (fitting and evaluation) • 15% savings on a contact lens exam (fitting and evaluation)	$0

Extra Savings

Glasses and Sunglasses
- Extra $20 to spend on featured frame brands. Go to vsp.com/offers for details.
- 20% savings on additional glasses and sunglasses, including lens enhancements, from any VSP provider within 12 months of your last WellVision Exam.

Routine Retinal Screening
- No more than a $39 copay on routine retinal screening as an enhancement to a WellVision Exam

Laser Vision Correction
- Average 15% off the regular price or 5% off the promotional price; discounts only available from contracted facilities

Plans are 100% paid for by the District. Voluntary Reduced Plan is an option for AFSCME, PSWA, CSEA, NUHW, and EGTEAMS bargaining unit members enrolled in Kaiser and Sutter Health Plan only.

EMPLOYEE ASSISTANCE PROGRAM

Resources for Living
To access services:
1-888-866-4827, TTY: 711 / resourcesforliving.com
Username: EGUSD / Access Code: EAP

Elk Grove Unified School District

Resources for Living is an employer-sponsored program, available at no cost to you and all members of your household. Children living away from home can access services up to age 26.

Services are confidential and available 24 hours a day, 7 days a week.

Emotional wellbeing support

You can access up to 5 counseling sessions per issue each year. You can also call us 24 hours a day for in-the-moment emotional well-being support.

Counseling sessions are available face-to-face, online with televideo, chat therapy or by phone. Services are free and confidential. We're always here to help with a wide range of issues including:

- Anxiety
- Relationship support
- Depression
- Stress management
- Work/life balance
- Family issues
- Grief and loss
- Self-esteem and personal development
- Substance misuse and more

Find care

It's easy to find a counselor you'd like to work with. You can:

- View provider options — images, bios, specialties and more
- Compare details — ethnicity, gender, language and more
- See which providers are open to new patients and when they're available
- Find options to schedule your first appointment online
- Get started quickly without any added steps or calls

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Resources *for* Living®

Daily life assistance

Competing day-to-day needs can make it tough to know where to start. Call us for personalized guidance. We'll help you find resources for:

- Child care, parenting and adoption
- Care for older adults
- Caregiver support
- Special needs
- Pet care
- Community resources/ basic needs
- Summer programs for kids
- Household services and more

Legal services

You can get a free 30-minute consultation with a participating attorney for each new legal topic. Some of the areas of law and issues covered include:

- Family or domestic law
- Civil and criminal law
- Wills and estate planning
- Real estate and more

If you opt for services beyond the initial consultation you can get a 25 percent discount. You also have free access to legal documents and forms on your member website.

*Services must be related to the employee or an eligible household member. Exclusions include work-related and lack of merit issues. Discount does not include flat legal fees, contingency fees and plan mediator services.

Financial services

Simply call for a free 30-minute phone consultation for each new financial topic related to:

- Budgeting
- Retirement or other financial planning
- Mortgages and refinancing
- Credit and debt issues
- College funding
- Tax and IRS questions

You can get a 25 percent discount on standard tax preparation services. You also have access to financial articles, calculators and a financial assessment on your member website.

*Services must be for financial matters related to the employee or an eligible household member.

Online resources

Your member website offers a full range of tools and resources to help with emotional wellbeing, work/life balance and more. You'll find:

- Videos and podcasts
- Articles, blogs and self-assessments
- Mobile app
- Child and adult care provider search tool
- Live and on-demand webinars and more

Discount Center

Find deals on brand name products and services including electronics, entertainment, gifts and flowers, travel, fitness, nutrition and more.

Mind Companion Self-care

You have access to evidence-based support tools to help manage depression, anxiety, stress, substance misuse and more.

Additional services

Identity theft services — One hour fraud resolution phone consultation or coaching about ID theft prevention and credit restoration. Services include a free emergency kit for victims.

Educator resources — Explore articles and ideas related to topics such as classroom management, social and emotional learning, attention deficit hyperactivity disorder (ADHD), autism spectrum disorder, stress and more.

For legal disclaimers, visit **rfl.com/Disclaimers**.

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Resources *for* Living®

FLEXIBLE SPENDING ACCOUNT

The Flexible Spending Accounts (FSA) administered by Navia Benefit Solutions allow you to set aside pre-tax dollars from your paycheck to pay for many health care and dependent care expenses. By paying for these expenses with pre-tax dollars, you reduce the amount of your taxable income and increase your take-home pay. You may choose to participate in one or both FSAs - whether you elect any other benefits.

HOW MUCH CAN I CONTRIBUTE?

To participate, decide how much you would like to contribute to one or both accounts for the year. The money you allocate to each account is automatically deducted from your paycheck each pay period before taxes are calculated.

- Health Care Flexible Spending Account you could contribute up to the maximum of $3,400 for the 2026 year.
- Dependent Care Flexible Spending Account you could contribute up to the maximum of $7,500 for the 2026 year. The exceptions are:
  - If you and your spouse file separate tax returns, you may contribute $3,750 per year.
  - If your spouse is employed, your maximum contribution is the lesser of your spouse's taxable income (but no more than $7,500)
  - If your spouse is a full-time student or they are physically or mentally disabled, your maximum contribution is $3,750 a year if you claim expenses for one dependent and $7,500 a year if you claim expenses for two or more dependents.

IRS FSA Contribution Limits	2026
HCFSA (Individual)	$3,400
DCFSA	$7,500

Note: *Your plan has a Grace Period, which allows extra time (an additional 2 1/2 months) to incur services at the end of the plan year.*

GENERAL RULES AND RESTRICTIONS

In exchange for the tax advantages FSAs offer, the IRS has imposed the following rules and restrictions for both health care FSA and dependent care FSA:

- You may only use the money in your FSAs to reimburse expenses that you have incurred during the plan year for which the FSA was established.
- IRS requires you to use all of the money in your account by the end of the year or you lose it. This is called the "use it or lose it" rule. Your plan, however, has a Grace Period which allows you to incur services for an additional 2 1/2 months after the end of the Plan Year.
- You cannot transfer monies between Health Care and Dependent Care FSAs.
- You cannot begin, stop, or change the amount of your FSA contributions during the calendar year unless you experience a Qualified Life Event (such as: marriage, divorce or the birth/adoption of a child).
- You cannot claim expenses that are reimbursed through your FSA as a deduction on your income tax return.
- Reimbursement for dependent care FSA claims is only up to the total amount that is in your account at that time.
- The dependent care provider cannot be anyone considered your dependent for income tax purposes (such as one of your older children). In order to be reimbursed, you are required to provide the tax identification number or Social Security number of the party providing care.

navia
benefit solutions

SAVE 25 – 40%
ON YOUR
HEALTH AND DAY CARE EXPENSES

Flexible Spending Accounts (FSAs) let you set aside money from your paycheck on a tax-free basis, for out-of-pocket costs!

Health FSA Eligible Expenses

- Prescriptions & Copays
- Deductibles & Coinsurance
- Dental & Vision Expenses
- Braces

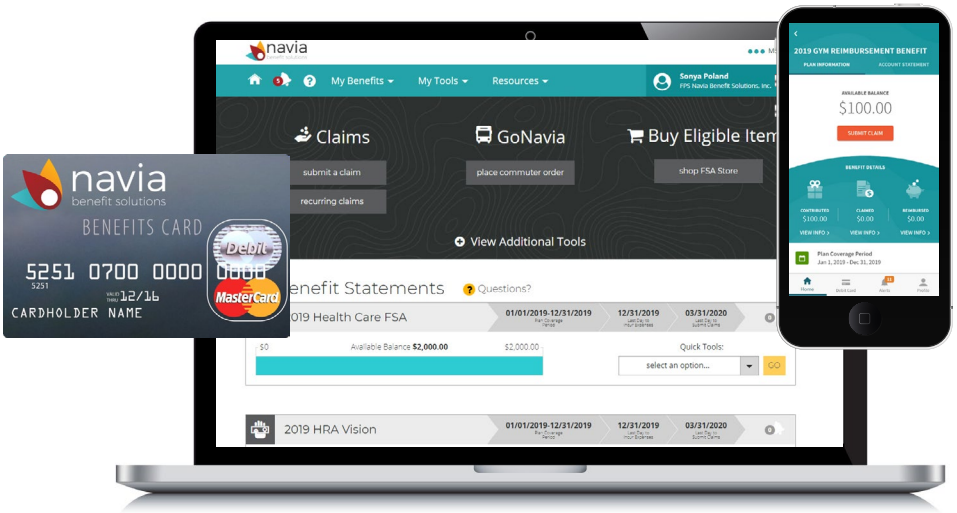
Day Care FSA Eligible Expenses

- Before and After School Care
- Day Camps
- Preschool
- Elder Care

Accessing your benefits couldn't be easier!

Just swipe your Navia Benefit Card to pay for eligible healthcare expenses. Funds come directly out of your FSA and are paid to the provider. Some swipes require us to verify the expense, so hang on to your receipts! If we need to see it, we will send you a notification. ***Learn more.***

IMPORTANT! Some plans do not include the Navia Debit Card, but that's ok! You can also submit claims through Navia's online portal, mobile app, email, fax, or mail. Claims are processed within a few days and reimbursements are issued according to your employer's reimbursement schedule. Navia also offers it's unique FlexConnect tool where you can get reimbursed for all healthcare claims with one click! ***Learn more.***



Navia is here for you!

We're committed to providing you with unparalleled customer service. If you have questions, we're here to answer them!

U.S.

100% US-based, live customer support with offices in every time zone

45 sec

If you have a question, you wait less than a minute to talk with a live Navia expert

2 days

Claims are turned around within 2 days to ensure you are reimbursed fast

navia
benefit solutions

38,000 ways to spend your FSA!

There are 38,000 products and services you can pay for with tax-free FSA money

Spend your money on anything from medicines and hospital services to acupuncture and training a service dog. Here are just a few to give you an idea:

Over-the-counter drugs
Feminine products
Prescriptions
Copays & Coinsurance
Deductibles
Office Visits
Dental work
Orthodontia
Glasses & Contacts
Chiropractic
Massage
Acupuncture
Capital improvements to your home, such as ramps, railings and support bars
Mileage for travel to and from healthcare appointments
Night guards

Bandages and other medical supplies
Birth control
Breast pumps
Breast reconstruction surgery
Childbirth classes
Eye surgery, including laser eye surgery and Lasik
Fertility treatments and monitors
Flu shots
Hearing aids and batteries
Insulin
Lab fees
Physical therapy
Prescription sunglasses
Prosthesis

Psychologists and therapy
Stop-smoking programs
Sunscreen
Vaccinations and immunizations
Walking aids like canes, walkers and crutches
Weight-loss program (if it's a treatment for a specific disease diagnosed by a physician)
Wheelchairs
X-rays
Nursing services

Click here for a full list of eligible items

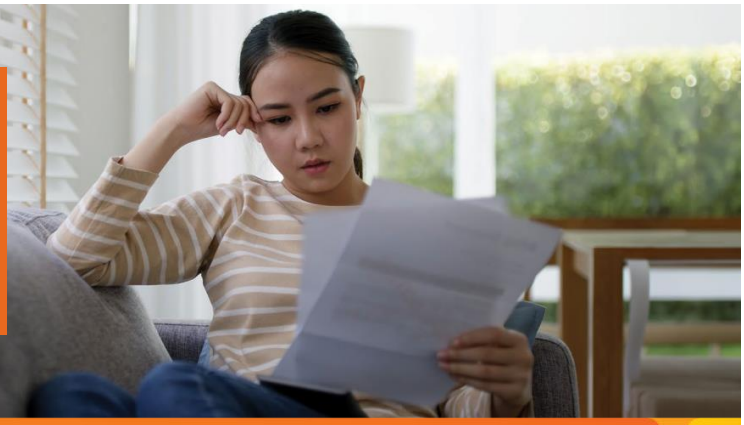
BASIC LIFE INSURANCE AND AD&D

EGUSD provides Basic Term Life and AD&D through Voya to active employees. To learn more about the benefit coverage amount, visit your benefits employee portal at www.benefitbridge.com/egusd.

Note: Basic Term Life and AD&D reduces to 65% of original coverage when the employee or spouse reaches age 70; and to 50% at age 75. Benefits will terminate when the insured person retires.

Empathy

Bereavement Support , including Funeral Planning & Will Preparation



Who is Empathy?

We work with Empathy to offer you and your loved ones Bereavement Support , including Funeral Planning & Will Preparation services. Combining technology and human care, Empathy helps families prepare for the future and navigate the emotional and practical challenges associated with loss.

From planning a funeral to the logistics of winding down an estate, Empathy offers an impactful solution to you and your family after the loss of a loved one. Empathy's bereavement support is also fully accessible to loved ones, and various family members can share and join their account.

Bereavement Support

On-demand personalized services includes:

- Custom Care Plan tailored to the family's unique needs
- For each family, a dedicated Care Manager will work with them step-by-step
- Hands-on assistance from and access to the Care Team

Curated bereavement tools include:

- **Obituary creator:** A beautifully written obituary, crafted in minutes
- **Grief resources:** Guided meditations, audio companions, and a journaling tool
- **Help claiming benefits:** Resources and dedicated assistance for claiming survivor or other available benefits, such as those from Social Security or the Veteran's Administration
- **Probate & estate administration:** State-specific guidance and resources on probate process
- **Account closing:** Closing unneeded financial accounts, subscriptions, and memberships
- **Family collaboration:** Intuitive dashboard for family members to share tasks, resources, and progress
- **Secure, scanned document storage:** Storage for important papers in one secured location

Funeral Planning services

Holistic funeral assistance with access to wide range of funeral resources such as:

- Guides and checklists
- Concierge support
- Funeral home finder
- Online planning and price comparison

Will Preparation services

Digital will, healthcare directive and POA access and support for such things as:

- Drafting a will
- Outlining your last wishes
- Issuing a financial power of attorney
- Articulating an advance healthcare directive

ReliaStar Life Insurance Company (Minneapolis, MN),
a member of the Voya® family of companies

Who is eligible for Empathy?

You and your family are eligible to receive Empathy's comprehensive system for grief and loss support if you are living in the U.S. and enrolled in Group Term Life Insurance offered by Voya. Empathy is not insurance and you should note that services and availability may vary by state. Eligible users receive dedicated care and support, combined with experienced resources and tools. Empathy is committed to helping you and your family prepare for the future and provide support in some of life's most challenging moments. We're here to meet you wherever you are, whenever you're ready.

How to get started

Navigating a loss can be challenging and knowing where to start can be difficult. Empathy's experienced Care Team is ready to provide support via web, app, or phone.

Beneficiary and loved one support

Have you experienced a loss of someone who had group term life insurance coverage through Voya?

- Call 769-305-2683,
- Log onto join.empathy.com/voya, or
- Download the Empathy app and use referral code: EMP-VOYA

General Care Team support

Have general questions about Empathy?

- Call 251-299-8482 or
- Email: support@empathy.com

Employee/insured support

Do you have group term life insurance coverage through Voya and have experienced a loss?

- Call 769-305-2683,
- Visit join.empathy.com/voyasupport-loss, or
- Download the Empathy app and use referral code: EMP-VOYALOSS

Do you have group term life insurance coverage through Voya and need help drafting a will, outlining your last wishes, or finding a funeral home?

- Call 769-305-2683, or
- Visit join.empathy.com/voyasupport-preplanning

How to sign up:

1. Select the appropriate link based on the support you're looking for
2. Click "Get Started" button at the top left of the webpage
3. Enter your phone number to verify yourself with a text code
4. Answer the prompted questions to get support tailored to your needs.

Please notify your Care Manager if you would like to switch between Pre-Planning Support (Will Preparation, Funeral Planning) and Loss Support (Bereavement Support) experiences

App access for [insured and] beneficiary loss support

1. Download the Empathy app by visiting the Apple App Store® or Google Play store or scanning the QR code
2. Enter your phone number to verify yourself with a text code
3. Enter appropriate referral code listed above
4. Answer the prompted questions to get support tailored to your needs

Additionally, beneficiaries filing a group term life insurance claim through the Voya Claims Center can agree to be contacted by the Empathy Care Team regarding any bereavement care benefits to which they may have access.

App Store® is a service mark of Apple Inc. Google Play is a service provided by Google LLC.

empathy.

Bereavement Support, including Funeral Planning & Will Preparation services are provided by The Empathy Project, Inc., New York, NY. Provisions and availability of each service may vary by state.

Group Term Life Insurance is underwritten by ReliaStar Life Insurance Company (Minneapolis, MN), a member of the Voya® family of companies. Provisions and availability may vary by state.

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PLAN
INVEST
PROTECT

VOYA® FINANCIAL

SUPPLEMENTAL LIFE AND AD&D

EGUSD offers Supplemental Basic Term Life and Accidental Death & Dismemberment (AD&D) to all eligible employees to help when you and your family need it the most. Beneficiaries will get an additional benefit payment if you or the insured person passes away.

This is a voluntary program and premiums are paid 100% by the Employee.

SUPPLEMENTAL LIFE AND AD&D INSURANCE

With Voya, EGUSD gives you the opportunity to buy valuable life insurance coverage for yourself, your spouse, and your dependent children — all at affordable group rates.

Employees

May elect up to 5 times annual salary in increments of $50,000 not to exceed $500,000.

Spouse*

May elect up to 50% of employee amount in increments of $25,000 to $100,000 and increments of $50,000 up to $250,000.

Child**

May elect a flat amount of $10,000.

Guaranteed Issue

IMPORTANT - The below Employee and Spouse guaranteed issue amounts are available to new hires and newly eligible dependents. Guaranteed Issue Limits are only available during your initial enrollment opportunity.***

Employees	Spouse	Child
Up to $250,000	Up to $50,000	$10,000

**Spouses Coverage is available only if employee coverage is elected.*
**The use of "spouse" in this document means a person insured as a spouse as described in the certificate of insurance or rider. This includes a domestic partner as defined by the group policy. Please contact your employer for more information.*
***Children birth to age 26 and as defined by your employer's plan. Coverage is available only if employee coverage is elected.*
****Enroll within 31 days if you are a new hire and 60 days of a qualifying life event for newly eligible dependents.*

Note: Supplemental Basic Term Life and AD&D reduces 65% of original coverage when the employee or spouse reaches age 70; and to 50% at age 75.

Visit your benefits employee portal at www.benefitbridge.com/egusd for personalized rates.

LEGAL PLAN - *This is a voluntary program and premiums are paid 100% by the Employee.*

Legal Insurance from ARAG

WHAT IS LEGAL INSURANCE?

Legal insurance helps you plan for the good times in life, like welcoming a child into your family and updating your will. It's also there to help you through life's struggles, like when kids make mistakes, you get caught speeding or true love just doesn't work out.

WHAT DOES LEGAL INSURANCE COVER?

A legal insurance plan from ARAG® covers a wide range of legal needs like the examples shown below – and many more – to help you address life's legal situations.

Consumer Protection Matters
- Auto repair
- Buying or selling a car
- Consumer fraud
- Consumer protection for goods or services
- Home improvement
- Personal property disputes
- Small claims court

Criminal Situations
- Juvenile
- Parental responsibility

Family Law Events
- Adoption
- Domestic partnership
- Guardianship/conservatorship
- Name change
- Pet-related matters and damages
- Pre-marital agreements
- Divorce

General Needs
- Document review
- Credit records correction
- Document preparation

Finance, Tax & Debt-Related Matters
- Debt collection
- Garnishments
- IRS tax audit
- Personal bankruptcy
- Student loan debt

Home Ownership or Renter Matters
- Buying and selling a home
- Contracts/lease agreements
- Contractor issues
- Deeds
- Foreclosures or evictions
- Disputes with a landlord
- Neighbor disputes
- Real estate disputes

Traffic Troubles
- License suspension/revocation
- Traffic tickets

Wills & Estate Planning Needs
- Funeral directives
- Powers of attorney
- Wills
- Trusts

WANT MORE INFORMATION?

For specific details about your plan, and to view a complete list of coverages, visit **ARAGlegal.com/myinfo** and enter Access Code: **19286eg**

To talk with someone, call ARAG at **800-247-4184**

WHICH PLAN IS RIGHT FOR YOU?

UltimateAdvisor Plus™ offers you all of the coverages listed and more including:
- Services for parents/grandparents
- Child support and custody
- Financial planning education
- Tax services
- And more

WHAT DOES IT COST?

UltimateAdvisor®
$19.66 monthly

UltimateAdvisor Plus™
$21.58 monthly

HOW LEGAL SHOWS UP IN YOUR LIFE

Most consumers believe legal troubles are rare, once-in-a-lifetime events. But they're far more common than you think.

85%

of individuals experienced a legal event in the past three years.[1]

These events often have a considerable impact on one's finances or family.

USING YOUR LEGAL PLAN IS EASY

1. When you have a legal need, you can go online, use the ARAG Legal app or call Customer Care.
2. Answer a few questions to confirm your coverage and receive information on local network attorneys who can help with your legal matter.
3. Then, meet with a network attorney virtually, over the phone or in person.

WHY SHOULD YOU GET LEGAL INSURANCE?

Work with a network attorney and attorney fees are **100% paid in full** for most covered matters.

Save thousands of dollars, on average, for legal matters by avoiding costly legal fees.

We help connect you with local attorneys – many who average 20+ years of experience.

Use DIY Docs® to create a variety of **legally valid documents,** like wills or powers of attorney, including state-specific templates.

Address your covered legal situations with a network attorney for **legal help and representation.**

ARAG Members rated network attorneys **9.2 out of 10** for **accessibility, responsiveness** and **professionalism.**[2]

9.2/10

More Tools & Resources

Your ARAG plan offers access to DIY Docs®. These are attorney-reviewed legal documents you can easily fill out, edit and store online. Many templates are state specific and include options for estate planning, powers of attorney and more.

The online Learning Center gives you access to guidebooks, videos and articles related to common legal and financial matters, what to do if you encounter a legal situation and more.

You can also download the Personal Information Organizer to help you keep track of important legal, financial, medical and contact information.

[1] ARAG Stress Research Study, general consumers and members with known legal issues, October 2022.

[2] 2023 ARAG Member Satisfaction Survey.

Limitations and exclusions apply. Depending upon a state's regulations, ARAG's legal insurance plan may be considered an insurance product or a service product. Insurance products are underwritten by ARAG Insurance Company of Des Moines, Iowa. Service products are provided by ARAG Services, LLC. This material is for illustrative purposes only and is not a contract. For terms, benefits or exclusions, contact us.

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Rev 6/24 2003336eg

2027 Important Notices

Important Notices

No Surprises Act Notice

Our medical plans are subject to the No Surprises Act, which limits the amount covered persons may have to pay for some out-of-network surprise medical bills. More information about surprise billing requirements included under the No Surprises Act and similar state laws can be found on the medical insurance company's website or the Plan Sponsor's website. Additional information may be found in your Explanation of Benefits for any affected claims.

Discrimination Is Against the Law

Elk Grove Unified School District complies with the applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin (including limited English proficiency and primary language), age, disability, or sex (including pregnancy, sexual orientation, gender identity, and sex characteristics). Elk Grove Unified School District does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Newborns' and Mothers' Health Protection Act (NMHPA)

Benefits for a pregnancy hospital stay (for delivery) for a mother and her newborn may not be restricted to less than 48 hours following a vaginal delivery or 96 hours following a cesarean section. Also, any utilization review requirements for inpatient hospital admissions will not apply to this minimum length of stay. Early discharge is permitted only if the attending health care provider, in consultation with the mother, decides an earlier discharge is appropriate.

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

Your plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services, including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema. For more information, you should review the Summary Plan Description or call your Plan Administrator.

Patient Protections

The medical plan requires the designation of a primary care provider. 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. Until you make this designation, the plan will designate one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, please contact your medical carrier.

For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from the plan or any other person (including a primary care provider) 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 a list of participating health care professionals who specialize in obstetrics or gynecology, please contact your medical carrier.

Networks/Claims/Appeals

The major medical plans described in this booklet have provider networks with Kaiser, Sutter Health, and Western Health Advantage. The listing of provider networks will be available to you automatically and free of charge. A list of network providers can be accessed immediately by using the Internet address found in the Summary of Benefits and Coverage that relates to the Plan. You have a right to appeal denials of claims and a right to a response within a reasonable amount of time. Claims that are not submitted within a reasonable time may be denied. Please review your Summary Plan Description or contact the Plan Administrator for more details.

COBRA Continuation Coverage

This notice has important information about your right to Consolidated Omnibus Budget Reconciliation Act (COBRA) continuation coverage, which is a temporary extension of coverage under covered medical, dental, and vision plans (the "Plan"). **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to receive it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

Important Notices

The right to COBRA continuation coverage was created by federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985. COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally does not accept late enrollees.

WHAT IS COBRA CONTINUATION COVERAGE?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "Qualifying Event." Specific Qualifying Events are listed later in this notice. After a Qualifying Event, COBRA continuation coverage must be offered to each person who is a "Qualified Beneficiary." You, your spouse, and your dependent children could become Qualified Beneficiaries if coverage under the Plan is lost because of the Qualifying Event. Under the Plan, Qualified Beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a Qualified Beneficiary if you lose coverage under the Plan because of the following Qualifying Events:

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

If you are the spouse of an employee, you will become a Qualified Beneficiary if you lose your coverage under the Plan because of the following Qualifying Events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than their gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or,
- You become divorced or legally separated from your spouse.

Your dependent children will become Qualified Beneficiaries if they lose coverage under the Plan because of the following Qualifying Events:

- The parent-employee dies;
- The parent-employee's employment ends for any reason other than their gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or,
- The child stops being eligible for coverage under the Plan as a "dependent child."

WHEN IS COBRA CONTINUATION COVERAGE AVAILABLE?

The Plan will offer COBRA continuation coverage to Qualified Beneficiaries only after the Plan Administrator has been notified of a Qualifying Event:

- The end of employment or reduction of hours of employment;
- Death of the employee; or,
- The employee becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other Qualifying Events (e.g., divorce or legal separation of the employee and spouse, or a dependent child losing eligibility for coverage as a dependent child, etc.), you must notify the Plan Administrator within 60 days after the Qualifying Event occurs. You must provide this notice to your employer.

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

NOTICE AND ELECTION PROCEDURES

Each type of notice or election to be provided by a covered employee or a Qualified Beneficiary under this COBRA Continuation Coverage Section must be in writing, must be signed and dated, and must be mailed or hand-delivered to the Plan Administrator, properly addressed, or as otherwise permitted by the COBRA administrator, no later than the date specified in the election form, and properly submitted to the Plan Administrator.

Important Notices

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

ELECTION AND ELECTION PERIOD

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

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

HOW IS COBRA CONTINUATION COVERAGE PROVIDED?

Once the Plan Administrator receives notice that a Qualifying Event has occurred, COBRA continuation coverage will be offered to each of the Qualified Beneficiaries. Each Qualified Beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation on behalf of their dependent children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain Qualifying Events, or a second Qualifying Event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

DISABILITY EXTENSION OF THE 18-MONTH PERIOD OF COBRA CONTINUATION COVERAGE

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled, and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. This disability would have to have started some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage (see Notice and Election Procedures).

SECOND QUALIFYING EVENT EXTENSION OF 18-MONTH PERIOD OF COBRA CONTINUATION COVERAGE

If your family experiences another Qualifying Event during the 18 months of COBRA continuation of coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation of coverage, for a maximum of 36 months, if the Plan is properly notified about the second Qualifying Event. This extension may be available to the spouse and any dependent children receiving COBRA continuation of coverage if the employee or former employee dies; becomes entitled to Medicare (Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second Qualifying Event would have caused the spouse or the dependent child to lose coverage under the Plan had the first Qualifying Event not occurred (see Notice and Election Procedures).

OTHER OPTIONS BESIDES COBRA CONTINUATION COVERAGE

Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, Children's Health Insurance Program (CHIP), or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

Important Notices

ENROLLMENT IN MEDICARE INSTEAD OF COBRA

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an eight-month special enrollment period[1] to sign up for Medicare Part A or B, beginning on the earlier of:

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you do not enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer), and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information, visit https://www.medicare.gov/medicare-and-you.

IF YOU HAVE QUESTIONS

For more information about the Marketplace, visit www.healthcare.gov.

The U.S. Department of Health and Human Services (HHS), through the Centers for Medicare & Medicaid Services (CMS), has jurisdiction with respect to the COBRA continuation coverage requirements of the Public Health Service Act (PHSA) that apply to state and local government employers, including counties, municipalities, public school districts, and the group health plans that they sponsor (Public Sector COBRA). COBRA can be a daunting and complex area of federal law. If you have any questions or issues regarding Public Sector COBRA, you may contact the Plan Administrator or email HHS at phig@cms.hhs.gov.

KEEP YOUR PLAN INFORMED OF ADDRESS CHANGES

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

EFFECTIVE DATE OF COVERAGE

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

COST OF CONTINUATION COVERAGE

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

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

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

The Plan will notify the Qualified Beneficiary, in writing, of any termination of COBRA coverage based on the criteria stated in this Section that occurs prior to the end of the Qualified Beneficiary's applicable maximum coverage period. Notice will be given within 30 days of the Plan's decision to terminate.

[1] http://www.socialsecurity.gov/

Important Notices

Such notice shall include the reason that continuation coverage has terminated earlier than the end of the maximum coverage period for such Qualifying Event and the date of termination of continuation coverage.

See the Summary Plan Description or contact the Plan Administrator for more information.

Uniformed Services Employment and Reemployment Rights Act (USERRA)

If you leave your job to perform military service, you have the right to elect to continue your existing employer-based health plan coverage for you and your dependents (including your spouse) for up to 24 months while in the military. Even if you do not elect to continue coverage during your military service, you have the right to be reinstated in your employer's health plan when you are reemployed, generally without any waiting periods or exclusions for pre-existing conditions except for service-connected injuries or illnesses.

Flexible Spending Accounts (FSAs) – Termination and Claims Submission Deadlines

Note: If you lose eligibility for any reason during the Plan Year, your contributions to your Health and/or Dependent Care FSAs will end as of the date your eligibility terminates. You may submit claims for reimbursement from your FSAs for expenses incurred during the Plan Year prior to your eligibility termination. You must submit claims for reimbursement from your Health and/or Dependent Care FSAs no later than 90 days after the date your eligibility terminates. Any balance remaining in your FSAs will be forfeited after claims submitted prior to this date have been processed.

Special Enrollment Rights Notice

CHANGES TO YOUR HEALTH PLAN ELECTIONS

Once you make your benefits elections, they cannot be changed until the next Open Enrollment. Open Enrollment is held once a year.

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if there is a loss of other coverage. However, you must request enrollment no later than 30 days after that other coverage ends.

If you declined coverage while Medicaid or the Children's Health Insurance Program (CHIP) is in effect, you may be able to enroll yourself and/or your dependents in this plan if you or your dependents lose eligibility for that other coverage. However, you must request enrollment no later than 60 days after Medicaid or CHIP coverage ends.

If you or your dependents become eligible for Medicaid or CHIP premium assistance, you may be able to enroll yourself and/or your dependents into this plan. However, you must request enrollment no later than 60 days after the determination to remain eligible for such assistance.

If you have a change in family status, such as a new dependent resulting from marriage, birth, adoption or placement for adoption, divorce (including legal separation and annulment), death, or a Qualified Medical Child Support Order, you may be able to enroll yourself and/or your dependents. However, you must request enrollment no later than 30 days after the marriage, birth, adoption, or placement for adoption or divorce (including legal separation and annulment).

For information about Special Enrollment Rights, please contact:

Payroll Department
(916) 686-7778

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

Elk Grove Unified School District Group Health Plan (Plan) maintains a Notice of Privacy Practices that provides information to individuals whose protected health information (PHI) will be used or maintained by the Plan. If you would like a copy of the Plan's Notice of Privacy Practices, please contact the Payroll Department at (916) 686-7778.

Important Notices

Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: GENERAL INFORMATION

This notice provides you with information about Elk Grove Unified School District in the event you wish to apply for coverage on the Health Insurance Marketplace. All the information you need from Human Resources is listed in this notice. If you wish to have someone assist you in the application process or have questions about subsidies that you may be eligible to receive, (for California residents only) you can contact KeenanDirect at 855-653-3626 or at www.KeenanDirect.com, or (for everyone) contact the Health Insurance Marketplace directly at www.healthcare.gov.

WHAT IS THE HEALTH INSURANCE MARKETPLACE?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget by offering “one-stop shopping” to find and compare private health insurance options. You may also be eligible for a tax credit that lowers your monthly premium right away.

Open Enrollment for health insurance coverage through Covered California begins on November 1 of each year and ends on January 31 of each year. For more information on Open Enrollment and other opportunities to enroll, visit www.coveredca.com, KeenanDirect at 1-855-653-3626 or www.KeenanDirect.com.

Open Enrollment for most other states begins on November 1 and closes on January 15 of each year. For more information on Open Enrollment and other opportunities to enroll, visit www.healthcare.gov.

CAN I SAVE MONEY ON MY HEALTH INSURANCE PREMIUMS IN THE MARKETPLACE?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer you coverage, offers medical coverage that is not “Affordable,” or does not provide “Minimum Value.” If the lowest cost plan from your employer that would cover you (and not any other members of your family) is more than 10.22% (for 2027) of your household income for the year, then that coverage for you is not Affordable. Affordability for dependent family members is determined separately and is based on the total cost of family coverage. Moreover, if the medical coverage offered covers less than 60% of the benefits costs, then the plan does not provide Minimum Value.

DOES EMPLOYER HEALTH COVERAGE AFFECT ELIGIBILITY FOR PREMIUM SAVINGS THROUGH THE MARKETPLACE?

Yes. If you have an offer of medical coverage from your employer that is both Affordable and provides Minimum Value, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer’s medical plan. If you receive premium savings for Marketplace coverage, the IRS may seek reimbursement of those funds.

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

STATES WITH INDIVIDUAL MANDATE

Taxpayers in CA, DC, MA, NJ, RI, and VT (this list is neither complete nor exhaustive) are reminded that your state imposes an individual mandate penalty (tax) should you, your spouse, and children choose to not have (and keep) Medical/Rx coverage for each tax year. Please consult your tax advisor for how a non-election for health coverage may affect your tax situation.

Important Notices

PART B: INFORMATION ABOUT HEALTH COVERAGE OFFERED BY YOUR EMPLOYER

In the event you wish to apply for coverage on the Exchange, all the information you need from Human Resources is listed below. If you are located in California and wish to have someone assist you in the application process or have questions about subsidies that you may be eligible to receive, you can contact KeenanDirect at 855-653-3626 or at www.KeenanDirect.com. The information is numbered to correspond to the Marketplace application.

3. Employer name **Elk Grove Unified School District**	**4. Employer Identification Number (EIN)** **94-6002501**	
5. Employer address **9510 Elk Grove-Florin Road**	**6. Employer phone number** **(916) 686-7778**	
7. City Elk Grove	**8. State** CA	**9. ZIP code** 95624
10. Who can we contact about employee health coverage at this job? Payroll Department		
11. Phone number (if different from above)	**12. Email address** payroll@egusd.net	

As your employer, we offer coverage that meets the minimum value standard to the employees as described in this Guide. The coverage offered to you meets the minimum value standard and the cost of this coverage to you is intended to be affordable based on employee wages.

Important Notices

Notice of Creditable Coverage: Information About Medicare Part D and Your Prescription Drug Coverage

Elk Grove Unified School District has determined that the prescription drug coverage offered by the Elk Grove Unified School District is, on average for all plan participants, expected to pay out the same or more than what the standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage.

Please read this notice carefully and keep it where you can find it. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice. NOTE: You are responsible for providing this notice to all Medicare eligible family members (or those about to become Medicare eligible).

WHEN CAN YOU JOIN A MEDICARE DRUG PLAN?

When someone first becomes eligible to enroll in a government-sponsored Medicare "Part D" prescription drug plan, enrollment is considered timely if completed by the end of his or her "Initial Enrollment Period," which ends three months after the month in which he or she turned 65.

Unfortunately, if you choose not to enroll in Medicare Part D during your Initial Enrollment Period, when you finally do enroll, you may be subject to a late enrollment penalty added to your monthly Medicare Part D premium. Specifically, the extra cost, if any, increases based on the number of full, uncovered months during which you went without either Medicare Part D or without "Creditable" prescription drug coverage from another plan, such as our plan.

Eligible individuals can enroll in a Medicare Part D prescription drug plan during Medicare's "Annual Coordinated Election Period" (a.k.a. "Open Enrollment Period") running from October 15 through December 7 of each year, as well as during what is known as a "Medicare Special Enrollment Period," which is triggered by certain qualifying events, including the loss of creditable group prescription drug coverage. Those who miss these opportunities are generally unable to enroll in a Medicare Part D plan until another enrollment period becomes available. Finally, please be cautioned that even if you elect our coverage, you could be subject to a payment of higher Part D premiums if you subsequently experience a break in coverage of 63 continuous days or longer before you enroll in the Medicare Part D plan. Carefully coordinating your transition between plans is therefore essential.

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

If you decide to join a Medicare drug plan, your current Elk Grove Unified School District coverage will not be affected. If you keep this coverage and elect Medicare, Elk Grove Unified School District coverage will not coordinate with Part D coverage. If you do decide to join a Medicare drug plan and drop your current Elk Grove Unified School District coverage, be aware that you and your dependents may be unable to get this coverage back.

It is important for those eligible for both Medicare and our group health plan to look ahead and weigh the costs and benefits of the various options on a regular, if not annual, basis. Based on individual facts and circumstances, some choose to elect Medicare only, some choose to elect coverage under the group health plan only, while some choose to enroll in both coverages. When both are elected, please note that benefits coordinate according to the Medicare Secondary Payer Rules. That is, one plan or the other would reduce their payment to prevent you from being reimbursed the full amount from both sources. Your age, the reason for your Medicare eligibility and other factors determine which plan is primary (pays first, generally without reductions) versus secondary (pays second, generally with reductions).

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

If you are Medicare eligible and 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 creditable coverage. For example, if you go 19 months without creditable coverage, your premium may be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) the entire time you have Medicare prescription drug coverage.

FOR MORE INFORMATION ABOUT YOUR OPTIONS UNDER MEDICARE PRESCRIPTION DRUG COVERAGE

If you have questions about your Medicare eligibility or how you can get help to pay for it, you can call the Social Security Administration at 1-800-772-1213 or visit www.socialsecurity.gov.

QUESTIONS ABOUT THIS NOTICE OR YOUR PRESCRIPTION DRUG COVERAGE

For questions about this notice or the prescription drug coverage offered through Elk Grove Unified School District, contact the Payroll Department at (916) 686-7778.

Important Notices

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, dial 1-877-KIDS-NOW, or visit 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 with paying your employer health plan premiums. The following list of states is current as of July 31, 2026. Contact your State for more information on eligibility.

ALABAMA - Medicaid
Website: http://myalhipp.com/
Phone: 1-855-692-5447

ALASKA - Medicaid
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

ARKANSAS - Medicaid
Website: http://myarhipp.com/
Phone: 1-855-MyARHIPP (1-855-692-7447)

CALIFORNIA - Medicaid
Health Insurance Premium Payment (HIPP) Program Website:
https://www.dhcs.ca.gov/services/health-insurance-premium-payment-program-cost-avoidance/

Phone: 1-916-445-8322
Fax: 1-916-440-5676
Email: hipp@dhcs.ca.gov

COLORADO - Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
Health First Colorado Website:
https://www.healthfirstcolorado.com/
Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711
CHP+: https://hcpf.colorado.gov/chp
CHP+ Customer Service: 1-800-359-1991/ State Relay 711
Health Insurance Buy-In Program (HIBI):
https://www.mycohibi.com/
HIBI Customer Service: 1-855-692-6442

FLORIDA - Medicaid
Website:
https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html
Phone: 1-877-357-3268

GEORGIA - Medicaid
GA HIPP Website: https://medicaid.georgia.gov/programs/third-party-liability/health-insurance-premium-payment-program-hipp
Phone: 1-678-564-1162, Press 1
GA CHIPRA Website:
https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra
Phone: 1-678-564-1162, Press 2

INDIANA - Medicaid
Website: https://www.in.gov/medicaid/ or
http://www.in.gov/fssa/dfr/
Family and Social Services Administration
Phone: 1-800-403-0864
Member Services Phone: 1-800-457-4584

Important Notices

IOWA – Medicaid & CHIP (Hawki)
Medicaid Website: https://hhs.iowa.gov/medicaid
Medicaid Phone: 1-800-338-8366
Hawki Website: https://hhs.iowa.gov/programs/welcome-iowa-medicaid/iowa-health-link/hawki
Hawki Phone: 1-800-257-8563
HIPP Website: https://hhs.iowa.gov/medicaid/plans-programs/fee-service/health-insurance-premium-payment-program
HIPP Phone: 1-888-346-9562

KANSAS - Medicaid
Website: https://www.kancare.ks.gov/
Phone: 1-800-792-4884
HIPAA Phone: 1-800-967-4660

KENTUCKY - Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website:
https://www.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

LOUISIANA - Medicaid
Website: https://www.ldh.la.gov/healthy-louisiana
Phone: 1-888-342-6207 (Medicaid hotline)
Email: healthy@la.gov
Louisiana Health Insurance Premium Program (LaHIPP)
Website: https://www.ldh.la.gov/lahipp
Phone: 1-877-697-6703

MAINE - Medicaid
Enrollment Website:
www.mymaineconnection.gov/benefits/s/?language=en_US
Phone: 1-800-442-6003 | TTY: Maine relay 711
Private Health Insurance Premium Webpage:
https://www.maine.gov/dhhs/ofi/applications-forms
Phone: 1-800-977-6740 | TTY: Maine relay 711

MASSACHUSETTS - Medicaid & CHIP
Website: https://www.mass.gov/masshealth/pa
Phone: 1-800-862-4840 | TTY: 711
Email: masspremassistance@accenture.com

MINNESOTA - Medicaid
Website: https://mn.gov/dhs/health-care-coverage/
Phone: 1-800-657-3672

MISSOURI - Medicaid
Website: https://dss.mo.gov/fsd
Phone: 1-573-751-2005

MONTANA - Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: 1-800-694-3084
Email: HHSHIPPProgram@mt.gov

NEBRASKA - Medicaid
Website: http://accessnebraska.ne.gov
Phone: 1-855-632-7633
Lincoln: 1-402-473-7000
Omaha: 1-402-595-1178

NEVADA - Medicaid
Medicaid Website: https://dhcfp.nv.gov
Medicaid Phone: 1-800-992-0900

NEW HAMPSHIRE - Medicaid
Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program
Phone: 1-603-271-5218
Toll free number for the HIPP program: 1-800-852-3345, ext. 15218
Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov

NEW JERSEY - Medicaid & CHIP
Medicaid Website: www.nj.gov/humanservices/dmahs/individuals-families/familycare/
Phone: 1-800-356-1561
CHIP Premium Assistance Phone: 1-609-631-2392
CHIP Website: https://njfamilycare.dhs.state.nj.us/
CHIP Phone: 1-800-701-0710 (TTY 711)

NEW YORK - Medicaid
Website: https://www.health.ny.gov/health_care/medicaid/
Phone: 1-800-541-2831

NORTH CAROLINA - Medicaid
Website: https://medicaid.ncdhhs.gov/
Phone: 1-919-855-4100

NORTH DAKOTA - Medicaid
Website: https://www.hhs.nd.gov/healthcare
Phone: 1-844-854-4825

OKLAHOMA - Medicaid and CHIP
Website: http://www.insureoklahoma.org/
Phone: 1-888-365-3742

OREGON - Medicaid
Website: http://healthcare.oregon.gov/Pages/index.aspx
Phone: 1-800-699-9075

PENNSYLVANIA - Medicaid & CHIP
Website: https://www.pa.gov/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp
Phone: 1-800-692-7462
CHIP Website: https://www.dhs.pa.gov/CHIP/Pages/CHIP.aspx
CHIP Phone: 1-800-986-KIDS (5437)

Important Notices

RHODE ISLAND - Medicaid and CHIP
Website: http://www.eohhs.ri.gov/
Phone: 1-855-697-4347, or 1-401-462-0311 (Direct RIte Share Line)

SOUTH CAROLINA - Medicaid
Website: https://www.scdhhs.gov
Phone: 1-888-549-0820

SOUTH DAKOTA - Medicaid
Website: http://dss.sd.gov
Phone: 1-888-828-0059

TEXAS - Medicaid
Website: https://www.hhs.texas.gov/services/financial/health-insurance-premium-payment-hipp-program
Phone: 1-800-440-0493

UTAH - Medicaid & CHIP
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/

VERMONT - Medicaid
Website: https://dvha.vermont.gov/members/medicaid/hipp-program
Phone: 1-800-250-8427

VIRGINIA - Medicaid & CHIP
Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select
Medicaid/CHIP Phone: 1-800-432-5924

WASHINGTON - Medicaid
Website: https://www.hca.wa.gov/
Phone: 1-800-562-3022

WEST VIRGINIA - Medicaid and CHIP
Website: https://bms.wv.gov/
WV HIPP Website: http://mywvhipp.com/
Medicaid Phone: 1-304-558-1700
CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)

WISCONSIN - Medicaid & CHIP
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm
Phone: 1-800-362-3002

WYOMING - Medicaid
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, 2026, 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

CONTACTS

For any questions or concerns you may have regarding your 2027 Benefits you can contact the following:

MEDICAL

Kaiser Permanente - Group #1659
Member Services: (800) 464-4000
Sun-Sat 24 hours; closed holidays
Nurse Advice Line: (833) 574-2273
www.kp.org

Sutter Health Plan - Group #171802
Member Services: (855) 315-5800
M-F 8:00 a.m. - 7:00 p.m.; closed holidays
Nurse Advice Line: (855) 836-3500
www.sutterhealthplan.org

Western Health Advantage
Member Services: (888) 563-2250
Sun-Sat 24 hours; closed holidays
Nurse Advice Line: (877) 793-3655
www.westernhealth.com

TruHearing (applicable to SHP members only)
Member Services: (833) 312-3010
M-F: 8:00 a.m. - 8 p.m. MST
www.truhearing.com/ElkGrove

DENTAL - Group #: 2433
Delta Dental
(800) 765-6003
www.deltadentalins.com

VISION - Group #: 12143078
VSP
(800) 877-7195
www.vsp.com

FLEXIBLE SPENDING ACCOUNT
Navia Benefits Solutions
(800) 669-3539
www.naviabenefits.com

EMPLOYEE ASSISTANCE PROGRAM
Aetna
(888) 866-4827
www.resourcesforliving.com
Username: EGUSD
Password: EAP

Note: *If you are unable to locate an available provider, call Aetna EAP for assistance to make an appointment.*

BASIC LIFE AND AD&D - Group #: GL-402633
SUPPLEMENTAL LIFE AND AD&D - Group #: GL-402633
Voya
(877) 236-7564
www.voya.com

LEGAL PLAN
ARAG
(800) 247-4184
ARAGlegal.com/myinfo
Access Code: 19286eg

BENEFITBRIDGE TECHNICAL ASSISTANCE CUSTOMER CARE:
800-814-1862
M-F: 8am-5pm
benefitbridge@keenan.com

AIRBO BENEFITS BOARD
For more information about your benefits, visit: https://app.airbo.com/ard/elk-grove-usd-2026 or scan the QR code:

Questions?
(916) 686-7778

BENEFITS

Active –
Cindy Capel – Ext. 67041

Retiree/Transition to EGBERT –
Karen Johnson – Ext. 67461

Leave of Absence –
Karen Johnson – Ext. 67461

403(b)/457/FSA/Standard -
Cindy Capel – Ext. 67041

For general questions regarding your benefits you can also email benefits@egusd.net.

2027 EMPLOYEE BENEFITS GUIDE