



Retiree Benefits Guide

2026 – 2027





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Our benefits are effective October 1 through September 30 of each plan year

WELCOME TO YOUR RETIREE BENEFITS

Whether you're enrolling in benefits for the first time, getting ready for retirement, or somewhere in between, the Santa Barbara Unified School District supports you with benefit programs and resources to help you thrive today and prepare for tomorrow.

We are providing you with this overview to help you understand the benefits that are available to you and how to best use them. Please review it carefully and make sure to ask about any important issues that are not addressed here. A list of plan contacts is provided at the back of this Benefit Guide.

While we've made every effort to make sure that this guide is comprehensive, it cannot provide a complete description of all benefit provisions. For more detailed information, please refer to your plan benefit booklets or evidence of coverage (EOCs). The plan benefit booklets determine how all benefits are paid.



How to Make Changes to Your Coverage

- Review your plan benefits, providers and rates
- Obtain and complete your enrollment forms
- Be sure to sign and submit your forms by the **Friday, July 10, 2026** deadline

No Changes to Your Coverage?

- SB Unified will automatically continue your current coverage into 2026 at the new rates. **However, we do require that you sign and return your forms.**

2026 - 2027 BENEFITS

**Open Enrollment Period:
June 23 to July 10, 2026**

**The benefits in this summary are effective
October 1, 2026 through September 30, 2027**



DEADLINES

- The deadline to return your completed and signed insurance form is **Friday, July 10, 2026.**
- Please sign the Retiree Insurance Rate Sheet and return the top copy to Human Resources
- If you wish to cancel your insurance plan through the Santa Barbara Unified School District, please inform the District via email at hrbenefits@sbunified.org, or letter to:

**Santa Barbara Unified School District
Attn: Human Resources
720 Santa Barbara Street
Santa Barbara, CA 93101**

Setting up Automatic Payments (ACH) from your savings or checking account is **strongly recommended**. Otherwise, checks are to be payable to **Santa Barbara Unified School District** and are **due by the 1st of each month**.

QUESTIONS ABOUT YOUR BENEFITS?

Because there are no changes to your benefits this year, the district will not be holding a formal open enrollment presentation. You may review a recording of last year's presentation by visiting the link below or scanning the QR code to the right with your smart phone.

- [Retiree Open Enrollment Presentation](#) (Passcode: 3Py7t\$W)



Additionally, to ensure that you continue to receive open enrollment support, a district representative will be available in-person

- When: **Thursday, June 25, 2026** from **10:00AM - 4:00PM**
- Where: **District Office Board Room**

During these hours, you have the option to drop by to submit your Enrollment Forms in-person and get answers to any questions you may have about your benefits.

RETIREE ENROLLMENT INFORMATION

WHO MAY ENROLL

If you are a retiree, you and your eligible dependents may participate in SB Unified's benefits program. Review the dependent eligibility rules below:

DEPENDENT ELIGIBILITY RULES

- Your legal spouse or legally registered domestic partner; any gender
- Your natural children, stepchildren, children who are either legally adopted by you or placed in your custody during the adoption process, children for whom you are the legal guardian, and any child named in a qualified medical child support order for which you are required to provide health coverage. Dependent children must be under the age of 26 and not be eligible for medical insurance through his or her employer.
- Your eligible physically or mentally handicapped children who depend on you for support, regardless of age. Eligibility is determined by the insurance carriers. You must fill out a Disabled Form and submit it to the insurance carriers for review and approval.
- A child of a covered domestic partner who satisfies the same conditions as listed above for natural children, stepchildren, or adopted children, and in addition is not a "qualifying child" (as that term is defined in the Internal Revenue Code) of another individual.

OVER-AGE DEPENDENTS

Report and drop dependents as soon as they no longer qualify for coverage on your district insurance; this may entitle you to a decrease in your monthly premium. An annual certification is required by the carrier for each over-age dependent that is eligible to remain on your insurance. In the event that you do not drop a dependent who is ineligible for coverage under the district plans, you will be responsible for benefit claims

WHEN YOU MAY ENROLL

As an eligible retiree, you may enroll at the following times:

- As a new retiree, you may participate in SB Unified's benefits program within 30 days of your eligibility date. If you do not enroll for coverage within 30 days of your eligibility date, you will lose eligibility.
- Each year, during open enrollment. **Annual Open Enrollment Periods** are the annual periods during which you have the opportunity to enroll in or change healthcare plans. If you are enrolling in or changing plans for 2026-2027, your forms must be received by the district no later than **July 10, 2026**; otherwise you will not be able to make changes until the 2027 Open Enrollment. If changing carriers, you must submit a disenrollment form for the old plan as well as an enrollment form for the new plan.
- Within 30 days of a qualifying event as defined by the IRS (see **Mid-Year Benefit Change Rules** on the next page).

IMPORTANT

- **You must be enrolled in a medical plan in order to enroll in a dental and/or a vision plan.**
- **Eligibility for dental benefits:** The Dental PPO plan is open to all retirees. You are eligible to participate in a district-sponsored dental plan only if you never cancelled or waived coverage while maintaining enrollment in a district medical plan.



RETIREE ENROLLMENT INFORMATION

MID-YEAR BENEFIT CHANGE RULES

You will not be allowed to change your plan selections or add dependents until the next benefit year (2027 Open Enrollment) unless you experience a qualified status change, known as a “qualifying event”. If you qualify for a mid-year benefit change, you may be required to submit proof of change or evidence of prior coverage. Two rules apply for making changes to your benefits during the year:

- Any change must be consistent with the qualifying event.
- You must notify SB Unified and make the change within 30 calendar days of the date of the event, however if your status change is your enrollment in Medicare A and B, you should contact SB Unified for instructions 3 months prior to your Medicare effective date and must submit necessary documents and forms at least 60-90 days before your Medicare effective date

Qualifying Events for Mid-Year Enrollment:

- **Change in legal marital status**, including marriage, divorce, court documented legal separation, annulment, death of spouse, termination of registered domestic partnership, or establishment of registered domestic partnership.
- **Change in number of dependents**, including birth, adoption, placement for adoption, or death of a dependent child.
- **Change in employment status that affects benefit eligibility**, including the start or termination of employment by you, your spouse, or your dependent child.
- **Change in work schedule**, including an increase or decrease in hours of employment by you, your spouse, or your dependent child, that affects eligibility for benefits.
- **Change in a child's dependent status**, either newly satisfying the requirements for dependent child status or ceasing to satisfy them.
- **Change in residence or worksite** that affects the accessibility of network providers.
- **Change in your health coverage or your spouse's coverage attributable to your spouse's employment.**
- **A court order resulting from a divorce, court-ordered legal separation, annulment, or change in legal custody** (including a Qualified Medical Child Support Order) requiring coverage for your child.
- **An event that is a “special enrollment” under the Health Insurance Portability and Accountability Act (HIPAA)** including acquisition of a new dependent by marriage, birth or adoption, or loss of coverage under another health insurance plan.
- **An event that is allowed under the Children's Health Insurance Program (CHIP) Reauthorization Act.**
Under provisions of the Act, retirees have 60 days after the following events to request enrollment:
 - Retiree or dependent loses eligibility for Medicaid (known as Medi-Cal in CA) or CHIP (known as Healthy Families in CA).
 - Retiree or dependent becomes eligible to participate in a premium assistance program under Medicaid or CHIP.
- **Change in a covered individual's eligibility for Medicare or Medicaid:**
 - Enrolling in Medicare (A and B) is a qualifying event for purposes of changing plans mid-year.
 - Enrolling in Medicare (A and B) is a qualifying event for purposes of adding
 - Enrolling in Medicare (A and B) is a qualifying event for any applicable premium reduction in your current plan, after it is reported to SB Unified. Your premium will be reduced to the Medicare coordinated rate effective the later of the Medicare effective date –OR– the first of the month following 45 days from receipt of a copy of your Medicare card and an appropriate insurance change form.

MEDICARE REQUIREMENTS

IMPORTANT MEDICARE GUIDELINES

Retirees and their spouses/domestic partners that are age 65 or older are required to provide proof of Medicare Parts A and B. A copy of the Medicare card for the retiree and the spouse/domestic partner must be sent to SISC prior to the first of the month in which they turn 65 (or the first of the prior month if the birthdate falls on the first of the month), or when first enrolled in a SISC plan. Retirees must have continuous enrollment in Medicare while enrolled in a SISC retiree plan. Your benefits will remain with Anthem Blue Cross, and Medicare will continue to be the primary insurance for those enrolled that are age 65 or older.

Retirees and covered dependents should contact Social Security three months in advance of their 65th birthday or retirement, and provide the district proof of Medicare Parts A and B enrollment to avoid surcharges.

This non-refundable surcharge will be passed along to the retiree for failure to comply with requirements to provide proof of Medicare Part A and/or B enrollment card. As a courtesy, SISC will notify employees turning age 65 by mailing a letter to them. This letter will have an explanation on Medicare and when they must enroll.

If proof of Medicare is not provided to SISC, a non-refundable penalty surcharge will be applied to the monthly premium. The surcharge will be applied the first of the month in which the member turns 65 until the Medicare card is produced.

Turning 65 in 2026?

Be sure to **contact SB Unified three months before your 65th birthday to review options.**

If you (and/or your dependents) have or will have Medicare in the next 12 months, Federal law provides choices for prescription drugs coverage. See [Prescription Drug Coverage and Medicare](#).

2026-2027 Missing Medicare Surcharge

Missing Part A	\$700
Missing Part B	\$900
Missing Parts A and B	\$1,600



IMPORTANT CARRIER INFORMATION

SISC does not allow retirees to waive coverage and re-enroll at a later date. **IMPORTANT: If you do not enroll in a plan now, you will lose coverage eligibility indefinitely.** This policy also applies to your dependents. If you do not enroll your spouse or your dependents now, they cannot be added at a future date or during a future open enrollment. This is designated by the carriers. It is your responsibility to enroll yourself and your dependents by submitting an enrollment form and any required documentation as proof of dependent status.

MEDICARE COORDINATION OF BENEFITS

MEDICARE COORDINATION OF BENEFITS

When your group health plan provides benefits after Medicare, the combined benefits from Medicare and your group plan will equal, but not exceed, what they would have paid if you were not eligible to receive benefits from Medicare (based on the lower of the Claims Administrator's Allowable Amount or the Medicare allowed amount). Your group plan deductible and co-payments will be waived.

When Covered by Medicare & Another Group Health Plan

Before receiving services from new providers, always ask:

1. Are you a "Medicare Assigned" doctor?
2. Are you a contracted Provider with my group health plan?

If the provider answers yes to both questions, you can feel secure about receiving the best benefits from your coordinated plans.

When Charge for Retiree is Covered by Medicare, Doctor Accepts Medicare's Fee Schedule & the Group Health Plan is Secondary

When your group health plan receives a Medicare claim from Medicare where Medicare has paid a portion, the group health plan processes the claim as the secondary payer and pays allowable amounts up to 100% of charges.

ILLUSTRATIVE EXAMPLE	
Office visit charge	\$100.00
Medicare fee schedule allows	\$80.00
Medicare pays 80% of the \$80.00 charge.	\$64.00
Balance of bill	\$16.00
Group health plan pays	\$16.00
Patient Responsibility	\$0.00

When Charge Not Covered by Medicare, the Group Health Plan Acts as Primary

When your group health plan receives a Medicare claim from Medicare with a denial of charges because it is a non-covered service, your group health plan processes the claim as if they were the primary payer.

ILLUSTRATIVE EXAMPLE	
Office visit charge	\$100.00
Medicare fee schedule allows	\$0.00
Medicare pays 0% of the \$100.00 charge	\$0.00
Balance of bill	\$100.00
Group health plan pays 80% of the charge	\$80.00
Balance of bill	\$20.00
Patient Responsibility	\$20.00

RETIREE BENEFITS OVERVIEW



Retiree Health Benefit Plans

For Retirees Under 65

- Anthem Blue Cross 80-E PPO
- Anthem Blue Cross 80-G PPO
- Anthem Blue Cross 80-M PPO
- Anthem Blue Cross Gold Proactive Care
- MetLife PDP Plus \$2,000
- MetLife PDP Plus \$3,000
- VSP vision plan

For Retirees Over 65 with No Medicare

- Anthem Blue Cross 80-G PPO
- MetLife PDP Plus \$2,000
- MetLife PDP Plus \$3,000
- VSP vision plan

For Retirees Over 65 with Medicare Parts A & B

- United Healthcare Medicare Advantage HMO
- Anthem Blue Cross Companion Care
- MetLife PDP Plus \$2,000
- MetLife PDP Plus \$3,000
- VSP vision plan

COST OF COVERAGE

MONTHLY CONTRIBUTIONS FOR MEDICAL / DENTAL / VISION PLANS

The monthly amount that you pay for your coverage is outlined below and depends on the plan(s) that you elect and whether or not you cover dependents.

	Retiree	Retiree + Spouse	Retiree + Family
Medical: Retirees Under 65			
Anthem Blue Cross PPO 80 E	\$1,793.00	\$3,543.00	\$4,501.00
Anthem Blue Cross PPO 80 G	\$1,663.00	\$3,283.00	\$4,171.00
Anthem Blue Cross Gold Proactive Care Plan	\$1,612.00	\$3,174.00	\$4,035.00
Anthem Blue Cross PPO 80 M	\$1,292.00	\$2,542.00	\$3,230.00
Medical: Non-Medicare Retirees Over 65			
Anthem Blue Cross PPO 80 G	\$2,393.00	\$4,786.00	\$5,238.00
Medical: Medicare Parts A & B-Eligible Retirees			
United Healthcare Medicare Advantage HMO	\$492.16	\$984.32	N/A
Anthem Blue Cross Companion Care	\$510.00	\$1,020.00	N/A
Dental			
MetLife \$2,000 PPO	\$87.41	\$176.60	\$247.72
MetLife \$3,000 PPO	\$93.50	\$188.93	\$265.03
Vision			
Vision Service Plan (VSP)	\$10.10	\$20.20	\$30.30



MEDICAL: RETIREES UNDER 65



	Anthem 80-E PPO Plan	Anthem 80-G PPO Plan
Cost Factors	In-Network	In-Network
Annual Deductible	\$300/Individual \$600/Family	\$500/Individual \$1,000/Family
Annual Out-of-Pocket Maximum	\$1,000/Individual \$3,000/Family	\$2,000/Individual \$4,000/Family
Lifetime Max	Unlimited	Unlimited
Office Visits	You Pay	You Pay
Primary Doctor	\$20 copay (deductible waived)	\$30 copay (deductible waived)
Specialist	\$20 copay (deductible waived)	\$30 copay (deductible waived)
Preventive Care	No charge	No charge
Urgent Care	\$20 copay	\$30 copay
Chiropractic	20%, after ded	20%, after ded
Acupuncture (Limited to 12 visits/year)	20%, after ded	20%, after ded
Other Services	You Pay	You Pay
Inpatient Hospitalization	20%, after ded	20%, after ded
Outpatient Surgery Hospital (5 Surgeries Subject to Limits ²)	20%, after ded	20%, after ded
Outpatient Surgery: Ambulatory Surgery Centers	20%, after ded	20%, after ded
Lab and X-Ray - Diagnostic - Complex (MRI/PET)	20%, after ded	20%, after ded
Emergency Facility (copay waived if admitted)	\$100 copay, then 20%, after ded	\$100 copay, then 20%, after ded
Ambulance	\$100 copay, then 20%, after ded	\$100 copay, then 20%, after ded
Prescription Drugs		
Brand Name Drugs: Annual Deductible	\$200 Individual / \$500 Family	\$200 Individual / \$500 Family
Annual Out-of-Pocket Maximum	\$2,500 Individual / \$3,500 Family	\$2,500 Individual / \$3,500 Family
Retail Pharmacy		
Retail: 30-Day Supply	Generic: \$10 / Brand: \$35	Generic: \$10 / Brand: \$35
Costco Pharmacy (30-Day Supply)	Generic: \$0 / Brand: \$35	Generic: \$0 / Brand: \$35
Costco Pharmacy (90-Day Supply)	Generic: \$0 / Brand: \$90	Generic: \$0 / Brand: \$90
Mail Order Pharmacy		
Pharmacy: 90-Day Supply (Navitus)	\$35 Specialty from Navitus	\$35 Specialty from Navitus
Costco: 90-Day Supply	Generic: \$0 / Brand: \$90	Generic: \$0 / Brand: \$90

¹ The dollar copay applies only to the visit itself. An additional 20% copay applies for any services performed in the office.

² Surgeries subject to benefit limits if performed in an outpatient hospital: Arthroscopy (\$4,500 max), Cataract (\$2,000 max), Colonoscopy (\$1,500 max), Upper GI Endoscopy (\$1,000 max) and Upper GI Endoscopy w Biopsy (\$1,250 max)

MEDICAL: RETIREES UNDER 65



	Anthem 80-M PPO Plan	Anthem Gold Proactive Care
	In-Network	In-Network
Cost Factors		
Annual Deductible	\$3,000/Individual \$6,000/Family	None
Annual Out-of-Pocket Maximum	\$4,000/Individual \$8,000/Family	\$3,000/Individual \$6,000/Family
Lifetime Max	Unlimited	Unlimited
Office Visits	You Pay	You Pay
Primary Doctor	\$40 copay ¹ (deductible waived)	\$0 copay
Specialist	\$40 copay ¹ (deductible waived)	\$100 copay
Preventive Care	No charge	No charge
Urgent Care	\$40 copay ¹	\$0 copay
Chiropractic	20%, after ded	\$0 copay
Acupuncture (Limited to 12 visits/year)	20%, after ded	\$0 copay
Other Services	You Pay	You Pay
Inpatient Hospitalization	20%, after ded	\$600 copay per day
Outpatient Surgery Hospital (5 Surgeries Subject to Limits ²)	20%, after ded	\$1,800 copay
Outpatient Surgery: Ambulatory Surgery Centers	20%, after ded	\$600 copay
Lab and X-Ray - Diagnostic - Complex (MRI/PET)	20%, after ded	Lab: \$0 - \$150 copay X-Ray: \$0 - \$225 copay Complex: \$300 - \$750 copay
Emergency Facility (copay waived if admitted)	\$100 copay, then 20%, after ded	\$700 copay
Ambulance	\$100 copay, then 20%, after ded	\$700 copay
Prescription Drugs		
Brand Name Drugs: Annual Deductible	\$200 Individual / \$500 Family	N/A
Annual Out-of-Pocket Maximum	\$2,500 Individual / \$3,500 Family	\$2,500 Individual / \$3,500 Family
Retail Pharmacy		
Retail: 30-Day Supply	Generic: \$10 / Brand: \$35	Generic: \$9 / Brand: \$35
Costco Pharmacy (30-Day Supply)	Generic: \$0 / Brand: \$35	Generic: \$0 / Brand: \$35
Costco Pharmacy (90-Day Supply)	Generic: \$0 / Brand: \$90	Generic: \$0 / Brand: \$90
Mail Order Pharmacy		
Pharmacy: 90-Day Supply (Navitus)	\$35 Specialty from Navitus	\$35 Specialty from Navitus
Costco: 90-Day Supply	Generic: \$0 / Brand: \$90	Generic: \$0 / Brand: \$90

¹ The dollar copay applies only to the visit itself. An additional 20% copay applies for any services performed in the office.

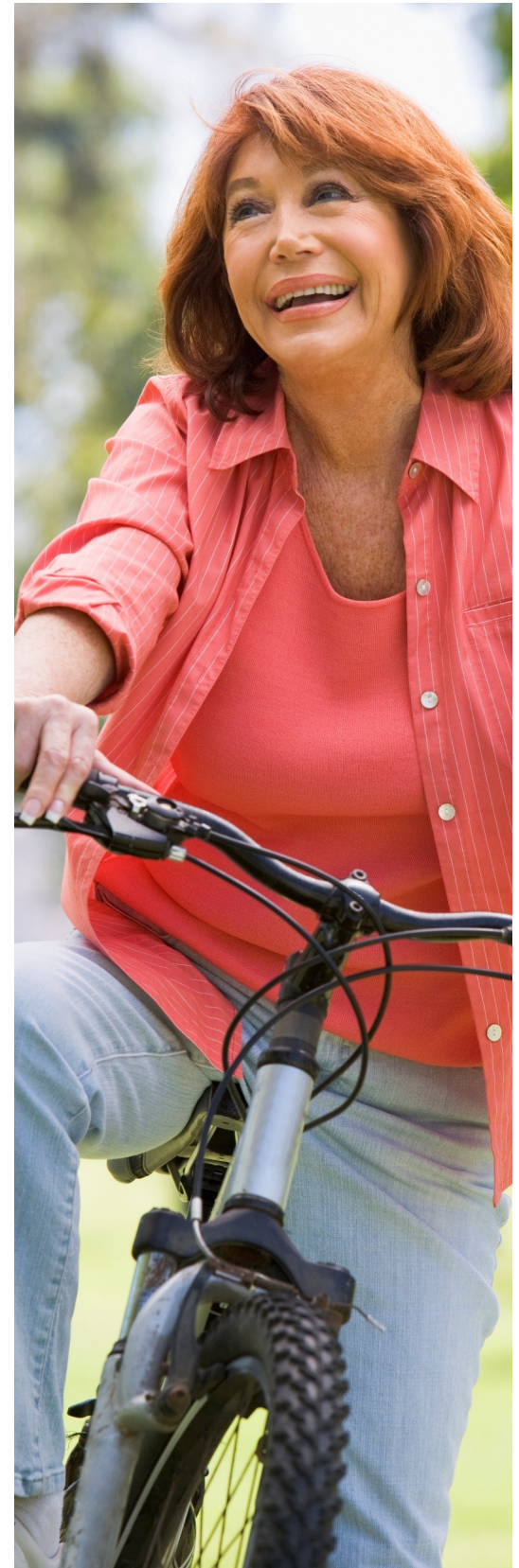
² Surgeries subject to benefit limits if performed in an outpatient hospital: Arthroscopy (\$4,500 max), Cataract (\$2,000 max), Colonoscopy (\$1,500 max), Upper GI Endoscopy (\$1,000 max) and Upper GI Endoscopy w Biopsy (\$1,250 max)

MEDICAL: NON-MEDICARE RETIREES OVER 65

The following Anthem Blue Cross plan is a **non-Medicare** medical plan.



Anthem 80-G PPO Plan - #40447Y	
In-Network	Out-of-Network
Cost Factors	
Annual Deductible	\$500/Individual \$1,000/Family
Annual Out-of-Pocket Maximum	\$2,000/Individual \$4,000/Family
Lifetime Max	Unlimited
Office Visits	
You Pay	
Primary Doctor	\$30 copay (deductible waived) All charges above fee schedule
Specialist	\$30 copay (deductible waived) All charges above fee schedule
Preventive Care	No charge Not covered
Urgent Care	\$30 copay (deductible waived) All charges above fee schedule
Chiropractic	20% Not covered
Acupuncture (Limited to 12 visits/year)	20% up to \$50/visit 50% of allowed amount
Other Services	
You Pay	
Inpatient Hospitalization	20% All charges over \$600/day
Outpatient Surgery Hospital (5 Surgeries Subject to Limits ²)	20% 50% of allowed amount
Outpatient Surgery: Ambulatory Surgery Centers	No charge All charges over \$350/day
Lab and X-Ray Diagnostic Complex (MRI/PET)	20% Not covered
Emergency Facility (copay waived if admitted)	\$100 copay, then 20% \$100 copay, then 20% for true emergency
Ambulance	\$100 copay, then 20% \$100 copay, then 20% of allowed amount for true emergency



- 1 The dollar copay applies only to the visit itself. An additional 20% copay applies for any services performed in the office.
- 2 Surgeries subject to benefit limits if performed in an outpatient hospital: Arthroscopy (\$4,500 max), Cataract (\$2,000 max), Colonoscopy (\$1,500 max), Upper GI Endoscopy (\$1,000 max) and Upper GI Endoscopy w Biopsy (\$1,250 max)

PRESCRIPTION DRUGS: NON-MEDICARE RETIREES OVER 65

Prescription drug coverage provides a benefit that is important to your overall health, whether you need a prescription for a short-term health issue like bronchitis or an ongoing condition like high blood pressure. If you enroll in medical coverage, you will automatically receive coverage for prescription drugs.



Anthem 80-G PPO Plan - #40447Y	
In-Network	Out-of-Network
Cost Factors	
Brand Name Drugs: Annual Deductible	\$200/Individual \$500/Family
Annual Out-of-Pocket Maximum	\$2,500/Individual \$3,500/Family
Pharmacy	
Retail: 30-Day Supply	Generic: \$10 Brand: \$35
Costco Pharmacy: – 30-Day Supply	N/A
Costco Pharmacy: – 90-Day Supply	N/A
Mail Order	
Pharmacy: 90-Day Supply (Navitus)	\$35 Specialty from Navitus
Costco: 90-Day Supply	Generic: \$0 Brand: \$90



Pharmacy Tips

Use generic and over the counter drugs when available.

The best way to save on prescriptions is to use generic or over the counter medications as opposed to brand name drugs. Generic drugs must use the same active ingredients as the brand name version of the drug. A generic drug must also meet the same quality and safety standards.

When to Use a Retail Pharmacy

Use a retail pharmacy to fill prescriptions for acute conditions (conditions that do not require the medication to be taken on a regular basis). At a participating pharmacy, you will receive up to a 30 day supply of your prescriptions.

Use the Mail Order Benefit for Maintenance Medications

To save money and time, consider using the mail order pharmacy to fill your maintenance medications.

MEDICAL:

MEDICARE PARTS A & B-ELIGIBLE RETIREES

UNITED HEALTH CARE GROUP MEDICARE ADVANTAGE HMO



United Health Care Group Medicare Advantage HMO *(California Residents in Qualifying Areas Only)*

In-Network Only*

Cost Factors

Annual Out-of-Pocket
Maximum

\$1,500

Doctor Visits

You Pay

Primary Care Physician

\$10

Specialist

\$15

Preventive Care

No charge

Telemedicine/Virtual Visit

No charge

Outpatient Mental Health/
Substance Abuse

\$15

Other Services

You Pay

Inpatient Hospitalization

\$50 copay per admission

Inpatient Mental Health

\$50 copay per admission

Skilled Nursing Care

Days 1-20: no charge;
Days 21-100: \$25 day;
100-day max

Home Health Care

No charge

Hospice

Covered by Medicare

Prescription Drugs: Retail (30-Day Supply)

You Pay

Tier 1

\$5

Tier 2

\$15

Tier 3

\$30

Tier 4

\$30

Prescription Drugs: Mail Order (90-Day Supply)

You Pay

Tier 1

\$10

Tier 2

\$30

Tier 3

\$60

Tier 4

\$60

*Out-of-Area Coverage: No matter where you are in the world, you should be covered for emergency and urgently needed services. Copays will apply and may vary.

PLAN SUMMARIES CONTINUED ON NEXT PAGE

MEDICAL: MEDICARE PARTS A & B-ELIGIBLE RETIREES

UNITED HEALTH CARE GROUP MEDICARE ADVANTAGE HMO



United Health Care
Group Medicare Advantage HMO
(California Residents in Qualifying Areas Only)

In-Network Only*

Preventive Care

You Pay

Bone Mass Measurement
Colorectal Screening
Immunizations
Mammogram
Pap Smears
Prostate Screening
Routine Physical (1 per year)

No charge

Copays for Outpatient Services

You Pay

Clinical/Diagnostic/
Therapeutic
Radiological Lab Services
CT/MRI/Pet Scans
Nuclear Medicine

No charge

Surgery-Ambulatory Surgery
Center (ASC)

\$25

Surgery-Outpatient at Hospital
(no overnight stay)

\$25

Comprehensive Outpatient
Rehabilitation Facility (CORF),
Physical Therapy (PT),
Occupational Therapy (OT)
Speech, & Cardiac
Rehabilitation

No charge

Ambulance

\$50

Emergency Care

\$50 (waived if admitted within 24 hours)

Urgent Care

\$35 in-network –waived if admitted within 24 hrs

Durable Medical Equipment
(DME) Prosthetics/Medical
Supplies

20%

*Out-of-Area Coverage: No matter where you are in the world, you should be covered for emergency and urgently needed services. Copays will apply and may vary.



PLAN SUMMARIES CONTINUED ON NEXT PAGE

MEDICAL: MEDICARE PARTS A & B-ELIGIBLE RETIREES

UNITED HEALTH CARE GROUP MEDICARE ADVANTAGE HMO



United Health Care Group Medicare Advantage HMO (California Residents in Qualifying Areas Only)	
In-Network Only*	
Podiatry	
Medicare Covered Copay	\$15
Routine Copay	\$15; 6 visits/calendar year max
Diabetes	You Pay
Self-monitoring Training & Medical Nutrition Therapy	No charge
Diabetic Supplies	20%
Dialysis	20%
Hearing	You Pay
Medicare Covered-Exams	\$15
Routine Tests	No charge (1 per year)
Hearing Aids	\$500 allowance every 24 months (combined for both ears)
Vision Services	You Pay
Medicare-covered Eye Exams	\$15
Medicare-covered Eyewear	No charge for Medicare-covered eyewear (one pair of eyeglasses or contact lenses after each cataract surgery)
Dental Services	You Pay
Medicare-covered Dental Services	\$15
Non-Medicare Dental Services	Not covered
Chiropractic Services	
Routine Care	\$5 (12 visits/year)
Medicare-covered Visit	50%

*Out-of-Area Coverage: No matter where you are in the world, you should be covered for emergency and urgently needed services. Copays will apply and may vary.



MEDICAL: MEDICARE PARTS A & B-ELIGIBLE RETIREES

COMPANIONCARE / MEDICARE SUPPLEMENTAL PLAN



	Medicare 2026 Benefits	Companion Care Based on Medicare 2026 Benefits
	In-Network Only	In-Network Only
Inpatient Hospital (Part A)	- Pays all but first \$1,736 for 1st 60 days - Pays all but \$434 a day for the 61st to 90th day - Pays all but \$868 a day - Lifetime Reserve for 91st to 150th day - Pays nothing after Lifetime Reserve is used (refer to Evidence of Coverage)	- Pays \$1,736 - Pays \$434 a day - Pays \$868 a day - Pays 100% after Medicare and Lifetime reserve are exhausted up to 365 days per lifetime
Skilled Nursing Facilities (Must Be Approved By Medicare)	- Pays 100% for 1st 20 days - Pays all but \$217 a day for 21st to 100th day - Pays nothing after 100th day	- Pays nothing - Pays \$217 a day for 21st to 100th day - Pays nothing after 100th day
Deductible (Part B)	\$283 Part B deductible per year	Pays \$283
Basis of Payment (Part B)	80% Medicare Approved (MA) charges after Part B deductible	20% MA charges including 100% of Medicare Part B deductible
Medical Services (Part B) (Doctor, X-ray, Appliances, and Lab)	80% MA charges 100% MA charges	20% MA charges - Pays nothing
Physical/Speech Therapy (Part B)	80% MA charges up to the Medicare annual benefit amount	80% MA charges up to the Medicare annual benefit amount (Physical/Speech therapy combined)
Blood (Part B)	80% MA charges after 3 pints	Pays first 3 pints unreplaced blood and 20% MA charges
Travel Coverage	Not covered	Pays 80% inpatient hospital, surgery, anesthesiologist and in-hospital visits for medically necessary services for 90 days of treatment per lifetime. For details call Anthem customer service at 800-825-5541



MEDICAL: MEDICARE PARTS A & B-ELIGIBLE RETIREES

COMPANION CARE/MEDICARE SUPPLEMENTAL PLAN



	Medicare 2026 Benefits	Companion Care Based on Medicare 2026 Benefits
	In-Network Only	In-Network Only
Outpatient Prescription Drugs	Medicare Part D Prescription Drug Plan Through Navitus Health Solutions	
Retail Pharmacy Mail Order	30-day supply \$9 Generic copay, \$35 Brand copay 90-day supply \$18 Generic copay, \$90 Brand copay	
Accessing Prescription Drug Benefits	Pharmacy benefits are administered through Navitus Health Solutions Medicare Rx using a Medicare D formulary. Some exclusions and prior authorizations may apply. Members that have questions regarding their medication coverage can call Navitus Health Solutions Medicare Rx at 866-270-3877 or TTY users please call 711.	

- CompanionCare is a Medicare Supplement plan that pays for medically necessary services and procedures that are considered a Medicare Approved Expense.
- SISC will automatically enroll CompanionCare Members into Medicare Part D. No additional premium required. SISC plans are not subject to the Medicare Part D coverage gap, also known as the “donut hole,” which is the temporary phase in some Part D plans where members may pay a higher share of prescription drug costs after reaching a certain spending limit until catastrophic coverage begins.
- **Eligibility:** Member must be retired and enrolled in Medicare Part A (hospital) and Medicare Part B (medical coverage). Retiree under age 65 with Medicare for the disabled (Parts A&B) may enroll in Companion Care.
- **Enrollment:** Enrollment forms and a copy of the Medicare card must **be received by SISC 45 days in advance of requested effective date, NO exceptions.** SISC will automatically enroll members in Medicare Part D for outpatient prescription medications. Members already enrolled in non SISC Medicare Part D plans will be automatically disenrolled from those plans.
- **Disenrollment:** Disenrollment throughout the year requires submission of a disenrollment form to SISC with a 45 calendar day advance notice of requested effective date. During the annual Medicare Part D Open Enrollment, members can enroll into Medicare Part D plans outside of SISC with a January 1 effective date. Enrollment in a Medicare Part D plan outside of SISC will terminate the SISC medical and Rx benefits.
- **Provider Network:** Physicians who accept Medicare Assignment.
- For additional **Medicare** benefit information, please go to www.medicare.gov or call **800-medicare (800-633-4227)**.
- For additional **Navitus Medicare RX** prescription drug information, please go to www.navitus.com or call **866-270-3877**.

TIPS ON PRESCRIPTION DRUGS

CHECK OUT THESE TIPS TO SAVE MONEY ON YOUR PRESCRIPTION DRUGS!

Your plan's formulary drug tiers determine how much you pay out of pocket:

\$	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.

GET THE MOST FROM YOUR COVERAGE WITH NAVITUS AND COSTCO!

Take advantage of your SISC benefits to help you save on prescription costs!

Navitus: Specialty Medications for Non-Medicare Anthem Plan Members

Specialty medications are high-cost injectable, infused, oral, or inhaled medications that generally require special handling and may be subject to special rules such as quantity limits, prior authorization and/or step therapy.

These medications have become a vital part of the treatment for chronic illnesses and complex diseases such as multiple sclerosis, rheumatoid arthritis and cancer. Some medications may involve special delivery and instructions that not all pharmacies can easily provide. These medications require personalized coordination between the member, the prescriber and pharmacy. 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 for Members at www.navitus.com. Not available to Medicare members.



Costco: Generic Prescriptions for Anthem Plan Members

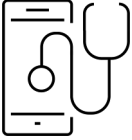
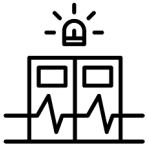
\$0 copay for most generic prescriptions! Costco membership is NOT required. 30 or 90-day supplies of most generics. Some narcotic pain and cough medications are not included in the Costco Free Generic or 90-day supply programs. This program is available to all Anthem PPO and HMO plans.

Find a Costco location by calling 800-774-2678 (press 1) or visit www.costco.com.

TIPS ON MEDICAL CARE OPTIONS

FIND THE RIGHT CARE ANYTIME!

Where you choose to access medical care from 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.

Visit Type	Best For	Examples	Access	Cost
Nurseline 	Quick answers from a trained nurse	- Identifying symptoms - Decide if immediate care is needed - Home treatment options and advice	24/7	\$0
Virtual Visit 	Many non-emergency health concerns	- 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	- 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	\$\$\$\$

CHECK OUT THESE VIDEOS:



**Primary Care vs
Urgent Care vs ER**



Telehealth

SISC BENEFITS FOR NON-MEDICARE ANTHEM PLAN MEMBERS

QUEST WELLNESS SCREENING

All non-Medicare Anthem Plan medical plan members are eligible for a free wellness screening through Quest Diagnostics. This biometric screening can provide important insights into your health risks. When you complete this screening, you will know your health numbers and can connect with your doctor to help manage health risks and prevent chronic disease.



Quest Diagnostics has more than 2,250 Patient Service Centers nationwide where you can get your screening. Here's how to schedule an appointment:

- Go to My.QuestForHealth.com.
- Use Registration Key: SISC2024.
- In the **Wellness Screening** section, under Patient Service Center, select **Schedule a Screening**.
- If you schedule as a walk-in, you may be required to make an appointment upon check-in.
- You will receive an email when your results are ready to view online.

If you'd like to speak with Quest, you can reach them at (855) 623-9355.

Please note, any member awards will be distributed to the email used at registration within 30 days of the completed appointment.

TELADOC EXPERT SECOND OPINION

This benefit provides all non-Medicare Anthem plan members with free support for making clear, informed medical decisions from leading medical experts. Teladoc can help answer medical questions, double-check a diagnosis, provide when help deciding on a treatment plan, or give guidance about surgery. Benefits include:



- Unlimited access to a top physician if you or a family member receive a difficult diagnosis.
- Your Physician Case Manager is backed by a team of leading doctors around the world, and the team collaborates to determine/confirm the correct diagnosis and the optimal plan for treatment.
- Your Physician Case Manager helps navigate the ins and outs of the healthcare system, making care more efficient and helping ease stress.
- Receive on-demand support in understanding the course of treatment, what to expect, and what the likely results are.
- You can access Teladoc at (855) 201-9925 or by visiting teladoc.com/SISC.

LARK DIABETES PREVENTION PROGRAM

Anthem Blue Cross has partnered with Lark to offer a diabetes prevention program that can help non-Medicare Anthem plan members determine if you're at risk for prediabetes and if needed, take steps to address it.



- You can participate in this program at no extra cost as part of your SISC health plan.
- Track your progress, check in with your coach, and learn more about prediabetes right in Lark's free mobile app. This program is flexible, convenient, and follows guidelines from the Centers for Disease Control and Prevention (CDC) to help you make small changes that can improve your health and decrease your risk over time.
- As part of the program, you will also receive a wireless scale that uploads your information to the app automatically so you can easily track your progress and share it with your coach.
- Lark will also send you a personal activity tracker, as long as you stay active in the program.
- Go to www.lark.com/anthemBC and take a quick one-minute survey to see if you could benefit from Lark's diabetes prevention program.

SISC BENEFITS FOR NON-MEDICARE ANTHEM PLAN MEMBERS

ANTHEM EMPLOYEE ASSISTANCE PROGRAM

The District provides retirees with support for a wide variety of challenges through the SISC Anthem Employee Assistance Program (EAP). It is available at no cost to retirees who are enrolled in one of the district's retiree medical plans. If you or a family member needs assistance with personal, family or work-life balance issues, you can contact the EAP for confidential assistance. You can access the EAP by calling (800) 999-7222 or by visiting www.anthemEAP.com (to log in, enter SISC as the program name).



Support and Counseling

The Employee Assistance Program (EAP) provides confidential support in balancing a wide array of challenges with up to 6 free counseling sessions per issue per benefit year, plus unlimited phone support for:

- Relationship difficulties
- Marriage, family or parenting concerns
- Managing change and stress
- Depression and anxiety
- Addiction and recovery
- Grief and loss
- Work/life balance
- Personal growth
- And more

You have the option to access your six free counseling sessions through Talkspace. You can also have unlimited messaging with a counselor, including text, voice, and video message. Talkspace's clinical network includes thousands of licensed counselors specializing in stress, anxiety, depression, eating disorders, substance use, sleep, identity struggles, chronic issues, trauma, grief, relationships, healthy living, and more. Self-guided exercises such as journaling and meditation are available to supplement counseling.

To access Talkspace, call the Anthem EAP at 800-999-7222 or visit talkspace.com/associatecare and use "SISC" as your organization name. You can download the Talkspace app on your mobile phone or access it on your desktop computer using a Chrome, Firefox, Safari, or Edge browser.

Identity Monitoring and Theft Resolution

- 24/7/265 free identity monitoring and theft resolution services through IDnotify.
- Your IDnotify specialist will help you determine if an identity theft event has occurred and guide you through any necessary restoration activities.

Legal and Financial Resources

- A library of articles on legal topics and issues.
- 100 legal forms for a variety of family and consumer situations, plus State-specific legal forms.
- Articles and resources that address estate planning questions.
- Financial Calculators that help you to get answers and explore different options regarding home and personal financing, investing, and retirement.

Learn to Live Wellbeing Support

- Access free, customized online programs based on proven principals of Cognitive Behavioral Therapy (CBT) to manage stress, depression, anxiety, substance use and sleep issues

Seminars and Articles

- Online resources for a wide array of topics, including both a library of articles and on-demand seminars.

Savings Center

- Discount shopping program provided through Perks At Work, with discounts of up to 25% on name brand, practical, and luxury items.

SISC BENEFITS FOR NON-MEDICARE ANTHEM PLAN MEMBERS

VIDA THERAPY AND HEALTH COACHING

- Non-Medicare Anthem plan members have free access to Vida. This virtual care platform can help with nutrition, weight loss, building healthy habits, mental health, and overall wellbeing.
- With Vida, your coach or therapist will personalize a plan for you, and help guide you every step of the way.
- To learn more, call 855-442-5885 or visit vida.com/sisc.



MDLIVE

Non-Medicare Anthem plan members have access to MDLIVE visits for a \$0 copay. This telemedicine service provides convenient 24/7 access to board certified doctors, pediatricians, and licensed therapists via online video, phone or secure email. You can use MDLive:

- When you'd like to access mental health support and resources.
- If you're considering a visit to an emergency room or urgent care center for a non-emergency medical issue.
- When your primary care doctor is not available.
- When you are traveling and in need of medical care.
- During or after normal business hours, nights, weekends and holidays.
- To request prescription drugs or to get refills.



To access MDLive, visit www.mdlive.com/sisc or call (888) 632-2738. Be prepared to provide your name, the patient's name, your member identification number and your phone number.

HINGE HEALTH — PHYSICAL THERAPY FOR BACK AND JOINT PAIN

- Non-Medicare Anthem PPO plan members can receive free, personalized, digitally delivered therapy for back and joint pain.
- Get access to free wearable sensors and monitoring devices, unlimited one-on-one coaching, and personalized exercise therapy.
- Reduce your back and joint pain in just 15 minutes a day.
- To access your Hinge Health benefit, call (855) 902-2777 or visit hingehealth.com/sisc.



CARRUM HEALTH — NO-COST HIP, KNEE, AND SPINE SURGICAL OPTIONS

- Non-Medicare Anthem PPO plan members can access top-quality surgeons at Scripps with no out-of-pocket cost through Carrum Health.
- All medical bills, including deductibles, coinsurance and even travel expenses are covered.
- To learn more, call Carrum Health at (888) 855-7806 or visit info.carrumhealth.com/sisc.



ACTIVE & FIT DIRECT DISCOUNTED GYM MEMBERSHIPS

Active and Fit Direct allows non-Medicare Anthem plan members to enroll in 12,000+ participating fitness centers and YMCAs nationwide for only \$25/month (plus \$25 enrollment fee and taxes). There are no annual fees or long-term contracts, and you can switch gyms at any time. In addition:

- You have access to 9,300+ On-Demand Fitness videos.
- 5,700+ Premium Gym Options at exercise studios, outdoor experiences, and others, with 20% - 70% discounts at most locations.
- To learn more, visit <https://www.anthem.com/ca/sisc/health-wellness>.



SISC BENEFITS FOR NON-MEDICARE ANTHEM PLAN MEMBERS

CENTIVO CARE

Non-Medicare Anthem PPO plan members have free, 24/7 access to a Care Team who works together to offer you primary care, mental health support, and answers to follow-up care questions through the Centivo Care app. The app is available to you and your dependents at no cost. You can receive help with:



- Diagnoses and treatments
- Prescription refills
- Scheduled video visits or live chat with a primary care physician
- Special referrals
- Mental health support

To learn more, go to <https://centivocare.com/sisc>.

LANTERN CANCER CARE

If you or a covered family member are diagnosed with cancer, you can receive treatment support through Lantern Cancer Care. This benefit provides:



- Guided support: A personal oncology nurse will partner with you through every step of your cancer journey.
- Access to excellent care: Access to in-network community oncology clinics, hospitals, and National Cancer Institutes for high-quality care.
- Expert review and advice: Lantern can coordinate expert reviews of your diagnosis and treatment plan, to make sure you're getting the right care, at the right place, at the right time.

To learn more, visit <https://lanterncare.com> or call (855) 961-4533.

VALUE BASED SITE OF CARE BENEFIT

- Reference pricing for five common procedures that can be performed safely at an Ambulatory Surgery Center (ASC) at costs significantly lower than at a hospital are listed below.
- If you choose to have your procedure at an in-network outpatient facility, only the amounts below will be paid for the procedure. You will be responsible for paying the remaining amount in full.
- There is no benefit limit when you obtain these procedures at an in-network Ambulatory Service Center.
- For questions, please contact the customer service number on your medical ID card.

Value Based Purchasing	Maximum Benefit at an in-network outpatient hospital facility	There is no limit at an in-network Ambulatory Service Center (ASC)
	In-Network	ASC Facility
Arthroscopy	\$4,500	n/a
Cataract Surgery	\$2,000	n/a
Colonoscopy	\$1,500	n/a
Upper GI Endoscopy with Biopsy	\$1,250	n/a
Upper GI Endoscopy without Biopsy	\$1,000	n/a

RENEW ACTIVE FOR UNITED HEALTHCARE MEMBERS

RENEW ACTIVE

Renew Active is the gold standard in Medicare fitness programs for body and mind, and it's available with your **United Healthcare Medicare Advantage HMO Plan** at no additional cost. Renew Active is a key part of Renew, which offers a wide variety of health and wellness resources and activities that help inspire you to take charge of your health everyday. Renew includes brain games, healthy recipes, learning courses, fitness activities, Renew magazine and more.

Stay Fit

- Work out where you want, whether that's at a gym, fitness location or from your home.
- Get access to an extensive, nationwide network of gyms and fitness locations.
- Get a personalized fitness plan.
- Bring your caregiver to the gym with you, at no additional cost.
- Get access to thousands of workout videos with Fitbit Premium—no Fitbit® device is needed.

Stay Focused

- Stay focused on brain health with an online program from AARP Staying Sharp, including the Cognitive Assessment and Lifestyle Check-Ins, as well as exclusive content for Renew Active members, such as videos and interactive challenges that can help you build healthy habits.

Stay Connected

- Stay connected socially through local health and wellness classes, clubs and events – such as walking and hiking, arts and crafts, dancing, gardening, bowling, reading, fishing and more.



How to Access Renew Active

Your Code is Key

Every Renew Active member has a unique confirmation code. Write it down and use it to access your gym membership, create an account on AARP Staying Sharp, join the Fitbit® Community for Renew Active and gain access to Fitbit Premium.

How to find your unique Renew Active confirmation code:

1. Sign into your plan website.
2. Click Health & Wellness in the upper right hand corner.
3. Look for Renew Active on the right side of the page.
4. Your Renew Active Confirmation Code will start with a letter, followed by 9 digits. You will see it at the bottom of the screen.
5. If you have any questions or to get your confirmation code, please call Customer Service at the number on the back of your member ID card.

SILVER & FIT FOR COMPANIONCARE MEMBERS



SILVER&FIT

CompanionCare Retirees Age 65+ Only

The Silver&Fit HealthyAging and Exercise program is available to all Companion Care retirees age 65+. You may participate in any of the following programs at no cost to you (unless specified otherwise):

- **Get Started Program:** Answer a few online questions about your fitness level and goals to receive a personal exercise plan, including suggested workout videos.
- **8,000+ Digital Workout Videos:** Go to www.SilverandFit.com or download the Silver&Fit mobile app to view workout videos for all fitness levels.
- **Standard and Premium Fitness Network Choices:** There are many participating fitness centers or select YMCAs, many with exercise classes for older adults. You also have access to 4,000+ Premium locations including fitness centers, studios, and unique fitness experiences for a buy-up price.
- **Healthy Aging Coaching:** Coaches will help you meet your fitness, nutrition, and lifestyle goals during scheduled phone sessions. You can create your own Healthy Aging Life Plan, choose areas to focus on, set goals and stay motivated!
- **Home Fitness Kits:** Pick your favorite kit once every benefit year (note: once selected, Home Fitness Kits cannot be exchanged).
 - Fitbit Wearable Fitness Tracker Kit
 - Garmin Wearable Fitness Tracker Kit
 - Pilates Kit
 - Beginner Strength Kit
 - Intermediate Strength Kit
 - Advanced Strength Kit
 - Beginner Swim Kit
 - Advanced Swim Kit
 - Beginner Yoga Kit
 - Intermediate/Advanced Yoga Kit

To get started with Silver&Fit, visit www.silverandfit.com or call (877) 427-4788.

DENTAL

METLIFE PPO PLANS

The MetLife Dental PPO plans allow you the freedom to visit the dentist of your choice, in or out of network. The plans are designed to provide you and your dependents with access to the full dental benefit allowance whether your dentist is in or out of the MetLife network.

Your costs are typically less when you utilize a network provider because benefits for in-network covered services are based on a percentage of the Negotiated Fee—the fee that participating dentists have agreed to accept as payment in full (subject to the deductible, coinsurance and benefit maximum). If you utilize a non-network provider who does not participate in the MetLife network, your out of pocket costs may be greater because benefits paid are based on a percentage of the Reasonable and Customary (R&C) charge.

Dental Care	MetLife PDP Plus \$2,000		MetLife PDP Plus \$3,000	
	In-Network ¹	Out-of-Network	In-Network ¹	Out-of-Network
Annual Maximum Benefit	\$2,000	\$2,000	\$3,000	\$3,000
Deductible	\$25/Individual \$75/Family	\$25/Individual \$75/Family	\$25/Individual \$75/Family	\$25/Individual \$75/Family
Deductible waived for preventive	Yes	Yes	Yes	Yes
Preventive services	100%	100% (UCR) ²	100%	100% (UCR) ²
Basic services	100%	100% (UCR) ²	100%	100% (UCR) ²
Major services	50%	50% (UCR) ²	50%	50% (UCR) ²
Services per category				
- Exams / cleanings / X-rays	Preventive	Preventive	Preventive	Preventive
- Extractions & fillings	Basic	Basic	Basic	Basic
- Endodontics	Basic	Basic	Basic	Basic
- Periodontics	Basic	Basic	Basic	Basic
- Oral surgery	Basic	Basic	Basic	Basic
- Crowns / inlays / onlays	Basic	Basic	Basic	Basic
- Bridges / dentures / implants	Major	Major	Major	Major

¹ Network benefits are paid based on Negotiated Fee.

² Non-network benefits are paid based on the Reasonable and Customary (R&C) charges based on the 90th percentile.

For More Information On Your Dental Benefits

- Go to www.mybenefits.metlife.com and register for an online account
- Download the MetLife Mobile App to manage your benefits anywhere, anytime
- Call (800) GET-MET8 or (800) 438-6388.



VSP VISION PLAN

Routine vision exams are important not only for correcting vision but also because they can detect other serious health conditions. Santa Barbara Unified School District provides vision coverage through VSP.

- You can see a VSP in-network provider or an out-of-network provider. However, your costs will be lower if you visit an in-network provider.
- If you visit an in-network provider, you will be responsible for a copay at the time of your service.
- If you receive services from an out-of-network doctor, you will pay all costs at the time of service and submit a claim for reimbursement.

Vision Care	Vision Service Plan (VSP)	
	In-Network	Out-of-Network
	You Pay	
Vision Exam (Once Every 12 Months)	\$5	Any charge above \$35 allowance
Eyeglass Lenses (Once Every 12 Months) – Single Vision – Bifocal – Trifocal	No charge No charge No charge	Any charge above \$25 allowance Any charge above \$40 allowance Any charge above \$50 allowance
Frames (Once Every 24 Months)	Any charge above \$180 allowance	Any charge above \$30 allowance
Elective Contact Lenses (Once Every 12 Months in Lieu of Frames and Lenses)	Any charge above \$180 allowance for Contact Lenses/ Contact Lens Exam	Any charge above \$90 allowance for Contact Lenses/Contact Lens Exam



Find Vision Network Providers

Go to www.vsp.com or call (800) 877 7195.



Additional Discounts Available

- LASIK and PRK Benefit: You are entitled to a 15% discount on the usual and customary fees for LASIK and PRK procedures, or a 5% discount on any promotional pricing, whichever is the greater benefit, through the US Laser Network.
- Continued Eyewear Savings: After your initial visits have been utilized, you are able to receive ongoing discounts on additional eye wear purchases at a network provider, which result in discounts up to 40% off the retail price of eye wear and accessories.

BENEFIT CONTACTS



CONTACTS & RESOURCES

SB Unified

District Office:

720 Santa Barbara Street
Santa Barbara, CA 93101

Carrier Information

Anthem Blue Cross of California

Member Services: (800) 322-5709
Website: www.anthem.com/ca/sisc

United Healthcare

Member Services: (888) 867-5548
Website: <https://retiree.uhc.com>

Anthem Blue Cross Companion Care

Member Services: (800) 972-1727
Website: www.anthem.com/ca/sisc

SISC Benefits for Anthem Members

Teladoc Medical Experts

Member Services: (855) 201-9925
Website: <http://www.teladoc.com/sisc>

Hinge Health

Member Services: (855) 902-2777
Website: www.hingehealth.com/sisc

Lantern Cancer Care

Member Services: (855) 961-4533
Website: <https://lanternhealth.com>

Lark Diabetes Prevention Program

Website: www.lark.com/anthemBC

SB Unified

Human Resources/Benefits

Email: hrbenefits@sbunified.org
Phone: (805) 963-4338 ext. 6240

MetLife Dental

Member Services: (800) 438-6388
Website: www.mybenefits.metlife.com

VSP Vision

Member Services: (800) 877-7195
Website: www.vsp.com

MDLive

Member Services: (888) 632-2738
Website: www.mdlive.com/sisc

Vida Digital Coaching

Member Services: (855) 442-5885
Website: www.vida.com/sisc

Carrum Health

Member Services: (888) 855-7806
Website: www.carrumhealth.com/sisc

Centivo Care

Website: <https://centivocare.com/sisc>

FREQUENTLY ASKED QUESTIONS

- 1 I am switching plans and insurance providers, what do I do?**
You will need to indicate that you are switching plans by completing and returning your Retiree Insurance Selection Plan Form.
- 2 I will be turning 65 and will become eligible for Medicare. What will I need to do?**
Upon reaching age 65, you will be eligible to select one of the two Medicare companion plans through United Healthcare and Anthem Blue Cross. You must be enrolled in Medicare Part A and B in order to participate in these Medicare companion plans.
- 3 I am over the age of 65 but I am not Medicare-eligible. Which plans may I elect?**
You may elect the Anthem Blue Cross 80-G PPO Plan, Group #40447Y.
- 4 I am the surviving spouse of a retired district employee. Will I remain eligible for insurance through the district's group plans?**
Yes, surviving spouses of a retired district employee remain eligible for insurance through the district's group plans.
- 5 If I remarry, will I able to enroll my new spouse?**
New spouses of retired district employees are eligible to be added to the district's group plans as long as they are enrolled within thirty (30) days of the qualifying event. Surviving spouses who maintain insurance through the district's plans may keep their coverage if they remarry, but their new spouse may not be added to the plan.
- 6 If I leave a district-offered plan and purchase private insurance coverage, would I be able to come back to a district plan in the future?**
No. Once you terminate and leave the district-offered insurance, you will not be able to come back to a district plan in the future.
- 7 If I cancel my district medical coverage, can I continue to enroll in only dental and vision insurance?**
You may not enroll in only dental and vision coverage with the district. You must be enrolled in a district medical plan in order to enroll in dental and vision insurance. MetLife offers a Dental TakeAlong plan, which is available for those who do not have a district medical plan. This is not a district-sponsored plan.

IMPORTANT FACTS

MEDICARE GUIDELINES

- **Age 65 and Medicare** — If you are turning 65 during the plan year, you should re-examine your insurance profile. Reaching age 65 could entitle you to enrollment in Medicare. Choosing whether or not to enroll or being ineligible for Medicare may have an effect on your district insurance premiums.
- **Medicare Advantage Plans (aka Part C)** — Medicare Advantage Plans, sometimes called "Part C" or "MA Plans," are offered by private companies approved by Medicare. If you join a Medicare Advantage Plan, you still have Medicare. You'll get your Medicare Part A (Hospital Insurance) and Medicare Part B (Medical Insurance) coverage from the Medicare Advantage Plan and not Original Medicare. If you are enrolled in the district's UnitedHealthcare Medicare Advantage plan, Medicare services are covered through this plan and not under Original Medicare. The district's UnitedHealthcare Medicare Advantage Plan includes Part D (prescription drug coverage). Do not join any other Medicare Prescription Drug Plan while you are enrolled in the UnitedHealthcare Medicare Advantage Plan, or Medicare will dis-enroll you from the UnitedHealthcare Medicare Advantage Plan and return you to Original Medicare.
- **Medicare Coordination with Other Coverage** — If you participate in the Anthem Companion Care plan and you are enrolled in Medicare A and B, the Anthem Companion Care plan provides comprehensive secondary insurance. When there is more than one payer, "coordination of benefits" rules decide which one pays first. The "primary payer" pays what it owes on your bills first, and then sends the rest to the "secondary payer" to pay.

IMPORTANT FACTS

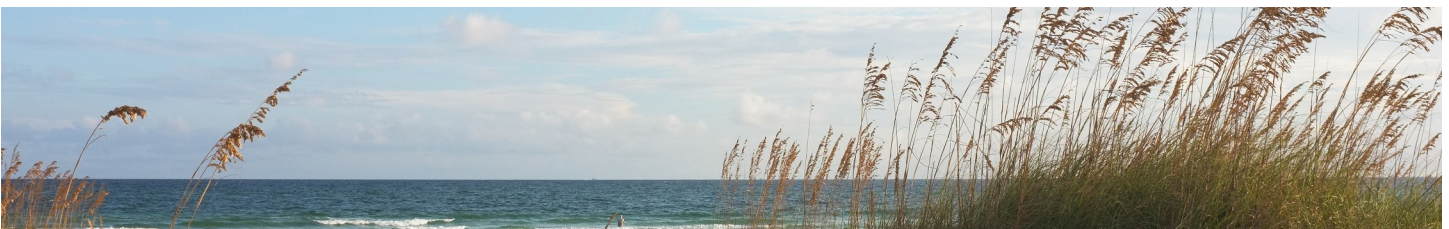
IMPORTANT FACTS, CONTINUED

MEDICARE GUIDELINES, CONTINUED

- **Medicare Part A or Medicare Part B Only** — If you participate in Medicare, but only in Part A or only Part B, you are not eligible for a reduced district insurance premium. You may wish to contact Medicare for information about enrolling in either.
- **Medicare Parts A & B and District Insurance**
 - If you are participating in a district-sponsored medical insurance plan (UnitedHealthcare Medicare Advantage Plan or Anthem Blue Cross Companion Care) and enroll in Medicare Parts A and B, you may be eligible for a reduction of your district medical insurance premium on or after your Medicare effective date and/or you may change your medical plan. **Be sure to let the district know 3 months before your Medicare effective date (usually this is the 1st of the month in which you turn 65)** or as soon as possible. You will need to submit forms to indicate whether you are dropping district insurance or wish to change plans or keep your current plan and have your insurance benefits coordinated and receive a reduction in your monthly district insurance premium.
 - You will also be asked to provide a copy of your Medicare card if you elect to keep the district's insurance. Retirees who have Medicare A & B and district insurance may find that, because of coordination of benefits, when services are obtained from providers that are Medicare assigned and also contracted by the district medical plan carrier, that they ultimately may not be responsible for the co-pays and deductibles of the district's insurance plan. Contact UnitedHealthcare or Anthem Blue Cross for details. Upon receipt of your insurance change form and Medicare Card copy, we will reduce your premium prospectively only.
- **Medicare Prescription Coverage Part D** — The prescription coverage included in the UnitedHealthcare Medicare Advantage Plan and Companion Care Plan is either Medicare D coverage or is considered creditable coverage because in most cases they offer a "richer" benefit than most Part D plans. If you are enrolled in a district-sponsored medical plan, you should not enroll in another Medicare Part D plan.

RETIREE ORGANIZATIONS AND RESOURCES

- **Health Insurance Marketplace** — Under the Affordable Care Act (ACA), if you are not covered under a health insurance plan, unless you are exempt, you may be assessed a penalty through your tax return. You have several ways to get insurance including through the district, your state's health insurance Marketplace (also called an Exchange), an insurance broker, or a public health group like Medicare, Medicaid, or the VA. For more information go online to: www.healthexchange.ca.gov, www.healthinsurance.org/learn/ or www.healthcare.gov.
- **Insurance Advocacy and Senior Resources** — Organizations such as Area Agency on Aging (https://www.aging.ca.gov/Providers_and_Partners/Area_Agencies_on_Aging) and Health Insurance Counseling and Advocacy Program (HICAP) (<https://cahealthadvocates.org/hicap/>) may be available for health insurance assistance and/or Senior resources in your area.
- **Centers for Medicare and Medicaid Services (CMS)** — The Centers for Medicare and Medicaid Services (CMS) is a federal agency within the United States Department of Health and Human Services (DHHS) that administers the Medicare program and works in partnership with state governments to administer Medicaid, the State Children's Health Insurance Program (SCHIP), and health insurance portability standards.



IMPORTANT FACTS

IMPORTANT FACTS, CONTINUED

OTHER

- **Office Visits & Preventive Services** — You should be aware that office visit co-pays and charges may vary based on the type of service received during the visit. Some “special” office visit services may fall outside of what is considered part of a normal office visit and therefore incur higher charges and/or change the way coverage works for that service. You should also be aware that preventive services billed as preventive with a preventive diagnosis code will not be subject to a deductible or co-pay/co-insurance. However, if a claim has a medical diagnosis code, services will be subject to the deductible or co-pay/coinsurance.
- **Premium Payment** — After the insurance subsidy is applied to the premium, any remaining balance is the retiree’s share of premium. This is paid by check or ACH.
- **Medical Travel** — This is also referred to as medical tourism, health tourism, or medical vacation, and it refers to the travel of people to another country for medical treatment. Traditionally, people would travel to major medical centers in highly developed countries for medical treatment that was unavailable in their own communities. More recently, people have also been traveling from highly developed countries with high quality, state-of-the art Centers of Excellence for medical treatments because of cost considerations



IMPORTANT INFORMATION

COBRA FACTS FOR RETIREES

It is important to know that you may be eligible for the continuation of your active employment insurance through COBRA.

Your medical, dental, and vision coverage will end on the last calendar day of the month in which your separation from employment occurs. Once your last employment payroll is processed, your insurance plan's COBRA administrator will send you an election notice detailing your rights to re-enroll with no lapse in coverage, no pre-existing conditions, and what your premium cost will be. The election notice will also include instructions on where to send your election form, when payment is due, and whom to contact if you have questions about your coverage or enrollment.

COBRA Coverage Period

- Federal COBRA coverage generally lasts for up to 18 months and allows you to continue your employer-sponsored health coverage for a limited time after a qualifying event. After the 18 months of federal COBRA coverage expires, if you reside in California, you may be eligible for an additional 18 months of Extended COBRA, for a total of up to 36 months of COBRA coverage.
- Your spouse and dependent children are eligible for 36 months of initial coverage under federal law. There is no California state extension of this coverage. They have the option to enroll separately from your coverage. SISC can answer any questions you may have about your COBRA coverage.
- Domestic partners do not have federal or state COBRA rights to continue health insurance coverage unless they otherwise meet the qualifications of a dependent.

If You Are A Recent Retiree With COBRA Coverage

Open Enrollment is an opportunity for you to elect different coverage, including a different carrier, within the COBRA tier. Your 18 month COBRA or 18 month Extended COBRA period will not reset, the COBRA coverage termination date will remain the same as if you had not changed coverage or carrier.

Terminating COBRA Or Extended COBRA Coverage

Terminating COBRA or Extended COBRA Coverage terminates the COBRA period permanently, it cannot be placed on hold and continued at a later time.

If You Turn 65 or Otherwise Become Eligible for Medicare During Your COBRA Period

It is important to know that your COBRA eligibility does not change the Medicare enrollment date. You are strongly encouraged to sign up for Medicare when you are eligible at age 65. Medicare will not consider your COBRA conclusion date as a Qualifying Event to enroll in Medicare outside the normal timeframe. If you do not sign up for Medicare when you are eligible, you will be penalized when you do enroll: you will pay a higher premium for life, and you will be subject to the Medicare Open Enrollment period, which may delay your enrollment in Medicare for up to a year.

- **Newly enrolling in Medicare while you have COBRA coverage** does not disqualify you from continuing your COBRA coverage. You may be responsible for reimbursement of claims paid incorrectly after your Medicare effective date. Continuation of COBRA benefits might be available in some cases for a COBRA-covered spouse. Extended COBRA is only available to California residents. Reaching the end of your COBRA eligibility period (18 months or three years) is a qualifying event enabling you to make insurance changes outside of Open Enrollment.
- **You are responsible for coordinating your Medicare enrollment.** The district does not collect Medicare premiums, nor coordinate your enrollment with the Centers for Medicare and Medicaid Services. It is your responsibility to contact Social Security Administration directly to coordinate your Social Security and Medicare enrollment.

IMPORTANT INFORMATION

ANNUAL NOTICES

ERISA and various other state and federal laws require that employers provide disclosure and annual notices to their plan participants. Santa Barbara Unified School District distributes these notices each year during open enrollment. You may also request a copy by contacting the Human Resources Department, or download a copy by clicking on the QR code or going to <https://www.sbunified.org/departments/humanresources/benefits>.

- Medicare Part D Notice of Creditable Coverage
- HIPAA Notice of Privacy Practices
- Women's Health and Cancer Rights Act (WHCRA)
- Newborns' and Mothers' Health Protection Act
- Special Enrollment Rights
- Medicaid & Children's Health Insurance Program
- Summary of Benefits and Coverage (SBC)



PLAN DOCUMENTS

Important documents for our retirement plans are available on our benefits website at <https://www.sbunified.org/departments/humanresources/benefits> and include:

- **Evidence of Coverage (EOCs):** An Evidence of Coverage, or EOC, is the legal document for describing benefits provided under the plan as well as plan rights and obligations to participants and beneficiaries.
- **Summary of Benefits and Coverage (SBCs):** A Summary of Benefits and Coverage (SBC) is a document required by the Affordable Care Act (ACA) that presents benefit plan features in a standardized format. All plan SBCs are available on our benefits website at <https://www.sbunified.org/departments/humanresources/benefits>.

Paper copies of these documents and notices are available upon request. Contact Human Resources at (805) 963-4338 ext. 6240 or via email at hrbenefits@sbunified.org.

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[illegible]

**Phone:**

(805) 963-4338 ext. 6240

**Email:**

hrbenefits@sbunified.org

**Website:**

<https://www.sbunified.org/departments/humanresources/benefits>



To view Important documents for our retirement plans, go to <https://www.sbunified.org/departments/humanresources/benefits> or scan the QR code above with your smartphone.

MAKING CHANGES TO YOUR HEALTH INSURANCE FOR 2026?

Review your Retiree Enrollment Packet, including your Retiree Benefit Guide, Retiree Plan Selection Form and Retiree Rate Sheet

- All forms must be submitted no later than **Friday, July 10, 2026**

Questions about your benefits?

- Speak to a district representative on June 25th in the District Board Room from 10:00am—4:00pm

View benefit materials beginning June 23rd

- Go to: <https://www.sbunified.org/departments/humanresources/benefits>



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Learn more at www.baldwin.com

This Employee Benefits Guide provides an overview of some of your benefit plan choices. It is for informational purposes only. It is not intended to be an agreement for continued employment. Neither is it a legal plan document. If there is a disagreement between this guide and the plan documents, the plan documents will govern.

In addition, the plans described in this guide are subject to change without notice. Continuation of any benefit plan or coverage is at the company's discretion and in accordance with federal and state laws. If you need additional information or have any questions about the benefit program, please contact the Human Resources Department.