Madera Unified School District

1902 Howard Road, Madera, CA 93637
559.675.4500
Fax: 559.675.1186
www.madera.k12.ca.us

To: Part-time and Substitute Employees
From: Vicki Mendoza, Human Resources Manager
Re: Health Benefits Open Enrollment 2024-2025

Health Coverage

As a part-time or substitute employee, you would not be eligible for district paid health insurance. However, Madera Unified School District (MUSD) offers you a *Bronze Plan* at a cost to the employee that meets the basic minimum standards. You have the option of accepting coverage for you and your eligible dependent children or you will have the option to decline coverage.

The Bronze Plan offers only medical coverage for **$437** per month for employee coverage only and **$643** per month for employee + child(ren). A spouse or domestic partner are not covered under the Bronze Plan. The cost of the Bronze Plan may change annually and will be announced each year during the designated open enrollment period. Employee premiums are due and payable to the district the 1st of each month and due one month in advance of coverage.

Whether you choose to **elect** or **decline** coverage, this letter will serve as your election form and must be completed and returned to Human Resources. In addition to the election form, should you choose to elect coverage, you must also complete the enrollment form and submit both documents to Human Resources, attention HR Benefits Technician, no later than July 31, 2024.

Patient Protection and Affordable Care Act (ACA)
The ACA requires that all legal residents must be enrolled in a health insurance plan through "*Covered California*" that meets basic minimum standards. If not enrolled, the individual may be required to pay a penalty. Employees are encouraged to visit www.coveredca.com before considering alternate health insurance coverage through MUSD. If you have any questions, feel free to contact the HR Benefits Technician at extension 273.

Employee Acknowledgement

I have read and understand the above notification. I understand that if I decline coverage or fail to provide the items required for enrollment before the deadline indicated above, I will not be able to enroll into coverage until the district's next open enrollment period.

☐ I choose to elect coverage and enroll in the district's Bronze Plan. Attached is my enrollment form and proof of eligibility for my dependent children (if applicable).

☐ I choose to decline health coverage at this time.

_____ _____
Employee Name (Please Print) SSN # (Last Four) Date

_____
Employee Signature

Copy: Human Resources Copy: Employee File