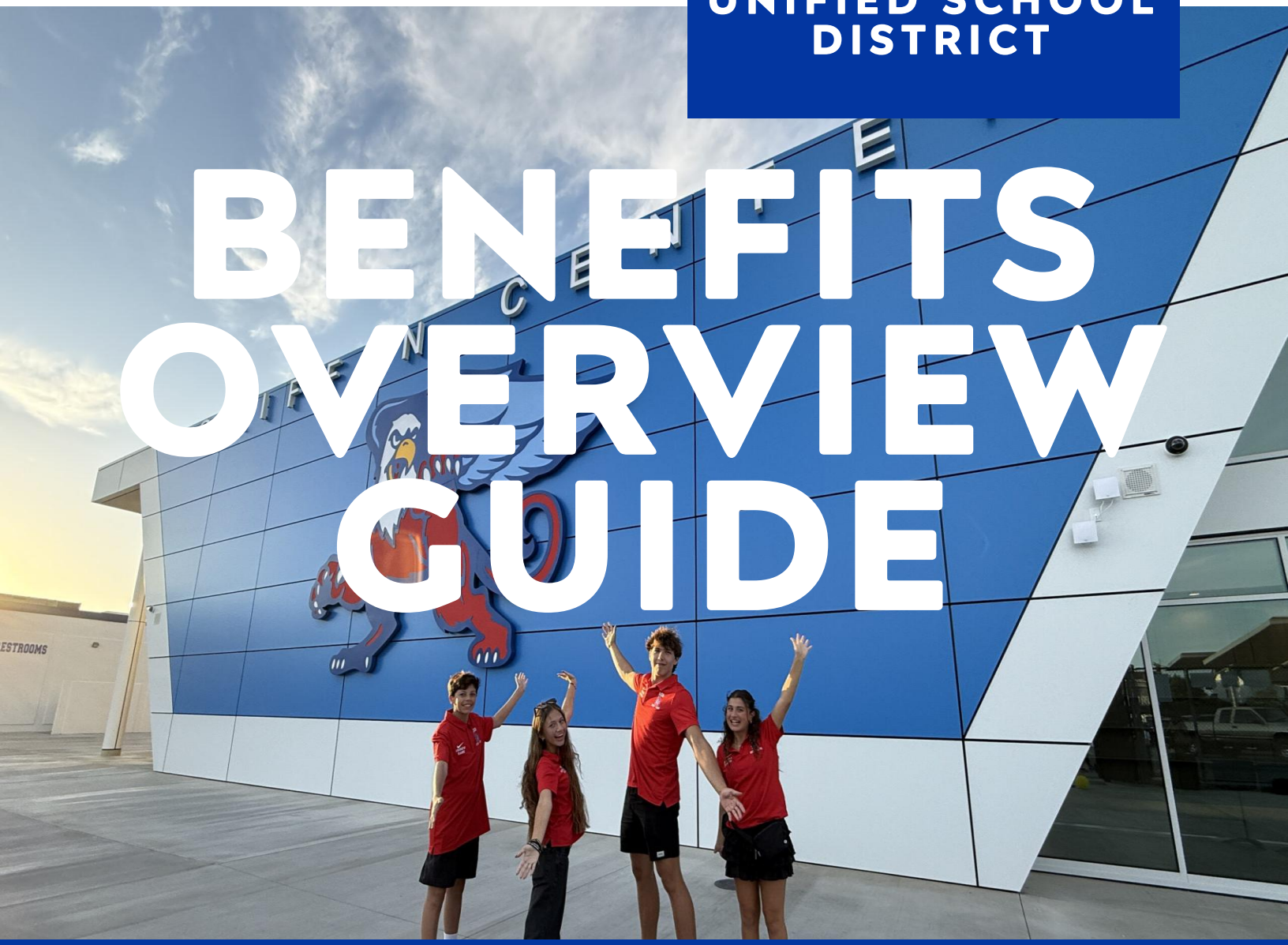
July 1, 2026 – June 30, 2027

LOS ALAMITOS UNIFIED SCHOOL DISTRICT

BENEFITS OVERVIEW GUIDE



Igniting Unlimited Possibilities

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LOS ALAMITOS UNIFIED SCHOOL DISTRICT

Your health and the health of your family are important to Los Alamitos Unified School District – this is the reason we offer a comprehensive benefits package designed to focus on your total well-being.

You have many resources available for any questions related to your plans as you enroll and throughout the year. Take advantage of those resources to be sure you receive the full benefits you need and all that is available to you.

The coverage you elect begins with your initial eligibility date and continues through the end of the enrollment year. The Flexible Spending Account (FSA) plan year begins January 1st and ends December 31st. Los Alamitos' benefit year for all other plans begins July 1st and ends June 30th.

EMPLOYEE ELIGIBILITY

Eligibility

Los Alamitos Unified School District is committed to offering employees a comprehensive benefits program that helps you stay healthy, feel secure, and maintain a healthy lifestyle. Employee contributions are based upon costs agreed to during negotiations.

Active Employees:

Full-time Classified-CSEA, Certificated-LAEA, Confidential, Supervisory, Management Employees:

- Employee and Family Medical Coverage
- Employee and Family Dental Coverage
- Employee and Family Vision Coverage
- Employee and Dependent Life Insurance
- Employee AD&D Insurance
- Voluntary Insurance Plans
- Flexible Spending Accounts

Part-Time Certificated-LAEA, Confidential, Supervisory, Management Employees:

Part-time employees: 0.50 Full-time equivalent [FTE]/20 hours or more

- Employee-only medical insurance
- Other types of insurance may be made available at full cost.

Part-Time Classified-CSEA:

Part-time employees: 0.75 Full-time equivalent [FTE]/30 hours or more

- Employee-only medical insurance
- Other types of insurance may be made available at full cost.

Retirees

Certificated and Classified: Eligible retirees are employees that are at least 55 years of age, qualify for retirement under PERS/STRS, and have served the District for 10 years if hired on or before June 30, 2010, or if hired on or after July 1, 2010, have either served the District for 20 years or have served the District for 10 continuous years and have a total of 20 or more years of verified PERS/STRS retirement service credit, are eligible to receive medical, vision and dental coverage at a cost. Classified retiree coverage ends at Medicare age and Certificated retirees are eligible for continued coverage at a cost after turning 65 years of age in accordance with AB528.

DEPENDENT ELIGIBILITY

Dependent Eligibility

Our commitment extends beyond the daily obligations of work and services of our employees. Los Alamitos Unified School District cares about your personal well-being and keeping your family healthy. Eligible employees and retirees are permitted to enroll dependents (based upon costs agreed to during negotiations) on any plan that covers dependents

Eligible Dependents:

- Legal Spouse as recognized by the state of California
- Children from birth to age 26 (regardless of marital or student status) including step, adopted, under legal guardianship and court ordered
- Adult Disabled Children with no age limit

Ineligible Dependents

The following individuals are NOT eligible dependents, even if they rely on you for support:

- Grandchildren (unless legal guardianship has been awarded)
- Foster children
- Parents
- Grandparents
- Siblings
- Ex-spouses and their children once a final decree has been issued or legal separation has been obtained (unless the member has been granted legal guardianship or is legally required to provide medical coverage under a QMCSO – Qualified Medical Child Support Order)

Certification Of Dependents For Health Plan Coverage

All employees are required to submit proof of eligibility certifying that their dependents meet the eligibility requirements to be enrolled. Before enrolling anyone as your dependent, verify that he or she qualifies under the plan rules.

ENROLLMENT

It is important that you make your benefit elections within the time frame allowed during your new hire or Open Enrollment period. Postponing the confirmation of your elections will result in a delay in enrollment processing. If you wish to see a doctor or fill a prescription soon after your benefits begin, please make your elections in a timely fashion or you may experience a delay.

Initial Enrollment Period

This is the first time you may enroll in District benefits after becoming eligible. You cannot enroll in dental and/or vision unless enrolling in medical. Enrollment is optional for dependents. Dependents will be enrolled in the same dental plan as the employee.

New Employees:

New employees are permitted to join the benefit plans within 31 days of the first day of payroll. Employees will be eligible for coverage the 1st of the month following the date of hire on active payroll. Employees may waive their benefits if they can provide proof of other health insurance coverage. You must submit the completed Enrollment Form within 31 days from your date of hire to the District Benefit Services office to enroll in the employer-sponsored benefit plans. Be sure to include any necessary supporting documents (e.g., tax documents, birth certificate, adoption certificate, etc.).

New Retirees:

Upon satisfying the requirements for qualified retiree benefits outlined on page 4, review your options and make your elections. Please submit your elections to the District Benefit Services Department prior to your retirement date to ensure a smooth transition in coverage.

Open Enrollment

Open enrollment is the period when you have the opportunity to change your benefit elections for the upcoming plan year and typically occurs during the month of April or May with the elections made during that time taking effect on July 1st. These plan elections remain in place through June 30th of the following year. During open enrollment, you can add or remove coverage for yourself and/or your dependents and otherwise change your coverage options.

When adding dependents, documentation will be required such as a marriage or birth certificate. Proof of other coverage is required if waiving medical coverage.

ENROLLMENT

The coverage(s) you elect during Open Enrollment cannot be changed during the plan year unless you have a Qualifying Life Event.

Qualifying Life Events

If you experience a Qualifying Life Event and wish to make changes to your current benefit elections, you must notify District Benefit Services within 31 days of the change in status. Documentation supporting the Qualifying Life Event must be provided. Qualifying Life Events as recognized under IRS regulations include:

- Legal marital status including marriage, divorce, annulment, death of spouse or legal separation
- Change in the number of dependent children including birth of a baby, adoption or death of a dependent child
- Employment status including termination or commencement of employment by the employee, spouse or dependent
- Change in your residence or worksite, which causes a loss or gain in coverage for the employee, spouse or dependent
- Becoming eligible for or losing coverage under a state's premium assistance program through Medicaid/CHIP
- Dependent reaches the age of 26 or any similar circumstance as provided in the health plan under which the dependent receives or loses coverage
- Work schedule including a reduction or increase in hours, a switch between part-time and full-time, or commencement or return from an unpaid leave of absence

Employees are responsible for notifying District Benefit Services of benefit status changes.

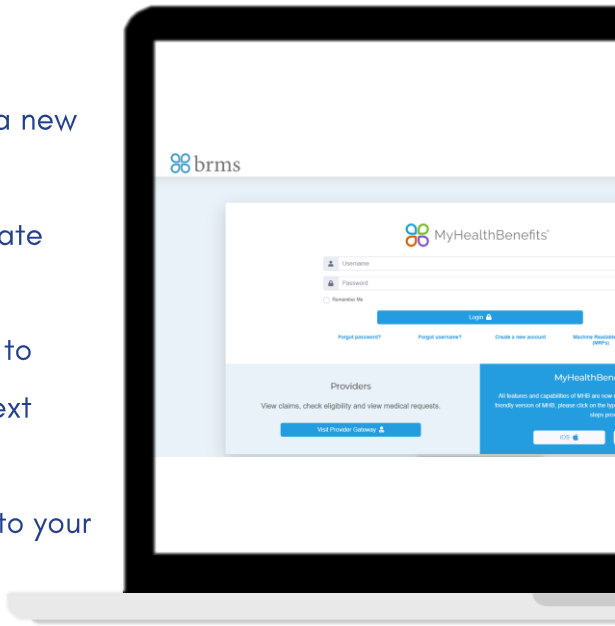
Any benefit change due to a qualifying life event must be made within 31 days of the event (or within 60 days for eligibility changes under Children's Health Insurance Program Act).

ONLINE ENROLLMENT

For your convenience, benefits are administered online through BRMS. This is an online benefits enrollment and communication system designed to give you and your eligible dependents access to important benefit information 24/7.

When it is time to enroll, you will need to have names, Social Security numbers and dates of birth for any dependents you wish to enroll and for your life insurance beneficiaries.

Logging In



1. Go to www.myhealthbenefits.com.
2. Click **Create New Account**. If you have already registered for a new account, skip to step 4.
3. Complete the registration process. You will be required to validate your account with an active email address.
4. Enter your username and password. The system will prompt you to validate your identity by entering a code (sent via phone call, text message or email).
5. Upon completing the authentication process, you will be taken to your benefits dashboard.

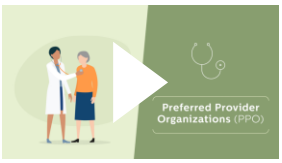
Enrolling in Benefits During Open Enrollment

1. On your benefits dashboard, click **Open Enrollment**.
2. Before you begin your enrollment, you will be asked to verify your personal information. To begin the verification process, click **Get Started**.
3. When you have finished the verification process, click **Proceed to Open Enrollment** to begin enrolling in benefits.
4. Starting with your first Benefit Election, the system will guide you through the election process for all benefit types available to you.
5. Click the appropriate option that indicates the action you want to take for each benefit. If you want to change any of your elections, click **I would like to change my election**.
6. When making changes, use the **Next** and **Back** buttons to move from page to page and be sure to click **Save** after making each change.
7. If you are satisfied with your elections, click the red button labeled **Click here to submit your elections** to complete your enrollment.

MEDICAL COVERAGE

Los Alamitos offers employees a comprehensive PPO (Preferred Provider Organization) medical plan administered by BRMS utilizing the Anthem network of doctors. The PPO plan offers freedom of choice by allowing members to choose any recognized provider or hospital, either in or out of the Anthem network when seeking care.

What is a PPO?



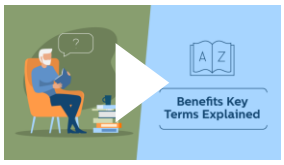
A Preferred Provider Organization (PPO) plan gives you the freedom to seek care from a provider of your choice. You will maximize your benefits and reduce your out-of-pocket costs if you choose a provider who participates in the Anthem network of doctors. These are established as "in-network" providers. The plan pays a percentage of the "maximum allowed amount" and you will not be responsible for any balance-billing for charges above the maximum allowed amount.

When you have services that are out-of-network and with non-PPO preferred providers, you will pay higher costs out-of-pocket. You may also be subject to balance-billing as non-contracted providers are not limited to the maximum allowed amount.

Pre-Authorization Requirement

Whether you choose to see a PPO or non-PPO provider, a pre-authorization MUST be obtained for any service that will result in claims exceeding $1,000.

What Is Your Cost For Services?



Your PPO plan will cover your preventive care service 100% when your care is with in-network providers. Outside of preventive care, you will have a share in the cost of your service. Your share can be in any of these forms:

- **copay** – a flat dollar amount
- **coinsurance** – a percentage of the cost
- **deductible** – an amount to meet before the insurance plan pays for coverage

Your plan also protects you from very costly services by putting a limit on the most you would pay for all covered services in a calendar year. This is called the out-of-pocket-maximum.

Whether your use your plan frequently or not at all, you must pay the premium to have medical coverage. Your premium is paid through a convenient payroll deduction.

MEDICAL COVERAGE

	Medical PPO Plan	
	In-Network (PPO)	**Out-of-Network (Non-PPO)**
Calendar Year Deductible		
Individual	$300	$600
Family	$900	$1,800
Calendar Year Out-of-Pocket Maximum		
Individual	$2,500	$5,000
Family	$6,250	$12,500
Preventive Care – Office Visits – Diagnostic		
Preventive Care Routine Physical Exams & Immunizations	No charge	Not covered
Office Visits Including Mental Health	$20 copay	40% after deductible
Specialist Visit	$20 copay	40% after deductible
Diagnostic Lab & X-Ray	20% after deductible	40% after deductible
Advanced Imaging (MRI / PET / CT Scans)	20% after deductible	40% after deductible
Physical/Occupational Therapy (max 60 visits/year combined)	$20 copay	40% after deductible
Chiropractic Care (max 30 visits/year)	$20 copay	Not covered
Hospital Services		
Urgent Care	$20 copay	40% after deductible
Inpatient Hospital	20% after deductible	40% after deductible
Outpatient Surgery	20% deductible waived	40% deductible waived
Emergency Room Non-emergencies are not covered	$150 copay + 20% after deductible	$150 copay + 40% after deductible
Ambulance Service	20% after deductible	20% after deductible

This is meant to be a brief summary only. For full plan details, exclusions and limitations, refer to the SPD.

IMPORTANT: Whether you choose to see a PPO or non-PPO provider, a pre-authorization MUST be obtained for any service that will result in claims exceeding $1,000.

CHIROPRACTIC COVERAGE

Los Alamitos is pleased to offer chiropractic services to employees and their dependents enrolled in the medical plan through the Anthem network and the Chiropractic Health Plan of California (CHPC). These services are designed to support your musculoskeletal health and overall well-being.

Why Use Chiropractic Services

Pain Relief: Effective for managing back, neck, and joint pain.

Improved Mobility: Helps enhance range of motion and flexibility.

Preventative Care: Supports overall health and can prevent future injuries.

Holistic Approach: Addresses various health issues without the use of medications.

You and each enrolled dependent may have up to

30 visits

per year combined between networks.

$20

copay

Access to Services

Anthem Network: Receive chiropractic care from a wide range of providers within the Anthem network; however, a referral from your provider is required for chiropractic services through Anthem.

Chiropractic Health Plan of California (CHPC): Access additional chiropractic services through CHPC's network of specialized providers. You and your dependents may self-refer to CHPC providers.

Anthem Network

- Visit https://www.anthem.com/ca/find-care/
- Under, **Use Member ID for Basic Search** type in the 3-letter prefix on your member ID (MDE)
- On the next page, first type in your zip code followed by the specialty (chiropractic)

Chiropractic Health Plan of California

- Visit https://chpc.com/
- Click on **Find a Chiropractor** for a list of in-network providers.

www.chpc.com

1-800-995-2442

info@chpc.com

KNOW WHERE TO GO

Where you get medical care can have a significant impact on the cost. Here's a quick guide to help you know where to go, based on your condition, budget and time.

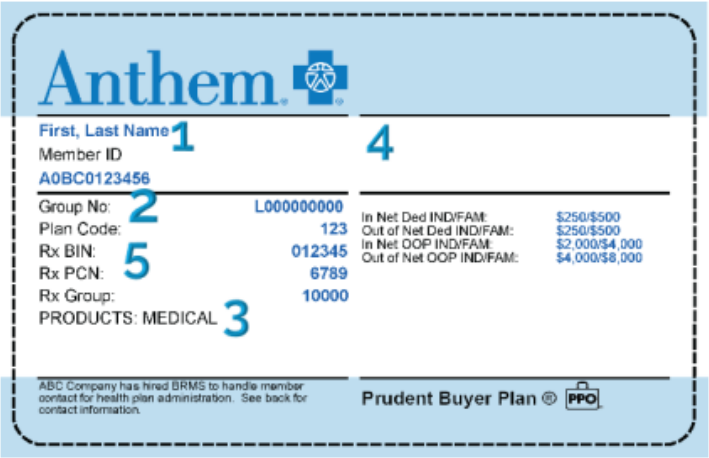
TYPE	APPROPRIATE FOR	EXAMPLES	ACCESS	COST
Nurseline	Quick answers from a trained nurse	• Identifying symptoms • Decide if immediate care is needed • Home treatment options and advice	24/7	$0
Virtual Visit	Many non-emergency health conditions	• Cold, flu, allergies • Headache, migraine • Skin conditions, rashes • Minor injuries • Mental health concerns	24/7	$
Office Visit	Routine medical care and overall health management	• Preventive care • Illnesses, injuries • Managing existing conditions	Office Hours	$$
Urgent Care, Walk-in Clinic	Non-life-threatening conditions requiring prompt attention	• Stitches • Sprains • Animal bites • Ear-nose-throat infections	Office Hours or up to 24/7	$$$
Emergency Room	Life-threatening conditions requiring immediate medical expertise	• Suspected heart attack or stroke • Major bone breaks • Excessive bleeding • Severe pain • Difficulty breathing	24/7	$$$$$

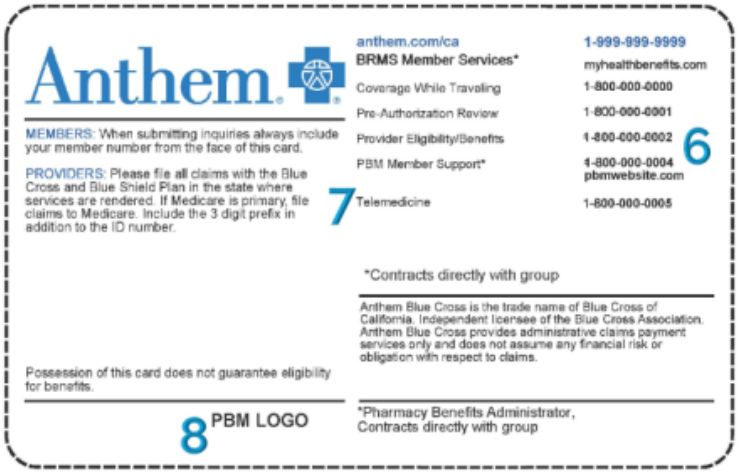
Watch this quick video to learn when to seek primary care versus urgent care versus the emergency room

UNDERSTANDING YOUR ID CARD

What Information is Included on your ID Card

Your health plan ID card is your direct link to healthcare. Remember to carry your ID card and show it to physicians, other providers and pharmacists whenever you need care or prescriptions. Please encourage your healthcare providers and pharmacists to make a copy of the front and back of this ID card, as it contains information necessary for the accurate submission and processing of claims.





1. Eligibility Information
Your eligibility information for your plan(s); Employee (the enrolled member's name); Identification Number (enrolled member's ID number).

2. Medical Plan Group Number
The eligibility number associated with your medical plan.

3. Coverages
The Anthem Blue Cross network information for BRMS administered plans you are enrolled in.

4. Dependents
If applicable, the dependents that are covered on your plan.

5. Pharmacy Information
Identifies the Rx numbers for your pharmacy.

6. Member Customer Service
- BRMS Member Services / Pre-Authorization – All plan questions
- Pharmacy Help Line – Pharmacy specific questions

7. Telehealth
If applicable, the Telehealth vendor for your medical plan.

8. Pharmacy Logo
The pharmacy vendor integrated into your medical plan.

PROVDER INFORMATION

Please verify eligibility through www.MyHealthBenefits.com. Do NOT verify with Anthem.

Providers will need to submit all claims to Anthem. Do NOT send claims to BRMS.

EXPLANATION OF BENEFITS

Explanation of Benefits (EOB)

You will receive an Explanation of Benefits (EOB) after a claim is filed with your medical plan. This document is an overview of the total charges from your provider visit and how much you and your health plan will have to pay. An EOB is NOT A BILL but does detail what to expect for the cost of your visit. You should review the invoice you get from your provider to see how it compares to the EOB.

Why is Your EOB Important?

Your EOB is a window into your medical billing history. Review it carefully to make sure you actually received the service being billed, that the amount your healthcare provider received and your share are correct, and that your diagnosis and procedure are correctly listed and coded.

It's also important to make sure that your records reflect the same numbers that the EOB show, in terms of your progress toward your deductible and out-of-pocket maximum for the year.

Once you've met your deductible, your health plan will start paying for more of your care. And once you've met your out-of-pocket maximum, the plan will start paying 100% of your covered, in-network costs for the rest of the year. So, it's important to make sure that these amounts are accurately reflected on each EOB.

Watch this video on How to Read an EOB

Preventative Care

The plan does cover preventive care services, but it is not subject to standard insurance requirements. These services are covered even if you have not met your annual deductible. The preventive care you will need to stay healthy varies by age, gender, and medical history. Visit cdc.gov/prevention for recommended guidelines.

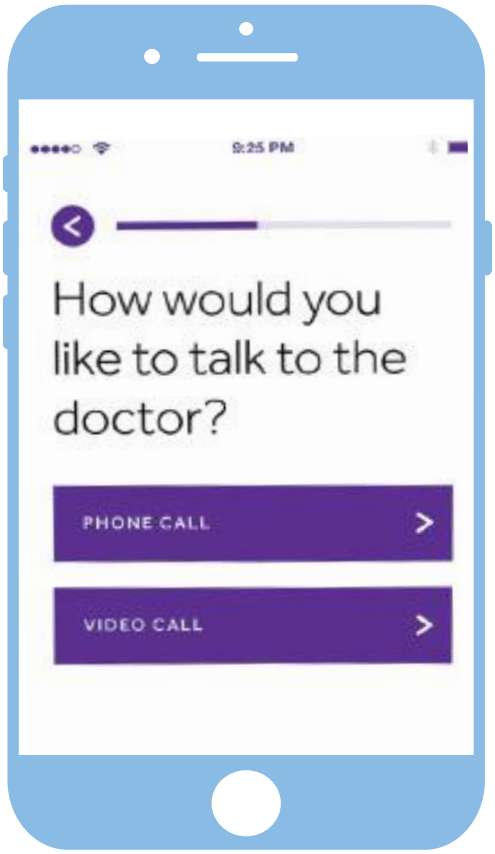
Typical screenings for adults:

- Blood pressure
- Cholesterol
- Diabetes
- Colorectal cancer screening
- Depression
- Mammograms
- OB/GYN screenings
- Prostate cancer screening
- Testicular exam

TELADOC

Teladoc virtual care makes your life easier. Teladoc is a healthcare service that offers convenient, confidential access to quality doctors 24/7, anytime, anywhere. By scheduling a visit with a U.S board-certified and licensed medical doctor, you can be diagnosed, treated and prescribed medication if necessary. With Teladoc you don't wait weeks for an appointment. Teladoc doctors and specialists can help you with the flu, infections, skin conditions, and provide advice on serious medical conditions.

Talk to a Doctor for Free!



1. Use a phone, app or website to create an account and complete your medical history
2. Request a time and a Teladoc doctor will contact you
3. The doctor will diagnose symptoms and send a prescription if necessary

What can I use Teladoc for?
Teladoc can help you with everyday, non-emergency healthcare issues, including sinus problems, allergies, flu symptoms and much more. Teladoc helps skip the waiting room and the trip to urgent care.

Does Teladoc replace my regular doctor?
No. Teladoc doesn't replace your primary care doctor. Teladoc should be used for non-emergency illnesses when it is not convenient to get to the doctor or it is outside of regular office hours.

Is there a time limit when talking to the doctor? And am I charged more for taking longer? There is no time limit for visits, and there is no extra charge for longer doctor visits.

Do I need to have my insurance information available?
No. Teladoc is a separate benefit, and your insurance information is not required.

LIVONGO

Livongo, a part of Teladoc Health, continues to support employees in effectively managing diabetes and hypertension. By combining cutting-edge technology with personalized coaching, Livongo empowers you to take control of your health and well-being. This program remains a key part of our commitment to providing comprehensive health solutions that cater to the diverse needs of our employees.

Why Participate in Livongo?

Improved Health Outcomes: Livongo's integrated approach helps you manage your condition more effectively, potentially reducing the risk of complications such as heart disease, stroke, and kidney problems, and enhancing your overall quality of life.

Cost Savings: Save on healthcare costs with no out-of-pocket expenses for essential supplies like devices, strips, and lancets. This benefit reduces the financial burden of managing chronic conditions.

Convenience: Manage your health anytime and anywhere with Livongo's user-friendly technology and dedicated support team. The convenience of having smart devices and real-time support means you can stay on top of your health without disrupting your daily routine.

Diabetes

Simplify diabetes management with quick checks and unlimited strips.

Diabetes Prevention

Improve your habits to help lower your risk of developing type 2 diabetes.

High Blood Pressure

Track your health trends to work toward reaching your health goals.

Weight Management

Find tools and strategies that will help healthy weight loss stick.

Personalized coaching and smart devices included at no cost to you!

TELADOC

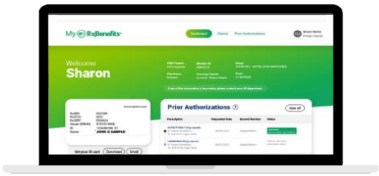
PRESCRIPTION DRUG COVERAGE

Our prescription benefits program through RxBenefits is designed to make it easy and affordable for you to access the medications you need. When you need help with your pharmacy benefits, RxBenefits can help.

Manage your Rx

By registering for My RxBenefits, you'll gain access to real-time prior authorization status, view, and view pharmacy benefits coverage information.

Sign up for the portal at:
https://member.rxbenefits.com



In-Network Benefits	
Annual Deductible	$250 (applies to specialty drugs only)
Out-of-Pocket Maximum	Combined with medical plan
Retail (30 days)	
Generic	$5 copay
Preferred brand	$25 copay
Non-preferred brand	$40 copay
Specialty Drugs	$60 copay after Rx deductible
Mail Order (90 days only)	
Generic	$10 copay
Preferred brand	$50 copay
Non-preferred brand	$80 copay
Specialty Drugs	Not available

Out-of-network services are not covered. For full plan details refer to the SPD.

Dispense As Written (DAW):

As part of our prescription drug coverage, we offer a broad range of medications, including both brand-name and generic options. However, it's important to note our DAW policy regarding brand-name drugs.

If you opt for a brand-name drug instead of its generic equivalent when filling a prescription at the pharmacy, you will be responsible for the brand-name copay, as well as the difference in cost between the medication and its generic counterpart.

Example:

Prescription | Nexium: **$250**
Alternative | Generic: **$30**
Difference between costs: **$220**

You will pay: Non-preferred brand drug copay: **$40**
Difference between costs: **$220**
Total: **$260**

This policy is designed to encourage the use of cost-effective generic medications while still offering flexibility for those who may have specific medical needs or preferences for brand-name drugs. For further details regarding your prescription drug coverage, please contact RxBenefits.

PRESCRIPTION DRUG COVERAGE

Our prescription benefits through RxBenefits includes access to the extensive CVS/Caremark network, providing convenient options for filling your medications. You can use CVS pharmacies and thousands of participating pharmacies nationwide, including major chains and local drugstores such as Walgreens and Target pharmacies.

CVS/Caremark Pharmacy Network

Our prescription benefits provide seamless access to medications through the CVS/Caremark network, designed for your convenience and flexibility.

30-Day Supplies: Available at retail pharmacies within the CVS/Caremark network, including major chains and local drugstores.

90-Day Refills: Available exclusively through CVS/Caremark mail order service for added convenience and cost savings.

Rx Delivery By Mail

With RxBenefits, you can have your medications delivered to your home through CVS Caremark® Mail Service Pharmacy. CVS/Caremark Mail Service Pharmacy offers a convenient and cost-effective way to manage your long-term medications.

Convenience: Receive your medications directly at your home, eliminating the need for frequent trips to the pharmacy.

Cost Savings: Often, you can save money with lower copayments for 90-day supplies compared to 30-day supplies at retail pharmacies.

Automatic Refills: Enjoy the ease of automatic refills and reminders, ensuring you never run out of essential medications.

Manage your Rx on Your Own Time

CVS caremark mobile app gives you a secure, simple way to manage your prescription benefits and member information. You'll find easy-to-use tools that help you save time, get organized and stay on your path to better health.

Find a nearby pharmacy no matter where you are. Learn about your medication and get information you can trust day or night.

DENTAL COVERAGE

Los Alamitos offers two comprehensive dental plans to choose from. Dental coverage is designed to assure that you receive regular preventive care. With routine examinations, minor dental problems can be diagnosed and treated before major more costly problems set in.

Direct Referral HMO Dental Plan

The Anthem Dental Net DHMO plan pays a high level of coverage provided you use a selected Dental Net dentist. There are no deductibles or copays for diagnostic or preventive services keeping your out-of-pocket expenses to a minimum. However, some procedures require a copay that you will need to pay at the time of service. The plan is simple to use. Just select a participating dentist at enrollment—then refer to your Schedule of Benefits to see what's covered and your costs.

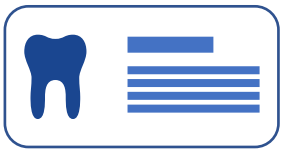
Anthem	DHMO In-Network
Network Access Level	
Calendar Year Deductible	None
Annual Maximum Benefit	Unlimited
Services	
Oral Exams	No charge
Teeth Cleaning	No charge (Limit 2)
Fluoride Treatment	No charge
Amalgam Fillings	No charge
Periodontal Scaling/Planing	No charge
Crowns	$0 – $85 copay
Orthodontia	
Child	$1,695 copay
Adults	$1,895 copay

The above is a high-level overview of the coverage available. For complete coverage details, please refer to the Schedule of Benefits

Plan Highlights

- You have a $0 copay per office visit.
- Routine cleanings and maintenance services are limited to twice a year.
- The participating dentist you select at enrollment will provide your routine dental care.
- Orthodontic Services are available for adults and children under this plan. Please refer to the Schedule of Benefits for additional information.

The Schedule of Benefits includes covered services, information on any limitations and charges for procedures, and services. It's important that you review this information before you see your dentist for the first time. You may request the Schedule of Benefits from your Benefits Coordinator.



Dental Plan ID Cards

Newly enrolled members will receive an ID card by mail. If you are a current Anthem Dental member and need to replace your ID card visit www.anthem.com/ca

DENTAL COVERAGE

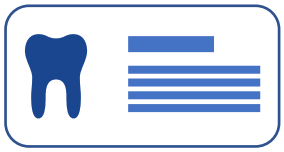
Delta Dental PPO Plan

This plan is a traditional, non-referral based plan that allows members the freedom to choose any recognized dentist, in or out of network. This plan makes it easy for you to find a dentist and to control your costs when you visit a network dentist by offering access to one of the largest dental networks in the country.

PPO network dentists accept reduced fees for covered services, so you'll usually pay the least when you visit a PPO network dentist. This also ensures Delta Dental dentists won't balance bill you the difference between the contracted amount and their usual fee. Reimbursement is based on the PPO contracted fees or Reduced Fee Schedule (RFS) for dentists both in and out of network.

DELTA DENTAL	Delta Dental PPO Plan	
	In-Network	Out-of-Network
Annual Deductible Individual/Family	$50 | $150	
Annual Maximum Benefit	$2,000	$1,500
Diagnostics & Preventative Services		
Periodic Exam, Teeth Cleaning, X-Rays	Plan pays 80%*	Plan pays 80% RFS*
Basic Services		
Amalgam Fillings, Root Canal, Oral Surgery, Simple Extractions, Periodontics	Plan pays 80%*	Plan pays 80% RFS*
Major Services		
Crowns, inlays, onlays and cast restorations	Plan pays 50%*	Plan pays 50% RFS*
Dental Accidents Benefits		
Dental Accident Benefits	Plan pays 100% (Separate $1,000 maximum per person each calendar year)	
*After Deductible	This is meant to be a brief summary only. For full plan details refer to the SPD.	

Check in without an ID



You don't need a Delta Dental ID card when you visit the dentist. Just provide your name, birth date and enrollee ID or Social Security number. If your family members are covered under your plan, they'll need your information. Prefer to have an ID card? Simply log in to your account at www.deltadentalins.com to view or print your card.

VISION COVERAGE

Los Alamitos understands the importance of good visual health and the need for regular eye examinations by providing one of the leading vision plans in the country. This vision plan, administered by EyeMed, is designed to provide you with access to qualified eye care professionals and coverage for a comprehensive vision examination and materials (eyeglasses or contact lenses).

	Plus Providers	In-Network	Out-Of-Network
	You pay:	You pay:	Plan reimburses you up to:
Eye Exam	$0 copay	$10 Copay	Up to $40
Frames	Amount over $180 allowance (20% discount for over allowance)	Amount over $130 allowance (20% discount for over allowance)	Up to $91
Standard Plastic Lenses			
Single	$0 copay	$0 copay	Up to $30
Bifocal	$0 copay	$0 copay	Up to $50
Trifocal - Lenticular	$0 copay	$0 copay	Up to $70
Progressive - Standard	$0 copay	$0 copay	Up to $50
Contact Lenses			
Conventional	Amount over $130 allowance (15% discount for over allowance)	Amount over $130 allowance (15% discount for over allowance)	Up to $91
Disposable	Amount over $130 allowance	Amount over $130 allowance	Up to $91
Medically Necessary	$0 copay	$0 copay	Up to $300

This is meant to be a brief summary only. For full plan details refer to the SPD.

How Often Can You Use Your Benefits

Schedule of Benefits	Frequency
Eye Exam	Every 12 months
Frames	Every 24 months
Lenses (in lieu of contacts)	Every 12 months
Contact Lenses (in lieu of lenses)	Every 12 months

EyeMed Member ID Cards

EyeMed provides two ID cards in your name, but you aren't required to have it at the time of service. If you lose your card or need extras for your family, you can print a replacement by creating an account at www.eyemed.com or downloading the EyeMed Members App to pull up a digital version anytime, anywhere.

VISION PLAN HIGHLIGHTS

Being an EyeMed member has its perks. You get a mix of special offers and discounts that give your benefits a boost — so you can keep your eyes healthy and save money.

Plan Highlights

- A separate allowance for frames and contact lens that gives you the ability to use the frame and contact lens allowances in the same benefit year – worth up to an extra $130
- A separate contact lens fit & follow-up coverage (leaving the entire allowance for materials)
- 40% off additional pairs of glasses during the same visit
- 15% off Lasik or PRK from US Laser Network Providers

As an EyeMed member you can also use your in-network benefits to purchase contact lenses and eyewear online at:

LensCrafters · Target Optical · Ray-Ban · Glasses.com · contactsdirect

How It Works:

Find a doctor at https://eyemed.com

Schedule an appointment

Complete your exam

Pay your $10 copay

Pick the frames/lenses that fit your budget (in-store or online)

Manage Your EyeMed Benefits In A Few Easy Steps:

1. Visit www.eyemed.com and click on Member Login.
2. Click on Create an Account.
3. Register using your member ID or the last four digits of your social security number.
   You'll get an email asking to confirm your account.
4. Finish setting up your new account with your email address and a password.
5. Come back anytime to change your password, email address and billing preferences. It's all under Manage Profiles.

FLEXIBLE SPENDING ACCOUNT (FSA)

Jan 1st – Dec. 31st Plan Year

Los Alamitos provides you with an opportunity to participate in two different flexible spending accounts (FSAs) administered by BRMS. Each year that you would like to participate in the FSAs, you must elect the amount you want to contribute to either or both of the FSAs.
Your contributions will be deducted from your paychecks in equal installments throughout the year and deposited into your account(s). Both accounts function separately.

Health Care FSA

You can use this account for qualified medical, dental and vision expenses for yourself, your spouse or your dependent children. Some qualified expenses include:

- Coinsurance
- Copayments
- Deductibles
- Orthodontia
- Eye exams/eyeglasses
- LASIK eye surgery
- Arches/orthotic Inserts
- First aid supplies
- Prescription sunglasses

For a complete list of eligible expenses, visit www.irs.gov/pub/irs-pdf/p502.pdf

Dependent Care FSA

You can use this account for expenses for services that allow you and your spouse (if you are married) to work or attend school full time. These services generally include day care, babysitters, most day camps, and caregivers for dependent children under age 13 and disabled adult dependents. Another eligible expense is care of a household member who is physically or mentally incapable of caring for him/herself and qualifies as your federal tax dependent.

Adoption Assistance Account

Adoption Assistance is a valuable addition to your benefits. It helps you pay for expenses related to what for many is an important life goal – having a family. Think of adoption assistance like a flexible spending account for common eligible adoption expense. An Adoption Assistance Account must be elected during open enrollment. The tax year for which you can claim the credit depends on when the expenses are paid; whether it's a domestic adoption or a foreign adoption; and when, if ever, the adoption was finalized. The IRS determines which expenses can be reimbursed, however, some of the most common items include adoption agency fees, travel expenses (including meals and lodging while away from home) and court costs.

FLEXIBLE SPENDING ACCOUNT (FSA)

2026 Contribution Limits

Health Care FSA	Dependent Care FSA	Adoption Assistance
$3,400	$5,000	$17,670
2026 IRS Annual Maximum Contribution	2026 IRS Annual Maximum Contribution	2026 IRS Annual Maximum Contribution

Health Care FSA Roll Over:

Los Alamitos has elected to offer the FSA Rollover feature for your Health Care FSA. It does not pertain to Dependent Care FSA. The FSA Rollover feature, allows you to roll over up to $680 of your unused Health Care FSA balance into the next plan year instead of 'losing it'.

Important Rules To Keep In Mind

FSAs offer sizeable tax advantages. The trade-off is that these accounts are subject to strict IRS regulations, including the following:

- The IRS has a strict "use it or lose it rule": If you do not use the full amount in your FSAs by the end of the plan year, you will lose any remaining funds above the rollover amount of $680.
- All claims must be submitted within 90 days of the end of the plan year.
- In the event of employment termination, contributions to our plan stop and you can no longer incur expenses for reimbursement. Claims must be submitted within 30 days of termination date.
- Once you enroll in the FSAs, you cannot change your contribution amount during the year unless you experience a qualified status change.
- You cannot transfer funds from one FSA account to another.

Why Enroll?

- By putting money aside pre-tax, this lowers your taxable income – which in turn may increase your spendable income!
- Funds can be used for planned and unplanned eligible health care expenses. You don't need to earmark funds for a specific purpose.

FLEXIBLE SPENDING ACCOUNT (FSA)

Flexible Spending Card

The Benefits Card makes using your FSA dollars simple and easy. The card deducts each payment directly from your FSA account. It's as convenient as using an ordinary credit card. What's more, the Benefits Card virtually eliminates the endless paperwork and reimbursement wait time that used to make FSAs so complex and cumbersome. All you need to do is save receipts for all your FSA purchases in the event they are requested by your plan administrator. In many cases you won't have to send in a receipt, because with the Benefits Card, your purchases will be auto-substantiated at thousands of retailer locations nationwide.

Medical-related facilities, including doctor's offices and hospitals, will accept your flex debit card. Retailers, such as drugstores and pharmacies with computer systems that recognize eligible expenses when scanned, will also accept your flex debit card.

Some expenses cannot be substantiated at the point-of-sale such as chiropractic, orthodontic, retail purchases and more. Be sure to save your receipts!

All purchases made over $200 will require additional documentation to BRMS to substantiate the expense.

Because these retailers have an Inventory Information Approval System (IIAS) in place, they will know instantly which items you purchase are eligible FSA purchases. With one swipe of your Benefits Card, approved purchases will be authorized and debited from your FSA account. You will be asked to remit another form of payment for the noneligible items. For optimal convenience, your Benefits Card offers 24/7/365 online access, so you can check your account balance and other vital information with a single click.

Important Note:

Regardless if you are enrolled in a Health Care FSA or Dependent Care FSA, you will use the same card. You can request an additional debit card for your dependents and/or spouse.

BASIC LIFE AND AD&D

Life and Accidental Death & Dismemberment coverages help ensure that if the unforeseen should happen, short-and long-term financial obligations could be met. It's important to take steps to make sure your family would be financially prepared if you were no longer there to handle expenses like:

100% Employer Paid

- Mortgage or rent payments
- Utilities
- Insurance premiums
- Childcare/education fees
- Transportation
- Credit card bills

Los Alamitos provides full-time employees with Basic Life and Accidental Death and Dismemberment (AD&D) insurance through VOYA and pays for the full cost of coverage:

Administrative	CSEA	Confidential
$40,000	$38,000	$40,000

LAEA	Management	Supervisory
$38,000	$40,000	$40,000

Benefit amounts reduce to 65% of original coverage at age 65, to 50% of original coverage at age 70 and to 35% of original coverage at age 75.

What does my life insurance include?

- **AD&D:** Pays a benefit to you or your beneficiary, separate from the life insurance benefit, if you are severely injured or die as the result of a covered accident.
- **Accelerated Death Benefit:** This benefit is payable if it has been determined that you have a terminal condition.
- **Portability:** You may apply to continue your coverage when you leave your current employer and pay premiums to the insurance company directly.

DEPENDENT LIFE

The District also provides each employee's spouse and unmarried children (from six months of age) with a $1,500 benefit.

100% Employer Paid

A beneficiary is the person to receive the benefits of your life insurance if you should pass. You must designate beneficiaries for your District-paid life insurance. Any beneficiaries you name are legally binding. However, you may make changes to your beneficiaries at any time.

VOLUNTARY BENEFITS

Los Alamitos offers voluntary benefits known as Supplemental Insurance through American Fidelity. These benefits help offset additional out-of-pocket expenses you may experience when you are sick or injured regardless of your medical insurance coverage. The cost of these benefits are covered by you and benefit payments are paid directly to you.

Accident

Limited Benefit Accident Only Insurance may help minimize the impact on your finances by helping with covered expenses, regardless of any other insurance coverage you may have. The plan pays for a range of benefits and payments are made directly to you.

The plan pays you an annual wellness benefit for you to receive a routine physical exam, including immunizations and preventive testing.

Cancer

With Limited Benefit Cancer Insurance, you may receive benefits to help ease your financial responsibilities and allow you to focus on your treatment and recovery. The plan is specially designed to help with a portion of the costs associated with cancer, with more than 25 plan benefits available for treatment

Only 40% of the overall medical cost of cancer is for direct expenses, while 60% of cancer treatment costs are indirect medical costs.

The plan may help cover the cost of important screenings, giving you the early detection that can be so critical when fighting the illness.

Critical Illness

Group Limited Benefit Critical Illness Insurance can assist with the expenses that may not be covered by traditional medical insurance. The plan is designed to pay a lump sum benefit amount to help cover expenses if you are diagnosed with a covered critical illness. The plan offers a benefit for your covered health screening test. This benefit features eight qualified tests, including a stress test, echo cardiogram, electrocardiogram (EKG), blood glucose testing and more.

Disability Insurance

Disability Income Insurance is a cost-effective solution designed to help protect you if you are unable to work due to a covered injury or sickness.

The plan provides a monthly benefit to cover expenses while you are unable to work. Based on your individual need, there are various elimination periods for you to choose from.

More than 1 in 4 of today's 20 year-olds will become disabled before they retire.

The plan pays a monthly benefit based upon a percentage of your gross monthly income once you have satisfied the elimination period. Your monthly benefit payments may be deposited directly into your bank account. This allows you to pay your living expenses and make other purchases as you see fit.

Term Life

Term Life Insurance is a renewable and convertible insurance policy that covers you during your peak-earning years when you need it the most. The policy covers you during a specific period, either 10, 20 or 30 years. You decide which term best meets the needs of you and your family. You may apply with minimal questions and no medical tests depending on the answers to a few medical questions.

Unlike most group policies offered through your employer, the plan is portable and you can take it with you if you leave employment for any reason.

Visit with your American Fidelity account manager to learn more about your voluntary benefits.

Hito Seng
Senior Account Executive

1-800-365-9180
951-397-4305

https://americanfidelity.com/

Whole Life

A permanent life insurance policy may help ease the financial cost placed on your family in the event of your death. Whole Life Insurance from American Fidelity Assurance Company is an individual whole life insurance policy that provides lifelong protection. The premium and amount of benefit stays the same as long as the policy is in force, provided premiums are paid. Policies are available for you, your spouse, children, and grandchildren.

EMPLOYEE ASSISTANCE PROGRAM (EAP)

Life doesn't always go as planned and while you can't always avoid the twists and turns, you can get help to keep moving forward. Los Alamitos offers an Employee Assistance Program (EAP) at no charge to you. An EAP is a voluntary, work-based program that offers free and confidential assessments, short-term counseling, and referrals and follow-up services to employees who have personal and/or work-related problems.

The EAP is available to help you and your household members to get professional support and guidance to make life a little easier. Your ComPsych® GuidanceResources® program offers someone to talk to and resources to consult whenever and wherever you need them.

Confidential Emotional Support

Our highly trained clinicians will listen to your concerns and quickly refer you to telephonic counseling and other resources for:

- Anxiety, depression, stress
- Grief, loss, life adjustments
- Relationships/marital conflicts

Online Support

GuidanceResources® Online is your 24/7 link to vital information, tools and support. Log on for:

- "Ask the Expert" personal responses to your questions
- Articles, podcasts, videos, slideshows
- On-demand trainings

Contact ComPsych at Anytime, Anywhere

No-cost, confidential solutions to life's challenges.

Website: www.guidanceresources.com
Web ID: My5848i

Phone: 1-877-533-2363

Mobile App: GuidanceResources® Now
Web ID: My5848i

FIND A PROVIDER

You will receive the best benefits if you choose providers in your plan network. However, you can also see providers outside the network but at a higher cost out-of-pocket.

MEDICAL PROVIDER

- Go to https://www.anthem.com/ca/find-care/
- Enter your Member ID; OR click **Basic Search as a Guests**
- Answer questions that will help you narrow your search
- Select **Medical** under "What type of care are you searching for?"
- Select **California** under "What state do you want to search in?"
- Select **Medical (Employer Sponsored)** under "What type of plan do you want to search with?"
- Select **Prudent Buyer PPO/EPO** under "Select a plan/network"

DENTAL PROVIDER HMO

- Go to https://www.anthem.com/ca/find-care/
- Enter your Member ID; OR click **Basic Search as a Guests**
- Answer questions that will help you narrow your search
- Select **Dental** under "What type of care are you searching for?"
- Select **California** under "What state do you want to search in?"
- Select **Dental** under "What type of plan do you want to search with?"
- Select **Dental NET HMO** under "Select a plan/network"

DENTAL PROVIDER PPO

- Go to www.deltadentalins.com
- Click on Find a dentist
- Enter your address, city or zip code under Location
- Select Delta Dental PPO under Network
- Click on Find a dentist

VISION PROVIDER

- Go to https://eyedoclocator.eyemedvisioncare.com/
- Select Insight Network
- Enter your zip code
- Click on Search by Zip

CONTACTS

For any questions or assistance regarding your employee benefits, our dedicated support team is here to help. Whether you need more information about health insurance, prescription benefits, chiropractic services, or any other aspect of your benefits package, please reach out to the appropriate contact below. We're committed to providing you with the support and resources you need to make the most of your benefits.

Medical Coverage

BRMS		Anthem Blue Cross	
www.brmsonline.com	800-372-0905	www.anthem.com/ca	800-372-0905
Outpatient Hospitalization Pre-Certification	800-368-0767	Inpatient Hospitalization Pre-Certification	800-274-7767

Prescription Drug Plan

RxBenefits

https://member.rxbenefits.com	800-835-2362	CustomerCare@rxbenefits.com

Telemedicine

Teladoc

Teladoc.com	800-835-2362

Chronic Condition Management

Livongo

Go.Livongo.com/BRMSWP/register	800-945-4355	Registration Code: BRMS-WP

CONTACTS

Dental Coverage

Anthem Blue Cross Dental Net HMO		Delta Dental PPO	
www.anthem.com/ca	800-627-0004	www.deltadentalins.com	800-765-6003

Vision Coverage

EyeMed	www.eyemed.com	888-581-3648

Life and AD&D

Voya Financial	https://claimscenter.Voya.com	888-238-4840

Flexible Spending Account (FSA) and Adoption Assistance

BRMS	brms-fsa@bmsonline.com	800-945-4355

Employee Assistance Program (EAP)

ComPsych	www.guidanceresources.com	877-533-2363

Voluntary Benefits

American Fidelity	www.americanfidelity.com	951-397-4305
Hito Seng, Account Manager	hito.seng@americanfidelity.com	

District Benefit Services Department

10293 Bloomfield Street
Los Alamitos, CA 90720

Phone: 562-799-4700
Ext. 80409

Did you receive a paper copy of this guide? Scan the QR code below to view an interactive guide on your mobile device or tablet. The interactive guide will allow you to access links to websites and to view any videos embedded.

SCAN ME

Revised July 2026
Prepared by:

McGriff
A Marsh & McLennan Agency LLC Company

The information in this Benefits Guide is presented for illustrative purposes and is based on information provided by the employer and the insurance companies. While every effort was taken to accurately report your information, discrepancies or errors are always possible. In case of a discrepancy between the Benefit Guide and the actual plan documents, the actual plan documents will prevail. All information is confidential, pursuant to the Health Insurance Portability and Accountability Act of 1996. If you have any questions about this summary, contact District Benefit Services Department.