EMPLOYEE 2025 BENEFITS GUIDE

SOLANA BEACH SCHOOL DISTRICT

Employee Benefits Guide 2025

General Information

Core Benefits

Other Benefits

Miscellaneous

Questions?

- For medical, go to myveba.org or call VEBA Advocacy at 888-276-0250
- Contact Personnel Services

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

If you (and/or your dependents) have Medicare or you will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage.

Please see page 38 for more details.

The information in this brochure is a general outline of the benefits offered under Solana Beach 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 employee benefits. To help you with your benefit needs, Solana Beach School District provides a comprehensive benefits program designed to protect you and your family from costs associated with illness, injury, or accident.

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

The District is part of the non-profit California Schools VEBA trust that provides high quality, affordable and accessible health care for education, municipal and public agency employees.

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 (ex: 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 (ex: if hire date is 8/19, your effective date is 10/1).
- The effective date for voluntary plans will vary by plan.

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.

Online Enrollment

Solana Beach School District will be going green and using an online benefits enrollment. Solana Beach School District has partnered with American Fidelity, the District's Section 125 provider, to offer you a web-based enrollment system that will streamline your benefits selection.

Making Changes

Once you make your benefit elections, coverage will remain in effect for the full plan year, January 1, 2025 to December 31, 2025. 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) or entitlement or loss of entitlement to Medicaid or Medicare.

You must notify Personnel Services and complete the enrollment change process 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.

Employee Benefit Questions

If you have questions:

- Go to myveba.org
- Call VEBA Advocacy at 888-276-0250
- Contact your Personnel Services

This Benefit Guide is intended to serve as a comprehensive resource for the Solana Beach 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 it is intended to otherwise create any legally enforceable obligations in the part of the District, its agents and its employees.

Introduction (continued)

What's New for 2025

VEBA Updates

Important Plan Changes

Effective December 31, 2024, VEBA will be discontinuing the UHC Performance HMO Network 3. You must enroll in a new plan for the 2025 plan year.

New VEBA Plans for 2025

The District will be offering three (3) new VEBA plans for 2025.

- UHC Alliance HMO $20
- Surest PPO $1,000
- UHC Journey Harmony HMO w/ HRA

New Digital ID Cards - All Members

Digital Medical ID cards will be available in 2025. This means that physical member ID cards will no longer be automatically mailed to members. Instead, members will have the choice to download their digital ID cards or request a card directly from the carriers.

UnitedHealthcare Members

UnitedHealthcare members will now have a combined medical and prescription drug out-of-pocket (OOP) maximum rather than a separate medical and prescription drug OOP maximum as in previous years.

Omada Health

California Schools VEBA is offering Omada Health to help members who may need to manage diabetes with one-on-one personal coaching, support from a specialist and the tools needed to make long-lasting health changes. The best part: is no additional cost to you if you're eligible to join.

Kaiser Members

Kaiser members will have a new hearing aid benefit of a $5,000 allowance per device, per ear, every 36-months. This new benefit will be automatically included in Kaiser plans starting in 2025.

VSP Vision Updates

The District has increased the frame and contact lens allowance from $150 to $200.

Important Plan Changes:

The plan below is being discontinued by VEBA effective December 31, 2024. If you are enrolled in the plan below you must enroll in a new plan effective January 1, 2025.

- UHC Performance HMO, Network 3

Eligibility - Full-Time & Part-Time

Employee Eligibility for health benefits varies by the number of hours you work per week. There may be a waiting period before benefits are effective.

	Certificated, Management, Confidential Employees and Board Members		Classified Employees	
Hours Requirement	Full-Time: 80% to 100% contract	Part-Time: 50% - 79% contract (Certificated)	Full-Time: 35 hours or more per week	Part-Time: Between 30 hours but less than 35 hours per week
Employer Core Benefits Offered	• Medical • Dental • Vision		• Medical • Dental • Vision	• Medical Only
Employer Core Benefits Contribution	The District's annual contribution for single, two party and family medical benefits is $17,634.80. The District will cover the annual contribution for the: • Family DeltaCare Dental Plan • Single and two party Delta Premier PPO Dental Plan • Family VSP Plan	Part-Time Certificated FTEs: 50% to 79% will receive a prorated District fringe benefit contribution	The District's annual contribution for single, two-party and family medical benefits is $17,134.80 The District will cover the annual contribution for the: • Family DeltaCare Dental Plan • Single and two party Delta Premier PPO Dental Plan • Family VSP Plan	The District's annual contribution for single, two-party and family medical benefits is $17,134.80
Other Employer Paid Fringe Benefits	• Basic Life and Accidental Death & Dismemberment *(AD&D) - $100,000 (subject to age reductions)* • Short Term and Long Term Disability			N/A
When do Benefits Start for the Employee?	• Employees hired with a start date between the 1st and 15th of the month — Benefits will become effective on the first day of the month following the first day of paid service. **EXAMPLE**: An employee starting on August 10th would become eligible for benefits on September 1st. • Employees hired and starting work after the 15th of the month — Benefits will become effective the first day of the second full month of paid service. **EXAMPLE**: An employee starting on August 26th would become eligible for benefits on October 1st.			
When do Benefits End for the Employee and Enrolled Dependents?	If worked the entire school year, the benefits terminate September 30th.			
	If separated from the District mid-school year, the benefits will terminate as follows: • Prior to the 15th: First of the month following termination notice *(**EXAMPLE** - August 10th, termination date is August 31st)* • The 15th of the month of after: The first of the month following the month of separation notice *(**EXAMPLE** - August 26th, termination date is September 30)*			
Voluntary Benefits	All benefit eligible employees may enroll in any of the available Voluntary plans offered through American Fidelity and the Fringe Benefits Consortium.			

Dependent Eligibility

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

Benefit Plans Eligibility

- Legally married spouse
- Registered domestic partner
- **Children to age 26:**
  - Natural
  - Step-children
  - Children of a registered domestic partner
  - Legally adopted
  - Legal guardianship appointment
  - Disabled adult child over age 26
  - Qualified Medical Support Order (children of divorced parents)
  - Foster children are eligible for the dental plans only

Eligibility (continued)

Required Documents for Enrolling Dependents

If you are adding a new dependent to your coverage, you must submit proof of eligibility documentation with your enrollment/change form within 30 calendar days of a qualifying life event or during the Open Enrollment period.

If documentation is not received within the required time period, your dependent's coverage may be retroactively terminated.

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
Domestic Partners	• Declaration of Domestic Partnership issued by the State of California *(Enrolling a Domestic Partner may cause the employer contribution to become taxable)*
Children up to age 26	• Legal Birth Certificate • 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 *(contact your medical insurance provider by calling the number on your ID card)*

Social Security numbers must be provided at time of enrollment or as soon as obtained for newborns. SSN information must be provided due to IRS-mandated reporting requirements for medical plans.

Important Reminder

Please be advised that the following circumstances are the only times you can make a benefit election change outside of the Open Enrollment period. Changes must be submitted with proof of the qualifying event to the Personnel Services within 30 calendar days of the event; otherwise, you must wait until the next Open Enrollment period to make changes to your benefit elections, effective January 1, 2025.

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
- Loss of other coverage

Remove a Dependent

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

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 may continue the District's health, dental and vision plans until age 65.

*Refer to your union contract and Personnel Services 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

Medical: Plan Options

Whether you have a common cold or will be undergoing surgery, medical benefits cover a range of services and can provide peace of mind to help you offset health care costs.

You have several health plans options to choose from under the VEBA umbrella. The main difference between the plans are network of providers and copays for services. There is one Kaiser plan option and five UHC HMO plan options to choose from. Please see the 2025 plan options and changes below:

- **Kaiser HMO, $20**
- **United HealthCare (UHC)**
  - UHC Performance HMO $10
  - UHC Performance HMO $20/$30
  - UHC Harmony HMO $20
  - UHC Alliance HMO $20
  - UHC Journey Harmony HMO w/ HRA
  - UHC Journey Alliance HMO w/ HRA
  - Surest PPO $1,000

Selecting a Plan that's Right for You

As you evaluate your health plan options and insurance needs, consider the following factors:

- **Choice:** If you prefer to seek services from specific physicians, specialists or facilities, check to see if the medical plan option will cover services from those providers. While some health plans restrict your provider selection, others provide greater flexibility and choice
- **Cost:** Cost may be a large determining factor in your selection and each plan may contain a variety of cost components. Plan expenses such as deductibles, copayments or coinsurance and consider the amount of your payroll deduction

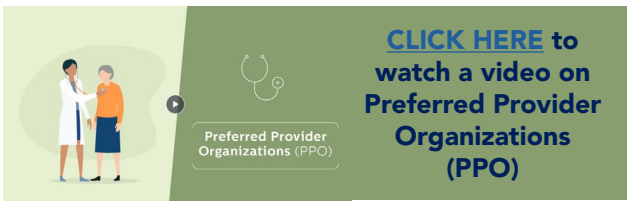
Choice of Providers

On the next page, is a table that illustrates your various plan options by the participating medical groups in San Diego County. This is where to start to pick a medical plan that meets your needs.

IMPORTANT: The following plan will be discontinued by VEBA, effective December 31, 2024:

- UHC Performance HMO, Network 3

If you are currently enrolled in this plan, you must select and enroll in a new plan effective January 1, 2025.



Medical Plan Overview (continued)

	VEBA Medical Plan Options							
San Diego County Medical Groups (10/2024*)	**Kaiser $20**	**UHC Performance HMO $10**	**UHC Performance HMO $20/$30**	**UHC Harmony HMO $20**	**UHC Alliance HMO $20**	**UHC Journey Alliance HMO w/ HRA**	**UHC Journey Harmony w/ HRA**	**Surest PPO $1,000**
Rady's Children's	All services must be managed by Kaiser. There are many Kaiser facilities throughout San Diego County.	✔	✔		✔	✔		The Surest network is UnitedHealthcare (Choice Plus, Select or Options PPO) and Optum Behavioral Health. There are several providers to choose from. Please visit surest.com/members to find an In Network provider.
Greater Tri-Cities IPA					✔	✔		
Mercy Physicians Medical Group					✔	✔		
Optum Care Associates *(formerly Cassidy Medical Group and Primary Care Associates)*		✔	✔	✔	✔	✔	✔	
Scripps Clinic					✔	✔		
Scripps Coastal Medical Center					✔	✔		
Scripps Physicians Medical Group					✔	✔		
Sharp Community Medical Group		✔	✔	✔			✔	
Sharp Rees-Stealy Medical Group		✔	✔	✔			✔	
SCMG - Arch Health Partners		✔	✔	✔			✔	
UCSD Medical Group				✔	✔	✔	✔	
UCSD Medical Group - Affiliates				✔			✔	

* Contracts between insurance companies and medical groups are subject to change due to negotiations between the entities. If there should be a contract change, the Department of Managed Care requires timely notification to insured members.

Medical Plan Overview (continued)

Need Help Looking for a Provider?

How to Choose Your UHC HMO Primary Care Provider (PCP)

For a full listing of Participating Medical Groups, or to find a PCP, follow the directions below:

1. **Go to:** https://www.whyuhc.com/csveba.
2. Select "Search for a Provider" that appears near the top of the page.
3. Scroll down and choose from the plan options.
4. Select Continue.
5. Select Change Location and enter your zip code, then select Update Location.
6. Now you can search by People, Places, Service and Treatments, or Care by Condition.

How to Search for a Surest PPO Provider

1. Go to: surest.com/members to find an In Network provider.

How to Find a Chiropractic or Acupuncture Provider (for UHC and Kaiser members)

Chiropractic care and acupuncture is provided by OptumHealth Physical Health of California, which has more than 2,700 network providers in California.

Three ways to find a provider:

1. Go to myoptumhealthphysicalhealthofca.com and select "Provider Locator." Choose "California Schools VEBA" from the dropdown menu for Plan/Product.
2. **Call Optum Member Services at:** 800-428-6337 (5:00 a.m. to 5:00 p.m., PST, Monday - Friday) for the most current and up to date information.
3. Call the provider directly to schedule an appointment and verify they are part of the Optum network for VEBA.

Questions?

- Go to myveba.org
- Call VEBA Advocacy at 888-276-0250 or email Advocacy@mcgregorinc.com
- Contact Personnel Services

Medical Plan Comparison

Cost – Plan Expenses

Carefully review the copays, deductibles, out-of-pocket maximums etc., as you review the following medical plan comparisons.

Effective Period: January 1, 2025 - December 31, 2025

Benefit Summary	Kaiser $20	UHC Performance HMO $10	UHC Performance HMO $20/$30	UHC Alliance HMO $20	UHC Harmony HMO $20	UHC Journey Alliance HMO w/ HRA	UHC Journey Harmony HMO w/ HRA	Surest PPO $1,000	
								In Network	Out of Network
Medical Deductible *(individual/family)*	None	None	None	None	None	$2,000 / $4,000	$2,000 / $4,000	None	None
Medical Out-of-Pocket Maximum *(individual/family)*	$1,500 / $3,000	$1,500 / $3,000	$3,000 / $6,000	$1,500 / $3,000	$1,500 / $3,000	$3,500 / $7,000	$3,500 / $7,000	$3,000 / $6,000	$8,000 / $16,000
Health Reimbursement Arrangement (HRA)	None	None	None	None	None	HealthInvest HRA $350 / $700 / $1,100	HealthInvest HRA $1,000 / $1,600 / $2,200	None	None
PCP Office Visit	$20 copay	$10 copay	$20 copay	$20 copay	$20 copay	$25 copay	$25 copay	$5 to $40 copay	$120 copay
Specialist Office Visit	$20 copay	$10 copay	$30 copay	$20 copay	$20 copay	$40 copay	$40 copay	$5 to $40 copay	$120 copay
Preventive Care	No charge	No charge	No charge	No charge	No charge	No charge	No charge	No charge	$60 copay
Inpatient Hospital Care	$250 admit copay	No charge	$500 admit copay	$250 admit copay	$250 admit copay	20% coinsurance (after deductible)	20% coinsurance (after deductible)	$1,000 copay	$3,000 copay
Mental Health Services *(outpatient/inpatient)*	$20 copay / $250 admit copay	$10 copay / No charge	$20 copay / $500 copay	$20 copay / $250 admit copay	$20 copay / $250 admit copay	$25 copay / 20% coinsurance (after deductible)	$25 copay / 20% coinsurance (after deductible)	$50 copay / $1,000 copay	$150 copay / $3,000 copay
Substance Abuse Services *(outpatient/inpatient)*	$20 copay / No charge	No charge	No charge	No charge	No charge	No charge	No charge	$50 copay / $1,000 copay	$150 copay / $3,000 copay
Outpatient Diagnostic Laboratory and Radiology *(standard procedures)*	No charge	No charge	No charge	No charge	No charge	No charge	No charge	No charge	No charge
Complex Radiology *(PET & MRI)*	$100 copay	No charge	$200 copay	$100 copay	$100 copay	$100 copay	$100 copay	$40 to $280 copay	Up to $840
Outpatient Surgery	$20 copay	No charge	$250 copay	No charge	No charge	20% coinsurance (after deductible)	20% coinsurance (after deductible)	$50 to $320 copay	$960 copay
Outpatient Physical/ Rehabilitation Therapy *(office visit)*	$20 copay	$10 copay	$20 copay	$20 copay	$20 copay	$25 copay	$25 copay	$5 to $35 copay	Up to $105 copay

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

Medical Plan Comparison (continued)

Benefit Summary	Kaiser $20	UHC Performance HMO $10	UHC Performance HMO $20/$30	UHC Alliance HMO $20	UHC Harmony HMO $20	UHC Journey Alliance HMO w/ HRA	UHC Journey Harmony HMO w/ HRA	Surest PPO $1,000	
								In Network	Out of Network
Chiropractic and Acupuncture Services*	$20 copay	$10 copay	$20 copay	$20 copay	$20 copay	$30 copay	$30 copay	$10 copay (Chiro) / $20 copay (Acu)	$30 copay (Chiro) / $60 copay (Acu)
Urgent Care	$20 copay	$10 copay	$20 copay	$20 copay	$20 copay	$25 copay	$25 copay	$20 copay	$60 copay
Emergency Room *(copay waived if admitted)*	$150 copay	$100 copay	$150 copay	$150 copay	$150 copay	20% coinsurance (after deductible)	20% coinsurance (after deductible)	$180 copay	$180 copay
Rx Deductible *(individual/family)*	None	None	None	None	None	None	None	None	None
Rx Out-of-Pocket Maximum *(individual/family)*	N/A	$0 combined with medical	$0 combined with medical	$0 combined with medical	$0 combined with medical	$0 combined with medical	$0 combined with medical	$0 combined with medical	$0 combined with medical
Rx Formulary List	Kaiser	National Preferred	National Preferred	National Preferred	National Preferred	National Preferred	National Preferred	National Preferred	National Preferred
Rx Pharmacy Network	Kaiser	Express Advantage Network**	Express Advantage Network**	Express Advantage Network**	Express Advantage Network**	Express Advantage Network**	Express Advantage Network**	Express Advantage Network**	Express Advantage Network**
Short-Term Prescription Drugs*** *(up to 30-day supply)*	G: $15 copay B: $30 copay (up to a 30-day supply)	$5 Generic $25 PB 50% $40 min $175 max NPB	$10 Generic $25 PB 50% $40 min $175 max NPB	$10 Generic $30 PB 50% $40 min $175 max NPB	$10 Generic $25 PB 50% $40 min $175 max NPB	$10 Generic $30 PB 50% $40 min $175 max NPB	$10 Generic $30 PB 50% $40 min $175 max NPB	$10 Generic $30 PB 50% $40 min $175 max NPB	Must submit a paper claim; reimbursed at the in-network rate less copay.
Long-Term Prescription Drugs*** *(up to 90-day supply)*	G: $30 copay B: $60 copay (up to a 100-day supply)	$10 Generic $50 PB 50% $80 min $350 max NPB	$20 Generic $50 PB 50% $80 min $350 max NPB	$20 Generic $60 PB 50% $80 min $350 max NPB	$20 Generic $50 PB 50% $80 min $350 max NPB	$20 Generic $60 PB 50% $80 min $350 max NPB	$20 Generic $60 PB 50% $80 min $350 max NPB	$20 Generic $60 PB 50% $80 min $350 max NPB	No coverage for non-network pharmacy

Infertility services are excluded/not covered under non-Kaiser HMO plans and are included/covered under Kaiser HMO (excluding Kaiser Bronze) plans, please see your policies for details. VEBA offers a Kindbody fertility and wellness benefit for UHC plans, please see page 13 for more details.

* Chiropractic services have no annual visit maximums, must be medically necessary and may be subject to prior authorization from OptumHealth. This also applies to acupuncture services if elected by your employer, as it is optional.

** Pay standard copays if you fill your prescription at an EAN Pharmacy (EAN Pharmacies include Rite Aid, Costco, Ralphs, Kmart, Vons, Haggen, Safeway, SuperValue, WinnDixie, Walmart, and many independent pharmacies) visit www.Express-scripts.com for a complete list of EAN pharmacies.

** Pay standard copays plus $5/prescription if you fill your prescription at a non-EAN Pharmacy (Non-EAN Pharmacies include CVS, Walgreens, and certain independent pharmacies).

** You will pay the Retail Refill Allowance (RRA) penalty (equal to 2 times short-term medication copay for 30-day supply) if you fill long-term prescriptions at a network pharmacy other than Smart90.

** Copays waived for preferred generic hypertension, hypoglycemic and cholesterol medications purchased at mail or Smart 90. This does not include normal retail use or brand drugs.

*** **G** = Generic, **P** = Preferred, **B** = Brand, **PB** = Preferred Brand, **NPB** = Non-preferred Brand, **S** = Specialty

This document is an outline of the coverage proposed by the carrier(s), based on information provided by your company. It does not include all the terms, coverages, exclusions, limitations, and conditions of the actual contract language. The policies themselves must be read for those details. The intent of this document is to provide you with general information about your employee benefit plans. It does not necessarily address all the specific issues which may be applicable to you. It should not be construed as, nor is it intended to provide, legal advice. Questions regarding specific issues should be directed to Personnel Services.

Health Reimbursement Account (HRA) Plans

UHC Journey Alliance and UHC Journey Harmony HMO Plans w/ HRA

The Journey Alliance and Journey Harmony HMO plans are the only medical plans that includes a deductible and coinsurance; however, the plans also includes a Health Reimbursement Account (HRA) provided by VEBA*.

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:** All the plans include an out-of-pocket maximum. This is the maximum amount you must pay out of your own pocket (under the applicable copay and/or coinsurance percentage) after meeting the deductible (if applicable). Once you reach the out-of-pocket maximum, the plan pays 100% of in-network charges for the remainder of the plan year

What is an HRA (Health Reimbursement Arrangement)?

The Health Reimbursement Arrangement (HRA) account is an employee-owned investment account, funded by VEBA, to use for qualified healthcare expenses. Any unused funds roll over from year-to-year.

The annual funding amount is based on family tier (funds available by March 1 after each open enrollment):

UHC Journey Alliance HMO w/ HRA

- **Employee Only:** $350
- **Two Party:** $700
- **Family:** $1,100

UHC Journey Harmony HMO w/ HRA

- **Employee Only:** $1,000
- **Two Party:** $1,600
- **Family:** $3,200

The money goes in tax-free, is invested tax-free and comes out tax-free when used for IRS approved medical expenses. You can begin spending your HRA right away or save it up to take with you when you separate from service or retire. Go to https://www.healthinvesthra.com/ for more information on the HRA.

Important:

If you enroll in one of these plans and in the Healthcare Flexible Spending Account (FSA) available through American Fidelity (or your spouse's employer), the IRS requires you to exhaust the FSA benefits before submitting claims to your HRA. The good news is that you can enroll in both tax-advantaged plans each year.

Medical Plan Overview (continued)

Employee tenthly costs vary by medical plan selected, family status and work status.

Employee costs are deducted from your pay on a pre-tax basis for yourself, your spouse and dependent children's coverage (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.

	VEBA Medical Plan Options							
	Kaiser $20	UHC Performance HMO $10	UHC Performance HMO $20/$30	UHC Alliance HMO $20	UHC Harmony HMO $20	UHC Journey Alliance HMO w/ HRA	UHC Journey Harmony HMO w/ HRA	Surest PPO $1,000
Certificated, Management and Confidential								
Single	$0	$0	$0	$0	$0	$0	$0	$0
Two Party	$184.52	$289.52	$193.52	$449.52	$52.52	$127.52	$0	$1,042.52
Family	$981.52	$1,115.52	$978.52	$1,326.52	$779.52	$887.52	$654.52	$2,155.52
Classified Employees								
Single	$0	$0	$0	$0	$0	$0	$0	$0
Two Party	$234.52	$339.52	$243.52	$499.52	$102.52	$177.52	$24.52	$1,092.52
Family	$1,031.52	$1,165.52	$1,028.52	$1,376.52	$829.52	$937.52	$704.52	$2,205.52

Full-Time Employees Only	Delta Dental Premier PPO	DeltaCare (HMO)	VSP
Single	$0	Family Composite	Family Composite
Two Party	$0		
Family	$49.15	$0	$0

VEBA Value-Adds and Resources

Free VEBA Benefits

Teladoc Medical Experts

Free access to medical experts to make sure you have the correct treatment and diagnosis. Visit their site at https://www.teladoc.com/medical-experts/.

Optum EAP

Get through life's challenges with counseling, budgeting, legal advice, child and eldercare support, and more! Visit https://www.liveandworkwell.com/content/en/public.html (access code: VEBA) or call 888-625-4809.

VEBA Advocacy

Navigating healthcare can be difficult at times. Our Advocacy team is here to help you. Call 888-276-0250 or email Advocacy@mcgregorinc.com.

Omada Health for UHC Members

New Diabetes and Weight Loss Services through Express Scripts: Including GLP-1 & Lifestyle Change Support.

Omada Health is a virtual program that helps members who may need to manage diabetes with 1:1 personal coaching, specialist support, and the tools needed to make long-term health changes. What sets this program apart is the emphasis on fostering a strong relationship between members and their care team. This relationship is built on proactive and human-led care, where the team works together with members to address barriers to change. By using various elements such as food, activity, behavioral health, and medication support, the program aims to provide comprehensive support for members in their journey toward better health.

What does this mean for members with Express Scripts coverage?

- Personalized. 1:1 Health Coach support with expert lifestyle guidance from a Diabetes Specialist
- Easy monitoring with smart devices & tools
- The program is no added member cost.

See if you're eligible: express-scripts.com/healthsolutions

Log in to get your exclusive access code and link to apply to Omada.

VEBA Resource Center

The VEBA Resource Center (VRC) is here to support you as you define your path to well-being. We understand everyone has unique needs and we are here to help you every step of your journey. As a VEBA member, you have free access to personalized resources designed to help you achieve your well-being goals.

Accessing the VRC has never been easier! All of our programs and classes are offered online from the comfort of your own home so all you need to do is log in!

Group Classes

The VRC offers more than 40 live group classes each week. Whether you want to relax with yoga or mindfulness, reduce stress by learning about your finances, or step-up your cardio through one of our movement classes, we have you covered!

Visit our entire calendar of online offerings at https://vebaresourcecenter.com/calendar/.

VEBA Value-Adds and Resources (continued)

Personalized Care

If you are looking for a place to start or if you have a specific health condition or concern, we offer personalized one-on-one visits with a Care Navigator. The Care Navigator will help you explore your challenges and develop a personalized plan for your mind, body, and spirit.

Individual health coaching is also available for VEBA members and covered dependents. To request an appointment, members can go to https://vebaresourcecenter.com/care-navigation/ or call 619-398-4220.

Kindbody Benefit

VEBA members that are enrolled in a UHC plan are eligible for the Kindbody benefit. Kaiser members are eligible to utilize Kindbody at a discount. Benefit include:

- Up to one (1) KindCycle including in vitro fertilization (IVF), intrauterine insemination (IUI) with fertility medication through KindBodyRx.
- Conception, fertility, and male assessments to help you learn more about your fertility
- Six (6) sessions of virtual holistic health services; support includes menopause, mental well-being, nutrition, doula/birth coaches, lactation support, back-to-work care, and more
- Access to Kindbody's menopause program offering specialty providers who will support women experiencing menopause; services include lifestyle assessment, hormone testing and virtual holistic session

Out-of-Area Insurance for UHC Dependents

If your child is moving out of the San Diego County area, UHC offers an insurance solution. VEBA members who are enrolled in any of the offered UHC plans may enroll their covered dependent(s) in the Surest PPO plan at no additional cost. Enrolling your child in the Surest PPO plan will not affect your insurance UHC plan enrollment and coverage. To enroll your child, please inform Personnel Services of the new mailing address.

Dental

Full-time Employees Only

Your Dental Plan Options

You and your dependents have the choice of enrolling in one of two dental plans offered by the District: Delta Dental PPO or DeltaCare USA Managed Dental HMO.

Delta Dental PPO

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: www.deltadentalins.com or call 800-449-3001.

Delta Dental

Helpful Delta Dental PPO Hints

- **Benefit Predetermination:** If total dental charges will exceed $250 for a course of treatment, it is recommended that your dentist submit the treatment plan and x-rays to Delta Dental before treatment commences. Delta Dental will advise you and the dentist as to which services will be covered and the amount of benefits that will be paid for each service
- To research Delta Dental's provider networks, go to www.deltadentalins.com and use their online dentist directory
- No Dental ID cards are provided for this plan. When visiting your provider you will simply share your social security number.

DeltaCare USA Managed Dental HMO

Under this Managed Dental HMO plan, you must receive services from a panel of dentists and specialists by choosing a primary care dentist from a network of dentists www.deltadentalins.com and select DeltaCare USA as your network to find a dentist). You must choose a dentist and enter a facility number when enrolling.

If you do not choose a dentist you will need to contact DeltaCare USA after enrollment and select one. The DeltaCare USA dental plan offers members the convenience of no claims to file, no balance billing, no deductibles, no annual maximums and minimal out-of-pocket expenses.

Delta Dental

Helpful DeltaCare USA Dental HMO Hints

- Familiarize yourself with the copays of the dental plan. It is suggested to bring the plan summary with you to review with your dentist.
- You will receive a dental ID card for this plan. It is important to verify that your ID card is for the dentist you chose during open enrollment. If not, contact DeltaCare USA at 800-422-4234. Please retain this card and bring with you to your dental appointments.

* If you do not select a dentist when enrolling you will not receive an ID card and will need to contact DeltaCare USA to update your dental provider.

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Dental (continued)

Plan Benefits	Delta Dental PPO Plan		DeltaCare Dental HMO Plan
	Member Responsibility		
	Delta Dental PPO Dentists	Non-Delta Dental PPO Dentists	Delta Dental HMO Dentists
Annual Deductible			
• Individual	None	None	None
• Family	None	None	None
Annual Maximum Benefit	$2,000	$2,000	None
Diagnostic and Preventive Services			
• Office Visit & X-rays	0%	0%	$0 copay
• Cleanings	0%	0%	$0 copay
Basic Services			
• Fillings *(amalgam)*	30% - 0%	30% - 0%	$0 copay
• Fillings *(porcelain/ceramic)*	30% - 0%	30% - 0%	$0 - $75 copay
• Endodontics *(root canals)*	30% - 0%	30% - 0%	$45 - $205 copay
• Oral Surgery	30% - 0%	30% - 0%	$25 - $90 copay
• Periodontics *(gum treatment)*	30% - 0%	30% - 0%	$45 - $195 copay
Major Services			
• Implants	30%-0%	30%-0%	Not Covered
• Crowns, Inlays, Onlays, Cast Restorations	30% - 0%	30% - 0%	$0 - $195 copay
• Prosthodontics *(Dentures, Bridges)*	40%	50%	$100 - $195 copay
Temporomandibular Joint (TMJ)	70%	70%	Not Covered
Orthodontics			
• Adult and Dependent Children Only	50%	50%	Dependent Child up to Age 19: $1,700 copay Adults (and dependent children age 19 to 26): $1,900
• Lifetime Maximum	$1,000	$1,000	None

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

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Vision

Full-time Employees Only

Your vision plan through VSP (Vision Service Plan) offers flexibility and a wide network. Covered employees and qualifying dependents 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.

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 (Signature Providers)
Frequency	
• Eye Exam	Once every 12 months
• Lenses/Contacts	Once every 12 months
• Frames	Once every 12 months
Copay	**MEMBER RESPONSIBILITY**
• Exam and Materials	$20 copay, exam and/or glasses Various copays for materials
Prescription Lenses	
• Single	Copay included in $20 exam copay
• Lined Bifocal	Copay included in $20 exam copay
• Lined Trifocal	Copay included in $20 exam copay
Frames	**PLAN PAYS**
	$200 allowance; 20% off remaining amount $170 allowance for featured frame brands
Contacts *(in lieu of lenses and frames)*	**PLAN PAYS**
• Medically Necessary	100%
• Elective	$200 allowance
• Fitting and Evaluation	$60 allowance
Laser VisionCare Preferred Program	**PLAN PAYS**
	15% off regular price or 5% off promotional price

If you received services from an Out-of- Network doctor/provider, you can complete a claim online or by mail.

- **Online:** Go to www.vsp.com
- **Mail:** VSP, PO Box 385018, Birmingham, AL 35238-5018

LightCare Benefit

With VSP LightCare, you can use your frame and lens benefit to get non-prescription eyewear from your VSP network doctor. Sunglasses or blue light filtering glasses may be just what you're looking for.

Protect your eyes from the sun's ultraviolet rays that can damage your corneas and cause eye-related diseases like cataracts. 100% UVA and UVB protection is the best choice for your sunglasses. Wear blue light filtering glasses indoors to combat digital eye strain. Digital screens and fluorescent lighting emit blue light that can contribute headaches, blurred vision, and sore eyes—all possible symptoms of digital eye strain.

Visit a VSP network doctor and choose either prescription eyewear coverage, or use your frame and lens allowance toward ready-to-wear non-prescription sunglasses and blue light filtering glasses.

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Basic Life & AD&D

Full-time Employees Only

As a benefit eligible full-time 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 Full-time Active Employees.
Coverage Amount	$100,000
Maximum Benefit	$100,000
Guaranteed Issue	$100,000
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	A portion 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
Waiver of Premium	Yes (allows an employee to continue coverage without paying premium while disabled)

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Voluntary Life Insurance

Open to new employees only: As a benefit eligible full-time employee of the District, you may purchase supplemental coverage through after-tax payroll deductions in amounts of coverage to suit your needs, in increments of $10,000, up to $500,000, not to exceed five times your annual earnings. If you elect voluntary life insurance for yourself, you may also purchase additional life insurance for your spouse and for your children.

Plan Benefits	MetLife Voluntary Life
Eligible Class	Active full-time employees
Coverage Amount	
• Employee	Increments of $10,000
• Spouse	Increments of $10,000
• Child(ren)	$2,000, $5,000 or $10,000
Maximum Benefit	
• Employee	5 times base annual salary to a maximum of $500,000
• Spouse	Up to $500,000 (cannot exceed 100% of employee's approved coverage)
• Child(ren)	$10,000 (terminates at age 26)
Guaranteed Issue[1] Guarantee Issue is only available to new employees and must be applied for within 30 days of the hire date. During open enrollment, you must complete and Evidence of Insurability form and be approved by MetLife. Forms are available from Personnel Services.	
• Employee	The lesser of 2 times your base annual earnings or $100,000
• Spouse	$25,000
• Child(ren)	$10,000
Waiver of Premium	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.
Accelerated Benefit Option	A portion 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

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 are subject to underwriting where you will be required to complete an EOI form.

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Voluntary Life Insurance (continued)

MetLife Voluntary Life Rates - 10thly Rates

	<25	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70+
Rate per $1,000	$0.060	$0.060	$0.084	$0.108	$0.132	$0.240	$0.420	$0.708	$1.140	$1.608	$2.376
$10,000	$0.60	$0.60	$0.84	$1.08	$1.32	$2.40	$4.20	$7.08	$11.40	$16.08	$23.76
$20,000	$1.20	$1.20	$1.68	$2.16	$2.64	$4.80	$8.40	$14.16	$22.80	$32.16	$47.52
$30,000	$1.80	$1.80	$2.52	$3.24	$3.96	$7.20	$12.60	$21.24	$34.20	$48.24	$71.28
$40,000	$2.40	$2.40	$3.36	$4.32	$5.28	$9.60	$16.80	$28.32	$45.60	$64.32	$95.04
$50,000	$3.00	$3.00	$4.20	$5.40	$6.60	$12.00	$21.00	$35.40	$57.00	$80.40	$118.80
$60,000	$3.60	$3.60	$5.04	$6.48	$7.92	$14.40	$25.20	$42.48	$68.40	$96.48	$142.56
$70,000	$4.20	$4.20	$5.88	$7.56	$9.24	$16.80	$29.40	$49.56	$79.80	$112.56	$166.32
$80,000	$4.80	$4.80	$6.72	$8.64	$10.56	$19.20	$33.60	$56.64	$91.20	$128.64	$190.08
$90,000	$5.40	$5.40	$7.56	$9.72	$11.88	$21.60	$37.80	$63.72	$102.60	$144.72	$213.84
$100,000	$6.00	$6.00	$8.40	$10.80	$13.20	$24.00	$42.00	$70.80	$114.00	$160.80	$237.60
$150,000	$9.00	$9.00	$12.60	$16.20	$19.80	$36.00	$63.00	$106.20	$171.00	$241.20	$356.40
$200,000	$12.00	$12.00	$16.80	$21.60	$26.40	$48.00	$84.00	$141.60	$228.00	$321.60	$475.20
$250,000	$15.00	$15.00	$21.00	$27.00	$33.00	$60.00	$105.00	$177.00	$285.00	$402.00	$594.00
$300,000	$18.00	$18.00	$25.20	$32.40	$39.60	$72.00	$126.00	$212.40	$342.00	$482.40	$712.80
$350,000	$21.00	$21.00	$29.40	$37.80	$46.20	$84.00	$147.00	$247.80	$399.00	$562.80	$831.60
$400,000	$24.00	$24.00	$33.60	$43.20	$52.80	$96.00	$168.00	$283.20	$456.00	$643.20	$950.40
$450,000	$27.00	$27.00	$37.80	$48.60	$59.40	$108.00	$189.00	$318.60	$513.00	$723.60	$1,069.20
$500,000	$30.00	$30.00	$42.00	$54.00	$66.00	$120.00	$210.00	$354.00	$570.00	$804.00	$1,188.00

Child Coverage Options	
$2,000	$0.20
$5,000	$0.50
$10,000	$1.00

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Voluntary Accidental Death & Dismemberment

Voluntary Accidental Death & Dismemberment (AD&D) Benefit

Open to new employees only: As a benefit eligible full-time employee of the District you are eligible for AD&D benefits that provide benefits beyond disability of life insurance for losses due to covered accidents -- while commuting, traveling by public or private transportation and during business trips.

You can choose the Voluntary AD&D option that meets your needs:

- **Option 1:** $1,000 (at no cost)
- **Option 2:** Flat $10,000 increments, plus $1,000

If you elect an amount in excess of $250,000, the maximum amount will be the lesser of:

- 10 times your annual earnings, plus $1,000 OR
- $501,000

You have the option of selecting Employee Only benefit or Employee Plus Family benefit.

Employee Amount: Employees may apply for benefit amounts in $10,000 increments, not to exceed $500,000.

Family Amount: The Family benefit amount provides 60% of your benefit amount for your spouse/domestic partner if no eligible children.

- ***Or*** 50% of your benefit amount for your spouse/domestic partner and 10% of your benefit amount for each of your eligible children
- ***Or*** 25% of your benefit amount for your children only if you do not have a spouse/domestic partner. The maximum amount payable is $25,000 for child benefit.

Evidence of good health is not required. This is inexpensive insurance for accidental death or dismemberment only.

Voluntary AD&D Rates - 10thly Billing

	Employee Only	Employee + Family
Rate per $1,000	**$0.042**	**$0.066**
$10,000	$0.42	$0.66
$20,000	$0.84	$1.32
$30,000	$1.26	$1.98
$40,000	$1.68	$2.64
$50,000	$2.10	$3.30
$60,000	$2.52	$3.96
$70,000	$2.94	$4.62
$80,000	$3.36	$5.28
$90,000	$3.78	$5.94
$100,000	$4.20	$6.60
$150,000	$6.30	$9.90
$200,000	$8.40	$13.20
$250,000	$10.50	$16.50
$300,000	$12.60	$19.80
$350,000	$14.70	$23.10
$400,000	$16.80	$26.40
$450,000	$18.90	$29.70
$500,000	$21.00	$33.00

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Unum STD & LTD Disability plans

Full-time Employees Only

Benefit Programs	Eligibility	Benefit Plan Highlights (Employee must be eligible for the benefit)
Short Term Disability (STD) *(Provided by District)*	All full-time benefit eligible certificated and classified employees in active employment with the District and reside within the United States.	**Weekly Benefit** Minimum $70 per week if receiving sick pay, after sick pay and vacation pay are exhausted 75% of weekly earnings, maximum $2,000 per week. Elimination Period: 30 days (duration 52 weeks, given remain disabled)
Long Term Disability (LTD) *(Provided by District)*	All District full-time benefit eligible certificated and classified employees who, on the date of initial loss, participates in but have less than five years of credited service under the California State Teachers Retirement System or Public Employees Retirement System. Must be in active employment and reside in the United States.	**Monthly Benefit** After sick pay and vacation pay are exhausted 50% of monthly earnings, maximum $6,000 per month. Elimination Period: 360 days (duration to age 65 (but not less than 5 years), given remain disabled)

Contact Personnel Services for benefit and/or claim inquiry.

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Employee Assistance Programs (EAP)

Evernorth Emotional Health and Family Support

We all face life events and personal challenges once in a while. If you need extra support, Evernorth is always there with confidential services. The best part? It's all available at no additional cost to all SBSD employees and anyone in your household whether you are a part-time or full-time employee.

Support is here. Any time. Any day.

No-cost counseling: If you need counseling, you can access up to six (6) in-person or virtual sessions per issue, per year with our network of EAP professional counselors. Call for a referral, go online to search our provider directory. Virtual care options include secure text messaging to fit your schedule.

Employee Assistance and Work/ Life Support is available 24/7.

1. Contact Evernorth at 888-736-7009
   - **Employer ID:** EASE (for initial registration)
2. Or visit well.evernorth.com
   - **Employer ID:** EASE (for initial registration)

Evernorth provides assistance at no-cost for a wide range of personal topics such as:

- Adoption
- Parenting
- Mental Health
- Loss
- Anxiety
- Senior Care
- Identity Theft
- Legal assistance
- Life Balance
- Financial services
- Pet care

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Flexible Spending Accounts

You Can Save on Your Taxes

An American Fidelity 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, coinsurance 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 help you enroll or you can meet with a representative virtually. 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 or within 30 days of a qualifying life event.

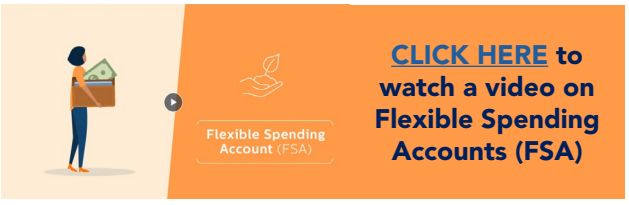
You must submit appropriate documentation to Personnel Services within 30 days of any qualifying life event to make changes to this enrollment.

Qualifying Life Events:

- 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, as required by HIPAA, then a participant may revoke a prior election for group health plan coverage and make a new election. Special Enrollment rights include (not exhaustive):
  - Loss of coverage under another group plan;
  - A new dependent is acquired as a result of marriage, birth, adoption or placement of adoption;
  - Loss of MediCal (Medicaid) or state exchange eligibility (participant has 60 days to notify Personnel Services 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 Irrevocability of Elections:**
  - Significant change in cost in benefit as determined by the plan document.

These exceptions may not be all inclusive.

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



HRA, FSA, HSA numbers are reflected for the 2024 calendar year. 2025 amounts are not typically determined until after the release of the Benefit Guide. Employees making elections for the 2025 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 $3,200. The Carryover amount from the 2024 plan year is $610.

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).

Plan Carefully

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

If you are no longer working for the Solana Beach School District, you can continue to submit reimbursement requests for expenses incurred up to your date of separation. Please note, all requests for reimbursement must be received by American Fidelity within 90 calendar days of your last day of employment.

HRA, FSA, HSA numbers are reflected for the 2024 calendar year. 2025 amounts are not typically determined until after the release of the Benefit Guide. Employees making elections for the 2025 year should keep this in mind.

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 where some may be purchased with pre-taxed dollars:

- Accident Only Insurance
- Cancer Insurance
- Disability Income Insurance
- Life Insurance
- Critical Illness
- 403b
- TexasLife Accelerated Death Benefit for Chronic Illness Rider

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

Other Programs Include:

- **MetLife Legal Services:** MetLife Legal plan is offering a new enrollment option called Plus Parents. The Plus Parents plan covers you, your spouse, dependents and parents for many common legal issues your family may face. You can join the MetLife Pre-Paid Legal Plan for $23.40 tenthly or $30.60 tenthly for MetLife Legal Plans Plus Parents.
- **MetLife Pet Insurance:** Help protect your pet from costly vet bills. More than ever, pets play such a huge role in our lives. We want to do everything to keep them safe and healthy. Help make sure your furry family members are protected against unplanned vet expenses for covered accidents or illnesses with MetLife Pet Insurance. For a quote please visit www.metlife.com/getpetquote or call 1-800-GET-MET8. When directed, select or mention: Fringe Benefits Consortium.
- **Keenan ID Theft Protector:** paid by employee payroll deductions. Credit monitoring for subscriber (employee or one family member), Internet and data monitoring, 24/7/365 Crisis Response Team for full recovery/restoration for you and your family in the event of an ID theft. You can join the ID Theft plan for $12.00 tenthly.
- **KeenanDirect:** Exchange for Health Insurance for non-benefit eligible employees, early retirees, COBRA, family or friend without access to employer sponsored plans, children reaching age 26, and Medicare eligibles. Keenandirect.com or 855-653-3626.

Other Retirement

- **CalSTRS:** 800-228-5453 or www.calstrs.com
- **CalPERS:** 888-225-7377 or www.calpers.ca.gov
- **Supplemental Retirement Plans:** Email: FBCsupport@planmember.com

2025 Certificated, Management and Confidential Tenthly Premiums, District Contribution Amount and Employee Amount by Health Plan

Certificated, Management and Confidential Employees - Pay Tenthly				
	Plan Type	**Premium**	**Dist Amt**	**Emp Amt**
Kaiser $20	Single	$986.00	$986.00	$0
	Two Party	$1,948.00	$1,763.48	$184.52
	Family	$2,745.00	$1,763.48	$981.52
UHC Performance HMO $10	Single	$1,033.00	$1,033.00	$0
	Two Party	$2,053.00	$1,763.48	$289.52
	Family	$2,879.00	$1,763.48	$1,115.52
UHC Performance HMO $20/$30	Single	$986.00	$986.00	$0
	Two Party	$1,957.00	$1,763.48	$193.52
	Family	$2,742.00	$1,763.48	$978.52
UHC Alliance HMO $20	Single	$1,192.00	$1,192.00	$0
	Two Party	$2,213.00	$1,763.48	$449.52
	Family	$3,090.00	$1,763.48	$1,326.52
UHC Harmony HMO $20	Single	$924.00	$924.00	$0
	Two Party	$1,816.00	$1,763.48	$52.52
	Family	$2,543.00	$1,763.48	$779.52
UHC Journey Alliance HMO w/ HRA	Single	$977.00	$977.00	$0
	Two Party	$1,891.00	$1,763.48	$127.52
	Family	$2,651.00	$1,763.48	$887.52
UHC Journey Harmony HMO w/ HRA	Single	$905.00	$905.00	$0
	Two Party	$1,738.00	$1,738.00	$0
	Family	$2,418.00	$1,763.48	$654.52
Surest PPO $1,000	Single	$1,440.00	$1,440.00	$0
	Two Party	$2,806.00	$1,763.48	$1,042.52
	Family	$3,919.00	$1,763.48	$2,155.52
OTHER BENEFITS				
Delta Dental Premier (PPO)	Single	$65.51	$65.51	$0
	Two Party	$132.17	$132.17	$0
	Family	$181.32	$132.17	$49.15
DELTA PMI *(DeltaCare USA)*	Family (composite)	$50.55	$50.55	$0
VSP	Family (composite)	$19.08	$19.08	$0
HARTFORD *(Life Insurance)*	Employee Only	$15.12	$15.12	$0
UNUM *(Short Term and Long Term Disability Insurance)*	Employee Only	Varies by Salary		$0

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.

2025 Classified Tenthly Premiums, District Contribution Amount and Employee Amount by Health Plan

Classified Employees - Pay Tenthly				
	Plan Type	**Premium**	**Dist Amt**	**Emp Amt**
Kaiser $20	Single	$986.00	$986.00	$0
	Two Party	$1,948.00	$1,713.48	$234.52
	Family	$2,745.00	$1,713.48	$1,031.52
UHC Performance HMO $10	Single	$1,033.00	$1,033.00	$0
	Two Party	$2,053.00	$1,713.48	$339.52
	Family	$2,879.00	$1,713.48	$1,165.52
UHC Performance HMO $20/$30	Single	$986.00	$986.00	$0
	Two Party	$1,957.00	$1,713.48	$243.52
	Family	$2,745.00	$1,713.48	$1,028.52
UHC Alliance HMO $20	Single	$1,192.00	$1,192.00	$0
	Two Party	$2,213.00	$1,713.48	$499.52
	Family	$3,090.00	$1,713.48	$1,376.52
UHC Harmony HMO $20	Single	$924.00	$924.00	$0
	Two Party	$1,816.00	$1,713.48	$102.52
	Family	$2,543.00	$1,713.48	$829.52
UHC Journey Alliance HMO w/ HRA	Single	$977.00	$977.00	$0
	Two Party	$1,891.00	$1,713.48	$177.52
	Family	$2,651.00	$1,713.48	$937.52
UHC Journey Harmony HMO w/ HRA	Single	$905.00	$905.00	$0
	Two Party	$1,738.00	$1,713.48	$24.52
	Family	$2,418.00	$1,713.48	$704.52
Surest PPO $1,000	Single	$1,440.00	$1,440.00	$0
	Two Party	$2,806.00	$1,713.48	$1,092.52
	Family	$3,919.00	$1,713.48	$2,205.52
OTHER BENEFITS (FULL TIME EMPLOYEES ONLY)				
Delta Dental Premier (PPO)	Single	$65.51	$65.51	$0
	Two Party	$132.17	$132.17	$0
	Family	$181.32	$132.17	$49.15
DELTA PMI *(DeltaCare USA)*	Family (composite)	$50.55	$50.55	$0
VSP	Family (composite)	$19.08	$19.08	$0
HARTFORD *(Life Insurance)*	Employee Only	$15.12	$15.12	$0
UNUM *(Short Term and Long Term Disability Insurance)*	Employee Only	Varies by Salary		$0

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.

Important Notices

No Surprises Act Notice

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

Discrimination is Against the Law

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

Newborns' and Mothers' Health Protection Act (NMHPA)

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

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

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

Patient Protections

The medical plan requires the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. Until you make this designation, the plan will designate one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, go to United Healthcare at whyuhc.com/csveba or go to Kaiser at my.kp.org/veba.

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, , go to United Healthcare at whyuhc.com/csveba or go to Kaiser at my.kp.org/veba.

Networks/Claims/Appeals

The major medical plans described in this booklet have provider networks with United Healthcare 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.

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.

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

OTHER OPTIONS BESIDES COBRA CONTINUATION COVERAGE

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

Important Notices (continued)

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.

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

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

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

IF YOU HAVE QUESTIONS

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

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

KEEP YOUR PLAN INFORMED OF ADDRESS CHANGES

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

EFFECTIVE DATE OF COVERAGE

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

COST OF CONTINUATION COVERAGE

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

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

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

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

[1] https://www.medicare.gov/basics/get-started-with-medicare/sign-up/when-does-medicare-coverage-start

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

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

Uniformed Services Employment and Reemployment Rights Act (USERRA)

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

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

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

Special Enrollment Rights Notice

CHANGES TO YOUR HEALTH PLAN ELECTIONS

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

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

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

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

If you have a change in family status such as a new dependent resulting from marriage, birth, adoption or placement for adoption, divorce (including legal separation and annulment), death, or 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:

Jessica Archuleta
PS Specialist, Personnel Services
jessicaarchuleta@sbsd.net

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

Solana Beach 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 Personnel Services.

Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: GENERAL INFORMATION

This notice provides you with information about Solana Beach 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 on November 1, 2024, and end on January 31, 2025. For more information on Open Enrollment and other opportunities to enroll, visit www.coveredca.com or KeenanDirect at 855-653-3626 or www.KeenanDirect.com.

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

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

You may qualify to save money and lower your monthly premium, but only if your employer does not offer you coverage, offers medical coverage that is not "Affordable," or does not provide "Minimum Value." If the lowest cost plan from your employer that would cover you (and not any other members of your family) is more than 8.39% (for 2024) of your household income for the year, then that coverage for you is not Affordable. **Note**: The IRS will update the applicable percentage for 2025. Affordability for dependent family members is determined separately and is based on the total cost of family coverage. Moreover, if the medical coverage offered covers less than 60% of the benefits costs, then the plan does not provide Minimum Value.

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

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

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

STATES WITH INDIVIDUAL MANDATE

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

PART B: INFORMATION ABOUT HEALTH COVERAGE OFFERED BY YOUR EMPLOYER

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

3. Employer name Solana Beach School District	**4. Employer Identification Number (EIN)** 95-6002967	
5. Employer address 309 N. Rios Ave	**6. Employer phone number** 858.794.7110	
7. City Solana Beach	**8. State** CA	**9. ZIP code** 92075
10. Who can we contact about employee health coverage at this job? Jessica Archuleta, PS Specialist, Personnel Services		
11. Phone number (if different from above)	**12. Email address** jessicaarchuleta@sbsd.net	

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

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, 2024. 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://hcpf.colorado.gov/child-health-plan-plus
CHP+ Customer Service:
800-359-1991 | TTY: Colorado relay 711
Health Insurance Buy-In Program (HIBI):
https://www.mycohibi.com/
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
Website: https://www.in.gov/medicaid/
Or http://www.in.gov/fssa/dfr/
Family and Social Services Administration
Phone: 800-403-0864
Member Services Phone: 800-457-4584

Important Notices (continued)

IOWA – Medicaid and CHIP (Hawki)
Medicaid Website: https://hhs.iowa.gov/programs/welcome-iowa-medicaid
Medicaid Phone: 800-338-8366
Hawki Website: http://hhs.iowa.gov/programs/welcome-iowa-medicaid/iowa-health-link/hawki
Hawki Phone: 800-257-8563
HIPP Website:
https://hhs.iowa.gov/programs/welcome-iowa-medicaid/free-service/hipp
HIPP Phone: 888-346-9562

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

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/agencies/dms

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.mymaineconnection.gov/benefits/s/?language=en_US
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: Massachusetts relay 711
Email: masspremassistance@accenture.com

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

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
Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov
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/
Phone: 800-356-1561
CHIP Premium Assistance Phone: 609-631-2392
CHIP Website: http://www.njfamilycare.org/index.html
CHIP Phone: 800-701-0710 (TTY: 711)

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: https://www.hhs.nd.gov/healthcare
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
Phone: 800-699-9075

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

Important Notices (continued)

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

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

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

UTAH – Medicaid and CHIP
Utah's Premium Partnership for Health Insurance (UPP)
Website: https://medicaid.utah.gov/upp/
Email: upp@utah.gov
Phone 888-222-2542
Adult Expansion Website: https://medicaid.utah.gov/expansion/

Utah Medicaid Buyout Program
Website: https://medicaid.utah.gov/buyout-program/
CHIP Website: https://chip.utah.gov/

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

VIRGINIA – Medicaid and CHIP
Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select
https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs
Medicaid 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, 2024, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
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

Important Notice from Solana Beach School District About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can easily find it. This notice has information about your current prescription drug coverage with Solana Beach 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.**
- **Solana Beach School District has determined that the prescription drug coverage offered by the United Healthcare and Kaiser 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.**

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 Solana Beach School District coverage will not be affected. If you keep this coverage and elect Medicare, the Solana Beach School District coverage will coordinate with Part D coverage.

If you do decide to join a Medicare drug plan and drop your current Solana Beach 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 Solana Beach 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 (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'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Solana Beach School District changes. You also may request a copy of this notice at any time.

Date:	October 1, 2024
Name of Entity / Sender:	Solana Beach School District
Contact:	Jessica Archuleta
Address:	309 N. Rios Ave
	Solana Beach, CA 92075
Phone:	858.794.7110

FOR MORE INFORMATION ABOUT YOUR OPTIONS UNDER MEDICARE PRESCRIPTION DRUG COVERAGE…

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

For more information about Medicare prescription drug coverage:

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

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

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

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 website (if available) to access information from providers for the various plans.

Plan	Phone Number	Website
Medical		
• California Schools VEBA	888-276-0250	vebaonline.com
• UnitedHealthcare HMO	888-586-6365	whyuhc.com/csveba
• Express Scripts	800-918-8011	express-scripts.com
• Kaiser	800-464-4000	my.kp.org/veba
• Surest PPO	866-683-6440	surest.com/contact-us
• OptumHealth		
– Chiropractic/Acupuncture		
• Kaiser Members	800-428-6337	https://www.myoptumhealthphysicalhealthofca.com/
• UHC Members	888-586-6365	https://myoptumhealthphysicalhealthofca.com/
• Financial *(UHC Journey Alliance HMO w/ HRA)*	844-342-5505	https://www.healthinvesthra.com/
• Optum Emotional Wellbeing Solutions *(formerly Employee Assistance Program- EAP)*	888-625-4809	liveandworkwell.com Access code: veba
• Teladoc Medical Experts	800-835-2362	teladoc.com/medical-experts
Dental		
• DeltaCare HMO	800-422-4234	www.deltadentalins.com
• Delta Dental PPO	866-499-3001	www.deltadentalins.com
Vision		
• VSP Vision Care	800-877-7195	vsp.com
Basic Life/AD&D		
• Hartford	858-794-7110	Contact Personnel Services
Optional Life		
• MetLife	858-794-7110	Contact Personnel Services
Long Term and Short Term Disability Insurance		
• Unum	858-794-7110	Contact Personnel Services
Flexible Spending Accounts (FSA)		
• American Fidelity	800-662-1113	americanfidelity.com
Benefit Consultant Keenan & Associates		
• Crystal Bonker - Account Executive	951-715-0190, x1157	cbonker@keenan.com
• ChrisAnn Galeotti - Service Analyst	949-940-1760, x5130	cgaleotti@keenan.com

Glossary

Affordable Care Act and Patient Protection (ACA)

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

Allowed Amount

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

Balance Billing

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

Brand Name Drug

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

COBRA (Consolidated Omnibus Budget Reconciliation Act)

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

Children's Health Insurance Program (CHIP)

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

Claim

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

Coinsurance

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

Copayment (Copay)

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

Comprehensive Coverage

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

Deductible

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

Formulary

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

Generic Drug

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

High-Deductible Health Plan (HDHP)

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

Glossary (continued)

Health Savings Account (HSA)

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

Health Reimbursement Arrangements (HRAs)

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

In-Network

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

Non-Preferred Provider

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

Out-of-Pocket Maximum

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

Out-Of-Network

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

Out-Of-Pocket Limit

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

Plan Year

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

Preferred Provider

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

Premium

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

Preventive Care

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

Qualifying Life Event

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

Skilled Nursing Care

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

Urgent Care

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