EMPLOYEE BENEFITS *Guide*

2026

Del Mar
• UNION SCHOOL DISTRICT •

Employee Benefits Guide 2026

General Information

Core Benefits

Other Benefits

Miscellaneous

Click this icon in your benefits guide to watch a video explaining the associated topic.

Regarding Medicare prescription coverage in general, please see page 38 for more details.

The information in this brochure is a general outline of the benefits offered under Del Mar Union School District's benefits program. Specific details and plan limitations are provided in the Summary Plan Descriptions (SPD), which is based on the official Plan Documents that may include policies, contracts and plan procedures. The SPD and Plan Documents contain all the specific provisions of the plans. In the event the information in this brochure differs from the Plan Documents, the Plan Documents will prevail.

Introduction

Your Prescription for Healthy Living

This booklet is designed to provide information about your benefits. To help you with your benefit needs, Del Mar Union School District is providing a comprehensive benefits program designed to protect you and your family from costs associated with illness, injury, or accident.

Del Mar Union School District offers medical, dental, vision and life insurance coverage along with tax-favored spending accounts. In addition, a variety of voluntary plans and retirement saving options are available to employees.

For medical insurance, the District is part of the non-profit Joint Powers Authority (JPA) called SISC (Self-Insured Schools of California). The program is administered by the Kern County Superintendent of Schools Office. For dental, vision and life insurance, the District is part of another non-profit JPA called the FBC (Fringe Benefits Consortium) administered by the San Diego County Office of Education.

General Enrollment Information

When First Eligible – New Hires

You must enroll for benefits within 30 days of the date you are first eligible. Coverage is effective based on your hire (or start) date:

- If your hire date is the 1st through the 15th of the month, benefits will commence on the first day of the month following your date of hire (if hire date is 8/5, your effective date is 9/1).
- If your hire date is the 16th through the 31st of the month, benefits will commence on the first day of the calendar month following one month of employment (if hire date is 8/19, your effective date is 10/1).
- The effective date for voluntary plans will vary by plan.

At Annual Enrollment

During Open Enrollment in the fall, you may enroll eligible family members or change your current benefit elections with new coverage effective January 1 each year.

Making Changes

Once you make your benefit elections, coverage will remain in effect for the full plan year, January 1, 2026 to December 31, 2026. You cannot change plans until the next Open Enrollment period unless you (or a family member) experience an IRS approved qualifying change in family status such as losing health coverage under another plan, marriage, divorce or legal separation, death, birth, adoption (or placement of adoption), entitlement to Medi-Cal, or loss of entitlement to Medi-Cal.

You must notify Human Resources within 30 days of a qualified status change in order to make different benefit elections or wait until the next Open Enrollment period to make a change. Any benefit change must be consistent with the status change (for example, you may add dependent coverage after the birth of a child).

Employee Benefit Questions

If you have questions, please contact Karlyn Stone, Benefits & Risk Management Coordinator at 858-755-9301 Ext. 3692 or at Kstone@dmusd.org. You can also visit the DMUSD homepage at http://www.dmusd.org (click on Department, Human Resources, Benefits) for additional information.

This Benefit Guide is intended to serve as a comprehensive resource for the Del Mar Unified School District health and welfare program. The purpose of this Guide is to summarize the District's employee benefits and the policies and procedures regarding these benefits. This Guide is not intended to be a contract (expressed or implied), nor is it intended to otherwise create any legally enforceable obligations on the part of the District, its agents and its employees.

What's New

PPO Members over the age of 45 are eligible for a free at-home colorectal cancer screening kit. When caught early, colorectal cancer has a 5-year survival rate of over 90%. Members with positive test results will receive guidance from a Lantern case nurse through next steps in treatment.

MDLive copay will change from $10 to $0. (Available to Anthem members only. A deducible may apply to HSA members.)

Midi Health is a virtual menopause clinic where members can access expert care for perimenopause and menopause through a specialized virtual clinic that offers flexible appointments. They provide personalized care for symptoms like hot flashes, mood changes, poor sleep and more. (Available to Anthem PPO members. Standard cost-sharing applies.)

SISC Navitus Pharmacy: Most generic medications have a $0 copay for a 30 or 90 day supply when filled at a Costco pharmacy. Members can get their prescriptions delivered from their local Costco for free with Instacart. Once a prescription is filled, members will receive a text with a link to access Instacart for free!

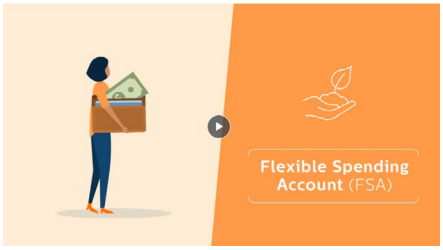
Kaiser Permanente Gym Program Updates:

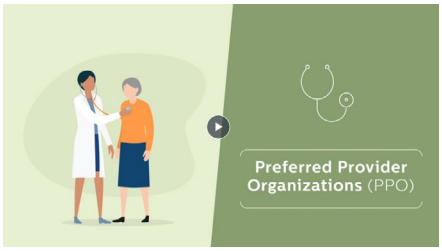
- **Active employees:** The ASH Active and Fit program has changed to Commercial One Pass. This is a discounted gym membership for active employees.
- **Retirees:** The ASH Silver and Fit program has changed to Medicare Members One Pass. This is a free gym membership program for KPSA members.

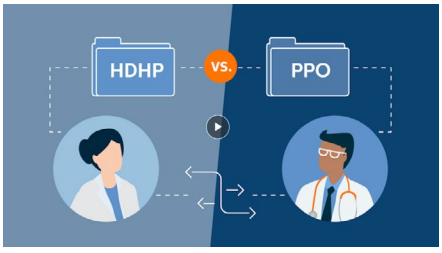
The maximum contributions for Dependent Care Flexible Spending Accounts is increasing from $5,000 to $7,500.

Videos that Explain Benefits Topics

Find answers to your benefits questions and learn about a variety of subjects in this video library.
Click on a topic below to learn more.







Eligibility - Full-Time & Part-Time

Eligibility for health benefits varies by the number of hours you work per week. Certificated employees who share an assignment have several options. There may be a waiting period before benefits are effective.

Employee Classification	Eligibility for Benefits		
	Full-Time	**Part-Time**	**Certificated Shared Assignment**
Hours Requirement	• 100% FTE or 40 hours per week.	• 75%+ FTE or 30 to 39 hours per week. • 20 to 29 hours per week, after 3 years continuous employment with the District. *(Open Enrollment during eligibility year, effective 1/1 of following plan year.)*	• Two teachers may share an assignment. They may take entire benefits package with Medical premium contribution prorated to FTE and contribute to Dental, Vision, Life (DVL) as a whole, OR they may waive medical and take DVL, OR waive benefits completely.
Waiting Period *(benefits effective date)*	• If hired between the 1st - 15th of the month, first day of the calendar month following date of employment *(hire date 8/5, effective date is 9/1).* • If hired between the 16th - 31st of the month, the first day of the calendar month following one month of employment *(hire date 8/19 effective date is 10/1).*		
Benefits Offered	• Medical • Dental • Vision • Basic Life and Accidental Death & Dismemberment (AD&D) - $50,000	• Medical	• Life and Accidental Death & Dismemberment (AD&D) • Share medical, dental and vision as negotiated amongst shared assignment holders
Voluntary Benefits	All benefits eligible employees may enroll in any of the available voluntary plans offered through the Fringe Benefits Consortium (FBC) and American Fidelity. Part-time employees may enroll in dental insurance directly through the FBC.		
Employee Waivers	• An employee may waive/decline medical with proof of group medical coverage *(spousal, military or Medicare).* A signed waiver form is required annually. Waiving medical, includes waiving dental and vision coverage. • Enrollment in Life and AD&D is required.	• 30 hour or 75% FTE employees may waive/decline medical. A signed waiver form is required annually.	• An employee may waive/decline medical with proof of group medical coverage *(spousal, military or Medicare).* A signed waiver form is required annually. • Enrollment in Life and AD&D is required.
Employer Contribution	$15,000 per year	70% of the employee only cost	$15,000 per year (Medical Premium Prorated)
When Benefits Terminate	Last day of the month after the last payroll plan contribution.		

Board Members are also eligible for benefits.

Dependent Eligibility

The District offers medical, dental and vision insurance to all benefit-eligible employees' dependents. Eligible dependents include:

Medical Plans Eligibility	Dental and Vision Plans Eligibility
• Legally married spouse • Registered domestic partner* • Children to age 26: – Natural – Step-children – Children of a registered domestic partner – Legally adopted – Legal guardianship appointment – Disabled adult child over age 26 – Qualified Medical Support Order *(children of divorced parents)*	• Legally married spouse • Registered domestic partner* • Children to age 26: – Natural – Step-children – Children of a registered domestic partner – Legally adopted – Legal guardianship appointment – Disabled adult child over age 26 – Qualified medical support order for children of divorced parents

* Effective January 1, 2020, all couples regardless of age or sexual orientation that are eligible to be married may register with the California Secretary of State as domestic partners. Go to https://www.sos.ca.gov/registries/domestic-partners-registry/ for additional information.

Eligibility (continued)

Required Documents for Enrolling Dependents

SISC requires that if you are adding a new dependent you must provide documentation. A copy of the documentation must be included with your change form. Dependents will not be covered until proper documentation is received by the District to forward to SISC.

Acceptable documentation includes:

Dependent Type	Required Documentation (copies only; originals will not be accepted)
Spouse	• Prior year's Federal Tax Form that shows the couple as married *(Income may be blocked out along with first 5 digits of social security number)*, • Marriage Certificate for newly married couple where tax return is not available or a Marriage Affidavit.
Domestic Partners	• Certificate of Domestic Partnership issued by the State of California, • SISC Affidavit of Domestic Partnership *(when applicable)* *(Enrolling a Domestic Partner may cause the employer contribution to become taxable)*
Children up to age 26	• Legal Birth Certificate or Hospital Verification Letter *(include full name of child, parent(s) name and child's date of birth)* • Legal Adoption Documentation
Guardianships up to age 18	• Legal Court Documentation establishing Guardianship
Disabled Dependents over age 26	• Birth Certificate • Front page of most recent income tax return showing the child listed as a dependent • Proof of six months of prior creditable coverage • Completed Certification Form

Social security numbers must be provided at time of enrollment or as soon as obtained for newborns. This is an IRS requirement due to the required reporting medical plans must provide the IRS on an annual basis.

Eligibility (continued)

Important Reminder

Please be advised that the following circumstances are the only times you can make a benefit election change before the next Open Enrollment period. These permissible changes must be communicated to the Payroll/Benefits Department within 30 days of the event; otherwise you will need to wait until the next Open Enrollment for benefits effective January 1, 2027 to change your benefit elections.

Add a Dependent

- Marriage/Registered Domestic Partnership - may add spouse/Registered Domestic Partner and their children
- Birth
- Adoption
- Legal Guardianship or Legal Custody with proper documentation to age 18
- Child to age 26 - Need not be a student
- Loss of other coverage

Delete a Dependent

- Divorce/Dissolution of Registered Domestic Partnership
- Death
- Child no longer meets eligibility requirements - to age 26
- Guardianship no longer applies (to age 18)

Special Note Regarding Early Retirees and Medicare Eligible Spouses

Certain employees based on their age (at least age 55) and years of full-time service are eligible for early retirement benefits through the District. If the retiree meets the contract language stipulations*, the retiree and his/her dependents may continue the District's health, dental and vision plans until age 65 at District expense (consistent with District payment for current employees).

*Refer to the DMCTA contract and Human Resources for eligibility determination.

If you are an actively employed (not retired) school district employee and SISC member:

- It is to your advantage to enroll in Part A when you turn age 65 if you qualify for premium free Part A, however, it is not required at this time.
- It is not necessary to enroll in Medicare Part B until 3 months prior to your retirement date. In this case the Social Security Administration will allow a special enrollment period for Medicare at the time of your retirement.
- When you retire and reach the age of 65, you must enroll in Medicare A and B and find alternative coverage outside of the District's plans.

If you are a spouse or domestic partner of an actively employed (not retired) school district employee and SISC member:

- It is to your advantage to enroll in Part A when you turn age 65 if you qualify for premium free Part A, however, it is not required at this time.
- It is not necessary to enroll in Medicare Part B until 3 months prior to your spouse's/domestic partner's (the school district employee's) retirement date. In this case the Social Security Administration will allow a special enrollment period for Medicare at the time of your spouse's retirement.
- Failure to enroll in Medicare on a timely basis will result in penalties imposed by SISC, not the District. These penalties can be as much as $1,300 monthly. The District retiree will be responsible for this penalty.
- Medicare may impose additional penalties for late enrollment.
- Your coverage as the spouse or domestic partner of a school district employee will end when the school district employee reaches age 65.

Medicare Enrollment Tips

Within 3 to 6 months of turning age 65 go to www.Medicare.gov and/or call Social Security at 800-772-1213 to learn more about Medicare and the enrollment process. Please note, you must enroll in both parts of Medicare A and B prior to you 65th birthday to ensure a smooth transition into a Medicare plan of your choice.

Medical Plan Overview

You have three distinct types of medical plans from which to choose:

1. **Health Maintenance Organization (HMO):**
   - Kaiser Permanente HMO
   - Anthem HMO Full Network
   - Anthem HMO Priority Select Network
   - Anthem HMO Select Network
2. **Preferred Provider Organization (PPO):**
   - Anthem
3. **High Deductible Health Plan (PPO) (compatible with a health savings account):**
   - Anthem

Health Maintenance Organizations (HMOs)

HMOs allow you to receive comprehensive coverage at set prices, called copays.

- **Doctors/Other Medical Care Providers:** You can only use doctors, hospitals, and pharmacies that participate in the HMO network. Doctors who participate in the HMO network are called in-network providers. There is no coverage if you go to out-of-network providers, except for emergency services.
- **Annual Deductible:** You don't need to pay an annual deductible before the plan begins to pay for a portion of covered medical services.
- **Copays:** When you receive medical care, you pay a set dollar amount called a copay.
- **Annual Out-of-Pocket Maximum:** The HMO plans include an annual out-of-pocket maximum. This is the maximum amount you must pay out of your own pocket for copays during the plan year. Once you reach the out-of-pocket maximum, the plan pays 100% of covered charges for the remainder of the plan year.

Preferred Provider Organization (PPO)

The PPO plan allows you to use any provider you want.

- **Doctors/Health Care Providers:** You can choose any doctor you want, and you can go to any hospital or pharmacy. However, you'll pay less when you use a provider or facility that participates in the Anthem PPO network. There is a limited network of providers that may be used for bariatric, hip, knee and spine surgeries. Providers for such services are limited to Blue Distinction or Blue Distinction+ Centers. Go to www.anthem.com/ca/sisc or call 800-825-5541 to find Blue Distinction providers in your area.
- In addition, in San Diego (and other areas), SISC has partnered with Carrum Health to provide PPO members access to an enhanced benefit with selected physicians at Scripps Health for hip/knee replacements and many inpatient spine surgeries. Use of this benefit is optional but is not administered by Anthem Blue Cross; the benefit must be accessed through Carrum. Under the Carrum benefit with Scripps:
  - There are no medical bills! Coinsurance and deductibles will be waived (due to IRS regulations, on Health Savings Accounts the deductible applies but coinsurance is waived).
  - Travel expenses will be covered for patient and adult companion.
  - A personal Carrum Care Concierge will assist throughout the entire process.

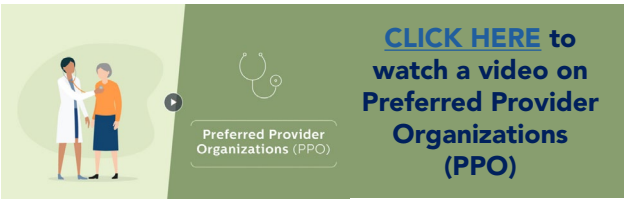
To access hip/knee replacements or inpatient spine surgery services contact Carrum directly at 888-855-7806.

Hip, knee or spine surgeries will NOT be covered unless those services are accessed through a Blue Distinction provider or Carrum Health.

- **Preventive Care:** Preventive care is 100% covered when you use in-network providers. Visit www.healthcare.gov/preventive-care-benefits/ for a complete list of preventive care benefits required to be covered at 100% per the Affordable Care Act.

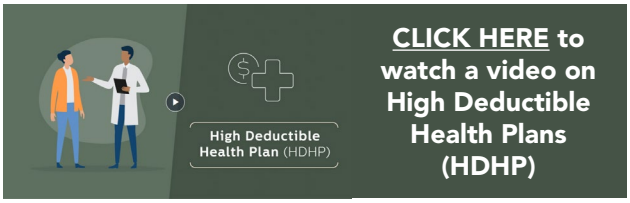
Medical Plan Overview (continued)

- **Annual Deductible:** You generally pay an annual deductible before the plan begins to pay for a portion of covered medical services. The only services that don't require you to pay a deductible first are preventive care, office visits, and prescription drugs.
- **Paying for Care:** When you receive medical care, there are two ways you pay for services:
  - **Copays:** When you go to an in-network doctor for an office visit, go to the emergency room, or pick up a prescription, you pay a set dollar amount called a copay. (You may need to pay the annual deductible first before the copay applies.)
  - **Coinsurance:** When you receive any other medical services, you pay a percentage of the cost of the service, and the plan pays the remaining percentage. This is called coinsurance. (You will need to pay the annual deductible first before coinsurance applies.)
- **Annual Out-of-Pocket Maximum:** The PPO includes an out-of-pocket maximum. This is the maximum amount you must pay out of your own pocket (under the applicable coinsurance percentage) after meeting the deductible. Once you reach the out-of-pocket maximum, the plan pays 100% of in-network charges for the remainder of the plan year. Please note that your out-of-pocket maximum will be lower when you use in-network providers.



High Deductible Health Plan (HDHP)

- The HDHP plan's network of providers is Anthem's PPO network. Like the PPO plan, you can choose any doctor you want, and you can go to any hospital or pharmacy. However, you'll pay less when you use a provider or facility that participates in the Anthem PPO network.
- The HDHP looks a lot like the PPO except the HDHP has a higher deductible and out-of-pocket limit. The IRS defines the acceptable deductibles and out-of-pocket maximums for a plan to be considered an HDHP that can be paired with an HSA. Like the PPO, preventive services will be covered at 100% and coinsurance will apply.



Health Savings Account (HSA)

If you are interested in saving for your healthcare costs in retirement, you may want to consider this option!

If you are enrolled in the HDHP plan, you may choose to open an HSA at the financial institution of your choice or through an American Fidelity direct deposit account. If you are interested in exploring this option, please meet with American Fidelity. It is not required that you open an HSA to be enrolled in an HDHP. However, due to tax savings and portability you may want to consider an HSA.

Medical Plan Overview (continued)

A Health Savings Account is an employee-owned, tax advantaged savings account that you can use to pay for eligible health care expenses. Unlike the medical Flexible Spending Account (FSA), your account balance rolls over from year-to-year and you take the money with you when you retire or separate from the District.

- An HSA is a bank account that is controlled by you
- You decide how much to use for current health expenses and how much to save for future health expenses
- Contributions and interest gains accumulate tax-free*
- Distributions are tax-free* when used to pay for qualified medical expenses
- You will never forfeit money at the end of the plan year because unused funds roll over year after year
- You may keep your account even if you leave the District

* HSA's are subject to California taxes

HSA Eligibility

Not everyone can contribute to an HSA. You must be enrolled in a qualifying high-deductible health plan (HDHP) at the District or elsewhere to participate. In addition, the following circumstances are disqualifying for HSA coverage:

- You are enrolled in Medicare Parts A and/or B and enrolled in a Medicare plan
- You are covered by another non-qualified high deductible health plan (such as your spouse's plan)
- You receive benefits from TRICARE or are active military
- You can be claimed as a dependent on another individual's Federal tax return
- You received VA benefits within the past three months
- You have a balance in a medical FSA from 2025

How Much Can I Contribute to an HSA for 2026?

The IRS determines the contribution limits for HSA's.

HDHP Single Coverage

- You can contribute up to $4,400 per year if enrolled in an HDHP at the employee-only level of coverage.

HDHP Family Coverage (includes Employee + One or more)

- You can contribute up to $8,750 per year if enrolled in an HDHP at the employee + one or employee + family level of coverage. However, if you are married and both spouses have eligible self-only coverage, each spouse may contribute up to $4,400 in separate accounts.

Catch-Up Contribution for Individuals 55+

If you are age 55 or older you can contribute an additional $1,000 catch-up contribution to your HSA. If your spouse is age 55 or older your spouse can also contribute an additional $1,000 catch-up contribution to a separate HSA in your spouse's name. You cannot make a catch-up contribution on behalf of your spouse, or vice-versa. The maximum contribution is $10,750 if catch-up provisions apply.

HSA is a Triple-Tax Savings Plan

HSA payroll deductions are tax free

Invest HSA funds tax-free (options may vary by financial institution)

Take tax-free distributions for qualified medical expenses

Medical Plan Overview (continued)

HSAs and HDHPs Go Hand in Hand

HSAs and HDHPs work together to provide the medical coverage you need and an account to help pay for medical expenses. Since preventive care is covered at 100% by the medical plan, the HSA account can cover your HDHP's deductible and coinsurance/copays. Since you own the account, it is up to you when you use your HSA dollars.

REMINDER
Important Medical Plan Benefits!

Kaiser offers a wide variety of programs and services at kp.org. Manage your care online, sign-up for healthy lifestyle programs, get a wellness coach, join health classes and access member discounts. In addition, Kaiser members have free access to the highly acclaimed Calm meditation and mindfulness smart phone application. Adult members can get the Calm app at no cost at kp.org/selfcareapps.

Take advantage of additional no cost benefits to help you get and stay healthy. SISC members have access to all or some of the following services:

Expert Medical Opinion Program (All Anthem & Kaiser Members)

Teladoc Medical Experts provides members with access to the best health care possible. The benefit gives access to second opinions from world-leading experts without leaving home. This service is available at no cost! Contact Teladoc at 800-835-2362 or visit teladoc.com/sisc.

For employees and family members enrolled in Anthem HMO or PPO plans the following added benefits are available:

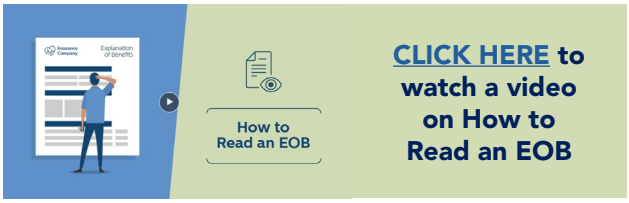
- **MDLive (All Anthem Members)** gives you access to a physician or behavioral health provider, 24/7, anytime, anywhere. Consult with doctors and pediatricians over the phone or using online video for medical conditions such as a cough, cold, fever, sore throat, flu, infection, bronchitis and children's health issues. MDLive physicians can diagnose and prescribe medication when appropriate. Online behavioral health visits are also available for confidential sessions with licensed therapist or psychiatrist. Plus, you save money - $0 per consultation. Register by calling MDLive at 888-632-2738 or go to mdlive.com/sisc. (It is recommended you register ***before*** you need to access MDLive services).
- **Vida Health (Anthem HMO & PPO Members, excludes HSA Members)** a digital coaching application with one-on-one health coaching, therapy and management tools for pre-diabetes, diabetes, hypertension, depressions and more. Not available for SISC HDHP plan members. Call 855-442-5885 or go to vida.com/sisc.
- **Free Generic Medications (All Anthem members)** (excludes certain pain and cough medications) through Costco and Costco Mail Order. Take your prescription to a Costco pharmacy, no need to be a Costco member. Call 800-774-2678 (press 1) to find a Costco location.
- **Centivo Care (Anthem PPO Members)** virtually connects you with a primary care team to manage all of your healthcare needs. Centivo Care providers diagnose conditions, manage prescriptions, refer to specialists, and answer follow-up questions using video visits or live chat.
- **Lantern Cancer Care (Anthem PPO Members)** offers personalized guidance and support from a personal oncology nurse who can partner with you on every step of your cancer journey, including a review of your initial diagnosis and development of a care plan. Visit Lanterncare.com.

Medical Plan Overview (continued)

- **Hinge Health (Anthem PPO Members, excludes HSA Members)** is a digital program for Back and Knee pain including one-on-one coaching. Not available for SISC HDHP plan members. Call 855-902-2777 or go to hingehealth.com/sisc.
- **Carrum Health (Anthem PPO Members):** Consult top-quality surgeons on hip and knee replacements and certain spine surgeries. Benefit covers all related travel and medical bills. Call 888-855-7806 or go to carrum.me/sisc
- **Maven (Anthem PPO Members)** provides 24/7 Access to Virtual Maternity and Postpartum Support. Consult with a care advocate and be connected with trustworthy content delivered by doctors, specialists, coaches and other maternity providers. Visit mavenclinic.com/join/SISC.
- **The SISC PPO medical and Rx plans** (not the High Deductible PPO plan) has a 4th quarter deductible carryover. This means that anything applied to the deductible in the last quarter of the calendar year (October – December) will be applied to the following year's calendar year deductible.

SISC HDHP plan members have access to the following benefits. However, most of these benefits are subject to the plan deductible per IRS guidelines.

- Carrum Health
- MDLive
- Teladoc
- Lantern Cancer Care
- Maven



CLICK HERE to watch a video on How to Read an EOB

Medical Plan Comparison

HMO Plans

Benefits	SISC (Self-Insured Schools of California)			
	Kaiser	Anthem HMO*		
	Kaiser HMO	Full Network*	Priority Select Network*	Select Network*
Annual Deductible	N/A	N/A		
Medical Out-of-Pocket Maximum	$1,500 individual $3,000 family	$1,000 individual $2,000 family		
Office Visit	$15 copay	$10 copay		
Specialist Visit	$15 copay	$10 copay		
Inpatient Hospitalization	100% covered	100% covered		
Outpatient Surgery	$15 copay	100% covered		
Urgent Care	$15 copay	$10 copay (from your primary care medical group)		
Emergency Room	$100 copay (waived if admitted)	$100 copay (waived if admitted)		
Ambulance	$50 copay	$100 copay		
Preventive Care	100% covered	100% covered		
Chiropractic/Acupuncture Services *(All Anthem and Kaiser HMO plans will combine chiropractic & acupuncture thru ASH, limits apply)*	$10 copay	$10 copay		
X-Ray & Laboratory	100% covered	100% covered $100 complex radiology		
Pharmacy Benefit Manager	Kaiser	Navitus		
		Full Network	Priority Select Network*	Select Network
Prescription Out-of-Pocket Maximum	Included in medical Out-of-Pocket Maximum	$1,500 individual $2,500 family		$2,500 individual $3,500 family
Retail-Network *(Other than Costco)*	$5 generic $20 brand (30 day supply)	$5 generic $20 brand (30 day supply)		$9 generic $35 brand (30 day supply)
Costco Walk-In	N/A	$0 generic (up to a 90 day supply) $20 brand (30 day supply) $50 brand (90 day supply)		$0 generic (up to a 90 day supply) $35 brand (30 day supply) $90 brand (90 day supply)
Costco Mail Order	N/A	$0 generic $50 brand (90 day supply)		$0 generic $90 brand (90 day supply)
		*Contracts are subject to change between Anthem Blue Cross and health care providers.		

* The Anthem HMO plan options offer the same medical benefits while allowing you to select a network based on your needs and budget. (Prescriptions benefits vary by plan.)

- **Anthem HMO Full Network:** This network includes most medical groups in San Diego.
- **Anthem HMO Priority Select Network:** This network has expanded service locations for Scripps Clinic, USCD and UCSD Palomar Health.
- **Anthem HMO Select Network:** Includes Sharp and UCSD; lowest cost Anthem HMO plan option.

This is a brief description of each plan. Any variances from the master policy; the master policy will prevail.

Medical Plan Comparison (continued)

ANTHEM HMO Network Medical Groups

San Diego County

The below network comparison is subject to change due to contract negotiations. Member must verify directly with Anthem at time of enrollment.

For the latest information, use Provider Finder at https://www.anthem.com/ca/sisc/find-care by selecting Find a Doctor/Find Care.

Prime Code	PMG/IPA name	Full Network	Priority Select HMO	Select HMO
2VN	Blue Zones Health of California	✔	✔	✔
99R	Graybill North Coastal	✔		✔
0TI	Greater Tri Cities IPA	✔	✔	✔
0UW	Optum Care Network - Monarch*	✔		✔
0WD	Optum Care Network - North County SD	✔	✔	✔
WDA	Optum Care Network - North County SD	✔	✔	✔
0MY	Optum Care Network Desert Cities*	✔		✔
1KN	Perlman Clinic-PMG Bressi Ranch*	✔	✔	✔
1JW	Perlman Clinic-PMG Carlsbad*	✔	✔	✔
1LA	Perlman Clinic-PMG Carmel Mountain Ranch*	✔	✔	✔
1JR	Perlman Clinic-PMG Chula Vista*	✔	✔	✔
1JU	Perlman Clinic-PMG Del Mar*	✔	✔	✔
1JY	Perlman Clinic-PMG Downtown*	✔	✔	✔
1KW	Perlman Clinic-PMG Downtown LA Jolla*	✔	✔	✔
1JS	Perlman Clinic-PMG Encinitas*	✔	✔	✔
1JN	Perlman Clinic-PMG Hillcrest*	✔	✔	✔
1KU	Perlman Clinic-PMG Kensington*	✔	✔	✔
1JQ	Perlman Clinic-PMG La Jolla*	✔	✔	✔
1K2	Perlman Clinic-PMG Mira Mesa/Scripps Ranch*	✔	✔	✔
1KT	Perlman Clinic-PMG Mission Bay/Pac Bch*	✔	✔	✔
1KP	Perlman Clinic-PMG North Park*	✔	✔	✔
1L4	Perlman Clinic-PMG Solana Beach*	✔	✔	✔
1L7	Perlman Pediatrics-PMG Point Loma*	✔	✔	✔
2XI	Prospect Medical Group*	✔	✔	✔
0PY	Prospect Medical Group Inc.*	✔	✔	✔
39W	Prospect Medical Group Inland Empire*	✔	✔	✔
41T	Prospect Medical Group San Diego	✔	✔	✔
KY4	Rady Childrens Health Network	✔	✔	✔
ZM5	Rady Childrens Health Network	✔	✔	✔

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Medical Plan Comparison (continued)

ANTHEM HMO Network Medical Groups

San Diego County

The below network comparison is subject to change due to contract negotiations. Member must verify directly with Anthem at time of enrollment.

For the latest information, use Provider Finder at https://www.anthem.com/ca/sisc/find-care by selecting Find a Doctor/Find Care.

Prime Code	PMG/IPA name	Full Network	Priority Select HMO	Select HMO
AAC	Scripps Clinic Carmel Valley	✔	✔	
AAE	Scripps Clinic Encinitas	✔	✔	
W9T	Scripps Clinic La Jolla/Anderson	✔	✔	
K77	Scripps Clinic Med Group/Liberty Station*	✔	✔	
GQP	Scripps Clinic Med Group/Mission Valley #2*	✔	✔	
GQ2	Scripps Clinic Med Group/Rancho San Diego#2*	✔	✔	
69S	Scripps Clinic Medical Grp/Del Mar	✔	✔	
AAG	Scripps Clinic Mission Valley	✔	✔	
AAH	Scripps Clinic Rancho Bernardo	✔	✔	
AAJ	Scripps Clinic Rancho San Diego	✔	✔	
AAK	Scripps Clinic Santee	✔	✔	
AAB	Scripps Clinic Torrey Pines	✔	✔	
ADD	Scripps Coastal Med Center/Carlsbad	✔	✔	
ACQ	Scripps Coastal Med Center/Cedar Road	✔	✔	
AAL	Scripps Coastal Med Center/Eastlake	✔	✔	
ACM	Scripps Coastal Med Center/Encinitas #1	✔	✔	
ABB	Scripps Coastal Med Center/Encinitas #2	✔	✔	
ABA	Scripps Coastal Med Center/Hillcrest	✔	✔	
Z2S	Scripps Coastal Med Center/Jefferson	✔	✔	
ADJ	Scripps Coastal Med Center/San Marcos	✔	✔	
G8N	Scripps Coastal Med Center/Solana Beach	✔	✔	
ADQ	Scripps Coastal Medical Center/Oceanside	✔	✔	
GQQ	Scripps Coastal Medical Group/Encinitas#4*	✔	✔	
GQ3	Scripps Coastal Medical Group/Hillcrest#2	✔	✔	
0ZN	Scripps Physicians Medical Group	✔	✔	✔
9QP	Scripps Physicians Medical Group	✔	✔	✔
0HP	Sharp Community Medical Group	✔		✔
LGT	Sharp Community Medical Group	✔		✔
24F	Sharp Community Medical Group-Inland North	✔		✔

Medical Plan Comparison (continued)

ANTHEM HMO Network Medical Groups

San Diego County

The below network comparison is subject to change due to contract negotiations. Member must verify directly with Anthem at time of enrollment.

For the latest information, use Provider Finder at https://www.anthem.com/ca/sisc/find-care by selecting Find a Doctor/Find Care.

Prime Code	PMG/IPA name	Full Network	Priority Select HMO	Select HMO
9JA	Sharp Community Medical Group-Palomar Health	✔		✔
AWJ	Sharp Rees-Stealy Carmel Del Mar	✔		✔
AWA	Sharp Rees-Stealy Chula Vista	✔		✔
ZWM	Sharp Rees-Stealy Del Mar	✔		✔
AWW	Sharp Rees-Stealy Genesee	✔		✔
AWH	Sharp Rees-Stealy La Mesa	✔		✔
AWD	Sharp Rees-Stealy Mira Mesa*	✔		✔
AWL	Sharp Rees-Stealy Otay Ranch	✔		✔
AWF	Sharp Rees-Stealy Point Loma*	✔		✔
AWG	Sharp Rees-Stealy Rancho Bernardo	✔		✔
AWK	Sharp Rees-Stealy San Diego	✔		✔
0AW	Sharp Rees-Stealy San Diego Downtown	✔		✔
Z40	Sharp Rees-Stealy Santee	✔		✔
AWX	Sharp Rees-Stealy Scripps Ranch	✔		✔
SIMNSA	Sistemas Medicos Nacionales, S.A. (CaliforniaCare is Large Group only)*	✔	✔	✔
AWT	Sharp Rees-Stealy Sorrento Mesa	✔		✔
4N5	UC San Diego Health Bankers Hill	✔	✔	✔
K27	UC San Diego Health Downtown*	✔	✔	✔
KEO	UC San Diego Health Eastlake*	✔	✔	✔
K4N	UC San Diego Health Encinitas*	✔	✔	✔
1CS	UC San Diego Health Genesee Avenue	✔	✔	✔
ZU0	UC San Diego Health Pacific Highlands Ranch*	✔	✔	✔
1CZ	UC San Diego Health Pediatrics Kearny Mesa	✔	✔	✔
Q9Y	UC San Diego Health Pediatrics La Jolla	✔	✔	✔
LKM	UC San Diego Health Rancho Bernardo	✔	✔	✔
1CT	UC San Diego Health Scripps Ranch	✔	✔	✔
ZLN	UC San Diego Health Sorrento Valley*	✔	✔	✔
X3E	UC San Diego Health University Center Lane	✔	✔	✔

Medical Plan Comparison (continued)

ANTHEM HMO Network Medical Groups

San Diego County

The below network comparison is subject to change due to contract negotiations. Member must verify directly with Anthem at time of enrollment.

For the latest information, use Provider Finder at https://www.anthem.com/ca/sisc/find-care by selecting Find a Doctor/Find Care.

Prime Code	PMG/IPA name	Full Network	Priority Select HMO	Select HMO
LIQ	UC San Diego Health Vista	✔	✔	✔
YGL	UCLA Medical Group*	✔		
XIU	UCSD Med Grp-Fam Med/4th & Lewis	✔	✔	✔
AEF	UCSD Med Grp-Int Med/Front St	✔	✔	✔
1CX	UCSD Med Grp-Internal Med/La Jolla	✔	✔	✔
1CW	UCSD Med Grp-Internal Med/Lewis	✔	✔	✔
OCP	UCSD Physician Network - Palomar Health		✔	
X8V	UCSD Physician Network Primary Care	✔	✔	✔
KF3	UCSD-One Medical Carlsbad	✔	✔	✔
KF2	UCSD-One Medical Downtown	✔	✔	✔
KEN	UCSD-One Medical La Jolla	✔	✔	✔
KBP	UCSD-Palomar Health 4s Ranch		✔	
JZ0	UCSD-Palomar Health Citracado		✔	
KBF	UCSD-Palomar Health El Norte		✔	
KBT	UCSD-Palomar Health Fallbrook		✔	
JZ5	UCSD-Palomar Health Grand Avenue		✔	
KBO	UCSD-Palomar Health Oceanside		✔	
JZ3	UCSD-Palomar Health Poway		✔	
JZ4	UCSD-Palomar Health Poway Outpatient Ctr		✔	
JZ1	UCSD-Palomar Health Ramona		✔	
KBS	UCSD-Palomar Health Sabre Springs		✔	
KBG	UCSD-Palomar Health San Marcos		✔	
KBN	UCSD-Palomar Health Second Avenue		✔	
JZZ	UCSD-Palomar Health Valley Center		✔	
KBE	UCSD-Palomar Health Vista		✔	
OFX	UCSD-Perlman Clinic Bressi Ranch*	✔	✔	✔
ZF2	UCSD-Perlman Clinic Carlsbad*	✔	✔	✔
OF0	UCSD-Perlman Clinic Carmel Mtn Ranch*	✔	✔	✔
ZEP	UCSD-Perlman Clinic Chula Vista*	✔	✔	✔

Medical Plan Comparison (continued)

ANTHEM HMO Network Medical Groups

San Diego County

The below network comparison is subject to change due to contract negotiations. Member must verify directly with Anthem at time of enrollment.

For the latest information, use Provider Finder at https://www.anthem.com/ca/sisc/find-care by selecting Find a Doctor/Find Care.

Prime Code	PMG/IPA name	Full Network	Priority Select HMO	Select HMO
OFC	UCSD-Perlman Clinic Chula Vista/Sunbow*	✔	✔	✔
ZE2	UCSD-Perlman Clinic Clairemont*	✔	✔	✔
ZF0	UCSD-Perlman Clinic Del Mar	✔	✔	✔
ZEJ	UCSD-Perlman Clinic Downtown*	✔	✔	✔
ZFB	UCSD-Perlman Clinic Downtown La Jolla*	✔	✔	✔
ZEQ	UCSD-Perlman Clinic Encinitas*	✔	✔	✔
ZFC	UCSD-Perlman Clinic Hillcrest	✔	✔	✔
AEE	UCSD-Perlman Clinic Internal Medicine*	✔	✔	✔
ZFI	UCSD-Perlman Clinic Kensington*	✔	✔	✔
ZF4	UCSD-Perlman Clinic La Jolla	✔	✔	✔
ZEZ	UCSD-Perlman Clinic La Mesa*	✔	✔	✔
OFZ	UCSD-Perlman Clinic Mira Mesa*	✔	✔	✔
1FL	UCSD-Perlman Clinic Mission Bay*	✔	✔	✔
1RZ	UCSD-Perlman Clinic Mission Valley*	✔	✔	✔
ZF3	UCSD-Perlman Clinic North Park*	✔	✔	✔
1Q8	UCSD-Perlman Clinic Santee*	✔	✔	✔
BWW	UCSD-Perlman Clinic Solana Beach*	✔	✔	✔
ZEE	UCSD-Perlman Clinic Vista*	✔	✔	✔
BWI	UCSD-Perlman Pediatrics Hillcrest*	✔	✔	✔
1RU	UCSD-Perlman Pediatrics Mission Bay/Pac Bch*	✔	✔	✔
MXZ	UCSD-Perlman Pediatrics Point Loma*	✔	✔	✔
1SZ	UCSD-Perlman Pediatrics Torrey Hills*	✔	✔	✔

* Five primary care providers or fewer in county. Information is current as of July 1, 2025, and will be updated periodically. Provider group names may have changed.
For the latest information, use Provider Finder at anthem.com/ca by selecting Find Care.

Medical Plan Comparison (continued)

PPO Plans

Benefits	SISC (Self-Insured Schools of California)	
	Anthem PPO's	
	Anthem PPO Plan	Anthem HDHP Plan
	In-Network (Prudent Buyer Network)	In-Network (Prudent Buyer Network)
Network Access	See any licensed provider you choose. Save money by staying within the Blue Cross PPO Prudent Buyer (Large Group) provider network. Your costs will be significantly higher for covered services provided by out-of-network providers.	
Annual Deductible	$200 individual $500 family	$1,700 individual $3,400 family
Medical Out-of-Pocket Maximum	$1,000 individual $3,000 family	$3,400 individual $6,800 family
		After the deductible is met then:
Office Visit	$0 copay per visit for visits 1-3 (not applicable for specialists), then $20 copay per visit for visits 4+	10% coinsurance
Specialist Visit	$20 copay	10% coinsurance
Inpatient Hospitalization	After the deductible is met then 10% coinsurance	10% coinsurance
Outpatient Surgery	After the deductible is met then 10% coinsurance*	10% coinsurance*
Urgent Care	$20 copay	10% coinsurance
Emergency Room	$100 copay, then 10% coinsurance	$100 copay, then 10% coinsurance
Ambulance	$100 copay, then 10% coinsurance	$100 copay, then 10% coinsurance
Preventive Care	100% covered in-network	100% covered in-network
Chiropractic/Acupuncture Services *(limits apply)*	After the deductible is met then 10% coinsurance	10% coinsurance
X-Ray & Laboratory	After the deductible is met then 10% coinsurance	10% coinsurance
Rx Out-of-Pocket Maximum	$1,500 individual $2,500 family	Included in medical out-of-pocket maximum
Prescriptions		**After the deductible is met, then:**
Retail-Network *(Other than Costco)*	$5 generic $20 brand (30 day supply)	$9 generic, $35 brand (30 day supply)
Costco Walk-In	$0 generic (up to a 90 day supply) $20 brand (30 day supply) $50 brand (90 day supply)	$0 generic (up to 90 day supply) $35 brand (30 day supply) $90 brand (90 day supply)
Costco Mail Order	$0 generic $50 brand (90 day supply)	$0 generic $90 brand (90 day supply)

* The following services must be performed at a Freestanding Surgical Center. If services are received in a Hospital Facility, the benefit will be limited as follows:

- Arthroscopy limited to $4,500 per procedure
- Cataract surgery limited to $2,000 per procedure
- Colonoscopy limited to $1,500 per procedure
- Upper GI Endoscopy limited to $1 ,000 per procedure
- Upper GI Endoscopy with biopsy limited to $1,250 per procedure

Contact Anthem member services if you have any questions.

Out of network coverage for the PPO and HDHP plans cover benefits at 100% of the fee schedule. The member is responsible for any balance above the fee schedule. This is a brief description of each plan. Any variances from the master policy; the master policy will prevail.

Anthem Provider Finder Instructions

Anthem HMO Plans

Go to https://www.anthem.com/ca/sisc/find-care/

- Under Find a Doctor click on the corresponding provider network
  - HMO (Full Network)
  - HMO Priority Select Network
  - HMO Select Network
- Click on Search for an HMO/Select/Priority Select Provider
- Choose the type of provider you are looking for (Doctor/Medical Professional is default). Enter your zip code. Optional to choose by specialty or provider's name. Click on Search.
- Once you find your doctor, make note of the 6-digit PCP ID/Enrollment ID. Enter the ID on the enrollment form or in the enrollment system. If the provider is your current physician be certain to indicate Yes on the enrollment form.
- All family members will be enrolled in the same provider network (Full, Priority Select, or Select), but you may select a different PCP for each family member.

Tips:

- ➢ You may change your PCP during the plan year. Changes received before the 15th of the month will be effective the first of the following month. You should only seek services from your assigned PCP, unless you have a referral from your PCP.
- ➢ If you don't see your provider listed in the provider finder, you may want to call your provider to confirm if they participate in the network you have selected. If they are not accepting new patients, they may not show up in the provider finder.

Anthem PPO's – California

Go to https://www.anthem.com/ca/sisc/find-care/

- Under Find a Doctor click on PPO (Full Network)
- Click on Search for a PPO Network Provider
- To search as a guest:
  - Type the type of plan or network = Medical Plan or Network
  - Select the state where the plan is offered = California
  - Select how you get health insurance = Medical (Employer-Sponsored)
  - Select plan or network = Prudent Buyer PPO
- To search as a member:
  - Choose type of provider looking for (Doctor/Medical Professional is default). Enter your zip code. Optional to choose by specialty or provider's name. Click on Search.

You do not need to choose a PCP if you select a PPO plan.

Note: If you are searching for a provider outside California, click on PPO and Select PPO (Outside of California) instead of choosing PPO (Full Network).

2026 Employee Cost

Employee costs vary by which medical plan is chosen, family status and work status. For full-time employees, the annual cap the District provides for medical, dental, vision and life insurance is $15,000. The resulting employee cost (if any) is deducted from your pay check 11 times per year.

Part-time employees have the choice between three medical plan options (part-time employees are not eligible for dental, vision or life insurance coverage). The cap is 70% of the employee only medical rate so varies slightly on whether the Kaiser, the Anthem HMO Select Network - Rx, or the Anthem HMO Priority Select Network - Rx plan is chosen. The resulting employee cost is deducted from your pay check 11 times per year.

As a reminder, employee costs above the cap are automatically deducted from your pay on a pre-tax basis* for yourself, your spouse and dependent children (tax rules may vary for registered domestic partners, please consult your tax advisor). Depending on your tax bracket, this may be an average savings of between 20-30% of the premium costs.

* If you prefer to not pre-tax your employee costs, please contact Payroll.

	SISC (Self-Insured Schools of California)					
	Kaiser	Anthem HMO's			Anthem PPO's	
	Kaiser HMO	Full Network	Priority Select Network	Select Network	Anthem PPO	Anthem HDHP
FULL-TIME EMPLOYEES – 11 MONTH DEDUCTIONS (INCLUDES MEDICAL, DENTAL, VISION AND LIFE INSURANCE)						
Employee Only	$0.00	$0.00	$0.00	$0.00	$11.88	$0.00
Plus 1 Dependent	$779.88	$1,133.33	$900.97	$846.42	$1,243.51	$603.15
Plus 2 or More Dependents	$1,377.69	$1,850.06	$1,544.60	$1,474.78	$1,997.33	$1,159.51

	SISC (Self-Insured Schools of California)		
	Kaiser	Anthem HMO's	
	Kaiser HMO	Priority Select Network	Select Network
PART-TIME EMPLOYEES – 11 MONTH DEDUCTIONS (MEDICAL ONLY)			
Employee Only	$302.40	$316.47	$306.98
Plus 1 Dependent	$1,300.58	$1,388.84	$1,356.44
Plus 2 or More Dependents	$1,898.40	$2,032.47	$1,984.80

Refer to page 30 for complete plan costs and contribution amounts:

- 2026 Total 11thly Benefits Cost (includes medical, dental, vision, basic life and basic AD&D)
- District 11thly Contribution amounts (for medical, dental, vision, basic life and basic AD&D)
- Employee 11thly Contribution amounts (for medical, dental, vision, basic life and basic AD&D)

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Dental

This is an incentive plan; Delta Dental pays 70% of the PPO contract allowance for covered diagnostic, preventive, basic and major services during the first year of eligibility. The coinsurance percentage will increase by 10% each year (to a maximum of 100%) for each enrollee if that person visits the dentist at least once during the year. If an enrollee does not use the plan during the calendar year, the percentage remains at the level attained the previous year. If an enrollee becomes ineligible for benefits and later regains eligibility, the percentage will drop back to 70%.

You can visit any licensed dentists under this plan, but you will maximize plan value, through savings to you, by selecting a Delta Dental PPO dentist. PPO dentists have agreed to reduce contracted rates and cannot "balance bill" you for additional covered fees. To find a Delta Dentist PPO provider go to: deltadentalins.com or call 866-499-3001.

Plan Benefits	Delta Dental PPO Plan	
	Member Responsibility	
	Delta Dental PPO Dentists	Non-Delta Dental PPO Dentists
Annual Deductible		
• Individual	$25	$25
• Family	$25 for each enrollee	$25 for each enrollee
Annual Maximum Benefit	$2,500	$2,500
Diagnostic and Preventive Services		
• Oral Exams, Routine Cleanings, X-Rays, Fluoride Treatment	30% - 0%	30% - 0%
Basic Services		
• Fillings *(amalgam)*	30% - 0%	30% - 0%
• Fillings *(porcelain/ceramic)*	30% - 0%	30% - 0%
• Endodontics *(root canals)*	30% - 0%	30% - 0%
• Oral Surgery	30% - 0%	30% - 0%
• Periodontics *(gum treatment)*	30% - 0%	30% - 0%
Major Services		
• Crowns, Inlays, Onlays, Cast Restorations	30% - 0%	30% - 0%
• Prosthodontics *(Dentures, Bridges)*	40%	50%
Temporomandibular Joint (TMJ)	70%	70%
Orthodontics		
• Dependent Children Only	50%	50%
• Lifetime Maximum	$2,000	$2,000

Reimbursement is based on PPO contracted fees for PPO dentists, Premier contracted fees for Premier dentists and program allowance for non-Delta Dental dentists.

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Vision

Your vision plan through VSP offers flexibility and a wide network. You may use any vision care provider, but if you use a VSP Signature provider, you will get the most value from your VSP Signature benefits. With VSP providers there are no ID cards, no claim forms and no hassles. With other providers, you must pay the bill in full and file a claim for reimbursement at the scheduled benefit level. The plan allows an eye exam, lenses and frames every 12 months. You will also find discounts on extra glasses, sunglasses, contact lenses and laser vision correction.

Plan Benefits	VSP (Vision Service Plan)	
	In-Network	Out-of-Network
Frequency		
• Eye Exam	Once every 12 months	
• Lenses/Contacts	Once every 12 months	
• Frames	Once every 12 months	
Copay	**MEMBER RESPONSIBILITY**	**PLAN PAYS**
• Exam and Materials	$25 copay, Exam and/or Glasses Various copays for materials	Up to $45 allowance for Exam
Prescription Lenses		
• Single	Copay included in $25 exam copay	Up to $45 allowance
• Lined Bifocal	Copay included in $25 exam copay	Up to $65 allowance
• Lined Trifocal	Copay included in $25 exam copay	Up to $85 allowance
Frames	**PLAN PAYS**	**PLAN PAYS**
	$150 allowance; 20% off remaining amount $170 allowance for featured frame brands $80 allowance at Walmart/Sam's Club/Costco	Up to $47 allowance
Contacts, including Fitting and Evaluation *(in lieu of lenses and frames)*	**PLAN PAYS**	**PLAN PAYS**
• Medically Necessary	100%	Up to $210 allowance
• Elective	$150 allowance	Up to $105 allowance
Suncare	$150 allowance for ready-made non-prescription sunglasses or ready-made non-prescription blue light filtering glasses, instead of prescription glasses or contact lenses.	
Laser Vision Correction	**PLAN PAYS**	
	Average of 15% off the regular price; discounts available at contracted facilities.	

Discount Hearing Aids – TruHearing

VSP members can use their hearing aid allowance through Anthem Blue Cross (Kaiser members are not eligible) to purchase hearing aids from TruHearing.

Contact TruHearing for more information at 866-754-1607.

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Basic Life & AD&D

As a benefit eligible employee of the District, you automatically receive group term life insurance administered by The Hartford.

If a covered employee should die in an accident or be maimed accidently, there could be an additional benefit called Accidental Death and Dismemberment (AD&D).

Plan Benefits	Basic Life & AD&D/The Hartford
Eligible Class	All active full-time employees and certificated employees participating in shared assignments
Coverage Amount[1]	$50,000
Maximum Benefit	$50,000
Guaranteed Issue	$50,000
Age Reduction	
• At age 65	Reduction to 65% of the initial benefit amount
• At age 70	Reduction to 50% of the initial benefit amount
Accelerated Benefit Option	80% of the amount of the Life Insurance benefit is available to you if you incur a terminal condition. Terminal condition means an injury or sickness expected to result in your death within 12 months and from which there is no reasonable prospect of recovery as determined by the carrier.
Conversion	Yes
Portability	Yes

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Voluntary Life Insurance

If you prefer an amount of life insurance above the basic amount the District provides at no cost to you, you may purchase voluntary coverage through after-tax payroll deductions. You may choose the amount of coverage to suit your needs, from $10,000 to $300,000, but not to exceed five-times your annual earnings. Coverage must be purchased in $10,000 increments. If you elect voluntary life insurance for yourself, you may also purchase additional life insurance for your spouse and for your children.

Plan Benefits	Voluntary Life/The Hartford
Eligible Class	Benefit Eligible Employees Working 20 Hours or More Per Week
Coverage Amount	
• Employee	Increments of $10,000
• Spouse	Increments of $5,000 (cannot exceed 50% of employee approved coverage). Terminates at age 70.
• Child(ren)	$2,500/$5,000/$10,000. Terminates at age 26.
Maximum Benefit	
• Employee	5 times base annual salary to a maximum of $300,000
• Spouse	$100,000 (cannot exceed 50% of employee approved coverage)
• Child(ren)	$10,000 (cannot exceed 50% of employee approved coverage)
Guaranteed Issue[1]	
• Employee	$150,000
• Spouse	$50,000
• Child(ren)	$10,000
Waiver of Premium[2]	Included, terminates at age 65
Age Reduction	
• At age 70	Reduction to 50% of the initial benefit amount
Accelerated Benefit Option	Yes, if you are diagnosed as terminally ill with a life expectancy of 12 months or less, you may be eligible to receive payment for a portion of your life insurance. The request cannot exceed 80% of the in force amount of life insurance subject to a minimum of $3,000 and a maximum of $240,000. The remaining amount of your life insurance would be paid to your beneficiary when you die.
Conversion	Yes
Portability	Yes

1. Guarantee Issue is the amount of insurance you are guaranteed without having to complete Evidence of Insurability (EOI). Any amounts above the Guaranteed Issue amount is subject to underwriting where you will be required to complete an EOI form.
2. If you become Totally Disabled while insured, the Waiver of Premium Provision may continue your Life Insurance without any further payment of premiums by you.

Annual Enrollment - Increases in Amount of Life Insurance:

- Employees who are already enrolled in Voluntary Life Insurance for an amount below the Guarantee Issue (GI) amount ($10,000 - $140,000) may increase their Voluntary Life Insurance by $10,000 with no Evidence of Insurability (EOI).
- Any increase to Spouse Voluntary Life Insurance must be approved through the EOI process.
- Increases to Child(ren) Voluntary Life Insurance coverage does not require EOI, but the elected amount must be 50% or less of the Employee Voluntary Life Insurance amount.
- If not already enrolled, you and your dependents must provide Evidence of Insurability for any amount of Voluntary Life Insurance.

The information described on this page is only intended to be a summary of benefits. It does not describe or include all benefit provisions, limitations, exclusions, or qualifications for coverage. Please review plan documents for full details. If there are any conflicts with information provided on this page, the plan documents will prevail.

Voluntary Life Insurance (continued)

Tenthly rates per $10,000 of coverage (employee), per $5,000 of coverage (spouse) and children rates are as follow:

Age	Per $10,000 of Coverage	Per $5,000 of Coverage
Under 25	$0.60	$0.30
25-29	$0.60	$0.30
30-34	$0.84	$0.42
35-39	$1.08	$0.54
40-44	$1.32	$0.66
45-49	$2.40	$1.20
50-54	$4.20	$2.10
55-59	$7.08	$3.54
60-64	$11.40	$5.70
65-69	$16.08	$8.04
70-74	$23.76	N/A
75+	$23.76	N/A

Children	
$10,000	$1.00
$5,000	$0.50
$2,500	0.25

The information described on this page is only intended to be a summary of benefits. It does not describe or include all benefit provisions, limitations, exclusions, or qualifications for coverage. Please review plan documents for full details. If there are any conflicts with information provided on this page, the plan documents will prevail.

Employee Assistance Programs (EAP)

An employee assistance program (EAP) is a confidential program that provides professional counseling, financial advice, and referral services to employees and the members of their household. You and each member of your household have access to two EAP plans:

1. Evernorth no-cost counseling: Each member of your household can access up to six (6) in-person or virtual sessions per issue, per year with Evernorth's network of EAP professional counselors. Evernorth may be contacted at 888-736-7009. (Program name: San Diego & Imperial County Schools; Del Mar Union employer ID password: EASE).
2. Anthem EAP: If enrolled in any of the SISC medical plans (Anthem HMO, PPO, HDHP or Kaiser), each member of your household is entitled to 6 confidential counseling sessions per concern, per year. The Anthem EAP may be contacted at 800-999-7222 or at www.anthemeap.com (Program name: SISC).
3. **Kaiser Members:** Kaiser has made accessing mental health resources even easier with an easy-to-remember phone number: 1-833-KP-WITH-U (1-833-579-4848) and resources. Book an appointment during standard business hours, active referral not required. Or visit the kp.org mental health page to access additional resources and tools.

An EAP is designed to help you with everyday concerns and questions, both big and small, which impact you or anyone residing in your household.

These everyday problems we each face include:

- Relationship difficulties
- Marriage, family or parenting concerns
- Managing change and stress
- Grief and loss
- Legal and financial problems
- Work-related concerns
- Anxiety and depression

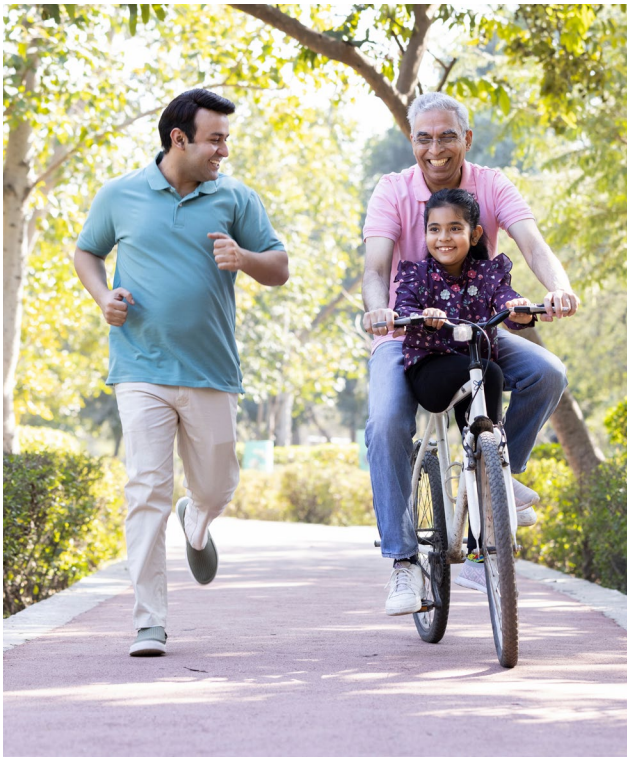
An EAP can assist you with more serious concerns such as alcohol and drug problems, family violence and threats of suicide. EAP resources are most effective when the services are accessed early in the progression of a problem, before the situation begins to impact personal life and work.

When you or a household member contact the EAP, they work with you to figure out the next steps. If you need counseling, up to 6 visits to a licensed professional will be arranged. If you have money concerns or legal questions, the EAP can put you in touch with a financial advisor or an attorney.

Important features:

- There is no cost for the EAP services, no copays or forms required
- Appointments can be made around your schedule
- Emergencies are handled by staff members available by phone 24 hours a day, 7 days a week

It is your choice which EAP to access when you need to.



Flexible Spending Accounts

You Can Save on Your Taxes

A Flexible Spending Account (FSA) is an IRS approved plan that allows you to pay for unreimbursed medical expenses and childcare/dependent expenses with pre-income tax and pre-FICA dollars. Each FSA dollar that you spend on copays and deductibles for medical, vision, dental, childcare, and dependent care expenses will reduce your taxable wages.

Open Enrollment

You can only enroll in the FSA once per year during the fall Open Enrollment with your elections effective January 1 of each year. American Fidelity is the administrator of the Section 125 plan and visits each school site annually to allow you to enroll. If you choose not to enroll during the Open Enrollment period, you must wait until the Open Enrollment period the following year to sign up.

You must notify Human Resources within 30 days of any qualifying life event to make changes to this enrollment. The changes must be consistent with the life event (if you are adding a baby, you may increase medical spending account election, but may not decrease the election).

There are limited exceptions to this rule:

- Change in Status
  - Change in employees' legal marital status, including marriage, divorce, death of a spouse, legal separation and annulment;
  - Change in number of dependents, including birth, adoption, placement for adoption, and death;
  - Change in employment status, including any employment status change affecting benefit eligibility of the employee, spouse or dependent, such as termination or commencement of employment, change in hours, strike or lockout, a commencement or return from unpaid leave of absence, and a change in worksite.
- Special Enrollment Rights (applies to medical plan election only) – if an employee, spouse or dependent is entitled for Special Enrollment rights under a group health plan (other than an excepted benefit), as required by HIPAA, then a participant may revoke a prior election for group health plan coverage and make a new election. Special Enrollment rights include (not exhaustive):
  - Loss of coverage under another group plan,
  - A new dependent is acquired as a result of marriage, birth, adoption or placement of adoption,
  - Loss of MediCal (Medicaid) or state exchange eligibility (participant has 60 days to notify Human Resources in this event);
  - Certain judgments, decrees or orders;
  - Entitlement to Medicare or MediCal (Medicaid);
  - Family Medical Leave Act (FMLA);
  - COBRA qualifying event;
  - Change in eligibility of adult children
- **Other Exceptions to the Irrevocability of Elections:**
  - Significant change in cost in benefit as determined by the plan document.

These exceptions may not be all inclusive.

Please contact Human Resources for guidance with your specific situation. Human Resources will confer with American Fidelity to determine an outcome based on IRS rules and regulations.

CLICK HERE to watch a video on Flexible Spending Accounts (FSA)

Flexible Spending Accounts (continued)

How Your Health Care FSA Works

The Health Care FSA lets you use your tax-free dollars to pay for eligible health care expenses not covered by your health plans (medical, dental and vision), out-of-pocket expenses incurred by you, your spouse and your eligible dependents. The IRS has set the maximum contribution for Health Care at $3,300*.

* The Health FSA maximum reflected is for the 2025 calendar year. The 2026 limit is not typically determined until after the release of the Benefit Guide. Employees making elections for the 2026 year should keep this in mind.

Some examples of eligible expenses include:

- Over-the-counter medications and feminine care products
- Acupuncture
- Chiropractor care
- Dental care
- Eye glasses/contact lenses
- Hearing aids/batteries
- In vitro fertilization
- Laser eye surgery
- Orthodontia (Services must be incurred or already paid during plan year. Special rules apply, contact American Fidelity for further information.)

Some ineligible expenses include:

- Cosmetic expenditures
- Exercise equipment
- Insurance premiums
- Teeth whitening

Go to https://americanfidelity.com for a complete list of eligible and ineligible expenses.

During open enrollment, be sure to meet with your American Fidelity Representative to learn more.

How Your Dependent Care FSA Works

The Dependent Care FSA allows you to use tax-free dollars to pay for the child and elder day care expenses that enable you and your spouse to work or attend school full-time. You can use your FSA to pay for those regular expenses such as day care, baby sitting, and even summer day camp.

The IRS code has set the maximum contributions for the Dependent Care FSA to $7,500. However, if you are married and you and your spouse file separate tax returns, the maximum amount you can contribute is $3,750. It is important to note that the maximum for the Dependent Care FSA is a "family maximum." If your spouse has a Dependent Care FSA available at his or her employer and chooses to participate, your election amounts are combined. Your combined election amount cannot be higher than the maximum that pertains to you.

Dependent Care FSAs differ from Health Care FSAs in that they are not "pre-funded." This means that you can only be reimbursed for an amount up to the total you have deposited into your account at any given point in the year. However, expenses associated with the care of a dependent are most often accrued on a per week or per month basis, and therefore the total election amount is rarely needed all at once.

Premium Contribution Account

Any core benefit (medical, dental and vision) premiums that exceed the negotiated cap will automatically be deducted from your pay on a pre-tax basis for yourself, spouse and dependents (registered domestic partners may not be eligible for the benefit, please contact your tax advisor for additional information). If you prefer not to pre-tax your payroll deductions, contact Human Resources.

Plan Carefully

The best advice is to meet with your American Fidelity representative during Open Enrollment and carefully review anticipated expenses.

Voluntary Programs

Voluntary Programs Available Through Payroll Deductions

There are a variety of benefits you can purchase through payroll deductions (no contributions are provided by the District).

American Fidelity offers the following products:

- Accident Only Insurance
- Cancer Insurance
- Disability Income Insurance
- Life Insurance
- Critical Illness
- 403b

For more information, contact your account representative at 800-365-9180 or visit americanfidelity.com.

For forms, contact Karlyn Stone at KStone@dmusd.org or 858-755-9301 ext. 3692.

The Standard Insurance for DMCTA – CTA endorsed Disability and Life Insurance is offered through The Standard. These programs are designed specifically for CTA members. It is strongly urged that you review both plans within 180 days of new employment or within the first 120 days if you are transferring to a new District. Call CTA Customer Service at 800-522-0406 or CTAMemberBenefits.org/TheStandard for additional information.

Other Programs Include:

- **MetLife –** Legal Services
- **MetLife –** Pet Insurance

Retirement

- **CalSTRS –** 800-228-5453 or www.calstrs.com
- **CalPERS –** 888-225-7377 or www.calpers.ca.gov

Supplemental Retirement Plans:

403(b), 457(B) and Roth 403b, contact your FBC Plan*Member* representative, Anna Bernardo at abernardo@planmember.com or 619-614-6244.

2026 Plan Costs and Contribution Amounts

Active Employees	11thly Medical Premiums (SISC)	FBC 11thly Premiums			2026 Total 11thly Benefits Cost	District 11thly Contribution $15,000	Employee Out Of Pocket, 11thly
		Life	Vision	Dental			
		#40490	#33550	#33650			
Kaiser HMO - $15 OV, $5/$20 Rx							
Employee Only	$1,008.00	$5.18	$12.49	$119.66	$1,145.33	$1,363.64	$0.00
Plus 1 Dependent	$2,006.18	$5.18	$12.49	$119.66	$2,143.51	$1,363.64	$779.88
Plus 2 or More Dependents	$2,604.00	$5.18	$12.49	$119.66	$2,741.33	$1,363.64	$1,377.69
Anthem HMO Full Network - $10 OV, $5/$20 Rx							
Employee Only	$1,166.18	$5.18	$12.49	$119.66	$1,303.51	$1,363.64	$0.00
Plus 1 Dependent	$2,359.64	$5.18	$12.49	$119.66	$2,496.97	$1,363.64	$1,133.33
Plus 2 or More Dependents	$3,076.36	$5.18	$12.49	$119.66	$3,213.69	$1,363.64	$1,850.06
Anthem HMO Priority Select Network - $10 OV, $5/$20 Rx							
Employee Only	$1,054.91	$5.18	$12.49	$119.66	$1,192.24	$1,363.64	$0.00
Plus 1 Dependent	$2,127.27	$5.18	$12.49	$119.66	$2,264.60	$1,363.64	$900.97
Plus 2 or More Dependents	$2,770.91	$5.18	$12.49	$119.66	$2,908.24	$1,363.64	$1,544.60
Anthem HMO Select Network *(Narrow)* **- $10 OV, $9/$35 Rx**							
Employee Only	$1,023.27	$5.18	$12.49	$119.66	$1,160.60	$1,363.64	$0.00
Plus 1 Dependent	$2,072.73	$5.18	$12.49	$119.66	$2,210.06	$1,363.64	$846.42
Plus 2 or More Dependents	$2,701.09	$5.18	$12.49	$119.66	$2,838.42	$1,363.64	$1,474.78
Anthem PPO							
Employee Only	$1,238.18	$5.18	$12.49	$119.66	$1,375.51	$1,363.64	$11.88
Plus 1 Dependent	$2,469.82	$5.18	$12.49	$119.66	$2,607.15	$1,363.64	$1,243.51
Plus 2 or More Dependents	$3,223.64	$5.18	$12.49	$119.66	$3,360.97	$1,363.64	$1,997.33
Anthem HDHP							
Employee Only	$921.82	$5.18	$12.49	$119.66	$1,059.15	$1,363.64	$0.00
Plus 1 Dependent	$1,829.45	$5.18	$12.49	$119.66	$1,966.78	$1,363.64	$603.15
Plus 2 or More Dependents	$2,385.82	$5.18	$12.49	$119.66	$2,523.15	$1,363.64	$1,159.51

Part-Time Employees (All Premiums/Payroll Deductions 11thly)							
	11thly Medical Premiums (SISC)				11thly Medical	District 11thly Contribution (Employee Only)	Employee Out Of Pocket, 11thly
Kaiser HMO							
Employee Only	$1,008.00	N/A	N/A	N/A	$1,008.00	$705.60	$302.40
Plus 1 Dependent	$2,006.18	N/A	N/A	N/A	$2,006.18	$705.60	$1,300.58
Plus 2 or More Dependents	$2,604.00	N/A	N/A	N/A	$2,604.00	$705.60	$1,898.40
Anthem Select HMO Premier *(Narrow Network)* **- Rx (9/35)**							
Employee Only	$1,023.27	N/A	N/A	N/A	$1,023.27	$716.29	$306.98
Plus 1 Dependent	$2,072.73	N/A	N/A	N/A	$2,072.73	$716.29	$1,356.44
Plus 2 or More Dependents	$2,701.09	N/A	N/A	N/A	$2,701.09	$716.29	$1,984.80
Anthem HMO Priority Select Network - $10 OV, $5/$20 Rx							
Employee Only	$1,054.91	N/A	N/A	N/A	$1,054.91	$738.44	$316.47
Plus 1 Dependent	$2,127.27	N/A	N/A	N/A	$2,127.27	$738.44	$1,388.84
Plus 2 or More Dependents	$2,770.91	N/A	N/A	N/A	$2,770.91	$738.44	$2,032.47

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.

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 medical plan's customer service number as listed on your ID card.

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 call your medical plan's customer service number as listed on your ID card.

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 call your medical plan's customer service number as listed on your ID card

Networks/Claims/Appeals

The major medical plans described in this booklet have provider networks with Anthem and Kaiser. 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 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.

The right to COBRA continuation coverage was created by federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). 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.

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.

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.

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

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you 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.

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 31 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 31 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:

Karlyn Stone
Benefits & Risk Management
KStone@dmusd.org or 858.755.9301

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

Del Mar Union 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 Karlyn Stone at KStone@dmusd.org.

Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: GENERAL INFORMATION

This notice provides you with information about Del Mar Union 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 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 9.96% (for 2026) 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.

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 Del Mar Union School District	**4. Employer Identification Number (EIN)** 95-6000995	
5. Employer address 11232 El Camino Real	**6. Employer phone number** 858.755.9301 x3692	
7. City San Diego	**8. State** CA	**9. ZIP code** 92130
10. Who can we contact about employee health coverage at this job? Karlyn Stone, Benefits & Risk Management Coordinator		
11. Phone number (if different from above)	**12. Email address** KStone@dmusd.org	

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.

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

Del Mar Union School District has determined that the prescription drug coverage offered by the Del Mar Union 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 Del Mar Union School District coverage will not be affected. If you keep this coverage and elect Medicare, the Del Mar Union School District coverage will not coordinate with Part D coverage. If you do decide to join a Medicare drug plan and drop your current Del Mar Union 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.

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, 2025. 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:
http://dhcs.ca.gov/hipp
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

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

Important Notices (continued)

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: www.medicaid.la.gov or www.ldh.la.gov/lahipp
Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)

MAINE - Medicaid
Enrollment Website:
https://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: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm
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://www.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:
https://www.nj.gov/humanservices/dmahs/clients/medicaid/
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)

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

Important Notices (continued)

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://dhhr.wv.gov/bms/
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, 2025, 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

Glossary

Affordable Care Act and Patient Protection (ACA)

Also called Health Care Reform, the ACA requires health plans to comply with certain requirements. The ACA became law in March 2010. Since then, the ACA has required some changes to medical coverage—like covering dependent children to age 26, no lifetime limits on medical benefits, covering preventive care without cost-sharing, etc, among other requirements.

Allowed Amount

Maximum amount on which payment is based for covered health care services. This may be called "eligible expense," "payment allowance" or "negotiated rate." If your provider charges more than the allowed amount, you may have to pay the difference. (See Balance Billing.)

Balance Billing

When a provider bills you for the difference between the provider's charge and the allowed amount. For example, if the provider's charge is $100 and the allowed amount is $70, the provider may bill you for the remaining $30. A preferred provider may not balance bill you.

Brand Name Drug

The original manufacturer's version of a particular drug. Because the research and development costs that went into developing these drugs are reflected in the price, brand name drugs cost more than generic drugs.

COBRA (Consolidated Omnibus Budget Reconciliation Act)

The Consolidated Omnibus Budget Reconciliation Act allows people who lose their jobs to continue their employer-sponsored insurance coverage for up to 18 months.

Children's Health Insurance Program (CHIP)

The government program that provides free or low-cost health coverage for children up to age 19 in families whose income is too high to qualify for Medicaid but too low to afford private insurance. CHIP covers U.S. citizens and eligible immigrants. In some states, CHIP covers pregnant people. CHIP goes by different names in some states.

Claim

A request for payment that you or your health care provider submits to your health insurer to be paid or reimbursed for items or services you have received. Most often, you will not be responsible for making claim requests. Usually, billing and claims specialists employed by the health care provider (e.g. primary care office, hospital) will make the claim on your behalf.

Coinsurance

A percentage of costs you pay "out-of-pocket" for covered expenses after you meet the deductible.

Copayment (Copay)

A fee you have to pay "out-of-pocket" for certain services, such as a doctor's office visit or prescription drug.

Comprehensive Coverage

A health insurance plan that covers the full range of care that you may need. This may include preventive services (like flu shots), physical exams, prescription drugs, and doctor or hospital care.

Deductible

The amount you pay "out-of-pocket" before the health plan will start to pay its share of covered expenses.

Formulary

A list of prescription drugs covered by the health plan, often structured in tiers that subsidize low-cost generics at a higher percentage than more expensive brand-name or specialty drugs.

Generic Drug

Lower-cost alternative to a brand name drug that has the same active ingredients and works the same way.

High-Deductible Health Plan (HDHP)

High-deductible health plans (HDHPs) are health insurance plans with lower premiums and higher deductibles than traditional health plans. Only those enrolled in an HDHP are eligible to open and contribute tax-free to a health savings account (HSA).

Glossary (continued)

Health Savings Account (HSA)

A health savings account (HSA) is a portable savings account that allows you to set aside money for health care expenses on a tax-free basis. State taxes may apply. You must be enrolled in a high-deductible health plan in order to open an HSA. An HSA rolls over from year to year, pays interest, can be invested, and is owned by you—even if you leave the company.

Health Reimbursement Arrangements (HRAs)

Unlike HSAs, only an employer may fund an HRA and the funds revert back to the employer when the employee leaves the organization. HRAs are not subject to the same contribution limits as HSAs, and they may be paired with either high-deductible plans or traditional health plans.

In-Network

Doctors, clinics, hospitals and other providers with whom the health plan has an agreement to care for its members. Health plans cover a greater share of the cost for in-network health providers than for providers who are out-of-network.

Non-Preferred Provider

A provider who doesn't have a contract with your health insurer or plan to provide services to you. You'll pay more to see a non-preferred provider.

Out-of-Pocket Maximum

The most you pay each year "out-of-pocket" for covered expenses. Once you've reached the out-of-pocket maximum, the health plan pays 100% for covered expenses.

Out-Of-Network

A health plan may not cover treatment for doctors, clinics, hospitals and other providers who are out-of-network, but covered employees will pay more out-of-pocket to use out-of-network providers than for in-network providers.

Out-Of-Pocket Limit

The most an employee could pay during a coverage period (usually one year) for his or her share of the costs of covered services, including co-payments and co-insurance.

Plan Year

The year for which the benefits you choose during Annual Enrollment remain in effect. If you're a new employee, your benefits remain in effect for the remainder of the plan year in which you enroll, and you enroll for the next plan year during the next Annual Enrollment.

Preferred Provider

A provider who has a contract with your health insurer or plan to provide services to you at a discount.

Premium

The amount that must be paid for a health insurance plan by covered employees, by their employer, or shared by both. A covered employee's share of the annual premium is generally paid periodically, such as monthly, and deducted from his or her paycheck.

Preventive Care

Health care services you receive when you are not sick or injured— so that you will stay healthy. These include annual checkups, gender- and age-appropriate health screenings, well-baby care, and immunizations recommended by the American Medical Association.

Qualifying Life Event

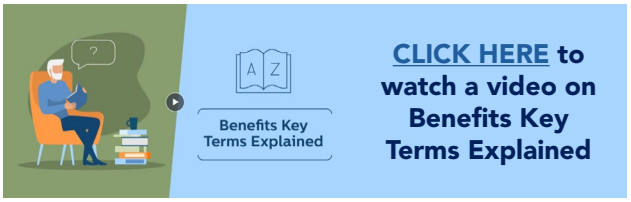
A change in your life that can make you eligible for a Special Enrollment Period to enroll in health coverage. Examples of qualifying life events include moving to a new state, certain changes in your income, and changes in your family size.

Skilled Nursing Care

Services from licensed nurses in your own home or in a nursing home. Skilled care services are from technicians and therapists in your own home or in a nursing home.

Urgent Care

Care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room care.



Contact Information

Below is a listing of the telephone numbers you can call with questions about the plans available to you. You can also use the web site (if available) to access information from providers for the various plans.

Plan	Phone Number	Web Site
Medical		
• Anthem Blue Cross	800-825-5541	www.anthem.com/ca/sisc
• Navitus Health Solutions *(prescription benefit for all Anthem Blue Cross medical plans)*	866-333-2757	www.navitus.com
• Kaiser	800-464-4000	www.kp.org
Dental		
• Delta Dental	866-499-3001	www.deltadentalins.com
Vision		
• VSP	800-877-7195	www.vsp.com
Employee Assistance Program (EAP)		
• Anthem Blue Cross EAP	800-999-7222	www.anthem.com/ca/sisc
• Evernorth	888-736-7009	www.well.evernorth.com Employer program: San Diego & Imperial County Schools. Del Mar Union employer ID password: EASE. (for initial registration)
• Kaiser Mental Health Appointments	833-KP-WITH-U (833-579-4848)	For members seeking mental health care appointments (Kaiser members only)
• Kaiser 24/7 Urgent Mental Health Advice	800-900-3277	Mental Health Services (Kaiser members only)
Basic Life/AD&D		
• The Hartford		Del Mar USD Human Resources
Voluntary Life		
• The Hartford		Del Mar USD Human Resources
Flexible Spending Accounts (FSA) and COBRA		
• American Fidelity	800-365-9180	americanfidelity.com
Other Voluntary Insurance Products		
• American Fidelity		
– Accident	800-365-9180	americanfidelity.com
– Cancer	800-365-9180	americanfidelity.com
– Disability	800-365-9180	americanfidelity.com
– Life	800-365-9180	americanfidelity.com
• MetLife Legal Plans	800-821-6400	www.legalplans.com
• Retirement Accounts – 403(b), 457(b), Roth 403(b)		
– Empower	844-732-7738	participant.empower-retirement.com
– FBC Plan*Member*	833-752-6322	support@fbcmodelplan.com www.fbcmodelplan.com
– Schools First (TPA)	800-462-8328 x 4727	
• The Standard (DMCTA) Disability and Life Insurance	800-522-0406	CTAMemberBenefits.org/TheStandard
Pet Insurance		
• MetLife	800-GET-MET8	www.metlife.com/getpetquote
Medical Benefit Consultant Keenan & Associates		
• Andrea Estrin	949-940-1760 x5133	aestrin@keenan.com
• Crystal Bonker	951-715-0190 x1157	cbonker@keenan.com