2026

Benefits Information Guide AACV, Charter and Non-Represented

Welcome

The benefits you'll find here are carefully chosen to support your life outside of work, whatever it looks like for you. Whether you're checking it out for the first time or stopping by for a visit, this guide is crafted to help you choose the right benefits. We'll talk about medical, dental, spending accounts, and more.

We'll also help you put those benefits to use whenever you need them throughout the plan year. You'll find answers to important questions like "How do I add my new baby to my insurance?" or "What will my rates change to if I add a dependent?"

Plan summary

Does this guide contain everything I need to know about my health plan?

While there are many brief benefit summaries listed throughout this guide, they're just that: summaries. When you're trying to figure out whether a medical service or a medical supply will be paid for by your health plan, it's best to take a look at the Evidence of Coverage or Summary Plan Description as well.

One important thing to note is that in order for a service or supply to be paid for by your health plan, it must be overseen by a doctor. Some of the guidelines for coverage also come down to the type of plan you choose, which you'll learn more about in this guide.

There's more important information in your health plan documents called Evidence of Coverage and Summary Plan Description. These documents have more details about your coverage. You can find them in your benefit administration portal, or by contacting Risk Management. They're the final place you'll need to look if you have questions about your coverage because they're the binding agreement between you and the plan.

If you notice differences between benefits in this guide and the Evidence of Coverage or Summary Plan Description, you should go by what's written in those documents, not this guide.

When you ask your health plan to cover a supply or service, it's called a "claim." These documents have the information you need to get your claim reviewed or to dispute it if you think there's been an error.

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, Federal law gives you more choices about your prescription drug coverage. Please see page 42 for more details.

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The rates quoted for these benefits may be subject to change based on final enrollment and/or final underwriting requirements. This material is for informational purposes only and is neither an offer of coverage nor medical advice. It contains only a partial, general description of the plan or program benefits and does not constitute a contract. Consult your plan documents (Schedule of Benefits, Certificate of Coverage, Group Agreement, Group Insurance Certificate, Booklet, Booklet-certificate, Group Policy) to determine governing contractual provisions, including procedures, exclusions and limitations relating to your plan. All the terms and conditions of your plan or program are subject to applicable laws, regulations and policies. In case of a conflict between your plan document and this information, the plan documents will always govern.

Check out your benefits

Dig into options, programs, and resources

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Keep an eye out for benefit examples

Quick note: these examples are meant to help you understand the different health plans we offer. If you have specific questions, it's a good idea to reach out to Benefits/Risk Management at 619.425.9600 ext 181352.

Cost of Benefits for 2026

January 1 through December 31, 2026

Summary of Benefits Payroll Deductions

Monthly Payroll Deductions for Medical includes Employee-Only Dental & Vision

	With Delta Dental PPO			With United Concordia Dental HMO		
	EE Only	EE & 1 Dep	EE & 2+ Dep	EE Only	EE & 1 Dep	EE & 2+ Dep
SISC - Kaiser	$0.00	$351.28	$573.95	$0.00	$325.02	$547.69
SISC - Anthem Blue Cross Select Network HMO	$0.00	$434.28	$695.95	$0.00	$408.02	$669.69
SISC - Anthem Blue Cross Full Network HMO	$0.00	$606.28	$948.95	$0.00	$580.02	$922.69
SISC - SIMNSA	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
SISC - Anthem Blue Cross PPO	$0.00	$152.28	$315.95	$0.00	$126.02	$289.69

Additional Deductions for:	EE Only	EE & 1 Dep	EE & 2+ Dep	EE Only	EE & 1 Dep	EE & 2+ Dep
Dependents' Dental	Included	$57.69	$88.38	Included	$16.99	$38.19
Dependents' Vision	Included	$6.21	$10.91	Included	$6.21	$10.91
MetLife Voluntary Legal Plan	$23.00 for EE/Family or $28.00 for Plan Plus Parents			$23.00 for EE/Family or $28.00 for Plan Plus Parents		
Norton Life Lock ID Protection Plan	$7.50 for Employee Only or $14.50 for Employee/Family			$7.50 for Employee Only or $14.50 for Employee/Family		

District Contribution: $15,500 EE; $18,000 EE+1; $23,200 FAM

Directory

Directory & Resources

Below, please find important contact information and resources for Chula Vista Elementary School District.

Information Regarding	Group / Policy #	Contact Information	
Enrollment & Eligibility			
Benefits & Risk Management		619.425.9600 ext. 181352	riskmanagementdepartmentteam@cvesd.org
Online Enrollment Vendor:			
• AF Enroll		800.365.9180	www.afenroll.com
Medical Coverage			
Kaiser			
• HMO		800.464.4000	www.kp.org
Anthem Blue Cross			
• Select HMO		800.825.5541	www.anthem.com/ca/sisc
• Full HMO			
• HSA-PPO			
• Navitus Prescription Drug Coverage		866.333.2757	www.navitus.com
SIMNSA			
• HMO		619.407.4082	www.simnsa.com
Chiropractic & Acupuncture Care (Kaiser & Anthem Only)			
• American Specialty Health (ASH)		800.678.9133	www.ashcompanies.com
Dental Coverage			
Delta Dental			
• DPPO		888.335.8227	www.deltadentalins.com
United Concordia			
• DHMO		866.357.3304	www.unitedconcordia.com
Vision Coverage			
VSP			
• Vision PPO		800.877.7195	www.vsp.com
Life & AD&D			
The Hartford			
• Life and AD&D Customer Service		800.523.2233	gbdcustomerservice@hartfordlife.com
• Life Claims		888.563.1124	
Flexible Spending Accounts			
American Fidelity		866.523.1857	www.americanfidelity.com
Employee Assistance Plan			
EASE		888.736.7009	well.evernorth.com; Employer ID: EASE

Eligibility & Enrollment

Eligibility & Enrollment

Quick answers to your questions

Who can sign up?

All employees who regularly work at least 20 hours per week are eligible to enroll in our medical, dental, and vision program. More good news: you can also cover your spouse, eligible child(ren), and any other individual described in an eligible class for that benefit. Just keep in mind, you may be required to enter into a registered domestic partnership or other official domestic partnership arrangement with the state of CA in order to elect coverage for a domestic partner or your domestic partner's child(ren). Coverage for your domestic partner and children will not be tax-free if they do not qualify as your tax dependent(s).

It may be possible for a registered domestic partner and/or their child(ren) to qualify as your tax dependents for state tax purposes even when they do not qualify as your federal tax dependent(s).

When does my coverage start?

Regular, full-time employees: You can sign up as soon as the date you're hired, but your coverage will start on the 1st of the month after your date of hire. You must enroll in all of your benefits within the first 30 days.

Once you enroll in a benefits plan, you can't make any changes until the end of the plan year, which is from January 1, 2026 – December 31, 2026.

If you miss the deadline to sign up, you can't enroll at a later date unless you experience what's called a Qualifying Life Event Change. It's always a good idea to check with your plan administrator and your section 125 plan document to see if you're allowed to make a mid-year change based on your situation.

Can I make changes after I sign up?

After you've signed up, you can only make changes to your benefits if you have what's called a qualifying life event (QLE). A QLE is something that happens to you or someone in your family. The list of QLEs is defined by the federal government. Some examples are:

- New Marriage
  - Your new spouse may be enrolled in your plan on the first of the month following the date of marriage. However, unless Risk Management receives notice of a change within 30 days of the marriage, the new spouse may not enroll for coverage until the next Open Enrollment period. A copy of your marriage license must be presented to Risk Management Department.
- Registered Domestic Partner
  - Registered domestic partners must be added within 30 days of a Declaration of Domestic Partnership being filed and approved with the State of California. The employee must verify the status of their domestic partnership by providing the District with the original of the valid Declaration of Domestic Partnership filed with, and approved by, the State of California. Registered domestic partner.
- Divorce/Dissolution
  - The employee must notify the District within 30 days of the termination/dissolution of marriage or a registered domestic partnership. Once the court/state has officially ended the marriage or domestic partnership the dependent will be removed the first of the month following.
- Newborn Children
  - A newborn is automatically covered under your medical plan as of his or her birth date for the first 30 days. However, if the member elects to continue coverage past the first 30 days, the member must enroll the newborn and present a copy of the original birth certificate to the Risk Management Department within 30 days of the date of birth.
- Death of Dependent
  - The employee must notify the District within 30 days of the death of a covered dependent and a copy of the death certificate.
- Loss of Other Coverage
  - An employee and the employee's eligible dependents may enroll within 30 days of losing other coverage. The loss of other coverage must be due to ineligibility to continue the other coverage, group continuation of coverage has expired, or the other employer has ceased making contributions toward the other coverage and the loss of coverage is not due to the nonpayment of premiums or for cause. Proof of loss of coverage must be presented to Risk Management Department, along with the 1040 tax form, marriage and/or birth certificate.
- Medicare or Medicaid enrollment
  - A special enrollment opportunity to sign up for a plan in the Public Health Insurance Marketplace (i.e., Covered California or another state-run marketplace or Healthcare.gov)

These are just some examples. You can find a complete explanation of qualifying life event changes in "HIPAA Special Enrollment Rights Notice."

You might be able to add or drop coverage if one or more of these things happen to your family after you sign up. Most Qualified Life Event changes, such as getting married or having a baby, are time-sensitive and must be addressed within 30 days. Alternatively, if you lost eligibility or enrolled in Medicaid, Medicare, or state health insurance programs, you have to submit the request for change within 60 days. It's always a good idea to reach out to your plan administrator to find out if you can make changes.

Do I have to sign up?

No. You can "waive" medical coverage if you're covered through another plan, such as a plan offered through your spouse's job. To waive coverage, employees must fill out a waiver form and show proof of coverage. Keep in mind that if you waive coverage, you won't be able to enroll in our group benefits again until next year on January 1, 2027, unless you experience a qualifying life event.

If you don't sign up for any health insurance coverage at all, you might have to pay a penalty. Although the federal penalty requiring individuals to maintain health coverage was reduced to $0, some states have their own mandates.

To avoid paying these penalties in certain states, you can sign up for health insurance through our benefits program or purchase coverage from somewhere else, such as from a State or Federal Health Insurance Exchange.

Curious about Healthcare Reform and the Individual Mandate? Reach out to Human Resources or visit Healthcare.gov. You can also visit www.coveredca.com for details on the Covered California State Health Insurance Exchange.

How do I get started with my enrollment?

- After reviewing your options, visit the online enrollment site at http://www.afenroll.com/enroll
- At the login screen, enter the site using the following information:
    - **Enter your user ID:** This is your Social Security Number
    - **Enter your Temporary PIN:** The last four digits of your SSN and 8-digit date of birth (For example, for SSN 123-45-6789 and you were born on July 1, 1974, you would type in 678907011974).
    - **Two-Factor Authentication:** American Fidelity has implemented two-factor authentication to add an extra layer of security to your enrollment experience. You will be prompted to select either an email address or a mobile phone number to receive a verification code. Once that code is received, you will input it into the prompt in AFenroll to verify your account.
    - **Changing your PIN:** After you enter your Temporary PIN you will be prompted to change your PIN to one of your choosing. You will enter your new PIN, where prompted, then re-enter your new PIN to verify. **PIN requirements**: Eight character minimum to include: one upper case letter, once lower case letter, and one special character. Before you can complete your PIN change, you must select a security question, answer it, and provide your email address. **NOTE: It is important to remember your new PIN as this will be how you will log into the site moving forward. Select Next to begin enrolling.**
- What You Need
    - Spouse and children's dates of birth and Social Security Numbers
    - Beneficiary information (and, if a trust, the full name and date of trust)

Helpful Tips

Log Out: If you leave the site in the middle of the process, click the 'Log Out' button to save your selections.

Print Confirmation: Be sure to print your confirmation. Once you confirm your enrollment, you may click on the confirmation link at the bottom of the 'Sign/Submit Complete' to print your confirmation statement.

Re-Enter/Make Changes: You may re-enter the enrollment site (including to 'View Only' your original selections) to make changes at any time during your enrollment period. **Please note: Before you log out, you must re-confirm with your signature or your enrollment will not be valid.**

Opting Out: If you choose not to select medical benefits, you must still enroll in dental, vision, basic life and disability.

Required: Social Security Numbers and Dates of Birth are required for all employees and their dependents.

Adding Dependent: If you are adding a dependent as a beneficiary, their Social Security Number is required.

Physician Codes: Have your Primary Care Physician (PCP) codes available.

Signature: You will use your signature to confirm applications and your enrollment confirmation.

To view a step-by-step video on how to enroll using AFenroll®, please visit americanfidelity.com/howtoenroll.

If you prefer to make a virtual appointment with an American Fidelity Representative, please click the link: https://americanfidelity.com/chulavistaesd.

Medical Plans

Medical Plans

Breaking down plan types (and understanding acronyms)

HMO

On a Health Maintenance Organization plan or HMO, your first important step is to choose a Primary Care Physician (PCP). Your PCP will provide you with care or refer you to other services. Any other medical services you need throughout the year must come from a certain group of providers—the ones in the plan's network. If you go to a provider or facility outside the network, the health plan will not pay for those services unless it's an emergency.

Advantages

Out-of-pocket costs are lower

Your care is coordinated by your PCP

Ideal if...

...you want less money taken out of your monthly paycheck and are comfortable with a PCP directing your care.

Out-of-pocket costs

Your health plan can charge different fees: a flat fee called a "copay", a fee that's a percentage of the total cost of the service called "coinsurance", and an amount that must be paid before your plan kicks in, called a "deductible." Sometimes, these types of fees are lower in an HMO than they are in other types of plans.

Using an HMO plan: an example

Meet Ben. Ben needed an annual exam but was also worried about an area on his skin. Ben first went to the insurance company website, found an in-network primary care physician (PCP), and made an appointment. Ben told the PCP about his skin concerns, and the PCP referred Ben to a dermatologist in the plan network.

That worked great for Ben. He was too overwhelmed to find the dermatologist himself, and he likes coordinating his care with the PCP. Ben's first visit cost $25 in copay fees, which will count toward the out-of-pocket cost.

PPO HSA

CVESD's PPO HSA plan is a High-Deductible Health Plan (HDHP). With this plan, you must pay more out-of-pocket before your health plan starts covering services. The amount you have to pay before the plan kicks in is called the "deductible." To help cover these expenses, you can access a special savings account called a "Health Savings Account (HSA)." You can contribute pre-tax funds to this account and use it to pay for different health-related expenses called "qualified medical expenses."

Unlike a healthcare flexible spending account (HCFSA), there is no deadline to spend the money. Another perk is your HSA is transferable, so you can take any money left in the account with you even if you were to terminate employment with Chula Vista Elementary School District.

Advantages

HSA contributions are tax-deductible

Your HSA can help you save on taxes

Interest on an HSA is tax-deferred

Unspent balances from one year roll over to the following year and can accumulate over a lifetime to help pay for uncovered Medicare expenses after retirement

HSA balances pass on free of tax to their spouse, if the spouse is the named beneficiary

Out-of-pocket costs

If you choose the Anthem PPO HSA, you'll pay most of your out-of-pocket expenses upfront until you reach your deductible

How Much Can I Contribute to my HSA

The maximum amount that can be contributed to an HSA for 2026 is $4,400 for an individual and $8,750 for a family

HSA holders 55 and older can save an extra $1,000, which means $5,300 for an individual and $9,550 for a family for 2026

Ideal if…

…you don't usually need much health care throughout the year and have enough money set aside to cover expenses until you reach your deductible

Note:

You can only use your HSA funds to pay for qualified medical expenses, such as copays and purchases of over-the-counter medications. It's a good idea to keep your receipts in case your taxes are audited

Using the Anthem PPO HSA plan: an example

Taylor almost never goes to the doctor, but when she experienced a fever, chills, and chest congestion, she decided to visit urgent care. Taylor found a nearby in-network facility for treatment. Because Taylor hadn't yet met the plan's annual deductible, the health plan didn't cover the visit.

Taylor had savings set aside after choosing to pay less in monthly premiums, so this unusual visit wasn't a big deal. Taylor paid a $150 copay, which counts toward the plan's annual deductible.

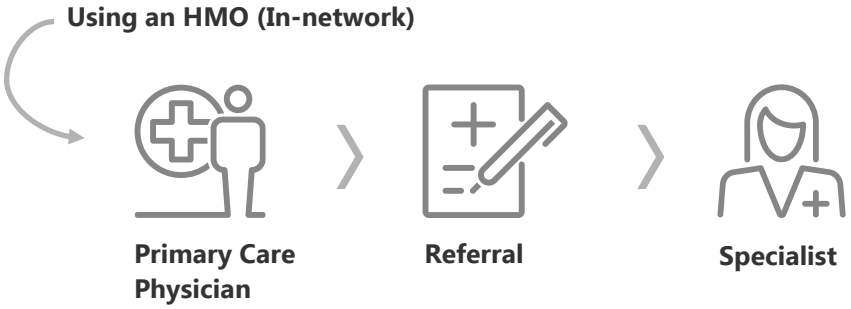
How do I find a doctor?

To find a provider in your HMO plan's network:

Anthem HMO

- Go to http://anthem.com/ca/sisc
- Select Find Care
- Choose HMO (Full Network) or HMO Select Network
- Confirm network options with your school district.

Using an HMO (In-network)

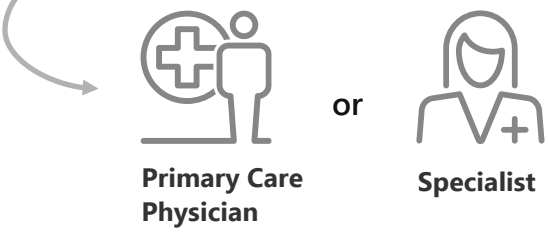


To find a provider in your PPO plan's network:

Anthem PPO

- Go to http://anthem.com/ca/sisc or use our Sydney Health mobile app on a smartphone.
- Select Find Care to search for doctors and facilities
- Ask doctors and other healthcare professionals to only refer you to doctors in your plan's network. If you need care at a hospital, ask if all the facility-based professionals, such as radiologists, anesthesiologists, and pathologists, are part of your plan's network.
- Call the Member Services number on your Member ID card to check if certain providers are part of your plan's network.

Using a PPO (In-network or Out-of-network)



Participating Medical Groups (PMG) – San Diego County

Anthem Blue Cross HMO Plans

	HMO Networks	
Participating Medical Groups	**Select Network**	**Full Network**
Graybill North Coastal	Yes	Yes
Greater Tri-Cities IPA	Yes	Yes
Primary Care Associates Medical Group (Includes Cassidy Medical Group)	Yes	Yes
Radys Childrens Health Network	Yes	Yes
Scripps Physicians Medical Group (Formerly San Diego Physicians)	Yes	Yes
Sharp Community Medical Group	Yes	Yes
Sharp Rees-Stealy	Yes	Yes
UCSD Medical Group	Yes	Yes
UCSD Physician Network	Yes	Yes
Optum Care Network	Yes	Yes
Scripps Clinic Medical Group	No	Yes
Scripps Coastal Medical Center	No	Yes

*All of an employee's family members must be enrolled in the same HMO network, but each can elect a different Medical Group and can change groups within the network during the year by calling Anthem.

Saving money on your medications

Your benefits cover a lot of prescription medications, but how much you pay for them, and how much your health plan covers, is determined by a system of "tiers." These tiers are more like a layer cake than a rating system: The quality is the same no matter where you are, but the higher you go on these tiers, the more expensive and/or hard to access the medication may be.

Here are some examples of the types of medications in each tier:

Tier 1 - Generic Formulary:

These medications have the same active ingredients as brand-name medications, but they cost less.

Tier 2 - Brand name:

These medications are only made by one manufacturer.

Tier 3 - Non-formulary:

Medications that aren't on your health plan's list of preferred medications, which is called their "formulary." Usually, this happens when there is a safe and effective alternative that is less expensive—often a generic. If your doctor prescribes a non-formulary prescription, it's a good idea to speak with them or your pharmacist about generic alternatives.

Tier 4 - Specialty:

These medications treat chronic or complex conditions. They often require step therapy and/or prior authorization to be approved to fill.

Why pay more for your medications?

Use the mail

You can save time and money by getting your medications shipped directly to you through a mail-order service. You can have a larger quantity, usually a 90-day supply, regularly shipped to your door. Go to www.navitus.com or rx.costco.com to sign-up for delivery service.

Shop around

Some pharmacies offer less expensive medications. Try calling pharmacies inside warehouse clubs or discount stores to see if they offer a lower price. Shopping around could pay off.

Try over-the-counter

For colds, headaches, and other common conditions, over-the-counter medications can sometimes work just as well as prescription ones—and cost a lot less, too.

Chiropractic Care & Acupuncture

Chiropractic Care and Acupuncture coverage through American Specialty Health (ASH) is included on all health plans except SIMNSA. Please confirm the copay for each visit shown on pages 19-21. Please contact 800.678.9133 or www.ashcompanies.com for more information.

Out of Area Medical Coverage

Kaiser Away From Home

Out-of-Area Dependent OUTSIDE of Kaiser Service Area:

- For nonurgent care, use your kp.org account or Kaiser app to get 24/7 care and advice from Kaiser clinicians by phone or online – usually at no cost.
- If there is an emergency, no matter where you are, you can simply go to the nearest hospital emergency room. If it's a Kaiser location or a Cigna PPO provider, you'll only pay your normal copay or coinsurance.
- You can get urgent care at the following locations outside Kaiser states, and you'll only pay your copay or coinsurance for care or prescriptions related to your urgent care visit – no need to file a claim later. At all other locations, you must pay the full cost of care upfront and file a claim for reimbursement later. For more information call the Away from Home Travel Line at 951.268.3900 or visit kp.org/travel.
    - Cigna PPO Network providers
    - MinuteClinic
    - Concentra clinics
    - The Little Clinic

Out-of-Area Dependent INSIDE of Kaiser Service Area:

- As a member, you can get most of the same services you would get in your home service area when visiting another Kaiser Permanente service area. You can get these services as long as they're provided or referred by a Kaiser Permanente doctor in the service area you're visiting.
- To get care, call the Away from Home Travel at 951.268.3900 and let them know you plan to visit another Kaiser service area for care. You'll get a medical record number (MRN) or health record number (HRN) for the other Kaiser service area and information on making an appointment. You'll only use this MRN or HRN in the service area you're visiting.

Anthem Blue Cross

- If you are enrolled in the HSA (PPO-HDHP), as long as there is a Blue Cross Network where your student is going to college, they can access primary care. Otherwise, they would only have access to urgent/emergency services.
- For Anthem HMO plans, members can have access to primary care, via the Anthem's "Away from Home Guest Membership" program. To get care, call the Away from Home guest membership program at 800.827.6422. There are three types of guest memberships:
    - **Long-term Traveler** is for members who will be away from home at least 90 days.
    - **Families Apart** is for members' covered spouse or dependent(s) who live outside of Anthem's service area.
    - **Student Guest** is non-California dependent(s) who go to school outside of Anthem's service area for 90 or more days. While many colleges have health clinics, they may or may not take the student's health insurance. With guest membership, students can receive care from a doctor in the program at a lower out-of-pocket cost.

"How much will specific services cost?"

Plan Highlights	Kaiser HMO	SIMNSA Health HMO[2]
Annual Calendar Year Deductible		
Individual	None	None
Family	None	None
Maximum Calendar Year Out-of-pocket [1]		
Individual	$1,500	$6,350
Family	$3,000	$12,700
Professional Services		
Primary Care Physician (PCP)	$10 Copay	$5 Copay
Specialist	$10 Copay	$5 Copay
Preventive Care Exam	No Charge	No Charge
Diagnostic X-ray and Lab	No Charge	No Charge
Complex Diagnostics (MRI/CT Scan)	No Charge	No Charge
Acupuncture Services	$10 Copay	Not Covered
Chiropractic Services	$10 Copay	Not Covered
Hospital Services		
Inpatient	No Charge	No Charge
Outpatient Surgery	$10 Copay	No Charge
Urgent Care	$10 Copay	$25 Copay Mexico / $50 Copay out
Emergency Room	$100 Copay	$250 Copay
Mental Health & Substance Abuse		
Inpatient	No Charge	No Charge
Outpatient	$10 Individual / $5 Group	$5 Copay
Retail Prescription Drugs		
Tier 1	$10 Copay (100 days)	$5 Copay (30 days)
Tier 2	$10 Copay (100 days)	$5 Copay (30 days)
Tier 3	N/A	$5 Copay (30 days)
Tier 4	$10 Copay (30 days)	$5 Copay (30 days)
Mail Order Prescription Drugs		
Tier 1	$10 Copay (100 days)	N/A
Tier 2	$10 Copay (100 days)	N/A
Tier 3	N/A	N/A
Tier 4	N/A	N/A

[1] Out-of-pocket maximum is based on the maximum allowable charge the carrier allows. This does not include any balance billing that may occur when using an out-of-network provider.

[2] The SIMNSA plan is only for members in Mexico.

The above information is a summary only. Please refer to your Evidence of Coverage for complete details of Plan benefits, limitations and exclusions.

"How much will specific services cost?"

Plan Highlights	Anthem Select HMO	Anthem Full HMO
Annual Calendar Year Deductible		
Individual	None	None
Family	None	None
Maximum Calendar Year Out-of-pocket [1]		
Individual	$1,000	$1,500
Family	$2,000	$3,000
Professional Services		
Primary Care Physician (PCP)	$10 Copay	$20 Copay
Specialist	$10 Copay	$20 Copay
Preventive Care Exam	No Charge	No Charge
Diagnostic X-ray and Lab	No Charge	No Charge
Complex Diagnostics (MRI/CT Scan)	$100 Copay	$100 Copay
Acupuncture Services (30 visit limit through American Specialty Health)	$10 Copay	$10 Copay
Chiropractic Services (30 visit limit through American Specialty Health)	$10 Copay	$10 Copay
Hospital Services		
Inpatient	No Charge	$200 per admit
Outpatient Surgery	No Charge	$100 Copay
Urgent Care	$10 Copay	$20 Copay
Emergency Room	$100 Copay	$100 Copay
Mental Health & Substance Abuse		
Inpatient	No Charge	$200 per admit
Outpatient	$10 Copay	$20 Copay
Retail Prescription Drugs (30-day supply)		
Generic	$5 Copay / $0 at Costco	$9 Copay / $0 at Costco
Brand	$10 Copay	$35 Copay
Specialty	Not covered	Not covered
Mail Order Prescription Drugs (90-day supply)		
Generic	No Charge through Costco	No Charge through Costco
Brand	$20 Copay through Costco (90-day)	$90 Copay through Costco (90-day)
Specialty	$10 Copay through Navitus (30-day)	$35 Copay through Navitus (30-day)

[1] Out-of-pocket maximum is based on the maximum allowable charge the carrier allows. This does not include any balance billing that may occur when using an out-of-network provider.

The above information is a summary only. Please refer to your Evidence of Coverage for complete details of Plan benefits, limitations and exclusions.

"How much will specific services cost?"

Plan Highlights	Anthem Blue Cross HSA-PPO	
	In-network	**Out-of-network**
Annual Calendar Year Deductible		
Individual	$1,700	
Family	$3,400	
Maximum Calendar Year Out-of-pocket [1]		
Individual	$3,400	No Limit
Family	$6,800	No Limit
Professional Services		
Primary Care Physician (PCP)	10% after deductible	See footnote 2
Specialist	10% after deductible	See footnote 2
Telehealth Visit	10% after deductible	See footnote 2
Preventive Care Exam	No Charge	Not Covered
Diagnostic X-ray and Lab	10% after deductible	Not Covered
Complex Diagnostics (MRI/CT Scan)	10% after deductible	See footnote 2 and 3
Acupuncture Services (Limit 12 visits)	10% after deductible	50% of maximum allowed amount[2]
Chiropractic Services	10% after deductible	Not Covered
Hospital Services		
Inpatient	10% after deductible	See footnote 2
Outpatient Surgery	10% after deductible	See footnote 2
Urgent Care	10% after deductible	See footnote 2
Emergency Room	$100 Copay then 10% after deductible	
Mental Health & Substance Abuse		
Inpatient	10% after deductible	See footnote 2 and 3
Outpatient	10% after deductible	See footnote 2
Retail Prescription Drugs (30-day supply)		
Generic	$9 after deductible; No charge at Costco	
Brand Name	$35 after deductible	
Specialty medicine through mail order	$35 after deductible	
Mail Order Prescription Drugs (90-day supply)		
Generic	No Charge through Costco	
Brand	$90 after deductible at Costco	

(1) Out-of-pocket maximum is based on the maximum allowable charge the carrier allows. This does not include any balance billing that may occur when using an out-of-network provider.

(2) When using Non-Network PPO Providers, members are responsible for any difference between the maximum allowed amount and actual charges, as well as any deductible & percentage copay.

(3) The plan may pay for the following services and supplies up to the maximum number of days or visits shown. When using non-network providers, the plan will pay the lesser of the benefit maximum or the maximum allowed amount. If the maximum allowed amount is less than the listed benefit maximum, the plan will not exceed the maximum allowed amount. Likewise, if the listed benefit maximum is less than the maximum allowed amount, the plan will not exceed the listed benefit maximum.

The above information is a summary only. Please refer to your Evidence of Coverage for complete details of Plan benefits, limitations and exclusions.

Dental Plans

Dental Plan HMO

Taking care of your smile

With the Dental HMO plan, your first important step is to choose a primary care dentist in the United Concordia network, so you and any dependents are covered. Your dentist will then either provide the care you need or refer you to a specialist.

If you see a dentist who isn't in your network, you'll have to pay the entire bill yourself. To avoid that, be sure to check if your dentist is in the provider network by searching on www.unitedconcordia.com or calling United Concordia.

"How much will specific services cost?"

Plan Highlights	United Concordia Dental HMO
	In-network Only (DHMO Concordia Plus)
Calendar Year Deductible/Annual Maximum	None
Preventive	
Examinations	No Charge
X-rays	No Charge
Cleanings	No Charge
Basic Services	
Amalgam Fillings (only)	No Charge
Extractions	No Charge
Root Canals	No Charge
Major Services	
Bridges	Services must be diagnosed and prescribed by the participating provider to be eligible for coverage.
Dentures	No Charge
Crowns	No Charge
Implants	Not Covered
Orthodontia Services	
Children	$1,500
Adults	$2,000

The above information is a summary only. Please refer to your Evidence of Coverage for complete details of Plan benefits, limitations and exclusions.

Dental Plan PPO

Taking care of your smile

With the Dental PPO plan, you can pick any licensed dentist. Just keep in mind that your dental plan has settled on lower rates with a smaller group of providers—those in their network. If you choose a dentist outside that network for yourself or your dependents, you might have to pay more.

To find out if your dentist is in your provider network, you can search on www.deltadentalins.com or calling Delta Dental.

"How much will specific services cost?"

Plan Highlights	Delta Dental PPO	
	In-network	**Out-of-network**
Calendar Year Deductible (Individual / Family)	$25 per person every year	
Annual Maximum	$1,750 per person	
Preventive	100% Covered	100% Covered
Basic Services	90% Covered	80% Covered
Major Services	50% Covered	50% Covered
Orthodontia Services	Not Covered	Not Covered
Lifetime Maximum	N/A	N/A

The above information is a summary only. Please refer to your Evidence of Coverage for complete details of Plan benefits, limitations and exclusions.

Vision Plans

Vision Plans

Bringing your benefits into focus

VSP Vision Care offers vision coverage as a Preferred Provider Organization (PPO) plan. With the vision plan, you can pick where to receive services. Just keep in mind that your vision plan has settled on lower rates with a smaller group of vision providers—those in their network. If you choose a vision provider outside that network for yourself or your dependents, you will have to pay for all the expenses yourself at the time of service. Then, you'll submit a claim, and VSP will reimburse you up to a certain "allowed" amount.

To find out if a vision provider is in your network, you can search on vsp.com or calling VSP.

Plan Highlights	VSP Choice Plan	
	In-network	**Out-of-network**
Exam – Every 12 months	No Charge	Up to $45
Contact Lens Exam (Fitting & Evaluation)	Standard and Premium fits are covered in full after copay. Member receives 15% off of contact lens exam services and member's copay will never exceed $40	
Lenses – Every 12 months		
Single	No Charge	Up to $30
Bifocal	No Charge	Up to $50
Trifocal	No Charge	Up to $65
Frames – Every 12 months	$150 Allowance + 20% off balance (Extra $50 for featured frame brands)	Up to $70
LightCare	$150 Allowance for ready-made non-prescription sunglasses or blue light filtering glasses, instead of prescription glasses (lenses and frames) or contacts	
Contacts – Every 12 months, in lieu of lenses & frames (Includes materials only)		
Medically Necessary	No Charge	Up to $210
Cosmetic	$150 Allowance	Up to $105
LASIK	15-20% Discount	
Essential Medical Eye Care	Supplemental medical coverage for specialty eyecare services and conditions, such as pink eye and other urgent eyecare needs. Requires $20 Exam Copay	

The above information is a summary only. Please refer to your Evidence of Coverage for complete details of Plan benefits, limitations and exclusions.

Spending Accounts

Spending Accounts

Make your money work for you

Flexible Spending Account (FSA)

With this type of account, you and your spouse, plus any eligible dependents, can use pre-tax dollars to cover health care/dependent care/transit/parking. There are different types of FSAs, but they all help reduce your taxable income. Here are the different types of FSAs.

FSA Type		Detail
	Healthcare FSA	• Can reimburse for eligible healthcare expenses not covered by your medical, dental, and vision insurance. • Maximum contribution for 2026 is $3,300.
	Dependent Care FSA	• Can be used to pay for a child's (up to the age of 13) childcare expenses and/or care for a disabled family member in the household, who is unable to care for themselves. • Eligibility rules require that if you are married, your spouse needs to be working, looking for work or attending school full-time. • Maximum contribution for 2026 is $7,500 ($3,750 if married, and filing separately).

Questions about your FSA? Reach out to TPA/Risk Management.

How to use your FSA

Estimate how much you'll need to cover with FSA funds this year.

Set up annual (pre-tax) deductions from your paycheck.

Use your FSA debit card for purchases made on your own behalf.

Use it or lose it! FSA funds don't roll over to the next year.

Life & Disability

Life & Disability

Life Insurance and AD&D

There's no easy way to talk about death, but your family might need help if something happens to you. A life and accidental death and dismemberment (AD&D) policy can provide that help. You are automatically signed up for this benefit and your family will be paid a lump sum of money when you die. If your death was caused by an accident, or if you lose a limb, you or the people you choose, called "beneficiaries," may get additional coverage.

Chula Vista Elementary School District pays for 100% of this benefit through The Hartford. It includes the following:

- Basic Life/AD&D Insurance of $50,000 for all eligible employees
- Your benefit amounts reduce by 40% at age 75 and by 50% at age 80

Quick note on IRS Regulations: You can receive employer-paid life insurance coverage up to $50,000 on a tax-free basis and do not have to report the payment as income. However, coverage of more than $50,000 will trigger taxable income for the "economic value" of the coverage provided to you.

The Standard Disability Insurance

Chula Vista Elementary School District provides Disability insurance coverage from The Standard that helps protect you against the loss of income that can occur should you be unable to work for an extended period due to a covered illness or injury.

You are eligible to participate in this plan year if you are:

- An active classified employee of Chula Vista Elementary
- Working at least 0.50 FTE (as determined by Chula Vista Elementary)
- A citizen or resident of the United States or Canada

Participating Classes:

- Class 1: Participants who, on the date of disability, have five or more years of credited service under the California State Teachers Retirement System (CalSTRS) and/or Public Employees Retirement System (CalPERS) or are not participants in either system
- Class 2: Participants who, on the date of disability, participate in but have less than five years of credited service under the California State Teachers Retirement System (CalSTRS) and/or Public Employees Retirement System (CalPERS)

Working at least 0.50 FTE (as determined by Chula Vista Elementary Benefits:

- While receiving sick leave: $12.50/per Regular Day of Required Attendance (RDRA)
- Benefit period after sick leave is exhausted: 75% of your Regular Daily Contract Salary, less deductible income for up to one Benefit Year. Minimum benefit is $30 per RDRA for up to one Benefit Year
- Benefit period after sick leave and one Benefit Year has been exhausted: 75% of your Regular Daily Contract Salary, less deductible income for up to one Benefit Year.
- Minimum benefit after sick leave and one Benefit Year has expired:
    - Class 1 Participants: Not Applicable
    - Class 2 Participants: $500 per Month
- Daily hospital: $25 per day up to a maximum of 60 days
- Accidental Death and Dismemberment Benefit: Flat $5,000

Voluntary Life and AD&D

You can choose to add more life insurance and AD&D coverage for you and/or your dependents. These can be taken out of your regular paycheck by The Hartford. Here are details on the additional coverage amounts you can choose from:

	For employees:	• Increments of $10,000 up to a $500,000 maximum with a guarantee issue benefit of $300,000 if you enroll in the plan within 30 days of your initial eligibility.
	For your spouse:	• Increments of $10,000 up to 100% of employee's amount up to $500,000 with a guarantee issue benefit of $150,000 if you enroll in the plan within 30 days of your initial eligibility.
	For your child(ren):	• Beginning at live birth in $5,000 increments up to 100% of employee's amount not to exceed $20,000
	Optional AD&D:	• Coverage is available for purchase in the same amounts as optional life insurance amounts above.

If you choose to get additional coverage, the insurance company may want to make sure you're in good health. Any amounts of insurance over the guaranteed issue benefit are subject to review and won't be effective until the insurance company approves.

If you do not enroll in the plan within the initial enrollment period, **any** amount of supplemental life insurance will require proof of good health, which is subject to approval by the insurance company before the insurance is effective There's more info in the Summary Plan Description.

Please note: Benefits coverage may reduce when you turn 75. Restrictions may apply if you and/or your dependent(s) are confined in the hospital or terminally ill. Take a look at your Summary Plan Description for exclusions and further detail.

Don't forget to update your beneficiaries!

The people or entities who you want to receive benefits from your policy are called beneficiaries. It's very important that they are up to date.

You may change your beneficiaries at any time

You may designate one person as your beneficiary or choose multiple beneficiaries, who will each get a percentage of the payout amount

To select or change your beneficiary, please contact the Risk Management Department for the necessary forms.

Additional Services Offered by The Hartford

Life Insurance from The Hartford can help you protect the financial future of your loved ones. Your District provided coverage includes valuable services that can help you and your family.

Empathy

Grief is hard. And when you add things like estate planning and probate management, immediate arrangements and taxes, it can be overwhelming and stressful. But you don't have to deal with it all on your own. You have access to resources and real, trained professionals who are there to listen and offer support during this difficult time thanks to your loved one's Life insurance. To get started, register online at join.empathy.com/hartfordcare then call numbers provided below to access their services.

Via Digital App, use Access Code: EMP-HART

- **Easy-to-use App:** Access resources and services in one place to help you navigate the challenges of loss.
- **Will Prep:** Whether you have a few assets or many, help protect your family's future by creating a will with the online will preparation service. Once you register, access these services by calling 1.229.544.2332.
- **Bereavement & Grief Counseling:** Licensed social workers are available to listen and give support for every Group Life beneficiary anticipating or dealing with loss, so that they and their families have everything they need during this difficult time. This includes grief support services, estate and probate services, helpful planning tools and after-loss support. Once you register, access these services by calling 1.229.544.2332.
- **Funeral Planning:** Detailed instructions and on-demand assistance are available to manage the logistics of funeral planning, burial, cremation and other related services. For questions, call 1.270.681.1364.

Travel Assistance with ID Theft Protections

Even the best-planned trips can be full of surprises. Travel Assistance with ID Theft Protection includes pre-trip information to help you feel more secure while traveling. It can also help you access professionals across the globe for medical assistance when traveling 100+ miles away from home for 90 days or less.

ID Theft services are available to you and your family at home or when traveling.

In case of a serious medical emergency while traveling, please obtain emergency medical services first (contact your local "911") and then contact Travel Assistance to alert them.

Call toll-free: 1.800.243.6108

From other locations, call collect: 202.828.5885

Email: assist@imglobal.com

What to have ready:

- Your employer's name
- Your phone number
- Nature of the problem
- Your policy number
- Your Travel Assist ID number: GLD-09012

Employee Assistance Program (EAP)

Employee Assistance Program (EASE)

Free resources for tough moments

Your Employee Assistance Program (EAP) is a set of services that can support you through personal and professional challenges with resources, information, and counseling. Everything is confidential—what you talk about won't be shared with your employer—and free.

Program Component	Coverage Details
Number of sessions	6 face-to-face sessions per year per member per incident
How to access	In-person with an Evernorth Provider or virtual via the TalkSpace network
Topics may include	**Mental Health Support:** • Marital, relationship or family problems • Bereavement or grief counseling • Substance use disorder and recovery **Community Support:** • Child and eldercare • Legal services and identity theft • Financial support
Who can utilize	You, your dependents, and even other members of your household.

Get in touch:

Visit our website: well.evernorth.com

Perks & More

Perks & More

Finally, the fun stuff

Your benefits package isn't all insurance. It still knows how to have fun. In that spirit, your employer offers these additional options on a Voluntary basis.

Legal Services

When you need guidance on personal legal matters, MetLife Voluntary Legal Plan's services can provide you with access to a network of qualified attorneys. This is a voluntary pre-paid legal plan. The 2026 cost of the plan for CVESD employees is only $23.00 per month with deductions beginning in your December 2025 pay warrant. The plan covers you, your spouse, or registered domestic partner and your dependent children up to age 26. In addition to the fully covered services such as wills, trusts, real estate closings, debt collection defense, identity theft defense and traffic matters, the plan also includes unlimited telephone advice and office consultation with a local attorney. If you use a participating attorney, there are no claim forms or out-of-pocket expenses for attorney fees. To learn more about your coverages and see our attorney network, create an account at members.legalplans.com or call 800.821.6400.

In addition, MetLife Legal also offers "Plans Plus Parents," which covers your parents, parents-in-law, and grandparents for many of the common legal issues a family faces. This enhanced option can be added on to your MetLife Legal plan for an additional $5 per month for a monthly cost of $28.00. The plan will cover attorney's fees for covered matters with no deductibles, copays, claim forms, or usage limits when using a network attorney.

IMPORTANT NOTE: If you elect to enroll, you must remain enrolled for a minimum of one full plan year (12 months). Additional information will be available at the Benefits Fair or on the District's website under "Employment/Benefits." You can also visit MetLife's website at www.legalplans.com.

Norton LifeLock Benefit Solutions

Your personal data is everywhere – from doctor's offices to mobile apps. Norton LifeLock Benefit Plans prevent fraud, block scams, monitor activity, and strengthen your financial wellbeing.

Protect your wellbeing from every angle:

- Fraud Detection
- Threat Prevention
- Financial Insights
- Identity Restoration
- Enhanced Privacy
- Scam Detection

The cost for an Employee Only is $7.50 per month, or $14.50 per month for an Employee and Family.

Enroll today at cvesd.norton-benefits.com.

SISC Member Resources

Teladoc Medical Experts

When you need answers, Expert Medical Opinion can help. Leading medical experts can answer any medical questions, double-check a diagnosis, help you decide on a treatment plan or provide guidance about a surgery. Anthem and Kaiser members can call 800.835.2362 or visit https://www.teladoc.com/SISC/ to get started.

Use Expert medical Opinion when you or your eligible dependents:

- Are unsure about a diagnosis or need help choosing treatment.
- Have medical questions or concerns and want a leading expert's advice.
- Need help finding a local expert who specializes in treating your condition.
- Have been admitted to the hospital and want expert guidance.

WINFertility

If you're struggling to have a baby, you're not alone. WINFertility provides support and family-building benefits. This program includes:

- Information about infertility causes, testing, and different treatment and medication options
- A personalized care plan with treatment recommendations
- 24/7 access to specially trained nurse care managers who can answer your questions, help you find doctors, and talk through your concerns
- Referrals to high-quality reproductive endocrinologists near you
- Preapprovals for fertility-related prescription medication, as well as help managing and taking those medications
- Preapprovals for outpatient and in-office fertility services
- Guidance through the fertility preservation process, including help finding egg-freezing facilities in your plan's network.

To get started:

1. Log in at anthem.com/ca and choose the **Care** tab at the top of the page.
2. Select **Discounts** from the options.
3. Choose the **WINFertility** special offer. (If it doesn't appear, select **Load More Offers**.) The WINFertility page will list a toll-free number you can call to enroll.
4. You can also call Member Services at the number on your ID card if you have any questions.

RX link / Costco is already mentioned on the Benefit Grids RX link / Costco is already mentioned on the Benefit Grids

MDLive (available to Anthem Members only)

Anthem members and their eligible dependents have access to board-certified physicians, pediatricians, therapists and psychiatrists 24 hours a day and seven days a week for a $0 copay per visit. Visit a doctor by phone, secure video, or the MDLive App. MDLive is an alternative to the emergency room or urgent care center. Providers are available after hours, nights, weekends, and even holidays to treat allergies, fever, respiratory problems, behavioral health problems, and much more. Prescriptions can be sent to your nearest pharmacy if medically necessary. Visit members.mdlive.com/sisc or call 800.657.6169 to learn more.

Centivo Care (available to Anthem PPO Members only)

As part of your PPO medical benefits from SISC, you and your enrolled adult dependents (18+) have access to free primary care through Centivo Care. We can address health concerns, assist with prescriptions, diagnose and manage chronic conditions and so much more – all from the palm of your hand.

The answer to most of your health questions is now simple: "Just ask Centivo Care."

Scan the QR code to register and start accessing great care today

Thanks for Reading

This guide contains just a few (or a few more than a few) words about your benefits, but it represents a network of resources and support. Now it's time to get back to living—knowing that this guide is here when and if you ever need it. If questions slow you down, keep in mind that the Chula Vista Elementary School District HR Team would be happy to help.

Here's to a happy, healthy year ahead!

Chula Vista Elementary School District's Health and Welfare Benefits Annual Notice Packet

For the 2026 Plan Year

Dear Valued Employee,

Enclosed is a packet of notices and disclosures that pertain to your employer-sponsored health and welfare plans, as required by federal law.

Enclosures:

- ☐ Medicare Part D Creditable Coverage Notice
- ☐ HIPAA Special Enrollment Rights Notice
- ☐ HIPAA Notice of Privacy Practices
- ☐ Children's Health Insurance Program (CHIP) Notice
- ☐ Women's Health and Cancer Rights Act (WHCRA) Notice
- ☐ Newborns' Mothers Health Protection Act (NMHPA) Notice
- ☐ General Notice of COBRA Continuation Rights

Should you have any questions regarding the content of the notices, please contact Jenny Venyak at (619) 425-9600 Ext. 181353.

Medicare Part D
Creditable Coverage Notice

Important Notice from Chula Vista Elementary School District
About Your Prescription Drug Coverage and Medicare

Important Notice from Chula Vista Elementary School District
About Your Prescription Drug Coverage and Medicare

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

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

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

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan while enrolled in Chula Vista Elementary School District coverage as an active employee, please note that your Chula Vista Elementary School District coverage will be the primary payer for your prescription drug benefits and Medicare will pay secondary. As a result, the value of your Medicare prescription drug benefits may be significantly reduced. Medicare will usually pay primary for your prescription drug benefits if you participate in Chula Vista Elementary School District coverage as a former employee.

You may also choose to drop your Chula Vista Elementary School District coverage. If you do decide to join a Medicare drug plan and drop your current Chula Vista Elementary School District coverage, be aware that you and your dependents may not be able to get this coverage back.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

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

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

For More Information About This Notice Or Your Current Prescription Drug Coverage…

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

For More Information About Your Options Under Medicare Prescription Drug Coverage…

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

For more information about Medicare prescription drug coverage:

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

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

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

Date: 01/01/2026

Name of Entity/Sender: Chula Vista Elementary School District
Contact--Position/Office: Senior Benefits and Risk Manager
Address: 84 East J Street, Chula Vista, CA, 91910
Phone Number: (619) 425-9600 Ext. 181353

HIPAA Special Enrollment Rights Notice

If you are declining enrollment in Chula Vista Elementary School District group health coverage for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Finally, you and/or your dependents may have special enrollment rights if coverage is lost under Medicaid or a State health insurance ("CHIP") program, or when you and/or your dependents gain eligibility for state premium assistance. You have 60 days from the occurrence of one of these events to notify the company and enroll in the plan.

To request special enrollment or obtain more information, contact Jenny Venyak at (619) 425-9600 Ext. 181353.

HIPAA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Chula Vista Elementary School District, Inc. ("Chula Vista Elementary School District") sponsors certain group health plan(s) (collectively, the "Plan" or "We") to provide benefits to our employees, their dependents and other participants. We provide this coverage through various relationships with third parties that establish networks of providers, coordinate your care, and process claims for reimbursement for the services that you receive. This Notice of Privacy Practices (the "Notice") describes the legal obligations of Chula Vista Elementary School District, the Plan and your legal rights regarding your protected health information held by the Plan under HIPAA. Among other things, this Notice describes how your protected health information may be used or disclosed to carry out treatment, payment, or health care operations, or for any other purposes that are permitted or required by law.

We are required to provide this Notice to you pursuant to HIPAA. The HIPAA Privacy Rule protects only certain medical information known as "protected health information." Generally, protected health information is individually identifiable health information, including demographic information, collected from you or created or received by a health care provider, a health care clearinghouse, a health plan, or your employer on behalf of a group health plan, which relates to:

(1) your past, present or future physical or mental health or condition;
(2) the provision of health care to you; or
(3) the past, present or future payment for the provision of health care to you.

Note: If you are covered by one or more fully-insured group health plans offered by Chula Vista Elementary School District, you will receive a separate notice regarding the availability of a notice of privacy practices applicable to that coverage and how to obtain a copy of the notice directly from the insurance carrier.

Contact Information

If you have any questions about this Notice or about our privacy practices, please contact the Chula Vista Elementary School District HIPAA Privacy Officer:

Chula Vista Elementary School District, Inc.
Attention: HIPAA Privacy Officer
Jenny Venyak
Senior Benefits and Risk Manager
(619) 425-9600 ext. 181353

Effective Date

This Notice as revised is effective January 1, 2026.

Our Responsibilities

We are required by law to:

- maintain the privacy of your protected health information;
- provide you with certain rights with respect to your protected health information;
- provide you with a copy of this Notice of our legal duties and privacy practices with respect to your protected health information; and

- follow the terms of the Notice that is currently in effect.

We reserve the right to change the terms of this Notice and to make new provisions regarding your protected health information that we maintain, as allowed or required by law. If we make any material change to this Notice, we will provide you with a copy of our revised Notice of Privacy Practices. You may also obtain a copy of the latest revised Notice by contacting our Privacy Officer at the contact information provided above. Except as provided within this Notice, we may not disclose your protected health information without your prior authorization.

How We May Use and Disclose Your Protected Health Information

Under the law, we may use or disclose your protected health information under certain circumstances without your permission. The following categories describe the different ways that we may use and disclose your protected health information. For each category of uses or disclosures we will explain what we mean and present some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose protected health information will fall within one of the categories.

For Treatment

We may use or disclose your protected health information to facilitate medical treatment or services by providers. We may disclose medical information about you to providers, including doctors, nurses, technicians, medical students, or other hospital personnel who are involved in taking care of you. For example, we might disclose information about your prior prescriptions to a pharmacist to determine if a pending prescription is inappropriate or dangerous for you to use.

For Payment

We may use or disclose your protected health information to determine your eligibility for Plan benefits, to facilitate payment for the treatment and services you receive from health care providers, to determine benefit responsibility under the Plan, or to coordinate Plan coverage. For example, we may tell your health care provider about your medical history to determine whether a particular treatment is experimental, investigational, or medically necessary, or to determine whether the Plan will cover the treatment. We may also share your protected health information with a utilization review or precertification service provider. Likewise, we may share your protected health information with another entity to assist with the adjudication or subrogation of health claims or to another health plan to coordinate benefit payments.

For Health Care Operations

We may use and disclose your protected health information for other Plan operations. These uses and disclosures are necessary to run the Plan. For example, we may use medical information in connection with conducting quality assessment and improvement activities; underwriting, premium rating, and other activities relating to Plan coverage; submitting claims for stop-loss (or excess-loss) coverage; conducting or arranging for medical review, legal services, audit services, and fraud & abuse detection programs; business planning and development such as cost management; and business management and general Plan administrative activities. The Plan is prohibited from using or disclosing protected health information that is genetic information about an individual for underwriting purposes.

To Business Associates

We may contract with individuals or entities known as Business Associates to perform various functions on our behalf or to provide certain types of services. In order to perform these functions or to provide these services, Business Associates will receive, create, maintain, use and/or disclose your protected health information, but only after they agree in writing with us to implement appropriate safeguards regarding your protected health information. For example, we may disclose your protected health information to a Business Associate to administer claims or to provide support services, such as utilization management, pharmacy benefit management or subrogation, but only after the Business Associate enters into a Business Associate Agreement with us.

As Required by Law
We will disclose your protected health information when required to do so by federal, state or local law. For example, we may disclose your protected health information when required by national security laws or public health disclosure laws.

To Avert a Serious Threat to Health or Safety
We may use and disclose your protected health information when necessary to prevent a serious threat to your health and safety, or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat. For example, we may disclose your protected health information in a proceeding regarding the licensure of a physician.

To Plan Sponsors
For the purpose of administering the Plan, we may disclose to certain employees of the Employer protected health information. However, those employees will only use or disclose that information as necessary to perform Plan administration functions or as otherwise required by HIPAA, unless you have authorized further disclosures. Your protected health information cannot be used for employment purposes without your specific authorization.

Special Situations

In addition to the above, the following categories describe other possible ways that we may use and disclose your protected health information. For each category of uses or disclosures, we will explain what we mean and present some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

Organ and Tissue Donation
If you are an organ donor, we may release your protected health information to organizations that handle organ procurement or organ, eye, or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

Military and Veterans
If you are a member of the armed forces, we may release your protected health information as required by military command authorities. We may also release protected health information about foreign military personnel to the appropriate foreign military authority.

Workers' Compensation
We may release your protected health information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks
We may disclose your protected health information for public health actions. These actions generally include the following:

- to prevent or control disease, injury, or disability;
- to report births and deaths;
- to report child abuse or neglect;
- to report reactions to medications or problems with products;
- to notify people of recalls of products they may be using;
- to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;

- to notify the appropriate government authority if we believe that a patient has been the victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree, or when required or authorized by law.

Health Oversight Activities
We may disclose your protected health information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes
If you are involved in a lawsuit or a dispute, we may disclose your protected health information in response to a court or administrative order. We may also disclose your protected health information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement
We may disclose your protected health information if asked to do so by a law enforcement official—

- in response to a court order, subpoena, warrant, summons or similar process;
- to identify or locate a suspect, fugitive, material witness, or missing person;
- about the victim of a crime if, under certain limited circumstances, we are unable to obtain the victim's agreement;
- about a death that we believe may be the result of criminal conduct;
- about criminal conduct; and
- in emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Directors
We may release protected health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about patients to funeral directors as necessary to carry out their duties.

National Security and Intelligence Activities
We may release your protected health information to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

Inmates
If you are an inmate of a correctional institution or are in the custody of a law enforcement official, we may disclose your protected health information to the correctional institution or law enforcement official if necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

Research
We may disclose your protected health information to researchers when:

(1) the individual identifiers have been removed; or
(2) when an institutional review board or privacy board has (a) reviewed the research proposal; and (b) established protocols to ensure the privacy of the requested information, and approves the research.

Required Disclosures

The following is a description of disclosures of your protected health information we are required to make.

Government Audits
We are required to disclose your protected health information to the Secretary of the United States Department of Health and Human Services when the Secretary is investigating or determining our compliance with the HIPAA privacy rule.

Disclosures to You
When you request, we are required to disclose to you the portion of your protected health information that contains medical records, billing records, and any other records used to make decisions regarding your health care benefits. We are also required, when requested, to provide you with an accounting of most disclosures of your protected health information if the disclosure was for reasons other than for payment, treatment, or health care operations, and if the protected health information was not disclosed pursuant to your individual authorization.

Notification of a Breach.
We are required to notify you in the event that we (or one of our Business Associates) discover a breach of your unsecured protected health information, as defined by HIPAA.

Other Disclosures

Personal Representatives
We will disclose your protected health information to individuals authorized by you, or to an individual designated as your personal representative, attorney-in-fact, etc., so long as you provide us with a written notice/authorization and any supporting documents (i.e., power of attorney). Note: Under the HIPAA privacy rule, we do not have to disclose information to a personal representative if we have a reasonable belief that:

(1) you have been, or may be, subjected to domestic violence, abuse or neglect by such person;
(2) treating such person as your personal representative could endanger you; or
(3) in the exercise or professional judgment, it is not in your best interest to treat the person as your personal representative.

Spouses and Other Family Members
With only limited exceptions, we will send all mail to the employee. This includes mail relating to the employee's spouse and other family members who are covered under the Plan, and includes mail with information on the use of Plan benefits by the employee's spouse and other family members and information on the denial of any Plan benefits to the employee's spouse and other family members. If a person covered under the Plan has requested Restrictions or Confidential Communications (see below under "Your Rights"), and if we have agreed to the request, we will send mail as provided by the request for Restrictions or Confidential Communications.

Authorizations
Other uses or disclosures of your protected health information not described above, including the use and disclosure of psychotherapy notes and the use or disclosure of protected health information for fundraising or marketing purposes, will not be made without your written authorization. You may revoke written authorization at any time, so long as your revocation is in writing. Once we receive your written revocation, it will only be effective for future uses and disclosures. It will not be effective for any information that may have been used or disclosed in reliance upon the written authorization and prior to receiving your written revocation. You may elect to opt out of receiving fundraising communications from us at any time.

Your Rights

You have the following rights with respect to your protected health information:

Right to Inspect and Copy
You have the right to inspect and copy certain protected health information that may be used to make decisions about your health care benefits. To inspect and copy your protected health information, submit your request in writing to the Privacy Officer at the address provided above under Contact Information. If you request a copy of the information, we may charge a reasonable fee for the costs of copying, mailing, or other supplies associated with your request. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to your medical information, you may have a right to request that the denial be reviewed and you will be provided with details on how to do so.

Right to Amend
If you feel that the protected health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the Plan. To request an amendment, your request must be made in writing and submitted to the Privacy Officer at the address provided above under Contact Information. In addition, you must provide a reason that supports your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- is not part of the medical information kept by or for the Plan;
- was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- is not part of the information that you would be permitted to inspect and copy; or
- is already accurate and complete.

If we deny your request, you have the right to file a statement of disagreement with us and any future disclosures of the disputed information will include your statement.

Right to an Accounting of Disclosures
You have the right to request an “accounting” of certain disclosures of your protected health information. The accounting will not include (1) disclosures for purposes of treatment, payment, or health care operations; (2) disclosures made to you; (3) disclosures made pursuant to your authorization; (4) disclosures made to friends or family in your presence or because of an emergency; (5) disclosures for national security purposes; and (6) disclosures incidental to otherwise permissible disclosures.

To request this list or accounting of disclosures, you must submit your request in writing to the Privacy Officer at the address provided above under Contact Information. Your request must state a time period of no longer than six years (three years for electronic health records) or the period ABC Company has been subject to the HIPAA Privacy rules, if shorter.

Your request should indicate in what form you want the list (for example, paper or electronic). We will attempt to provide the accounting in the format you requested or in another mutually agreeable format if the requested format is not reasonably feasible. The first list you request within a 12-month period will be provided free of charge. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions
You have the right to request a restriction or limitation on your protected health information that we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on your protected health information that we disclose to someone who is involved in your care or the payment for your care, such as a family member or friend. For example, you could ask that we not use or disclose information about a surgery that you had.

We are not required to agree to your request. However, if we do agree to the request, we will honor the restriction until you revoke it or we notify you. To request restrictions, you must make your request in writing to the Privacy Officer at the address provided above under Contact Information. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure, or both; and (3) to whom you want the limits to apply—for example, disclosures to your spouse.

Right to Request Confidential Communications
You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. To request confidential communications, you must make your request in writing to the Privacy Officer at the address provided above under Contact Information. We will not ask you the reason for your request. Your request must specify how or where you wish to be contacted. We will accommodate all reasonable requests if you clearly provide information that the disclosure of all or part of your protected information could endanger you.

Right to a Paper Copy of This Notice
You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. To obtain a paper copy of this notice, telephone or write the Privacy Officer as provided above under Contact Information.

For more information, please see Your Rights Under HIPAA**.**

Complaints
If you believe that your privacy rights have been violated, you may file a complaint with the Plan or with the Office for Civil Rights of the United States Department of Health and Human Services. You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting https://www.hhs.gov/hipaa/filing-a-complaint/complaint-process/index.html .

To file a complaint with the Plan, telephone write the Privacy Officer as provided above under Contact Information. You will not be penalized, or in any other way retaliated against, for filing a complaint with the Office of Civil Rights or with us. You should keep a copy of any notices you send to the Plan Administrator or the Privacy Officer for your records.

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

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

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

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272).**

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of March 17, 2025. Contact your State for more information on eligibility –

ALABAMA – Medicaid	ALASKA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid	**CALIFORNIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**FLORIDA – Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

GEORGIA – Medicaid	INDIANA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: (678) 564-1162, Press 2	Health Insurance Premium Payment Program All other Medicaid Website: https://www.in.gov/medicaid/ http://www.in.gov/fssa/dfr/ Family and Social Services Administration Phone: 1-800-403-0864 Member Services Phone: 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	**KANSAS – Medicaid**
Medicaid Website: Iowa Medicaid | Health & Human Services Medicaid Phone: 1-800-338-8366 Hawki Website: Hawki - Healthy and Well Kids in Iowa | Health & Human Services Hawki Phone: 1-800-257-8563 HIPP Website: Health Insurance Premium Payment (HIPP) | Health & Human Services (iowa.gov) HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
KENTUCKY – Medicaid	**LOUISIANA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kynect.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid	**MASSACHUSETTS – Medicaid and CHIP**
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremiumassistance@accenture.com
MINNESOTA – Medicaid	**MISSOURI – Medicaid**
Website: https://mn.gov/dhs/health-care-coverage/ Phone: 1-800-657-3672	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
MONTANA - Medicaid	**NEBRASKA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178

NEVADA – Medicaid	NEW HAMPSHIRE – Medicaid
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 15218 Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov
NEW JERSEY – Medicaid and CHIP	**NEW YORK – Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Phone: 1-800-356-1561 CHIP Premium Assistance Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710 (TTY: 711)	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**OREGON – Medicaid**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	**RHODE ISLAND – Medicaid and CHIP**
Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	**SOUTH DAKOTA - Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS – Medicaid	**UTAH – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program| Texas Health and Human Services Phone: 1-800-440-0493	Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/ Email: upp@utah.gov Phone: 1-888-222-2542 Adult Expansion Website: https://medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/ CHIP Website: https://chip.utah.gov/
VERMONT– Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924

WASHINGTON – Medicaid	WEST VIRGINIA – Medicaid and CHIP
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone:304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP	**WYOMING – Medicaid**
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since March 17, 2025, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Women's Health Cancer Rights Act (WHCRA) Notice

Do you know that your Plan, as required by the Women's Health and Cancer Rights Act of 1998 (WHCRA), provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema?

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. If you would like more information on WHCRA benefits, contact your plan administrator at (619) 425-9600 Ext. 181353.

Newborns' and Mothers' Health Protection Act (NMHPA) Notice

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Model General Notice of COBRA Continuation Coverage Rights

** Continuation Coverage Rights Under COBRA**

Introduction

You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation must pay for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

When is COBRA continuation coverage available?
The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee; or
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to: Jenny Venyak.

How is COBRA continuation coverage provided?
Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage
If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may

be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.

Second qualifying event extension of 18-month period of continuation coverage
If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

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

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?
In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period[1] to sign up for Medicare Part A or B, beginning on the earlier of:

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

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

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

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[1] https://www.medicare.gov/basics/get-started-with-medicare/sign-up/when-does-medicare-coverage-start. These rules are different for people with End Stage Renal Disease (ESRD).

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

If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit **www.dol.gov/agencies/ebsa**. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit **www.HealthCare.gov**.

Keep your Plan informed of address changes

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

Plan contact information

Jenny Venyak
Senior Benefits and Risk Manager
Jennifer.Venyak@cvesd.org
(619) 425-9600 Ext. 181353

APPENDIX

These are additional notices that may be appropriate based upon an employer's circumstances. We included the Surprise Billing Notice to assist with an employer's obligation to post the notice on its website (in those rare circumstances where it may be necessary).

- ☐ Fixed Indemnity Policy Notice
- ☐ Medicare Part D Cross-Reference
- ☐ HIPAA Privacy Notice of Availability
- ☐ HIPAA Wellness Program Reasonable Alternative Standards (RAS) Notice – Medical plans with wellness programs that offer health contingent incentives
- ☐ Surprise Billing Notice – "Your Rights and Protections Against Surprise Medical Bills"

Fixed Indemnity Policy Notice

IMPORTANT: This is a fixed indemnity policy, NOT health insurance

This fixed indemnity policy may pay you a limited dollar amount if you're sick or hospitalized. You're still responsible for paying the cost of your care.

- The payment you get isn't based on the size of your medical bill.
- There might be a limit on how much this policy will pay each year.
- This policy isn't a substitute for comprehensive health insurance.
- Since this policy isn't health insurance, it doesn't have to include most Federal consumer protections that apply to health insurance.

Looking for comprehensive health insurance?

- **Visit HealthCare.gov** or call **1-800-318-2596** (TTY: 1-855-889-4325) to find health coverage options.
- To find out if you can get health insurance through your job, or a family member's job, contact the employer.

Questions about this policy?

- For questions or complaints about this policy, contact your State Department of Insurance. Find their number on the National Association of Insurance Commissioners' website (naic.org) under "Insurance Departments."
- If you have this policy through your job, or a family member's job, contact the employer.

Medicare Part D Cross-Reference

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please see page 42 for more details.

HIPAA Notice of Availability of Notice of Privacy Practices

The Chula Vista Elementary School District, Inc Group Health Plan (Plan) maintains a Notice of Privacy Practices that provides information to individuals whose protected health information (PHI) will be used or maintained by the Plan. If you would like a copy of the Plan's Notice of Privacy Practices, please contact Jenny Venyak at (619) 425-9600 Ext. 181353.

HIPAA Wellness Program Reasonable Alternative Standards Notice

Your group health plan is committed to helping you achieve your best health. Rewards for participating in a wellness program are available to all eligible employees. If you think you might be unable to meet a standard for a reward under this wellness program, you might qualify for an opportunity to earn the same reward by different means. Contact us at (619) 425-9600 and we will work with you (and, if you wish, with your doctor) to find a wellness program with the same reward that is right for you in light of your health status.

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing. In these cases, you should not be charged more than your plan's copayments, coinsurance and/or deductible.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, like a copayment, coinsurance, or deductible. You may have additional costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" describes providers and facilities that haven't signed a contract with your health plan to provide services. Out-of-network providers may be allowed to bill you for the difference between what your plan pays and the full amount charged for a service. This is called "**balance billing**." This amount is likely more than in-network costs for the same service and might not count toward your plan's deductible or annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider. Surprise medical bills could cost thousands of dollars depending on the procedure or service.

You are protected from balance billing for:

Emergency services

If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most they can bill you is your plan's in-network cost-sharing amount (such as copayments, coinsurance, and deductibles). You **can't** be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers can bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **can't** balance bill you and may **not** ask you to give up your protections not to be balance billed.

If you get other services at these in-network facilities, out-of-network providers **can't** balance bill you, unless you give written consent and give up your protections.

You're <u>never</u> required to give up your protections from balance billing. You also aren't required to get out-of-network care. You can choose a provider or facility in your plan's network.

When balance billing isn't allowed, you also have the following protections:

You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay any additional costs to out-of-network providers and facilities directly.

Generally, your health plan must:

- Cover emergency services without requiring you to get approval for services in advance (also known as "prior authorization").
- Cover emergency services by out-of-network providers.
- Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
- Count any amount you pay for emergency services or out-of-network services toward your in-network deductible and out-of-pocket limit.

If you believe you've been wrongly billed, the following information and resources are available to help you understand your rights:

<u>Assistance by telephone</u> – You may contact the U.S. Department of Health & Human Services at (800) 985-3059 to discuss whether you may have any surprise billing protection rights for your situation.

Available online assistance – You can also visit the U.S. Centers for Medicare & Medicaid Services website to learn more about protections from surprise medical bills and for contact information for the state department of insurance or other similar agency/resource in your state to learn if you have any rights under applicable state law. Please click on your state in the map for contact information to appear.

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Prepared by: **Marsh & McLennan Insurance Agency LLC**

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