Employee Benefits Guide

2023

Del Mar
• UNION SCHOOL DISTRICT •

Employee Benefits Guide 2023

General Information

Core Benefits

Other Benefits

Miscellaneous

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

NEW! See page 34 for a glossary of terms.

Retirees (including a spouse) of Del Mar Union School District are not eligible for SISC medical plans upon reaching age 65. The retiree (or spouse) must enroll in Medicare Parts A and B and seek alternative coverage.

Regarding Medicare prescription coverage in general, please see page 28 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, 2023 to December 31, 2023. 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).

Click here to watch a video on Qualifying Life Events.

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, then Benefits) for additional information.

What's New – Effective January 1, 2023

- The SIMNSA medical plan will no longer be available to Del Mar Union School District employees effective January 1, 2023. If you are enrolled in this plan, you must make a new medical election for 2023.
- The High Deductible Health Plan family coverage deductible will increase to $3,000 (from $2,800).

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.

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.	• 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	$12,500 per year	70% of the employee only cost	$12,500 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 *(dental and vision plans do not allow coverage)* – 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 – Disabled adult child over age 26

* 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 Birth Certificate *(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 6 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, 2024 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 (or to age 25 for Dental and Vision plans)
- Guardianship no longer applies (to age 18)

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 spouse 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.

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 Premier
   - Anthem HMO Select Premier
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.

Click here to watch a video on Health Maintenance Organizations (HMO).

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 1.800.825.5541 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 1.888.855.7806.

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.

Click here to watch a video on Preferred Provider Organizations (PPO).

Click here to watch a video on PPO vs HMO.

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.

Click here to watch a video on High Deductible Health Plans (HDHP).

Click here to watch a video on HDHP vs PPO.

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 2022

How Much Can I Contribute to an HSA for 2023?

The IRS determines the contribution limits for HSA's.

HDHP Single Coverage

- You can contribute up to $3,850 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 $7,750 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 $3,850 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 $8,750 if catch-up provisions apply.

HSA is a Triple-Tax Savings Plan

- HSA payroll deductions are tax free
- Invest HSA fund 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.

Click here to watch a video on Health Savings Accounts (HSA).

Click here to watch a video on HSA vs FSA.

REMINDER
Important Medical Plan Benefits!

Health Programs Available to all SISC Members (Kaiser, Anthem HMO or PPO). All employees and their family members enrolled in a SISC medical plan have access to the following services:

Expert Medical Opinion Program

Teledoc 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 Teledoc at 800.835.2362 or visit teladoc.com/sisc.

MyStrength

MyStrength is a smart phone application that provides free emotional health and wellness tools to all employees and household members. Members may download MyStrength to their smart phone and call the Anthem EAP at 800.999.7222 for assigned access code.

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.

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

- **MDLive** 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 (through September 30, 2023). Register by calling MDLive at 1.888.632.2738 or go to mdlive.com/sisc. (It is recommended you register ***before*** you need to access MDLive services).
- **Vida Health** a digital coaching application with one-on-one health coaching, therapy and management tools for pre-diabetes, diabetes, hypertension, depressions and more. Call 855.442.5885 or go to vida.com/sisc.
- **Free Generic Medications** (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 1.800.774.2678 (press 1) to find a Costco location.
- **Lark Diabetes Prevention Program** is a digital program focused on helping members prevent diabetes and start improving overall health and well being by losing weight and adopting health habits. Go to Lark.com/anthembc to see if you qualify.
- **Sydney Health App** allows you to view all benefits, access wellness tools, and store your member ID card so you can show, email or fax it right from your phone.

Medical Plan Overview (continued)

For employees and family members enrolled in the Anthem PPO plans only, added benefits include:

- The first 3 visits to a primary doctor, per calendar year, are $0. Research shows that strengthening a relationship with a primary care provider leads to better health outcomes – thus lower premiums over time. Included provider types are: General and Family Practice, Internal Medicine, Pediatrics, Nurse Practitioner, Physicians' Assistant, Obstetrics and Gynecology. This benefit does not apply to the HDHP PPO plan.
- **Contigo Health** is an Oncology Center of Excellence Program for assistance in navigating cancer treatment. Call 877.220.3556 or go to sisc.contigohealth.com. Subject to the deductible for the HDHP with HSA members.
- **Hinge Health** is a digital program for Back and Knee pain including one-on-one coaching. Call 855.902.2777 or go to hingehealth.com/sisc.
- **Maven** 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 plan** (not the High Deductible PPO plan) has a 4th quarter 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.

Medical Plan Comparison

HMO Plans

Benefits	SISC (Self-Insured Schools of California)		
	Kaiser	Anthem HMO's	
	Kaiser HMO	Anthem HMO Full Premier	Anthem HMO Select Premier
Network Access	Kaiser network of providers.	Only Anthem HMO plan where you can access Scripps Clinic and Scripps Coastal Medical Group. In addition, access to all other providers in the Select HMO plans.*	Cannot access Scripps Clinic or Scripps Coastal Medical Group.
Annual Deductible	N/A	N/A	N/A
Medical Out-of-Pocket Maximum	$1,500 individual $3,000 family	$1,000 individual $2,000 family	$1,000 individual $2,000 family
Office Visit	$15 copay	$10 copay	$10 copay
Specialist Visit	$15 copay	$10 copay	$10 copay
Inpatient Hospitalization	100% covered	100% covered	100% covered
Outpatient Surgery	$15 copay	100% covered	100% covered
Urgent Care	$15 copay	$10 copay (from your primary care group)	$10 copay (from your primary care group)
Emergency Room	$100 copay (waived if admitted)	$100 copay (waived if admitted)	$100 copay (waived if admitted)
Ambulance	$50 copay	$100 copay	$100 copay
Preventive Care	100% covered	100% covered	100% covered
Chiropractic Services *(All Anthem and Kaiser HMO plans will combine chiropractic & acupuncture thru ASH)*	$10 copay, up to 30 visits per calendar year	$10 copay, up to 30 visits per calendar year	$10 copay, up to 30 visits per calendar year
X-Ray & Laboratory	100% covered	100% $100 complex radiology	100% $100 complex radiology
Prescription Out-of-Pocket Maximum	Included in medical Out-of-Pocket Maximum	$1,500 individual $2,500 family	$2,500 individual $3,500 family
Prescriptions	Kaiser Pharmacy Only		
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.	

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.

	Anthem Premier HMO's	
	Full Network HMO	Select Narrow Network HMO
Rady Children's Health Network	✔	✔
Graybill Medical Group	✔	✔
Greater Tri Cities IPA	✔	✔
Primary Care Associates Medical Group	✔	✔
Mercy Physicians Medical Group, Inc.	✔	✔
Scripps Clinic Torrey Pines	✔	
Scripps Coastal Medical Center/Hillcrest	✔	
Scripps Physicians Medical Group	✔	✔
Sharp Community Medical Group	✔	✔
Sharp Community Medical Group-Arch	✔	✔
Sharp Community Medical Group-Inland North	✔	✔
Sharp Rees-Stealy Medical Group, San Diego	✔	✔
UCSD Medical Group	✔	✔
UCSD Physician Network-Primary Care	✔	✔

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.

Medical Plan Comparison (continued)

PPO Plans

Benefits	SISC (Self-Insured Schools of California)	
	Anthem PPO's	
	Anthem PPO Plan	Anthem HDHP Plan
	In-Network	In-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	$1,500 individual $3,000 family
Medical Out-of-Pocket Maximum	$1,000 individual $3,000 family	$3,000 individual $6,000 family
Office Visit	$0 copay per visit for visits 1-3 (not applicable for specialists), then $20 copay per visit for visits 4+	10% coinsurance
		After the deductible is met then:
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 Services *(must be medically necessary)*	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.

2023 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 $12,500. The resulting employee cost (if any) is deducted from your pay check 11 times per year.

Part-time employees have the choice between two 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 Kaiser or the Anthem Premier Select Narrow Network HMO - 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	Anthem HMO Full Premier	Anthem HMO Select Premier	Anthem PPO Plan	Anthem HDHP Plan
FULL-TIME EMPLOYEES – 11 MONTH DEDUCTIONS (INCLUDES MEDICAL, DENTAL, VISION AND LIFE INSURANCE)					
Employee Only	$0.00	$0.00	$0.00	$0.00	$0.00
Plus 1 Dependent	$511.88	$779.15	$552.24	$950.42	$447.51
Plus 2 or More Dependents	$962.42	$1,318.06	$1,022.42	$1,543.88	$892.60

	Kaiser HMO	Anthem HMO Select Premier
PART-TIME EMPLOYEES – 11 MONTH DEDUCTIONS (INCLUDES MEDICAL ONLY)		
Employee Only	$228.44	$231.05
Plus 1 Dependent	$977.89	$1,012.15
Plus 2 or More Dependents	$1,428.44	$1,482.33

Refer to page 23 for complete plan costs and contribution amounts:

- 2023 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.

866.499.3001.

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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**
	$130 allowance; 20% off remaining amount $150 allowance for featured frame brands	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	$130 allowance	Up to $105 allowance
Suncare	$130 allowance for ready-made non-prescription sunglasses instead of prescription glasses or contact lenses.	
Laser VisionCare Preferred Program	**PLAN PAYS**	
	15% off regular price or 5% off promotional price	

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 as 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.

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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

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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. EASE through SDCOE. Each member of your household is entitled to 8 confidential counseling sessions per concern, per calendar year. EASE may be contacted at 800.487.4900.
2. Anthem EAP if enrolled in any of the SISC medical plans (Anthem HMO, PPO 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).

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, than a participant may revoke a prior election for group health plan coverage and make a new election. Special Enrollment right 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 Irrevocably 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).

HRA, FSA, HSA numbers are reflected for the 2022 calendar year. 2023 amounts are not typically determined until after the release of the Benefit Guide. Employees making elections for the 2023 year should keep this in mind.

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 $2,850.

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 $5,000. However, if you are married and you and your spouse file separate tax returns, the maximum amount you can contribute is $2,500. 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/The Standard for additional information.

Other Programs Include:

- **MetLife –** Legal Services
- **Liberty Mutual –** Home, Auto, Life. Contact Annabel.Buso@libertymutual.com

Retirement

- **CalSTRS –** 800.228.5453 or www.calstrs.com
- **CalPERS –** 888.225.7377 or www.calpers.ca.gov

Supplemental Retirement Plans:

403(b), 4527(B) and Roth 403b, contact your FBC representative, John Ma at 619.430.0711 or John.Ma@empower-retirement.com.

2023 Plan Costs and Contribution Amounts

	2023 11thly Premium Costs						2023 Employee 11thly Cost
Full-Time Employees (All Premiums/Payroll Deductions 11thly)							
	11thly Premium Cost Per Plan				2023 Total 11thly Benefits Cost		Your Cost
	Sisc 11thly Medical Premiums	FBC 11thly Premiums				District 11thly Contribution $12,500	Employee Out Of Pocket, 11thly
		Life #40490	Vision #33550	Dental #33650			
Kaiser HMO							
Employee Only	$761.45	$5.18	$12.49	$119.66	$898.78	$1,136.36	$0.00
Plus 1 Dependent	$1,510.91	$5.18	$12.49	$119.66	$1,648.24	$1,136.36	$511.88
Plus 2 or More Dependents	$1,961.45	$5.18	$12.49	$119.66	$2,098.78	$1,136.36	$962.42
Anthem HMO Premier, *(Full Network)*							
Employee Only	$883.64	$5.18	$12.49	$119.66	$1,020.97	$1,136.36	$0.00
Plus 1 Dependent	$1,778.18	$5.18	$12.49	$119.66	$1,915.51	$1,136.36	$779.15
Plus 2 or More Dependents	$2,317.09	$5.18	$12.49	$119.66	$2,454.42	$1,136.36	$1,318.06
Anthem Select HMO Premier, *(Narrow Network), Rx (9/35)*							
Employee Only	$770.18	$5.18	$12.49	$119.66	$907.51	$1,136.36	$0.00
Plus 1 Dependent	$1,551.27	$5.18	$12.49	$119.66	$1,688.60	$1,136.36	$552.24
Plus 2 or More Dependents	$2,021.45	$5.18	$12.49	$119.66	$2,158.78	$1,136.36	$1,022.42
Anthem PPO							
Employee Only	$980.73	$5.18	$12.49	$119.66	$1,118.06	$1,136.36	$0.00
Plus 1 Dependent	$1,949.45	$5.18	$12.49	$119.66	$2,086.78	$1,136.36	$950.42
Plus 2 or More Dependents	$2,542.91	$5.18	$12.49	$119.66	$2,680.24	$1,136.36	$1,543.88
Anthem HDHP							
Employee Only	$708.00	$5.18	$12.49	$119.66	$845.33	$1,136.36	$0.00
Plus 1 Dependent	$1,446.55	$5.18	$12.49	$119.66	$1,583.88	$1,136.36	$447.51
Plus 2 or More Dependents	$1,891.64	$5.18	$12.49	$119.66	$2,028.97	$1,136.36	$892.60

Part-Time Employees (All Premiums/Payroll Deductions 11thly)							
Kaiser HMO	11thly Medical Premiums (SISC)				11thly Medical	District 11thly Contribution (Employee Only)	Employee Out Of Pocket, 11thly
Employee Only	$761.45	N/A	N/A	N/A	$761.45	$533.02	$228.44
Plus 1 Dependent	$1,510.91	N/A	N/A	N/A	$1,510.91	$533.02	$977.89
Plus 2 or More Dependents	$1,961.45	N/A	N/A	N/A	$1,961.45	$533.02	$1,428.44
Anthem Select HMO Premier, *(Narrow Network), Rx (9/35)*							
Employee Only	$770.18	N/A	N/A	N/A	$770.18	$539.13	$231.05
Plus 1 Dependent	$1,551.27	N/A	N/A	N/A	$1,551.27	$539.13	$1,012.15
Plus 2 or More Dependents	$2,021.45	N/A	N/A	N/A	$2,021.45	$539.13	$1,482.33

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 certain 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. Additional information may be found in your Explanation of Benefits for any affected claims.

Newborns' and Mothers' Health Protection Act (NMHPA)

Benefits for pregnancy hospital stay (for delivery) for a mother and her newborn generally 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.

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, contact your health plan.

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, contact your health plan.

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 get 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.

Important Notices (continued)

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's 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 this Plan. The Plan Administrator may establish specific forms that must be used to provide a notice or election.

Important Notices (continued)

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 at 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 8-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] https://www.medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b/part-a-part-b-sign-up-periods

Important Notices (continued)

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 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 considered 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.

Important Notices (continued)

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

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

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

Special Enrollment Rights Notice

CHANGES TO YOUR HEALTH PLAN ELECTIONS

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

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

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

If you or your dependents become eligible for Medicaid or CHIP premium assistance, you may be able to enroll yourself and/or your dependents into this plan. However, you must request enrollment no later than 60 days after the determination for eligibility 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 Qualified Medical Child Support Order, you may be able to enroll yourself and/or your dependents. However, you must request enrollment no later than 30 days after the marriage, birth, adoption or placement for adoption or divorce (including legal separation and annulment).

For information about Special Enrollment Rights, please contact:

Karlyn Stone
Benefits
KStone@dmusd.org or 858.755.9301 ext. 3692

Medicare Part D – Important Notice About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Del Mar Union School District and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

- **Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.**
- **SISC has determined that the prescription drug coverage offered by Del Mar Union School District is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.**

Important Notices (continued)

WHEN CAN YOU JOIN A MEDICARE DRUG PLAN?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

WHAT HAPPENS TO YOUR 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 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 will be able to get this coverage back.

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

You should also know that if you drop or lose your current coverage with Del Mar Union School District and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without Creditable Coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (i.e., a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

FOR MORE INFORMATION ABOUT THIS NOTICE OR YOUR CURRENT PRESCRIPTION DRUG COVERAGE

Contact the person listed below for further information. **Note:** You will get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Del Mar Union School District changes. You also may request a copy of this notice at any time.

FOR MORE INFORMATION ABOUT YOUR OPTIONS UNDER MEDICARE PRESCRIPTION DRUG COVERAGE

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

FOR MORE INFORMATION ABOUT MEDICARE PRESCRIPTION DRUG COVERAGE

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

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

REMEMBER

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

Date:	September 2022
Name of Entity / Sender:	Del Mar Union School District
Contact:	Karlyn Stone
Address:	11232 El Camino Real San Diego, CA 92130
Phone:	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, 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 will begin November 1, 2022, and is anticipated to end on January 31, 2023. Open Enrollment for most other states will begin on November 1 and close on January 15 of each year. Some states have expanded the open enrollment period beyond January 15, 2023 for coverage to begin in 2023. Notably, Covered California continues its special enrollment periods for coverage beginning in 2023.

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 9.12% (for 2023) of your household income for the year, then that coverage is not Affordable. 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 a 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.

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	
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.

Important Notices (continued)

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

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

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

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

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

If you live in one of the following States, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2022. Contact your State for more information on eligibility.

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

ALASKA – Medicaid
The AK Health Insurance Premium Payment Program
Website: http://myakhipp.com/
Phone: 866-251-4861
Email: CustomerService@MyAKHIPP.com
Medicaid Eligibility:
https://health.alaska.gov/dpa/Pages/default.aspx

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

CALIFORNIA – Medicaid
Health Insurance Premium Payment (HIPP) Program Website:
http://dhcs.ca.gov/hipp
Phone: 916-445-8322
Fax: 916-440-5676
Email: hipp@dhcs.ca.gov

COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHIP+)
Health First Colorado Website:
https://www.healthfirstcolorado.com/
Health First Colorado Member Contact Center:
800-221-3943 | TTY: Colorado relay 711
CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus
CHP+ Customer Service:
800-359-1991 | TTY: Colorado relay 711
Health Insurance Buy-In Program (HIBI):
https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program
HIBI Customer Service: 855-692-6442

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

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

INDIANA – Medicaid
Healthy Indiana Plan for low-income adults 19-64
Website: http://www.in.gov/fssa/hip/
Phone: 877-438-4479
All other Medicaid
Website: https://www.in.gov/medicaid/
Phone: 800-457-4584

Important Notices (continued)

IOWA – Medicaid and CHIP (Hawki)
Medicaid Website: https://dhs.iowa.gov/ime/members
Medicaid Phone: 800-338-8366
Hawki Website: http://dhs.iowa.gov/Hawki
Hawki Phone: 800-257-8563
HIPP Website:
https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp
HIPP Phone: 888-346-9562

KANSAS – Medicaid
Website: https://www.kancare.ks.gov/
Phone: 800-792-4884

KENTUCKY – Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website:
https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx
Phone: 855-459-6328
Email: KIHIPP.PROGRAM@ky.gov
KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx
Phone: 877-524-4718
Medicaid Website: https://chfs.ky.gov

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

MAINE – Medicaid
Enrollment Website:
https://www.maine.gov/dhhs/ofi/applications-forms
Phone: 800-442-6003 | TTY: Maine relay 711
Private Health Insurance Premium Webpage:
https://www.maine.gov/dhhs/ofi/applications-forms
Phone: 800-977-6740 | TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP
Website: https://www.mass.gov/masshealth/pa
Phone: 800-862-4840
TTY: 617-886-8102

MINNESOTA – Medicaid
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp
Phone: 800-657-3739

MISSOURI – Medicaid
Website:
https://www.dss.mo.gov/mhd/participants/pages/hipp.htm
Phone: 573-751-2005

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

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

NEVADA – Medicaid
Medicaid Website: http://dhcfp.nv.gov/
Medicaid Phone: 800-992-0900

NEW HAMPSHIRE – Medicaid
Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program
Phone: 603-271-5218
HIPP Program Toll-Free Phone: 800-852-3345, ext. 5218

NEW JERSEY – Medicaid and CHIP
Medicaid Website:
http://www.state.nj.us/humanservices/dmahs/clients/medicaid/
Medicaid Phone: 609-631-2392
CHIP Website: http://www.njfamilycare.org/index.html
CHIP Phone: 800-701-0710

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

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

NORTH DAKOTA – Medicaid
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/
Phone: 844-854-4825

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

OREGON – Medicaid
Websites: http://healthcare.oregon.gov/Pages/index.aspx
http://www.oregonhealthcare.gov/index-es.html
Phone: 800-699-9075

PENNSYLVANIA – Medicaid
Website:
https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx
Phone: 800-692-7462

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

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

Important Notices (continued)

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

TEXAS – Medicaid
Website: http://gethipptexas.com/
Phone: 800-440-0493

UTAH – Medicaid and CHIP
Medicaid Website: https://medicaid.utah.gov/
CHIP Website: http://health.utah.gov/chip
Phone: 877-543-7669

VERMONT – Medicaid
Website: http://www.greenmountaincare.org/
Phone: 800-250-8427

VIRGINIA – Medicaid and CHIP
Website: https://www.coverva.org/en/famis-select
https://www.coverva.org/en/hipp/
Medicaid Phone: 800-432-5924
CHIP Phone: 800-432-5924

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

WEST VIRGINIA – Medicaid and CHIP
Website: https://dhhr.wv.gov/bms/
http://mywvhipp.com/
Medicaid Phone: 304-558-1700
CHIP Toll-Free Phone: 855-MyWVHIPP (855-699-8447)

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

WYOMING – Medicaid
Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/
Phone: 800-251-1269

To see if any other states have added a premium assistance program since July 31, 2022, or for more information on special enrollment rights, contact either:

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

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
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, reduced FSA contributions, 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. 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 will 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.

Click here to watch a video on Benefits Key Terms Explained.

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
• EASE	800.487.4900	www.sdcoe.net
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		
• The Standard (DMCTA) Disability and Life Insurance	800.522.0406	CTAMemberBenefits.org/TheStandard
• MetLife Legal Plans	800.821.6400	www.legalplans.com
• Liberty Mutual – Home, Auto, Life	760.795.0451	Annabel.Buso@libertymutual.com
• Retirement Accounts – 403(b), 457(b), Roth 403(b)	844.732.7738	myFBCretirement.com
• 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
Medical Benefit Consultant Keenan & Associates		
• Andrea Estrin	949.940.1760 x5133	aestrin@keenan.com
• Julie Revoir	949.940.1760 x5170	jrevoir@keenan.com