2025-2026 FULL-TIME BENEFITS

Saddleback Valley
Unified School District

BENEFITS FOR ALL SEASONS

CONTENTS

MEDICARE PART D NOTICE

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a federal law gives you more choices about your prescription drug coverage. Please see the Important Plan Information section for more details.

GETTING STARTED

2025 - 2026 BENEFITS
October 1, 2025
through
September 30, 2026

Whether you're enrolling in benefits for the first time, nearing retirement, or somewhere in between, Saddleback Valley Unified School District (SVUSD) supports you with benefit programs and resources to help you thrive today and prepare for tomorrow.

This guide provides an overview of your healthcare coverage, life, disability, and more.

You'll find tips to help you understand your medical coverage, save time and money on healthcare, reduce taxes, and balance your work and home life. Review the coverage and tools available to you to make the most of your benefits package.

WHO'S ELIGIBLE FOR BENEFITS?

ENROLLING FOR BENEFITS

All eligible employees will contact the **Ward Services Benefits Center** to speak with a Benefits Advisor by phone to elect or decline coverage. They will be able to answer general questions about your benefits offering. If you are enrolling dependents, please have their Social Security number and birth dates available during your enrollment session.

Ward Services Benefits Center is available at (800) 673-6472 Monday - Friday 5:30am to 2:00pm PST.

Employees

You and your eligible dependents may participate in SVUSD's full benefits program if you are;

- A management or certificated employee hired to work at least 50%
- A classified employee hired to work more than 30 hours per week.

Eligible dependents

- Legally married spouse.
- Registered Domestic Partner (RDP).
- Natural, adopted or stepchildren, or children of a registered domestic partner up to age 26.
- Children over age 26 who are disabled and depend on you for support (Additional documentation will be required).
- Children named in a Qualified Medical Child Support Order (QMCSO).

For additional information, please refer to the plan documents for each benefit.

Who is not eligible

Members who are not eligible for coverage include (but are not limited to):

- Parents, grandparents, and siblings.
- Grandchildren

When you can enroll

You can enroll in benefits as a new hire or during the annual open enrollment period. New hire coverage begins on the first of the month following your date of hire. If your hire date is on the 1st of the month, your benefits are effective on the date you are hired. You must enroll within 31 days of becoming eligible.

If you miss the enrollment deadline, you'll need to wait until the next open enrollment, the one time each year that you can make changes to your benefits for any reason. Open enrollment is generally held in August every year for an October 1st effective date.

CHANGING YOUR BENEFITS

Click to play video

LIFE HAPPENS

A change in your life may allow you to update your benefit choices. Watch the video for a quick take on your options.

THREE RULES APPLY TO MAKING CHANGES TO YOUR BENEFITS DURING THE YEAR:

1. Any change you make must be consistent with the change in status.
2. You must make the change within 31 days of the date the event occurs.
3. All proper documentation is required to cover dependents (marriage certificates, birth certificates, etc.).

Outside of open enrollment, you may be able to enroll or make changes to your benefit elections if you have a big change in your life, including:

- Change in legal marital status
- Change in number of dependents or dependent eligibility status
- Change in employment status that affects eligibility for you, your spouse, or dependent child(ren)
- Change in residence that affects access to network providers
- Change in your health coverage or your spouse's coverage due to your spouse's employment
- Change in an individual's eligibility for Medicare or Medicaid
- Court order requiring coverage for your child
- "Special enrollment event" under the Health Insurance Portability and Accountability Act (HIPAA), including a new dependent by marriage, birth or adoption, or loss of coverage under another health insurance plan
- Event allowed under the Children's Health Insurance Program (CHIP) Reauthorization Act (you have 60 days to request enrollment due to events allowed under CHIP).

You must submit your change within 31 days after the event.

Dependent Verification

Making changes to dependents is subject to eligibility verification in order to ensure only eligible individuals are participating in our plans. You will be required to provide proof of one or more of the following within 31 days of their eligibility:

- Government Issued Marriage Certificate
- Government issued Domestic Partner Registration
- Government Issued Birth Certificate
- Final decree of divorce
- Court documents showing legal responsibility for adopted children, foster children or children under legal guardianship
- For dependent children over age 26 incapable of self-support – employees must complete Anthem's (Overage Dependent) document

If you do not supply the proper documentation to make changes to dependents within the 31-day period, you will not be able to add the dependent(s) until the next open enrollment period. **Scan and email documentation to benefits@SVUSD.org**.

ELIGIBILITY DOCUMENTATION CHECKLIST

Dependent Type	Required Documentation
Spouse	• Prior year's Federal Tax Form that shows the couple was married (First page only, financial information may be blocked out). • A marriage certificate will be accepted for newly married couples when filing has not yet been required for the current tax year.
Domestic Partner	• A Certificate of Registered Domestic Partnership issued by the State of California or a certified copy of the Declaration of Domestic Partnership that includes the dated, signed Secretary of State Certification Stamp. (Enrolling a Domestic Partner may cause the employer contribution to become taxable.)
Children, Stepchildren, and/or Adopted Children up to age 26	• Legal Birth Certificate or Hospital Birth Certificate (to include full name of child, parent(s) name, and child's DOB) • Legal Adoption Documentation
Legal Guardianship up to age 18	• Legal U.S. Court Documentation establishing Guardianship
Unmarried Disabled Dependents over age 26 (requires enrollment in a SISC medical plan)	**Anthem Blue Cross (All items listed below are required)** • Legal Birth Certificate or Hospital Birth Certificate (to include full name of child, parent(s) name and child's DOB) • Prior year's Federal Tax Form that shows child is claimed as an IRS dependent (First page only, income information may be blocked out.) • Proof of 6 months prior creditable coverage under the employee/retiree's plan. There can be no break in coverage. • Completed Anthem Disabled Dependent Certification Form **Kaiser (All items listed below are required)** • Legal Birth Certificate or Hospital Birth Certificate (to include full name of child, parent(s) name & child's DOB) • Prior year's Federal Tax Form that shows child is claimed as an IRS dependent (First page only, income information may be blocked out) • Proof of 6 months prior creditable coverage under the employee/retiree's plan. There can be no break in coverage.
Retirees and/or Dependents on a Retiree Plan Age 65 or Over	• Proof of enrollment in Medicare Part A & Part B (copy of current Medicare card or Medicare enrollment confirmation letter showing effective dates of Part A and Part B).

QUALIFYING EVENTS OR STATUS CHANGES OUTSIDE OF OPEN ENROLLMENT

Employee/Retiree experiences the following qualifying event	Employee/Retiree may make the following change within 31 days of the qualifying event	Required Documentation: SISC Membership Change Form and applicable documents below
Birth, Adoption, or Legal Guardianship **NOTE:** HIPAA special enrollment rights may apply	• Enroll self, if applicable • Enroll newly eligible child and any other eligible dependents • Change health plans when options are available	• Birth certificate indicating parents' full names; or • Adoption/Guardianship documents issued by a U.S. court
Marriage or Commencement of Domestic Partnership **NOTE:** HIPAA special enrollment rights may apply	• Enroll self, if applicable • Enroll spouse/domestic partner and any newly eligible dependent children • Change health plans when options are available	• Marriage Certificate; or • Declaration of Domestic Partnership filed with the California Secretary of State • Other enrollment forms/documents as applicable
Divorce or Termination of Domestic Partnership **NOTE:** HIPAA special enrollment rights may apply	• Drop spouse/domestic partner • Drop stepchildren gained from marriage or domestic partnership • Enroll self and any newly eligible dependent children who lost eligibility under spouse/domestic partner's plan • Change health plans when options are available	• Final Divorce Decree; or • Dissolution of Domestic Partnership filed with the California Secretary of State • Other enrollment forms/documents as applicable
Death of Dependent (spouse/ domestic partner or child) **NOTE:** HIPAA special enrollment rights may apply	• Remove the dependent from coverage • Change health plans when options are available	• Membership Change Form
Qualified Medical Child Support Order (QMCSO) requiring enrollment of dependent child	• Enroll self, if not already enrolled in coverage • Enroll dependent child named on the QMCSO to employee's health coverage • Change health plans when options are available	• Membership Change Form • Birth certificate indicating parents' full names; and • Qualified Medical Child Support Order (QMCSO) court document
Gain or Loss of Entitlement to Medicare/Medicaid coverage by covered person **NOTE:** HIPAA special enrollment rights may apply	• Enroll self, spouse/domestic partner, and any eligible dependent children, if applicable • Drop coverage for person who became entitled and enrolled in Medicare/Medicaid • Change health plans when options are available	• Proof of enrollment in or loss of coverage in Medicare/Medicaid (whichever applicable) • Other enrollment forms/documents as applicable

QUALIFYING EVENTS OR STATUS CHANGES OUTSIDE OF OPEN ENROLLMENT CONT

Employee/Retiree experiences the following qualifying event	Employee/Retiree may make the following change within 31 days of the qualifying event	Required Documentation: SISC Membership Change Form and applicable documents below
Change in Employment Status (e.g., Part-time to Full-time, Full-time to Part-time, Active to Retiree, Hourly to Salaried, Unpaid Leave of Absence, Change in Bargaining Unit, etc.)	• Enroll self, spouse/domestic partner, and any eligible dependent children, if applicable • Drop spouse/domestic partner and/or any other dependent children • Change health plans when options are available	• Proof of employment change; and • Other enrollment forms/documents as applicable
Changes to coverage as a result of Open Enrollment under other employer plan/different plan year including enrollment in a Qualified Health Plan (QHP) through a Public Marketplace such as Covered CA	• Enroll self, spouse/domestic partner, and any eligible dependent children, if applicable • Drop spouse/domestic partner and/or any other dependent children • Change health plans when options are available	• Proof of coverage change; and • Other enrollment forms/documents as applicable
Significant increase or decrease in the cost of coverage or an unpaid leave where the district will no longer be making a contribution	• Enroll self, spouse/domestic partner, and any eligible dependent children, if applicable • Drop spouse/domestic partner and/or any other dependent children • Change health plans when options are available	• Proof of increase in cost of coverage (e.g. district submitted plan change); or • Proof of decrease in cost of coverage (e.g. district submitted plan change); and • Other enrollment forms/documents as applicable
Gain or Loss of Coverage Elsewhere, including but not limited to: • Change of home address causing loss of eligibility • Change in employment status of spouse/domestic partner or dependent child (including commencement or termination of employment) • Significant curtailment in employee's spouse's/domestic partner's group coverage **NOTE:** HIPAA special enrollment rights may apply	• Enroll self, spouse/domestic partner, and any eligible dependent children, if applicable • Drop spouse/domestic partner and/or any other dependent children • Change health plans when options are available	• Proof of significant curtailment in spouse's/domestic partner's group coverage; or • Proof of enrollment in other coverage; or • Proof of loss of coverage; and • Other enrollment forms/documents as applicable

MEDICAL

OUR SISC PLANS

The District offers different Self-Insured Schools of California (SISC) medical plans:

ANTHEM VIVITY HMO

ANTHEM SELECT HMO

ANTHEM CA CARE HMO

ANTHEM PPO

KAISER HMO

All About Medical Plans

Play the Health Lingo Game!

We offer 4 medical plans through Anthem Blue Cross, and 1 medical plan through Kaiser.

- **DEDUCTIBLE:** The amount of healthcare costs you have to pay for with your own money before your plan will start to pay anything.
- **OUT-OF-POCKET MAXIMUM:** Protects you from big medical bills. Once costs "out of your own pocket" reach this amount, the plan pays 100% of most eligible expenses for the rest of the plan year.
- **COINSURANCE:** After the deductible (if applicable), you and the plan share the cost. For example, if the plan pays 80%, your coinsurance share of the cost is 20%. You are billed for your coinsurance after your visit.
- **COPAY:** A set fee you pay instead of coinsurance for some healthcare services, for example, a doctor's office visit. You pay the copay at the time you receive care.
- **IN-NETWORK / OUT-OF-NETWORK:** In-network services will always be the lowest cost option. Out-of-network services will cost more or may not be covered. Check your plan's website to find doctors, hospitals, labs, and pharmacies that belong to the network.

WHICH PLAN IS RIGHT FOR YOU?

SYDNEY MOBILE APP

Use Sydney℠ Health to keep track of your health and benefits- all in one place. Access your plan details, view ID cards, Member Services, virtual care, and wellness resources. You can also set up an account at anthem.com/ca/register to access most of the same features from your computer.

FINDING A PROVIDER

To find a provider in your plan network, please click on the link for each network.

Anthem Vivity HMO: Call (800) 825-5541 or click HERE to search for a Vivity HMO provider.

Anthem Select HMO: Call (800) 825-5541 or click HERE to search for a Select HMO provider.

Anthem Traditional HMO (Full Network): Call (800) 825-5541 or click HERE to search for a CA Care HMO provider.

Anthem PPO: Call (800) 825-5541 or click HERE.

Kaiser HMO: Call (800) 464-4000 or click HERE.

Consider an HMO (Health Maintenance Organization) if:

- You want lower, predictable out-of-pocket costs
- You like having one doctor to manage your care
- You are happy with the selection of network providers
- You don't see any doctors that are out-of-network

Plans To Consider

- Anthem Vivity HMO
  - **Narrow network** that is available in most of Southern CA.
- Anthem Select HMO
  - This offers a **limited network** that is available in 22 counties in California and is roughly 63% of the size of the full network.
- Anthem CA Care HMO
  - This plan features the **full** Anthem HMO network with over 43,000 physicians and over 400 hospitals throughout California
- Kaiser HMO
  - This plan features the Kaiser HMO network

Consider a PPO (Preferred Provider Organization) if:

- You want to be able to see any provider, even a specialist, without a referral
- You are willing to pay more to see out-of-network providers

- Anthem PPO
  - You have the freedom to choose any doctor you wish for your care, including specialists.
  - When you access care from Prudent Buyer network providers, you receive higher levels of benefits and claim forms are filed by the providers.
  - You may also obtain care using out-of-network providers; however, you will be responsible for the difference between the covered amount and the actual charges, and you may be responsible for filing claims.

KNOW WHERE TO GO

Where you get medical care can have a significant impact on the cost. Here's a quick guide to help you know where to go, based on your condition, budget, and time. Please refer to page 9 to see the medical cost for various services.

Type	Appropriate for	Examples	Access	Cost
Nurseline 	Quick answers from a trained nurse Phone: (800)700-9186	▪ Identifying symptoms ▪ Decide if immediate care is needed ▪ Home treatment options and advice	24/7	**$0**
Online visit 	Many non-emergency health conditions Register at https://members.mdlive.com/sisc	▪ Cold, flu, allergies ▪ Headache, migraine ▪ Skin conditions, rashes ▪ Minor injuries ▪ Mental health concerns	24/7	**$**
Office visit 	Routine medical care and overall health management	▪ Preventive care ▪ Illnesses, injuries ▪ Managing existing conditions	Office Hours	**$$**
Urgent care, walk-in clinic 	Non-life-threatening conditions requiring prompt attention. Confirm participating facilities with your medical group.	▪ Stitches ▪ Sprains ▪ Animal bites ▪ Ear-nose-throat infections	Office Hours, or up to 24/7	**$$$**
Emergency room 	Life-threatening conditions requiring immediate medical expertise	▪ Suspected heart attack or stroke ▪ Major bone breaks ▪ Excessive bleeding ▪ Severe pain ▪ Difficulty breathing	24/7	**$$$$$**

Medical – Anthem HMO Plans

You always pay the copayment ($).

	ANTHEM VIVITY HMO	ANTHEM SELECT HMO	ANTHEM TRADITIONAL
	In-Network Only	In-Network Only	In-Network Only
Calendar Year Deductible[1] Individual Family	None	None	None
Calendar Year Out-of-Pocket Maximum[1,3] Individual[2] Family	$1,000 $2,000	$1,000 $2,000	$1,000 $2,000
Office Visit Primary Care (PCP) Specialist Telemedicine/Telehealth Visit MDLive Online Virtual Visit	$10 copay $10 copay $10 copay $10 copay	$10 copay $10 copay $10 copay $10 copay	$10 copay $10 copay $10 copay $10 copay
Preventive Services	No charge	No charge	No charge
Chiropractic/ Acupuncture (up to 30 visits/year)	$10 copay	$10 copay	$10 copay
Lab and X-ray	No charge	No charge	No charge
Urgent Care	$10 copay	$10 copay	$10 copay
Emergency Room	$100 copay (copay waived if admitted)	$100 copay (copay waived if admitted)	$100 copay (copay waived if admitted)
Inpatient Hospitalization	No charge	No charge	No charge
Outpatient Surgery	No charge	No charge	No charge
NAVITUS HEALTH SOLUTIONS PRESCRIPTION DRUG COVERAGE[4]			
Out-of-Pocket Maximum Individual Family	$1,500 $2,500	$1,500 $2,500	$1,500 $2,500
Generic **Network Pharmacy** **Costco Pharmacy** **Costco Mail Order**	$5 – 30-day supply $0 – 30/90-day supply $0 – 90-day supply	$5 – 30-day supply $0 – 30/90-day supply $0 – 90-day supply	$5 – 30-day supply $0 – 30/90-day supply $0 – 90-day supply
Brand **Network Pharmacy** **Costco Pharmacy** **Costco Mail Order**	$20 – 30-day supply $20 – 30-day supply/ $50 – 90-day supply $50 – 90-day supply	$20 – 30-day supply $20 – 30-day supply/ $50 – 90-day supply $50 – 90-day supply	$20 – 30-day supply $20 – 30-day supply/ $50 – 90-day supply $50 – 90-day supply
Specialty – Navitus Mail Order	$20 – 30-day supply	$20 – 30-day supply	$20 – 30-day supply
MENTAL HEALTH/SUBSTANCE ABUSE BENEFITS			
Office Visit/Facility Visit	$10 copay	$10 copay	$10 copay
Inpatient Hospital/Facility Fees	No charge	No charge	No charge
Inpatient Hospital/Doctor & Other Services	No charge	No charge	No charge

[1]Deductibles and out-of-pocket maximums accumulate on a calendar year from January 1 through December 31.
[2]An embedded family maximum means the plan will cover 100% for an individual member as soon as they reach their individual maximum.
[3]All covered expenses including your medical deductibles and prescription copays accumulate towards the out-of-pocket maximum.
[4] Pharmacy benefits are administered by Navitus Health Solutions.

Medical – Anthem PPO Plan

You always pay the deductible and copayment ($). The coinsurance (%) shows what you pay after the deductible has been met.

	ANTHEM PPO	
	In-Network	**Out-of-Network**
Calendar Year Deductible[1] Individual Family	 $200 $500	 $200 $500
Calendar Year Out-of-Pocket Maximum[1] Individual Family	 $1,000 $3,000	 No Limit
Office Visit Primary Care[3] Specialist Telemedicine/Telehealth Visit[3] MDLive Online Virtual Visit	 $0 copay for visits 1-3, then $20 copay for visits 4+ $20 copay $0 copay for visits 1-3, then $20 copay for visits 4+ $0 PCP/$20 specialist	 Billed charges exceeding out-of-network fee schedule[2]
Preventive Services	No charge	Not Covered
Chiropractic Limits apply	10% after deductible	Not Covered
Acupuncture Coverage is limited to 12 visits per benefit period	10% after deductible	50% of maximum allowed amount
Lab and X-ray	10% after deductible	Not Covered
Urgent Care	$20 copay	Billed charges exceeding out-of-network fee schedule[2]
Emergency Room	$100 per visit + 10% coinsurance after deductible	$100 per visit + 10% coinsurance after deductible
Inpatient Hospitalization	10% after deductible	All billed amounts exceeding $600/day[2]
Outpatient Surgery	10% after deductible	Hospital: Billed charges exceeding out-of-network fee schedule[2] Ambulatory Surgical Center: All billed amounts exceeding $350/day
NAVITUS HEALTH SOLUTIONS PRESCRIPTION DRUG COVERAGE[4]	**Pay**	**Supply Limit**
Out-of-Pocket Maximum Individual Family	 $1,500 $2,500	
Generic **Network Pharmacy** **Costco Pharmacy** **Costco Mail Order**	 $5 $0 $0	 30 Days 30/90 Days 90 Days
Brand **Network Pharmacy** **Costco Pharmacy** **Costco Mail Order**	 $20 $20/$50 $50	 30 Days 30 Days/90 Days 90 Days
Specialty – Navitus Mail Order	$20 copay	30 Days
MENTAL HEALTH/SUBSTANCE ABUSE BENEFITS		
Office Visit/Facility Visit	$20 copay	Billed charges exceeding out-of-network fee schedule[2]
Inpatient Hospital/Facility Fees	10% coinsurance after deductible	Billed charges exceeding out-of-network fee schedule[2]
Inpatient Hospital/Doctor & Other Services	10% coinsurance after deductible	Billed charges exceeding out-of-network fee schedule[2]

[1]Deductibles and out-of-pocket maximums accumulate on a calendar year from January 1st through December 31st.
[2] For services received from an out-of-network provider, the member may be held responsible for any costs beyond the permitted amount and the overall charges.
[3]After deductible
[4] Pharmacy benefits are administered by Navitus Health Solutions.

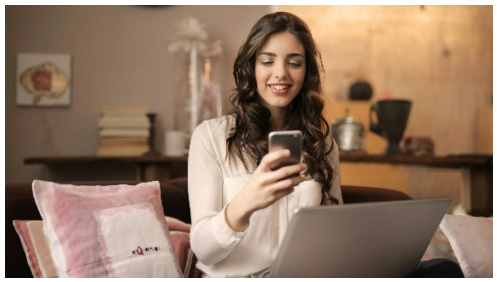
Medical – Kaiser HMO Plan

You always pay the deductible and copayment ($). The coinsurance (%) shows what you pay after the deductible has been met.

	Kaiser HMO
	In-Network
Calendar Year Deductible[1] Individual Family	None
Calendar Year Out-of-Pocket Maximum[1] Individual Family	$1,500 $3,000
Office Visit Primary Care Specialist Telemedicine/Telehealth Visit	$10 copay per visit $10 copay per visit No Charge
Preventive Services	No charge
Chiropractic Coverage is limited to 30 Chiropractic and Acupuncture combined visits per year	$10 copay per visit
Acupuncture Coverage is limited to 30 Chiropractic and Acupuncture combined visits per year	$10 copay per visit
Lab and X-ray	No Charge
Urgent Care	$10 copay per visit
Emergency Room	$100 per visit (copay waived if admitted)
Inpatient Hospitalization	No charge
Outpatient Surgery	$10 copay per visit
KAISER PRESCRIPTION DRUG COVERAGE[4]	**Pay**
Out-of-Pocket Maximum Individual Family	Combined with medical
Generic – Retail/ Mail Order	$10 copay – for up to 100-day supply
Brand – Retail/ Mail Order	$10 copay – for up to 100-day supply
Specialty	$10 copay – for up to 30-day supply
MENTAL HEALTH/SUBSTANCE ABUSE BENEFITS	
Inpatient Psychiatric Hospitalization	No Charge
Individual Outpatient Mental Health Evaluation and Treatment	$10 copay per visit
Group Outpatient Mental Health Treatment	$5 copay per visit
Inpatient Detoxification	No charge

[1]Deductibles and out-of-pocket maximums accumulate on a calendar year from January 1st through December 31st.
[2] For services received from an out-of-network provider, the member may be held responsible for any costs beyond the permitted amount and the overall charges.
[4] Pharmacy benefits are administered by Navitus Health Solutions.

SELF-INSURED SCHOOLS OF CALIFORNIA (SISC) Programs



24/7 HELP WITH PERSONAL CONCERNS

Available for Anthem and Kaiser members.

Access free, confidential resources for help with emotional, marital, financial, addiction, legal, or stress issues.

Visit www.anthemeap.com/sisc.

24/7 PHYSICAN ACCESS-ANYTIME ANYWHERE

MDLive program available to Anthem members.

Access to virtual visits with psychiatrists and therapists for members age 10 and up. Virtual urgent care services are available to all members. Physicians can prescribe medication when appropriate.

Visit mdlive.com/sisc.

Telehealth available to Kaiser members

Next time you have a minor health issue, you have many convenient ways to get care when and where it works for you.

Visit kp.org/telehealth.

EXPERT MEDICAL OPINIONS

Available to Kaiser Members

Get answers to health care questions and second opinions from world-leading experts.

Visit teladoc.com/SISC.

FREE GENERIC MEDICATIONS

Costco program available to Anthem members.

Access most generic medications at no cost through Costco retail and mail order pharmacies. You don't need to be a Costco member.

Visit costco.com.

NAVITUS SPECIALTY MEDICATIONS

Available to Anthem members.

Navitus Specialty helps patients stay on track with treatment while offering the highest standard of compassionate care through personalized support, free delivery and refill reminders. Most medications classified as Specialty can be found on the SISC Drug List located on Navitus' secure member website Navi-Gate at www.navitus.com/members.

PHYSICAL THERAPY FOR BACK OR JOINT PAIN

Hinge Health program available to Anthem members.

Get access to free wearable sensors and monitoring devices, unlimited one-on-one coaching and personalized exercise therapy.

Visit hingehealth.com/sisc.

SELF-INSURED SCHOOLS OF CALIFORNIA (SISC) Programs

24/7 VIRTUAL PRIMARY CARE DOCTOR

Centivo Care is available to Anthem PPO members.

Virtually connect with a primary care physician to manage all your physical and mental healthcare needs. Centivo Care providers diagnose conditions, manage prescriptions, refer to specialists, and answer follow up questions using video visits or live chat.

24/7 ACCESS TO VIRTUAL MATERNITY AND POSTPARTUM SUPPORT

Maven program available to Anthem PPO members.

Consult with a care advocate who connects you with trustworthy content delivered by doctors, specialists' coaches and other maternity providers to help deal with pregnancy and postpartum concerns.

Visit mavenclinic.com/join/SISC.

HIP, KNEE, AND SPINE BENEFIT

Carrum Health program available to Anthem PPO members.

Consult top-quality surgeons on hip and knee replacements and certain spine surgeries. Benefit covers all related travel and medical bills.

Visit carrumhealth.com.

ENHANCED CANCER BENEFIT

Lantern Cancer Care available to Anthem PPO members.

Consult experts on initial diagnosis and development of a care plan. Benefit includes care coordination services with at home provider, transportation, and more.

Visit https://lanterncare.com/.

VALUE-BASED SITE OF CARE BENEFIT

Applicable to Anthem PPO members.

Hospitals and Ambulatory Surgery Centers (ASCs)

PPO plans limit the maximum benefit amount at an in-network outpatient hospital facility for the following five procedures:

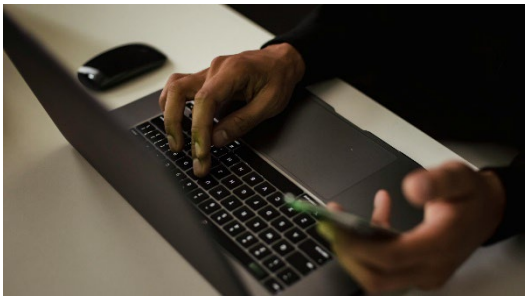
- Arthroscopy
- Cataract Surgery
- Colonoscopy
- Upper GI Endoscopy with Biopsy
- Upper GI Endoscopy without Biopsy

NOTE: The value-based site of care benefit applies to facility fees only. The fees paid to physicians and any other practitioners who assist in the procedure, such as anesthesiologists or radiologists, are not affected.

If you use an in-network outpatient hospital facility, you will be responsible for the regular deductible and coinsurance PLUS any amount by which the hospital charge exceeds the maximum benefit. If you use an in-network ASC, you will only be responsible for the regular deductible and coinsurance.

The benefit includes an exemption process. To learn more call member services.

ANTHEM RESOURCES



HEALTH ASSESSMENT

Complete your health assessment to receive your personalized report. Know what's going well and if there are any at-risk areas you need to work on to improve your health. Complete your health assessment by logging in to Anthem at anthem.com/ca

Autism Spectrum Disorder Program with Applied Behavioral Analysis

Receive support for a covered family member with an autism spectrum disorder. You'll have support from a licensed behavior analyst to help you navigate the health care system and address your unique family challenges. With a whole-family focus, we work with you to create a strong system of care and help you understand and access available care.

Building Healthy Families

Building Healthy Families offers personalized, digital support through the Sydney℠ Health mobile app or on anthem.com/ca. This all-in-one program, at no extra cost to you, can help your family grow strong whether you're trying to conceive, expecting a child, or in the thick of raising young children.

My Family Health Record

Access your health data, including health history and electronic medical records, all in one place. It's accessible through the More menu. You can track, store and share your personalized health information with doctors and other health providers right from your smartphone, computer or other mobile device. Be ready for your next appointment with myFHR.

ConditionCare

Receive one-on-one support from a health care professional for a chronic condition, like asthma or diabetes, to help you reach your health goals. Based on claims and data insights, you may get a call from us to see if ConditionCare is a good fit for your needs. For more information or to self-enroll, you can reach out to us by calling the number on the back of your member ID card.

KAISER RESOURCES

My Health Manager

Stay engaged with your health and simplify your busy life by using the Kaiser Permanente Website.

Kaiser Away From Home

Kaiser Members are covered for emergency and urgent care anywhere in the world. Whether you're traveling in the United States or a foreign country, Kaiser's travel website will explain what to do if you need emergency or urgent care during your trip.

myStrength

myStrength is designed to help navigate life's challenges, make positive changes, and support your overall well-being. The app can help you set goals and work towards them in the ways that work best for you. You can get myStrength at kp.org/selfcareapps and choose the mental health and wellness areas you want to focus on.

Calm

Try the Calm app for self-care and better sleep. Calm is an app that usese meditation and mindfulness to help lower stress, reduce, anxiety, and improve sleep quality. Adult members can get Calm at kp.org/selfcareapps .

ClassPass

Kaiser has teamed up with fitness industry leader ClassPass to make it easier for you to exercise from the comfort of your home or local gym/studio. Kaiser Permanente members can get on demand video workouts at no cost and reduced rates on livestream and in-person fitness classes. To get started, visit kp.org/exercise.

Mental Health

Members can get help with depression, anxiety, addiction, and mental or emotional health – without a referral for mental health care within Kaiser Permanente. To get stared, visit kp.org/mentalhealth

Away From Home Travel

No matter where life takes you, Kaiser Permanente has you covered. If something unexpected happens while you're away from home, it's easier than ever to get care. To get stared, visit kp.org/travel.

PRESCRIPTIONS BREAKING YOUR BUDGET?

Click to play video

THE FORMULARY DRUG TIERS DETERMINE YOUR COST

$	Generic Drug
$$	Brand Name Drug
$$$	Specialty Drug

Understanding the formulary can save you money

If your doctor prescribes medicine, especially for an ongoing condition, don't forget to check your health plan's drug formulary. It's a powerful tool that can help you make informed decisions about your medication options and identify the lowest cost selection.

What is a formulary?

A drug formulary is a list of prescription drugs covered by your medical plan. Most prescription drug formularies separate the medications they cover into four or five drug categories, or "tiers." These groupings range from least expensive to most expensive cost to you. "Preferred" drugs generally cost you less than "non-preferred" drugs.

- Link to Navitus Portal: HERE
- Link to Kaiser Formulary HERE

Get the most from your coverage

To get the most out of your prescription drug coverage, note where your prescriptions fall within your plan's drug formulary tiers and ask your doctor for advice. Generic drugs are usually the lowest cost option. Generics are required by the Food and Drug Administration (FDA) to perform the same as brand-name drug equivalents.

To find out if a drug is on your plan's formulary, visit the plan's website or call the customer service number on your ID card.

Medication Search

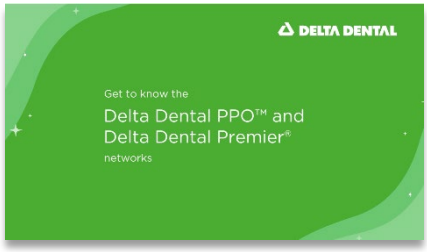
- Anthem HMO & PPO Plans: If you have any formulary questions, please call Navitus at (866) 333-2757 for support.
- Kaiser HMO Plan: If you have any formulary questions, please call (800) 464-4000 for support.

DENTAL

OUR PLAN

Delta Dental PPO

Click to play video



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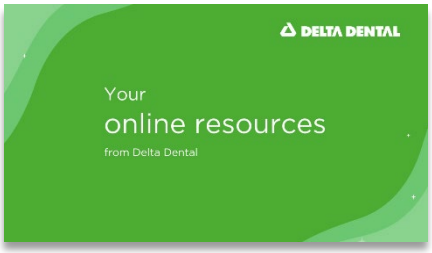


It's important to go to the dentist regularly. Brushing and flossing are great, but regular exams catch dental issues early before they become more expensive and difficult to treat.

That's where dental insurance comes in. Dental insurance makes it easier and less expensive to get the care you need to maintain good oral health.

Dental insurance covers four types of treatments:

- **Preventive** care includes exams, cleanings and x-rays
- **Basic** care focuses on repair and restoration with services such as fillings, root canals, and gum disease treatment
- **Major** care goes further than basic and includes bridges, crowns and dentures
- **Orthodontia** treatment to properly align teeth within the mouth.

Visit deltadentalins.com or call (800) 765-6003 for more information.

Dental – DELTA DENTAL PPO

You always pay the deductible for Premier and out-of-network services. We strongly recommend you ask your dentist for a predetermination if total charges are expected to exceed $300. Predetermination enables you and your dentist to know in advance what the payment will be for any service that may be in question.

	DELTA DENTAL PPO		
	In-Network (PPO)	**Premier**	**Out of Network**
Annual Deductible Individual Family	None	$50 $150	$50 $150
Annual Plan Maximum	$1,500	$1,500	$1,500
Diagnostic & Preventive	No charge	No charge	Any amount above Reasonable and Customary (R&C) expenses
Basic Services Fillings Root Canals Periodontics	No charge	No charge	Any amount above Reasonable and Customary (R&C) expenses
Major Services	No charge	No charge	Any amount above Reasonable and Customary (R&C) expenses
Orthodontia Adults Children (up to age 26)	No charge	No charge	Any amount above Reasonable and Customary (R&C) expenses
Ortho Lifetime Max	$1,000	$1,000	$1,000

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

What you need to know about this plan

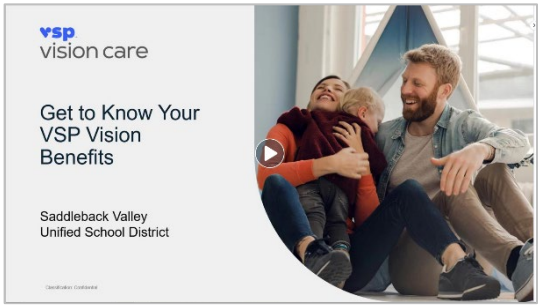
Features:	See any provider, but you'll pay more out of network
Am I restricted to in-network providers?	No
Do I have to select a primary dentist?	No
Can I use my Health FSA?	If you participate in a healthcare FSA, you can use your account to pay for dental expenses.
Where can I get more details?	Go to deltadentalins.com or call (800) 765-6003 to find an in-network provider. Download the Delta Dental app on the App Store or Google Play to access your plan information 247 from your mobile device.

VISION

OUR PLAN

VSP Signature PPO Vision

Click to play video



Vision coverage helps with the cost of eyeglasses or contacts. But even if you don't need vision correction, an annual eye exam checks the health of your eyes and can even detect more serious health issues such as diabetes, high blood pressure, high cholesterol, and thyroid disease.

You'll even find discounts on services like LASIK and PRK, rebates on contact lenses, and money off on hearing aids and other related services. Visit the plan's website to check out these extra savings.

Go to vsp.com or call (800) 877-7195 for more details.

Vision – VSP

Your vision checkup is fully covered after your Exam copay. After any Materials copay, the plan covers frames, lenses, and contacts as described below.

	VSP
	In-Network
Exams WellVision exam & glasses Frequency	 $25 copay Once every 12 months
Eyeglass Lenses Single vision, lined bifocal, lined trifocal lenses Frequency	 Combined with exam Once every 12 months
Frames Benefit Frequency	 $180 allowance for wide selection of frames $200 allowance for featured frame brands 20% savings on the amount over your allowance $100 Costco frame allowance Once every 24 months
Lens Enhancements Standard progressive lenses Premium progressive lenses Custom progressive lenses Tints/Light-reactive lenses Frequency	 $0 $80-$90 $120-$160 $0 Once every 12 months
Contacts (in addition to glasses) Annual supply of contacts Contact lens exam (fitting and evaluation) Frequency	 $50 copay Once every 12 months

What you need to know about this plan

What other services are covered?

The plan can also help you save money on LASIK procedures, sunglasses, computer glasses, and even hearing aids.

Eyeglasses are expensive. Will I still be able to afford them, even with insurance?

Look for moderately priced frames and remember that your benefit is higher in-network. If you participate in a healthcare FSA, you can use your account to pay for vision care and eyewear with tax-free dollars.

Where can I get more details?

Go to vsp.com or call (800) 877-7195 to find an in-network provider.

Important note

You are enrolled with VSP using your employee PIN in the same format as a SSN. Example: if your PIN is 12345, then your SSN would be 000-01-2345.

EMPLOYEE ASSISTANCE PROGRAM (EAP)

CONTACT THE EAP

Phone
Anthem: (800) 999-7222

Website
Anthem: anthemeap.com/sisc

Help for you and your household members

There are times when everyone needs a little help or advice, or assistance with a serious concern. The EAP through Anthem can help you handle a wide variety of personal issue such as emotional health and substance abuse; parenting and childcare needs; financial coaching; legal consultation; and eldercare resources.

Best of all, contacting the EAP is completely confidential, free and available to any member of your immediate household.

No cost EAP resources

The EAP is available around the clock to ensure you get access to the resources you need:

- Unlimited phone access 24/7
- In-person or video counseling for short-term issues; up to 6 visits per issue
- Unlimited web access to helpful articles, resources, and self-assessment tools

COUNSELING BENEFITS

- Difficulty with relationship
- Emotional distress
- Job stress
- Communication/ conflict issues
- Alcohol or drug problems
- Loss and death

PARENTING & CHILDCARE

- Referrals to quality providers
- Family day care homes
- Infant centers and preschools
- Before/after school care
- 24-hour care

FINANCIAL COACHING

- Money management
- Debt management
- Identity theft resolution
- Tax issues

LEGAL CONSULTATION

- Referral to a local attorney
- Family issues (marital, child custody, adoption)
- Estate planning
- Landlord/tenant
- Immigration
- Personal Injury
- Consumer protection
- Real estate
- Bankruptcy

ELDERCARE RESOURCES

- Help with finding appropriate resources to care for an elderly or disabled relative

ONLINE RESOURCES

- Self-help tools to enhance resilience and well-being
- Useful information and links to various services and topics

DISTRICT PROVIDED LIFE AND AD&D INSURANCE

A NOTE ABOUT TAXES

Company-provided life insurance coverage over $50,000 is considered a taxable benefit. The value of the benefit over $50,000 will be reported as taxable income on your annual W-2 form.

YOUR BENEFICIARY = WHO GETS PAID

If the worst happens, your beneficiary—the person (or people) on record with the life insurance carrier—receives the benefit. Make sure that you name at least one beneficiary for your life insurance benefit, and change your beneficiary as needed if your situation changes.

Basic Life and AD&D

Basic Life Insurance pays your beneficiary a lump sum if you die. AD&D (Accidental Death & Dismemberment) coverage provides a benefit to you if you suffer from loss of a limb, speech, sight, or hearing, or to your beneficiary if you have a fatal accident. Coverage is provided by Voya and premiums are paid in full by SVUSD.

Employees (Life and AD&D)

Age	Coverage
Under 30	$150,000
30-34	$137,500
35-39	$125,500
40-44	$100,000
45-49	$87,500
50-54	$62,500
55-59	$43,750
60-64	$24,000
65-69	$15,500
70-74	$10,500
75-79	$7,000
80 and over	$5,000

Child Dependents (Life only)

Age	Coverage
Under 6 months	$200
6 months and older	$2,000

Spouse (Life only)

Spouse	Coverage
	$2,000

VOLUNTARY PLANS

OUR VOLUNTARY PLANS

Supplemental Life Insurance

Universal Life with Long Term Care

Healthcare Flexible Spending Account (FSA)

Dependent Care Flexible Spending Account (DCFSA)

Disability Insurance

Accident

Cancer

Critical Illness

Hospital Stay

You're unique—and so are your benefit needs

Voluntary benefits are optional coverages that help you customize your benefits package to your individual needs.

SVUSD offers plans to help:

- replace income if you're injured or ill
- bridge the gap for special healthcare needs

You pay the entire cost for these plans. And you get the added convenience of paying through payroll deduction.

Voluntary benefits are just that: voluntary. You have the freedom and flexibility to choose the benefits that make sense for you and your family. Or, you don't have to sign up for voluntary benefits at all. The choice is yours.

LIFE INSURANCE

VOYA GUARANTEED ISSUE

If you purchase life insurance coverage above a certain limit (the "guaranteed issue" amount) or after your initial eligibility period, you will need to submit Evidence of Insurability with additional information about your health in order for the insurance company to approve the amount of coverage.

Protecting those you leave behind

Voluntary Life Insurance allows you to purchase additional life insurance to protect your family's financial security. Coverage is provided by Voya and available for your spouse and or child(ren).

Voya Supplemental Life

Employee	Increments of $10,000 up to $500,000, not to exceed 5x your annual salary **Guaranteed Issue:** $200,000 or 5x your annual salary, whichever is less if you are newly eligible.
Spouse	Increments of $10,000 up to $500,000, may not exceed 100% of your employee election **Guaranteed Issue:** $50,000if you are newly eligible.
Child(ren)	Coverage levels of $2,500, $5,000 or $10,000 **Guarantee Issue:** Up to $10,000

Note: Benefit amount reduces to 65% at age 65, 50% at age 70 and 30% at age 75.

Evidence of Insurability (EOI)

If you elect Voluntary Life coverage above guaranteed issue (noted on this page), or if you are a late entrant (enrolling more than 31 days after the date you become eligible), you must complete and submit EOI. You can find the form on Saddleport on the Benefits tab in the Benefits Forms folder.

Trustmark Universal Life with Long Term Care

Permanent Life Insurance offers protection beyond an individual's working years, especially for your lifetime. Some advantages of owning a permanent life policy are a guaranteed death benefit, a guaranteed premium rate that will never increase, and other living benefit options. This plan is portable, which means you can take it with you if you change jobs or retire.

Trustmark Universal Life with Long Term Care

Benefit Amount	Up to $300,000 for employees and spouses, you may purchase coverage for your children. Some health questions may be required.
Universal LifeEvents Option	Available in lieu of traditional Universe Life to employees under age 64. This option pays a higher death benefit during your working years when expenses are high. At age 70, when financial needs are typically lower, the death benefit reduces to one third the original amount.
Employee Contribution	100% employee paid

HEALTHCARE FLEXIBLE SPENDING ACCOUNT (FSA)

ARE YOU ELIGIBLE?

You don't have to enroll in one of our medical plans to participate in the healthcare FSA.

Find out more

- WEXinc.com
- WEX Phone: (866)-451-3399
- FSA Video
- Eligible Expenses– now include more over-the-counter items!
- Ineligible Expenses

CARRYOVER PROVISION FOR FSA

FSAs offer sizable tax advantages. Therefore, these accounts are subject to strict IRS regulations, including the use-it-or-lose-it rule. According to this rule, up to $660 of any unspent funds remaining in your account at the end of the plan year will carry-over to the next plan year, and unspent funds above $660 will be forfeited. We encourage you to plan ahead to make the most of your FSA dollars. If you are unable to estimate your health care and dependent care expenses accurately, it is better to be conservative and underestimate rather than overestimate your expenses.

Set aside healthcare dollars for the coming year

A healthcare FSA allows you to set aside tax-free money to pay for healthcare expenses you expect to have over the coming year. This program is administered through WEX.

How the HFSA works

- You estimate what you and your family's out-of-pocket costs will be for the coming year. Think about what out-of-pocket costs you expect to have for eligible expenses such as office visits, surgery, dental and vision expenses, prescriptions, even eligible drugstore items.
- You can contribute up to the $3,300 annual limit. Contributions are deducted from your pay pre-tax, meaning no federal or state tax on that amount.
- During the year, you can use your WEX debit card to pay for services and products. Withdrawals are tax-free as long as they're for eligible healthcare expenses.
- Expenses must be **incurred between 10/01/2025 (or benefits start date if later) and 9/30/2026**, employment termination date, or you change to an ineligible status, whichever comes first.
- Claims must be submitted for reimbursement **no later than 12/29/2026 or 90 days** from date of termination, or move to an ineligible status, whichever comes first.
- If you don't spend all the money in your account, you can rollover up to $660 to use the following year. Any additional remaining balance will be forfeited.
- Elections cannot be changed during the plan year, unless you experience a qualifying event.
- You must re-enroll in this program each year.

FSA TAX SAVINGS EXAMPLE (SINGLE FILERS)

$60,000 Annual Pay, with $1,500 FSA Contribution

$330 22% Federal income tax	**$115** 7.65% FICA tax	**$445** Annual FSA tax savings

$120,000 Annual Pay, with $2,850 FSA Contribution

$684 24% Federal income tax	**$219** 7.65% FICA tax	**$903** Annual FSA tax savings

Your tax savings may vary depending on tax filing status and other variables

PAYING FOR DAYCARE? MAKE IT TAX-FREE!

EVERY OPPORTUNITY TO SAVE

The biggest deduction from your paycheck is likely federal income tax. Why not take a bite out of taxes while paying for necessary expenses with tax-free dollars?

IMPORTANT NOTE

The dependent Care Spending Account maximum annual contribution limit for 2025 is $5,000 per household, or $2,500 if married, filing separately for the short plan year.

Expenses must be **incurred between 10/01/2025 (or benefits start date if later) and 9/30/2026**, employment termination date, or you change to an ineligible status, whichever comes first.

Claims must be submitted for reimbursement **no later than 12/29/2026 or 90** days from date of termination, or move to an ineligible status, whichever comes first.

You must re-enroll in this program each year.

Dependent Care FSA—up to $5,000 per year tax-free

A dependent care Flexible Spending Account (FSA) can help families save potentially hundreds of dollars per year on day care. This program is administered by WEX.

Here's how the Dependent Care FSA works

You set aside money from your paycheck, before taxes, to pay for work-related day care expenses. Eligible expenses include not only childcare, but also before and after school care programs, preschool, and summer day camp for children under age 13. The account can also be used for day care for a spouse or other adult dependent who lives with you and is physically or mentally incapable of self-care.

You can set aside up to $5,000 per household per year. If you are married but filing separately, federal regulations limit the use of Dependent Care FSA to $2,500 for the short plan year. You can pay your dependent care provider directly from your FSA account, or you can submit claims to get reimbursed for eligible dependent care expenses you pay out of pocket.

Estimate carefully! You can't change your FSA election amount mid-year unless you experience a qualifying event. Money contributed to a dependent care FSA must be used for expenses incurred during the same plan year. Unspent funds will be forfeited.

Recurring Dependent Care Form

This Recurring Dependent Care form can be completed if you want to receive recurring reimbursement of dependent care expenses. It makes claim filing simple as you only need to submit the form once in order to get reimbursed each pay period. Documentation must be retained for your records and provided to WEX when requested to do so (if a receipt is unavailable, a signature from the provider is sufficient). If any information on this request form changes during the plan year, you must submit an updated Recurring Dependent Care Request Form.

Find out more

- Dependent Care FSA Video
- Visit WEXinc.com or call (866) 451-3399

TRUSTMARK DISABILITY INSURANCE

EXPECT THE UNEXPECTED

Most people underestimate the likelihood of being disabled at some point in their life. Disability insurance replaces part of your pay while you are unable to work so you have a continuing income for living expenses.

SUBMITTING A CLAIM

If you are disabled due to an illness or accidental injury, unable to work, and under the care of a licensed physician, you are eligible to submit a claim for benefits under this plan. As long as you remain disabled and meet the plan's disability requirements, you will continue to receive a percentage of your earnings until benefits are no longer payable.

Contact Trustmark at (508) 853-2757

Trustmark disability insurance replaces part of your income for limited duration issues such as:

- Pregnancy issues (10 months after effective date)
- Complications with pregnancy
- Non-occupational sickness
- Non-occupational injury

You pay the cost of this coverage. Coverage is provided by Trustmark.

The plan provides for up to a 25% base earnings benefit. There is a pre-existing condition limitation on the plan of 12/12 months. This means that if you become disabled because of a pre-existing condition that occurred 12 months prior to the plan's effective date, the disability is not covered until you have been fully insured for 12 months. A disability due to pregnancy is covered the same as any other sickness when it begins 10 months after the effective date of the plan.

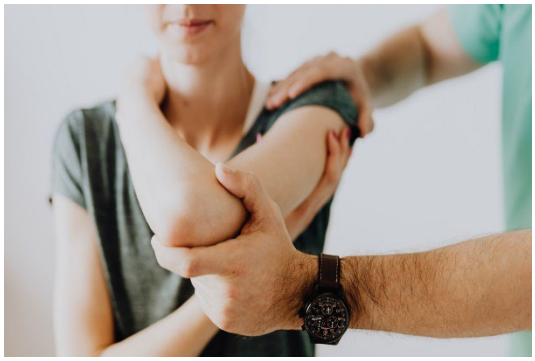
There are two plan options. You may enroll in both plan options for more comprehensive disability coverage.

- Elimination period of 14 days for an accident/sickness, benefit period is up to 3 months (Short Term Disability)
- Elimination period of 90 days for an accident/sickness, benefit period is up to 24 months (Long Term Disability)

Additional advantages

- Benefits paid in full, at the same frequency as your paycheck, regardless of other coverage. (A monthly payment option is available.)
- Coverage for time off of work due to pregnancy/childbirth 10 months after the coverage effective date, or due to complications of pregnancy.
- Waive your premium payments if you remain disabled for more than 90 consecutive days during the benefit period.
- Keep your coverage at the same price and benefits if you change jobs or retire. Coverage ends at age 72.

TRUSTMARK VOLUNTARY HEALTH-RELATED PLANS



THINGS TO CONSIDER

Your medical plan helps cover the cost of illness, but a serious or long-lasting medical crisis often involves additional expenses and may affect your ability to bring home a full paycheck. These plans provide you with resources to help you get by while there are additional strains on your finances.

Accident Insurance

Accident Insurance from Trustmark helps you pay for unexpected costs that can add up due to common injuries such as fractures, dislocations, burns, emergency room or urgent care visits, and physical therapy. If you or a covered family member has an accident, this plan pays a lump-sum, tax-free benefit. The amount of money depends on the type and severity of your injury and can be used any way you choose.

Cancer Insurance

Many people are concerned about the financial impact of a cancer diagnosis. Cancer insurance provides tax-free benefits for many of the costs associated with cancer treatment such as radiation, chemo, surgery, diagnostic tests, and physician charges. You can cover yourself and your family members if needed. Trustmark provides coverage for this program.

Critical Illness Insurance

Critical illness insurance from Trustmark can help fill a financial gap if you experience a serious illness such as cancer, heart attack or stroke. Upon diagnosis of a covered illness, a lump-sum, tax-free benefit is immediately paid to you. Use it to help cover medical costs, transportation, childcare, lost income, or any other need following a critical illness. You choose a benefit amount that fits your paycheck and can cover yourself and your family members if needed.

Hospital Stay Pay Indemnity Insurance

Hospital stay pay indemnity insurance from Trustmark can enhance your current medical coverage. The plan pays a lump sum, tax-free benefit when you or an enrolled dependent is admitted or confined to the hospital for covered accidents and illnesses. You can use the money you receive under the plan however you see fit, for paying medical bills, childcare, or for regular living expenses like groceries—you decide.

FSA-WEX RESOURCES

SAVE YOUR RECEIPTS

We recommend saving itemized receipts and EOBs for tax purposes. If you are enrolled in the HSA or FSA plan, you are responsible for reporting your contributions and distributions at tax time.

WEX MOBILE APP

- Check your balance and view account activity
- File a claim and upload documentation in seconds
- Report a card lost or stolen

Contact WEX at (866) 451-3399

How to set up and manage your account online

WEX will make it easy for you to manage your FSA with an online account through wexinc.com, free benefits mobile app as well as text and email alerts.

Features of WEXinc.com:

- Interactive FSA savings calculator - visit the Benefits Toolkit in the Insights tab
- Eligible expense list - visit the Benefits Toolkit in the Insights tab
- Manage account
- Educational tools

How to set up your online account:

1. Visit wexinc.com
2. Select Login > Benefit Accounts
3. Then select HSA,FSA, Wellness & Commuter
4. If this is your first time logging in, select New User and fill out the required information

Your WEX FSA debit card

You will receive two Debit Cards in your name **upon your initial enrollment** in the FSA, or when it expires; mailed directly to your home address. You can request additional cards for your spouse or registered domestic partner, or eligible adult children within your WEX Online Account. The Debit cards come ready to use, no activation is needed.

You can use the debit card to pay for eligible services and products. When you use the debit card, payments are automatically withdrawn from your FSA, resulting in fewer out-of-pocket costs for you.

How to file a claim if you pay out-of-pocket

If you choose to pay for your FSA eligible expenses out-of-pocket, you can file for a reimbursement.

- Log into your online account or use your mobile app to request a payment be sent directly to your provider or to you. The pay to provider option in only available by accessing your account online or mobile app.
- Don’t forget about direct deposit! You can set up direct deposit online and allow WEX to deposit reimbursements in your bank account!

PLAN CONTACTS

If you need to reach our plan providers, here is their contact information:

Plan Type	Provider	Phone Number	Website/Email
Medical	Anthem HMO & PPO Plans	(800) 825-5541	www. anthem.com/ca/sisc
	Navitus Health Solutions (Rx) – Anthem Members Only	(866) 333-2757 – Active EEs (866) 270 – 3877 – Medicare Supplement Enrollee	www.navitus.com
MDLive Online – Anthem Members Only	MDLive Online	(800) 657-6169	https://members.mdlive.com/sisc
Medical	Kaiser HMO	(888) 956-1616 – Active EEs (800) 443-0815 – Medicare Supplement Enrollee	https://my.kp.org/sisc/
	Kaiser (Rx)	(800) 464-4000	kp.org/pharmacy
Dental	Delta Dental PPO	(800) 765-6003	deltadentalins.com
Vision	VSP Signature Vision PPO	(800) 877-7195	vsp.com
EAP	Anthem Employee Assistance Program	(800) 999-7222	https://www.anthemeap.com/sisc
Life Insurance Benefits	Voya Basic Life & AD&D Insurance	(800) 955-7736	voya.com
Voluntary Benefits	Trustmark Customer Team	(800) 918-8877, Option 6	N/A
Voluntary Benefits Claims Customer Services	Trustmark	(877) 201-9373	trustmarksolutions.com/individual/file-claim
Voluntary Accident Insurance Claim Services	Trustmark	Fax: (508) 471-3208	riderclaims@trustmarkins.com
Voluntary Critical Illness w/ Cancer Claim Services	Trustmark	Fax: (508) 853-2757	Vbs_disability@trustmarkins.com
Voluntary Hospital StayPay	Trustmark	(508) 853-2867	hospitalclaimsvb@trustmarkbenefits.com
Voluntary Life Claim Services	Trustmark	(508) 853-0310	lifeclaims@trustmarkins.com
Voluntary Disability Claims Services	Trustmark	(508) 853-2757	Vbs_disability@trustmarkins.com
FSA	WEX	(866) 451-3399	wexinc.com

GLOSSARY

-A-

AD&D Insurance
An insurance plan that pays a benefit to you or your beneficiary if you suffer from loss of a limb, speech, sight, or hearing, or if you have a fatal accident.

Allowed Amount
The maximum amount your plan will pay for a covered healthcare service.

Ambulatory Surgery Center (ASC)
A healthcare facility that specializes in same-day surgical procedures such as cataracts, colonoscopies, upper GI endoscopy, orthopedic surgery, and more.

Annual Limit
A cap on the benefits your plan will pay in a year. Limits may be placed on particular services such as prescriptions or hospitalizations. Annual limits may be placed on the dollar amount of covered services or on the number of visits that will be covered for a particular service.
After an annual limit is reached, you must pay all associated health care costs for the rest of the plan year.

-B-

Balance Billing
In-network providers are not allowed to bill you for more than the plan's allowable charge, but out-of-network providers are. This is called balance billing. For example, if the provider's fee is $100 but the plan's allowable charge is only $70, an out-of-network provider may bill YOU for the $30 difference (the balance).

Beneficiary
The person (or persons) that you name to be paid a benefit should you die. Beneficiaries are requested for life, AD&D, and retirement plans. You must name your beneficiary in advance.

Brand Name Drug
A drug sold under its trademarked name. For example, Lipitor is the brand name of a common cholesterol medicine.

-C-

COBRA
A federal law that may allow you to temporarily continue healthcare coverage after your employment ends, based on certain qualifying events. If you elect COBRA (Consolidated Omnibus Budget Reconciliation Act) coverage, you pay 100% of the premiums, including any share your employer used to pay, plus a small administrative fee.

Claim
A request for payment that you or your health care provider submits to your healthcare plan after you receive services that may be covered.

Coinsurance
Your share of the cost of a healthcare visit or service. Coinsurance is expressed as a percentage and always adds up to 100%. For example, if the plan pays 70%, your coinsurance responsibility is 30% of the cost. If your plan has a deductible, you pay 100% of the cost until you meet your deductible amount.

Copayment
A flat fee you pay for some healthcare services, for example, a doctor's office visit. You pay the copayment (sometimes called a copay) at the time you receive care. In most cases, copays do not count toward the deductible.

-D-

Deductible
The amount of healthcare expenses you have to pay for with your own money before your health plan will pay. The deductible does not apply to preventive care and certain other services.

Family coverage may have an ***aggregate*** or ***embedded*** deductible. Aggregate means your family must meet the entire family deductible before any individual expenses are covered. Embedded means the plan begins to make payments for an individual member as soon as they reach their individual deductible.

Dental Basic Services
Services such as fillings, routine extractions and some oral surgery procedures.

Dental Diagnostic & Preventive Generally includes routine cleanings, oral exams, x-rays, and fluoride treatments.
Most plans limit preventive exams and cleanings to two times a year.

Dental Major Services
Complex or restorative dental work such as crowns, bridges, dentures, inlays and onlays.

Dependent Care Flexible Spending Account (FSA)
An arrangement through your employer that lets you pay for eligible child and elder care expenses with tax-free dollars. Eligible expenses include day care, before and after-school programs, preschool, and summer day camp for children underage 13. Also included is care for a spouse or other dependent who lives with you and is physically incapable of self-care.

-E-

Eligible Expense
A service or product that is covered by your plan. Your plan will not cover any of the cost if the expense is not eligible.
Excluded Service
A service that your health plan doesn't pay for or cover.

-F-

Formulary
A list of prescription drugs covered by your medical plan or prescription drug plan. Also called a drug list.

-G-

Generic Drug
A drug that has the same active ingredients as a brand name drug but is sold under a different name. For example, Atorvastatin is the generic name for medicines with the same formula as Lipitor.

Grandfathered
A medical plan that is exempt from certain provisions of the Affordable Care Act (ACA).

-H-

Health Reimbursement Account (HRA) An account funded by an employer that reimburses employees, tax-free, for qualified medical expenses up to a maximum amount per year. Sometimes called Health Reimbursement Arrangements.

Healthcare Flexible Spending Account (FSA)
A health account through your employer that lets you pay for many out-of-pocket medical expenses with tax-free dollars. Eligible expenses include insurance copayments and deductibles, qualified prescription drugs, insulin, and medical devices, and some over-the-counter items.

GLOSSARY

-I-

In-Network
In-network providers and services contract with your healthcare plan and will usually be the lowest cost option. Check your plan's website to find doctors, hospitals, labs, and pharmacies. Out-of-network services will cost more or may not be covered.

-L-

Life Insurance
An insurance plan that pays your beneficiary a lump sum if you die.

Long Term Disability Insurance
Insurance that replaces a portion of your income if you are unable to work due to a debilitating illness, serious injury, or mental disorder. Long term disability generally starts after a 90-day waiting period.

-M-

Mail Order
A feature of a medical or prescription drug plan where medicines you take routinely can be delivered by mail in a 90-day supply.

-O-

Open Enrollment
The time of year when you can change the benefit plans you are enrolled in and the dependents you cover. Open enrollment is held one time each year. Outside of open enrollment, you can only make changes if you have certain events in your life, like getting married or adding a new baby or child in the family.

Out-of-Network
Out-of-network providers (doctors, hospitals, labs, etc.) cost you more because they are not contracted with your plan and are not obligated to limit their maximum fees. Some plans, such as HMOs and EPOs, do not cover out-of- network services at all.

Out-of-Pocket Cost
A healthcare expense you are responsible for paying with your own money, whether from your bank account, credit card, or from a health account such as an HSA, FSA or HRA.

Out-of-Pocket Maximum
Protects you from big medical bills. Once costs "out of your own pocket" reach this amount, the plan pays 100% of most remaining eligible expenses for the rest of the plan year.

Family coverage may have an *aggregate* or *embedded* maximum. Aggregate means your family must meet the entire family out-of-pocket maximum before the plan pays 100% for any member. Embedded means the plan will cover 100% for an individual member as soon as they reach their individual maximum.

Outpatient Care
Care from a hospital that doesn't require you to stay overnight.

-P-

Participating Pharmacy
A pharmacy that contracts with your medical or drug plan and will usually result in the lowest cost for prescription medications.

Plan Year
A 12-month period of benefits coverage. The 12-month period may or may not be the same as the calendar year.

Preferred Drug
Each health plan has a preferred drug list that includes prescription medicines based on an evaluation of effectiveness and cost. Another name for this list is a "formulary." The plan may charge more for non-preferred drugs or for brand name drugs that have generic versions. Drugs that are not on the preferred drug list may not be covered.

Preventive Care Services
Routine healthcare visits that may include screenings, tests, check-ups, immunizations, and patient counseling to prevent illnesses, disease, or other health problems. Many preventive care services are fully covered. Check with your health plan in advance if you have questions about whether a preventive service is covered.

Primary Care Provider (PCP)
The main doctor you consult for healthcare issues. Some medical plans require members to name a specific doctor as their PCP and require care and referrals to be directed or approved by that provider.

-S-

Short Term Disability Insurance
Insurance that replaces a portion of your income if you are temporarily unable to work due to surgery and recovery time, a prolonged illness or injury, or pregnancy issues and childbirth recovery.

-T-

Telehealth / Telemedicine / Teledoc
A virtual visit to a doctor using video chat on a computer, tablet or smartphone. Telehealth visits can be used for many common, non-serious illnesses and injuries and are available 24/7. Many health plans and medical groups provide telehealth services at no cost or for much less than an office visit.

-U-

UCR (Usual, Customary, and Reasonable)
The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service. The UCR amount sometimes is used to determine the allowed amount.

Urgent Care
Care for an illness, injury or condition serious enough that care is needed right away, but not so severe it requires emergency room care. Treatment at an urgent care center generally costs much less than an emergency room visit.

-V-

Vaccinations
Treatment to prevent common illnesses such as flu, pneumonia, measles, polio, meningitis, shingles, and other diseases. Also called immunizations.

Voluntary Benefit
An optional benefit plan offered by your employer for which you pay the entire premium, usually through payroll deduction.

IMPORTANT PLAN INFORMATION

HEALTH PLAN NOTICES

These notices must be provided to plan participants on an annual basis and are available in the Annual Notices document.

- **Medicare Part D Notice:** Describes options to access prescription drug coverage for Medicare eligible individuals
- **Women's Health and Cancer Rights Act:** Describes benefits available to those that will or have undergone a mastectomy
- **Newborns' and Mothers' Health Protection Act:** Describes the rights of mother and newborn to stay in the hospital 48-96 hours after delivery
- **HIPAA Notice of Special Enrollment Rights:** Describes when you can enroll yourself and/or dependents in health coverage outside of open enrollment
- **HIPAA Notice of Privacy Practices:** Describes how health information about you may be used and disclosed
- **Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP):** Describes availability of premium assistance for Medicaid eligible dependents.
- **Notice of Choice of Providers:** Notifies you that your plan requires you to name a Primary Care Physician (PCP) or provides for you to select one

COBRA CONTINUATION COVERAGE

You and/or your dependents may have the right to continue coverage after you lose eligibility under the terms of our health plan. Upon enrollment, you and your dependents receive a COBRA Initial Notice that outlines the circumstances under which continued coverage is available and your obligations to notify the plan when you or your dependents experience a qualifying event. Please review this notice carefully to make sure you understand your rights and obligations.

DEADLINE FOR FILING LAWSUIT UNDER ERISA AFTER EXHAUSTION OF ALL CLAIMS PROCEDURES

Any lawsuit must be filed within 36 months of the final decision on the claim. Exhaustion of all claims and appeals procedure is required prior to filing suit. Please refer to the WRAP Summary Plan Description for the plan specific statute of limitations.

PLAN DOCUMENTS

Important documents for our health plan and retirement plan are available in the Annual Notices document. Paper copies of these documents and notices are available if requested. If you would like a paper copy, please contact the Plan Administrator.

SUMMARY PLAN DESCRIPTIONS (SPD)

The legal document for describing benefits provided under the plan as well as plan rights and obligations to participants and beneficiaries.

- ANTHEM VIVITY HMO
- ANTHEM SELECT HMO
- ANTHEM CA CARE HMO
- ANTHEM PPO
- KAISER HMO
- DELTA DENTAL PPO
- VSP SIGNATURE PPO VISION

SUMMARY OF BENEFITS AND COVERAGE (SBC)

A document required by the Affordable Care Act (ACA) that presents benefit plan features in a standardized format. SBC documents and Benefit Summaries are available on Saddleport on the Benefits tab in the Benefits Forms folder.

- ANTHEM VIVITY HMO
- ANTHEM SELECT HMO
- ANTHEM CA CARE HMO
- ANTHEM PPO
- KAISER HMO

NOTES

Saddleback Valley
Unified School District