SAN BERNARDINO CITY
UNIFIED SCHOOL DISTRICT

SUMMARY OF EMPLOYEE BENEFITS

2024-2025

Effective July 1, 2024 – June 30, 2025

Medical | Dental | Vision | Life

WHAT"S INSIDE

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This handbook provides a summary of your San Bernardino City Unified School District benefit options and is designed to help you make your choices and enroll for your coverage.

Along with this handbook, you should review the following:

- Benefit Announcements
- Rate Sheet

If you have any questions, please contact the Benefits Department at (909) 381-1114. You may also call the benefit plan providers directly or log on to their Web sites. See the Contacts table on page 15 for carrier contact information.

ELIGIBILITY & ENROLLMENT

ELIGIBILITY

You are eligible for the District's benefits on the first of the month following your date of hire.

You may enroll your eligible dependents in the same plans you choose for yourself. In general, eligible dependents include your spouse or legal domestic partner and children up to the age of 26. If your child is mentally or physically disabled, coverage may continue beyond the age of 26. Children may include natural, adopted, stepchildren, domestic partner's children or court ordered dependents.

> If you are enrolling during the open enrollment period, any changes you make will go into effect on July 1, 2024.

PROOF OF DEPENDENT ELIGIBILITY

If you are enrolling dependents, you must submit the following documents to SBCUSD or the dependent will not be added:

Spouse: A copy of your Certified Marriage Certificate AND a copy of the front page and signature page of your 2023 or 2024 federal tax return confirming your dependent as your spouse.

Registered Domestic Partner: A copy of your Declaration of Domestic Partnership registered with the California Secretary of State.

Child: (natural-born, adopted, placement for adoption, step, or registered domestic partner's children) to age 26:

- A copy of the child's birth certificate, or adoption certificate naming you, your spouse, or your domestic partner as the parent of the child **OR**
- A copy of the court order naming you, your spouse, or your domestic partner as the legal guardian of the child.

- Stepchild(ren) or children of your registered domestic partner, you must also provide documentation of your current relationship to your spouse or domestic partner as described above.

If you do not remove an ineligible dependent, you may be charged.

HOW AND WHEN TO ENROLL

You can enroll for coverage within 30 days of your eligibility date or during the annual Open Enrollment period by logging in to AFEnroll or meeting with an American Fidelity enrollment counselor.

If you do not submit your enrollment within 30 days of your eligibility date, you will not receive health coverage during the school year, unless you experience a qualified change in family status (see Making Changes During the Year for details).

MAKING CHANGES DURING THE YEAR

The choices you make when you first become eligible remain in effect for the remainder of the school year, which begins on July 1, 2024. Once you are enrolled, you must wait until the next open enrollment period to change your benefits or add or remove coverage for dependents, unless you have a qualified change in family status as defined by the IRS.

Examples include, but are not limited to, the following:

- Marriage, divorce, legal separation, or annulment
- Birth or adoption of a child
- Loss of other health coverage
- Change in your dependent's eligibility status because of marriage, age, etc.

You have 30 days to make changes to your coverage.

> If you have students or dependents out-of-state or located in out-of-network locations, you must be enrolled in the Health Net PPO plan in order for your dependent(s) to be covered.

MEDICAL PLAN OPTIONS

Nothing is more important than your health—and your family's health. That is why the District offers you medical plan choices designed to help you get the care you need at a price you can afford. Your options include two HMO's and a PPO.

If you enroll in an HMO, you must select a primary care physician to provide your care and refer you to specialists. Only in-network care is covered under an HMO, except in the case of a true emergency as determined by the plan.

The HMO through Health Net is referred to as Elect Open Access and allows you to access PPO providers for office visits only; a higher copay is required when you visit PPO providers.

If you enroll in the Health Net PPO, you have the freedom to visit any licensed provider each time you need care; however, you will save money when you visit Health Net preferred providers.

WELLNESS BENEFITS

Both Health Net and Kaiser offer wellness benefits to help you and your family get—and stay—healthy. Benefits include online health risk assessments as well as discounts on gym memberships, fitness books and videos, vitamins, weight management programs, and much more. Go to **www.healthnet.com** or **www.kp.org** for details.

CHIROPRACTIC CARE

Health Net HMO plan members have access to chiropractic care through American Specialty Health Plans (ASH). Coverage includes 30 visits per year at $10 per visit. Members may select a contracted provider by visiting **ashcompanies.com** or by contacting ASH at (800) 678-9133. A referral is not needed to visit a participating chiropractor.

For those enrolled in the Health Net PPO plan, you can access your chiropractic benefit directly through Health Net. The PPO plan includes 12 visits, combined in and out of network, with a $15 copay in-network and 30% coinsurance out-of-network. Members can search for a provider at **healthnet.com**.

Kaiser's HMO plan members have access to chiropractic care through Optum Health. Coverage is based on medical need and includes unlimited visits at a $20 copay. Members will receive an Optum ID card, which can be shown at the time of service. To locate a provider, please visit **www.myoptumhealthphysicalhealthofca.com** and look for VEBA on the list in the column headed "Participating Provider for." You may also contact Optum Member Services at (800) 428-6337.

MEDICAL PLAN OPTIONS

	Health Net Elect Open Access HMO	Kaiser HMO	Health Net PPO	
Plan Features	**HMO**	**HMO**	**Preferred Provider**	**Non-Preferred Provider**
Calendar Year Deductible Single Family	- -	- -	$250 $750	$250 $750
Out-of-Pocket Maximum Single Family	$1,500 $4,500	$1,500 $3,000	$3,000 $6,000	$5,000 $10,000
Routine Preventive Care	$0 Copay	$0 Copay	$0 Copay	Not covered
Well-Baby Care	$0 Copay	$0 Copay	$0 Copay	Not covered
Office Visit (PCP/Specialist)	$15 Copay	$15 Copay	$15 Copay	30% AD
Diagtnostic Labs I X-Rays	$0 Copay		10% AD	30% AD
Inpatient Hospital	$250 Copay when authorized	$0 Copay	$250 Copay +10% AD	$250 Copay +30% AD
Outpatient Hospital	$250 Copay when authorized	$15 Copay	$250 Copay +10% AD	$250 Copay +30% AD
Ambulance	$0 Copay	$0 Copay	$50 Copay +10% AD	$50 Copay +10% AD
Emergency Room Visit	$75 Copay WIA	$50 Copay	$100 Copay + 10%	$100 Copay + 10%
Urgent Care	$15 Copay	$15 Copay	10% AD	30% AD
Acupuncture I Chiropractic	$10 Copay (up to 30 combined visits/yr)	$15 Copay (unlimited visits/yr) I $20 Copay (unlimited visits/year)	$15 Copay (up to 12 visits combined/year for in- and out-of-network)	30% AD
Prescription Drugs (Retail 30-day supply) Generic Brand-Name Non-Formulary (Mail order 90-day supply) Generic Brand-Name Non-Formulary	 $10 Copay $25 Copay $35 Copay $20 Copay $50 Copay $70 Copay	 $10 Copay $20 Copay - $20 Copay $40 Copay -	 $10 Copay $25 Copay $35 Copay $20 Copay $50 Copay $70 Copay	 50% after $10 Copay 50% after $25 Copay 50% after $35 Copay - - -

AD=After Deductible

TELADOC

Health Net and Teladoc have partnered together to transform the healthcare system by providing access to technology that will drive better health outcomes. Health Net members have unlimited access to video conferencing with health care and behavioral health providers. These visits are provided at no charge. Members can book a video appointment 24/7 through the Teladoc app and can use the app to tap into a full suite of digital healthcare tools to get information about their health.

WHEN TO USE TELADOC?

- Instead of going to the ER or an urgent care center for a non-emergency issue
- During or after normal business hours, night, weekends, and even holidays
- If your primary care physician is not available
- If you are traveling and in need of medical care
- E-prescriptions can be sent to your local pharmacy (if needed)

Get started with Teladoc:

1.) Download the app

2.) Call: (800) Teladoc (835-2362)

3.) Web: www.Teladoc.com

MEDICAL CONDITIONS TREATED

- Allergies
- Congestion
- Cough
- Fever
- Mental Health
- Pain
- Rashes
- Upset Stomach
- And More!

BEHAVIORAL HEALTH CONDITIONS TREATED

- Addictions
- Depression
- Eating Disorders
- Relationship Issues
- Parenting Issues
- Stress
- Trauma and PTSD
- And More!

DENTAL PLAN OPTIONS

Good health includes healthy teeth and gums. The dental plans are designed to help you maintain a healthy smile through regular preventive dental care, and to fix any problems as soon as they occur.

You must visit in-network dentists under either of the dental HMOs. If you are enrolled in the PPO, you have the freedom to visit the provider of choice. However, visiting in-network (Delta PPO) providers will save you money on out-of-pocket costs. When you visit out-of-network providers, you are responsible for charges above Delta Dental's contract allowance.

Please see the table below for a comparison of dental benefits:

	Delta Dental PPO		DeltaCare HMO	MetLife HMO
Plan Features	**In-Network**	**Out-of-Network**	**In-Network**	**In-Network**
Calendar Year Deductible Single Family	N/A	$100 $300	N/A	N/A
Annual Maximums Per Member	$2,500	$2,000	N/A	N/A
Routine Treatment (e.g., oral exams, X-rays, cleanings, fillings, oral surgery)	(Changes each January; must visit dentist annually) Plan pays: 1st year*: 70% 2nd year: 80% 3rd year: 90% 4th year: 100%	(Changes each January; must visit dentist annually) Plan pays: 1st year*: 70% 2nd year: 80% 3rd year: 90% 4th year: 100%	$0 Copay	$0 Copay
Crowns and Pontics	Same as above; limitations may apply		$0 Copay	$0 Copay (charges apply for upgrades)
Bridges, Dentures & Implants	80% of contract allowance	50% of contract allowance	$0 Copay	$0 Copay
Orthodontia (Lifetime Maximum)	Plan pays 80% $2,000 (children only)		$1,800 Copay (adults & full-time students) $1,600 Copay (children) $350 start-up fee (excludes records)	$400 Copay (adults) $400 Copay (children)

*First year or after break in coverage

Important Note: If you are enrolled in the Delta Dental PPO, Delta Dental pays 70% of the contract allowance for covered diagnostic, preventive, basic, crowns and restorative benefits during the first calendar year of eligibility. This percentage increases 10% each consecutive year the dentist is visited to a maximum of 100%. If you do not use your plan, the percentage remains at the level you reached the previous year. If you lose eligibility or have any break in coverage the percentage will revert back to a 70% benefit.

VISION AND EAP PLANS

VISION

Eligible employees have the option to enroll in vision coverage through VSP. You may visit a doctor within the VSP network and take advantage of higher benefits coverage, or visit an out-of-network provider of your choice for a reduced benefit.

	Your Coverage with a VSP Provider		
BENEFIT	**DESCRIPTION**	**COPAY**	**FREQUENCY**
EXAM	• Focuses on your eyes and overall wellness	$15 (exam and glasses)	Every 12 months
FRAMES	• $145 featured frame brands allowance • $125 featured frame allowance • 20% savings on the amount over your allowance • $125 Costco/Walmart/Sam's Club frame allowance	Combined with exam	Every 12 months
LENSES	• Single vision, lined bifocal, and lined trifocal lenses • Impact-resistant lenses for dependent children	Combined with exam	Every 12 months
LENS ENHANCEMENTS	• Standard progressive lenses • Anti-glare coating • Premium progressive lenses	$0 $25 $90 - $105	Every 12 months
CONTACTS (Instead of glasses)	• $100 allowance for contacts; copay does not apply •Contact lens exam (fitting and evaluation) • Impact-resistant lenses for dependent children	Up to $60	Every 12 months

YOUR COVERAGE GOES FURTHER IN-NETWORK

With so many in-network choices, VSP makes it easy to get the most out of your benefits. You'll have access to preferred private practice, retail, and online in-network choices. Log in to **vsp.com** to find an in-network provider. Refer to the benefit summary for **out-of-network coverage**.

Please note: VSP does not provide ID cards. Simply identify yourself as a VSP member and provide your Social Security number at the time of service.

EMPLOYEE ASSISTANCE PROGRAM (EAP)

Because unresolved personal issues can affect every aspect of one's life, including work performance, the District provides you and your family with an Employee Assistance Program Support Services through The Counseling Team International (TCTI), at no cost to you. Call TCTI 24 hours a day, 7 days a week at (800) 222-9691, for confidential assistance with nearly any personal matter you may be experiencing. Counselors can provide you with access to face-to-face counseling for issues such as marital and family problems, stress/burnout, separation/divorce, grief/bereavement, substance abuse, career concerns as well as many other issues.

LIFE & AD&D INSURANCE

BASIC LIFE & AD&D INSURANCE

Providing economic security for your family if you die, become disabled, or experience an injury or illness is a major consideration in personal financial planning. The District provides you with employee life insurance coverage at no cost to you, if you are a full-time employee. (Part-time employees pay a proportionate share of the cost.) Please complete an enrollment form to obtain the life insurance benefit of $50,000. Benefits are reduced at age 70. Be sure to choose a beneficiary to receive benefits in the event of your death.

The District also provides life insurance coverage for your spouse and children in the following amounts:

- **Spouse:** $1,500
- **Child(ren):** $1,500
  - Must be unmarried and less than 26 year of age
  - Must be financially dependent on you
  - Stepchildren must live with the parent who has the coverage

VOLUNTARY LIFE INSURANCE

You can purchase additional life insurance coverage for yourself if you choose. Consider costs such as funeral expenses, legal expenses, and general living expenses for your surviving family members when determining an appropriate amount of additional coverage.

New Hires

- ❑ For you—You may elect up to $150,000 or 5 times your annual salary, whichever is less, without providing evidence of insurability.
- ❑ For your spouse—You may elect up to $30,000 of Supplemental Life Insurance without providing evidence of insurability.
- ❑ If you elect higher amount(s), you will need to submit evidence of insurability for approval before coverage becomes effective.

Annual Enrollment

- ❑ For you
  - If you currently have Supplemental Life Insurance, you may elect to increase your coverage amount by $10,000 up to a total of $150,000 during this annual enrollment period without providing evidence of insurability.
  - If you are currently not participating in the Supplemental Life Insurance, you must provide evidence of insurability to elect coverage for the first time during this annual enrollment period.
- ❑ For your spouse
  - You must provide evidence of insurability on your spouse for any new enrollment or increase to current coverage elected during this annual enrollment period. You may request a Voluntary Group Health statement from the Benefits Department.

VOLUNTARY AD&D INSURANCE

You may purchase additional AD&D coverage, which provides benefits in the event of a death or dismemberment due to an accident. Coverage is available for you and your eligible dependents, as long as you elect coverage for yourself.

- **Employees:** $10,000 to $500,000 (amounts in excess of $250,000 may not exceed 10 times your annual salary)
- **Dependents:** equal to a percentage of the principal sum you elect (see table below). Please note that coverage for children is to age 19 or to age 26, if a full–time student. Children must be dependent upon you for support in order to qualify. Please refer to page 13 for additional details.

Voluntary AD&D	Spouse Benefit without Dependent Coverage	Spouse Benefit with Dependent Coverage	Child Benefit without Spouse Coverage	Child Benefit with Spouse Coverage
Percentage of Employee AD&D Principal Sum	60% up to $300,000	50% up to $250,000	20% up to $25,000	10% up to $25,000

Coverage Amount	Employee Only Rate per $1,000	Employee + Family Rate per $1,000
$10,000	$0.27	$0.44
$20,000	$0.54	$0.88
$30,000	$0.81	$1.32
$40,000	$1.08	$1.76
$50,000	$1.35	$2.20
$60,000	$1.62	$2.64
$70,000	$1.89	$3.08
$80,000	$2.16	$3.52
$90,000	$2.43	$3.96
$100,000	$2.70	$4.40
$125,000	$3.38	$5.50
$150,000	$4.05	$6.60
$200,000	$5.40	$8.80
$250,000	$6.75	$11.00
$300,000	$8.10	$13.20
$400,000	$10.80	$17.60
$500,000	$13.50	$22.00

FULL-TIME EMPLOYEES

If you are a full-time employee, the Health Net HMO medical plan, the dental plan of your choice, the vision plan if you elect it, and basic life insurance are paid in full by the District according to the terms of your collective bargaining agreement.

Your monthly cost for medical, dental and vision coverage is based on your medical plan selection as shown in the table below:

Medical Plan	Employee Only	Employee + 1	Employee + Family
Health Net HMO	$0	$0	$0
Kaiser HMO	$198.22	$278.81	$444.57
Health Net PPO	$517.15	$1,111.88	$1,525.55

To arrive at your annual cost, simply multiply the total monthly cost by the number of months you are paid. Your monthly cost includes off-track months and summer recess. You may be required to supplement your benefits payment if a payroll deduction shortage occurs during off-track months.

PART-TIME EMPLOYEES

If you are a part-time employee, you share a proportionate amount of the cost for medical, dental and vision coverage with the District. The amount you pay for coverage is based on the weekly or daily number of hours you work. **Please refer to the separate rate sheets for benefit costs.**

Full and Part-Time Employees: If your payroll schedule is less than 12 months, you will see a deduction under the heading of Health Welfare Reserve – Section 125. This amount will be accumulated and applied toward the cost of your benefits in months that you do not have payroll or a deduction.

WHEN YOUR PAYROLL DEDUCTIONS BEGIN

For new hires and current employees, your payroll deductions should begin with the first paycheck of the month following your eligibility date. It is your responsibility to notify the Benefits Department immediately if no benefit deductions are subtracted from your paycheck. If you do not contact the Benefits Department immediately, you may receive retroactive payroll deductions on future paychecks to make up for the deductions that were not taken. This could be costly for you and/or result in cancellation of benefits.

FAQ'S

Will I receive new ID cards?

If you and/or your dependents are enrolling in the Health Net or Kaiser plan for the first time, you will receive new ID cards. For the 2024 open enrollment, those already enrolled in a Health Net plan will also receive a new ID card.

What is the effective date for my benefits?

The benefit choices you make will be in effect from the first of the month following your hire date (for current employees July 1, 2024) through the end of the school year, unless you have a qualified family status change.

How long is the initial enrollment period when I am first eligible?

30 days

What documentation do I need to enroll?

When you enroll in the benefit plans and when you add or re-enroll a new dependent, you must submit the following documents to SBCUSD or the dependent(s) will not be added:

- To add a child- Must submit a Certified Birth Certificate
- To add a spouse- Must submit the front page and the signature page of the 2023 or 2024 1040 Tax forms, showing Married filing jointly or showing Married filing separately and also a Certified Marriage Certificate.

If you do not remove an ineligible dependent, you may be charged.

Can I make changes after open enrollment?

After your initial enrollment period, you may change your choices within your selected plan only if you have a change in family status, as defined by IRS Regulations, Section 125. You have a family status change if the following apply:

- You get married or divorced. (If a divorce or legal separation occurs, you are mandated to remove an ex-spouse and stepchildren, if applicable, from our benefit plans.)
- You add or lose an eligible dependent
- Your or your spouse's employment status changes from part-time to full-time, or vice versa
- Your spouse begins or ends employment
- There is a significant change in your or your spouse's employment status, work schedule, or work location affecting medical coverage
- There is a significant change in the health or dental coverage your spouse has through his or her employment
- You or your dependent loses COBRA or other health coverage If you have a family status change after your initial enrollment, you must submit the change via the online enrollment portal within 30 days of the family status change. No changes are allowed after 30 days. You must wait until the next open enrollment period to make changes.

If you have a family status change after your initial enrollment, you must submit the change via the online enrollment portal within 30 days of the family status change. **No changes are allowed after 30 days**. You must wait until the next open enrollment period to make changes.

What happens if my dependents or I have a break in coverage with Delta Dental PPO?

The benefits will revert back to 70%.

FAQ'S

Do I have a deductible on the Delta Dental PPO Plan?

If you visit an in-network dentist, no deductible applies. If you visit an out-of-network dentist, you must pay a $100 deductible per person ($300 maximum per family).

When will my benefits end?

Your benefits will end on the last day of the month of your last service day in which any of the following occur:

- You do not return to your assignment on the reporting day following any track break
- You are in an unpaid status (i.e. you are on a personal leave or have exhausted all paid leave)
- You terminate employment

Who is eligible to receive benefits?

Employees who are eligible to participate in the insurance benefit programs are management employees, confidential employees, and all members of the Certificated Bargaining Unit (who work 10 or more hours per week) and all members of the Classified Bargaining Unit (who work four hours or more per day) and Police Officers Association (who work four or more hours per day), of the negotiated employees' contracts with the respective employees' associations and the District. Please refer to these sections. **The District will cover an employee or eligible dependent on only one medical and life insurance plan.**

If you and your spouse are both employed by the District and choose separate medical plans (Health Net and Kaiser, for example), all children must be enrolled under one or the other medical plan. They cannot be split amongst the plans.

In addition, if you and your spouse are both employed by the District and choose the same medical plan (Health Net HMO, for example), you must be enrolled together under the same policy and may not elect coverage individually.

Dependents eligible for participation in the insurance benefits program include the following:

- Your spouse, unless divorced or legally separated (fiancées are not covered)
- Your dependent children to age 26, including stepchildren, legally adopted children and court-appointed dependents.
- The Voya life insurance coverage for eligible dependents is through age 18, or through age 26 if unmarried.
- The Zurich insurance coverage is for unmarried children who rely on the employee for more than 50% of their support and are either 1) younger than age 19, 2) younger than age 26 if enrolled on a full-time basis in a college, university, or trade school, or who satisfy neither 1) nor 2), but who prior to his or her termination of coverage became incapable of self-sustaining employment by reason of mental retardation or physical handicap.
- Eligible dependents also include unmarried children who have reached age 19 but are incapable of self-support because of physical or mental incapacity (as defined by the insurance carrier) that began before age 19.
- Dependents in the military are not eligible for coverage.
- Your newborn children are automatically covered for 30 days after birth. You must enroll a newborn or legally adopted child with the District during the 30 days after birth in order for coverage to continue beyond the 30 days. You must provide a birth certificate or adoption papers at the time of enrollment.
- Your Domestic Partner as defined under California's Family Code Section 297.

Can an employee or a dependent be covered on more than one medical or insurance plan?

No. The District will cover an employee or eligible dependent on only one medical or insurance plan.

IMPORTANT NOTICES

ERISA and various other state and federal laws require employers to provide disclosure and annual notices to their plan participants. Below are summaries of each notice. For a copy of the full disclosure notice, please contact the Employee Benefits Department or download a copy from the AFEnroll benefits portal.

Medicare Part D Creditable Coverage Notice states that Medicare prescription drug coverage became available in 2006 and that the prescription drug coverage offered by your employer is on average expected to pay out as much as standard Medicare coverage pays and is therefore considered Creditable Coverage.

Women's Health and Cancer Rights Act (WHCRA) of 1998 protects breast cancer patients who choose breast reconstruction with a mastectomy. The US Departments of Labor and Health and Human Services are in charge of this act of law, which applies to group health plans if the plans or coverage provide medical and surgical benefits for a mastectomy.

Newborns' and Mothers' Health Protection Act of 1996 (NMHPA) protects the amount of time a mother and her newborn child are covered for a hospital stay following childbirth.

HIPAA Notice of Special Enrollment Rights provides information on special enrollment periods (outside of Open Enrollment) for loss of prior coverage or addition of a new dependent.

HIPAA – Notice of Privacy Practices
This notice is intended to inform employees of the privacy practices followed by your company's group health plan. It also explains the federal privacy rights afforded to you and the members of your family as plan participants covered under a group plan.

Notice of Choice of Providers states that you have the right to designate any primary care provider who participates in the network and who is available to accept you or your family members. Until you make this designation, the medical carrier designates one for you.

Children's Health Insurance Program (CHIP) Notice
provides information on how to contact your state Medicaid office (where applicable) to receive information on assistance if you are eligible for health coverage from your employer but are unable to afford the premiums.

ACA Disclaimer
This notice is intended to inform employees that this offer of coverage may disqualify you from receiving government subsidies for an Exchange plan even if you choose not to enroll. To be subsidy eligible you would have to establish that this offer is unaffordable for you, meaning that the required contribution for employee only coverage under our base plan exceeds 8.39% in 2024 of your modified adjusted household income.

The "No Surprises" Rules protect you from surprise medical bills in situations where you can't easily choose a provider who's in your health plan network. This is especially common in an emergency situation, when you may get care from out-of-network providers..

General Notice of COBRA Continuation 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.

Health Insurance Marketplace Notice provides basic information about the Marketplace that was established in 2014 and employment-based health coverage offered by your employer.

CONTACTS

Benefit	Contact	Telephone	Web Address
Medical			
Health Net HMO	Health Net	(844) 342-4046	www.healthnet.com
Health Net PPO	Health Net	(844) 342-4046	www.healthnet.com
Kaiser HMO	Kaiser	(800) 464-4000	www.kp.org
ASH (Chiropractic-Health Net HMO)	ASH	(844) 342-4046	www.ashcompanies.com
Optum (Chiropractic-Kaiser HMO)	Optum	(800) 464-4000	myoptumhealthphysicalhealthofca.com
Teladoc	Teladoc	(800) 835-2362	www.Teladoc.com
Dental			
Delta Care HMO	Delta Dental	(800) 422-4234	www.deltadentalins.com
Delta PPO	Delta Dental	(866) 499-3001	www.deltadentalins.com
MetLife HMO	MetLife	(800) 880-1800	www.metlife.com
Vision	VSP	(800) 877-7195	www.vsp.com
Employee Assistance Program (EAP)	The Counseling Team International (TCTI)	(800) 222-9691	www.thecounselingteam.com
Basic Life and Accidental Death & Dismemberment	VOYA	Contact Benefits Department	Contact Benefits Department
Voluntary Life	VOYA	Contact Benefits Department	Contact Benefits Department
Voluntary AD&D	Zurich	Contact Benefits Department	Contact Benefits Department
Enrolling or Terminating Benefits	Employee Benefits	(909) 381-1114	www.sbcusd.com
New Hires or Employees Returning from Leave	American Fidelity	(800) 365-9180	www.americanfidelity.com

The information in this Benefits Summary is presented for illustrative purposes. The text contained in this Summary was taken from various summary plan descriptions and benefit information. While every effort was taken to accurately report your benefits, discrepancies or errors are always possible. In case of discrepancy between the Benefits Summary and the actual plan documents the act plan documents will prevail. All information is confidential, pursuant to the Health Insurance Portability and Accountability Act (HIPAA) of 1996. If you have any questions about this summary, contact Human Resources.