2026 – 2027

BENEFITS

Classified COBRA

SANTA ANA UNIFIED SCHOOL DISTRICT

benefits

CONTENTS

GETTING STARTED **4**

WHO'S ELIGIBLE FOR BENEFITS? 5

OPEN ENROLLMENT 6

ENROLLING FOR BENEFITS 7

CHANGING YOUR BENEFITS 8

MEDICAL, DENTAL & VISION **9**

HMO MEDICAL PLANS 10

PPO MEDICAL PLANS 11

PRESCRIPTION PLAN – BLUE SHIELD ONLY 12

KNOW WHERE TO GO 13

DENTAL PPO 14

DENTAL HMO PLAN 15

VISION PLANS 16

GETTING CARE WHEN YOU NEED IT 17

EMPLOYEE ASSISTANCE PROGRAM 18

MEDICARE SOLUTIONS 19

IMPORTANT PLAN INFORMATION **20**

BENEFIT COSTS, PLAN CONTACTS, ANNUAL NOTICES

MEDICARE PART D NOTICE

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

GETTING STARTED

2026 - 2027 BENEFITS
July 1, 2026
through
June 30, 2027

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

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

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

WHO'S ELIGIBLE FOR BENEFITS?

You are eligible to participate in our COBRA plans if you meet the qualifications specified in your COBRA notifications. COBRA notifications are automatically generated and sent to each qualified participant.

Eligible dependents

- Legally married spouse.
- Domestic Partner with proof of a Declaration of Domestic Partnership filed with the California State Secretary. Any premiums paid for by SAUSD for your domestic partner will be deducted on an after-tax basis.
- Natural, adopted or stepchildren, or children of a domestic partner up to age 26.
- Children over age 26 who are disabled and depend on you for support.
- Children named in a Qualified Medical Child Support Order (QMCSO).

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

Who is not eligible

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

- Parents, grandparents, and siblings.

OPEN ENROLLMENT

Open Enrollment is a once-a-year opportunity to review your benefit choices, change plans, add or drop dependents, and enroll or re-enroll in Flexible Spending Accounts. After Open Enrollment ends, you cannot change your benefit elections until the next Open Enrollment in 2027, unless you experience an eligible life event.

Open Enrollment begins:

June 1, 2026, through June 11, 2026.

Any changes made during OE will be effective on July 1, 2026.

Do I need to enroll?

If you do not have any changes to make to your 2024 -2025 benefits, **no action is required.** You only need to fill out a form for Open Enrollment, if you would like to change your benefits.

What's new or changing

Our current benefit program will continue into the 2026 – 2027 school year with no changes to medical benefits. While your benefits aren't changing, you may have had some major life changes. Do your current choices still meet your needs? Review this benefits guide to understand your coverage options. Include your spouse or partner in the review if they have input into your family's benefits decisions.

These changes will be effective on July 1, 2026.

ENROLLING FOR BENEFITS

PlanSource

PlanSource is an online system that enables you to make all your benefit decisions in one place. If you don't have access to a computer, you can access the enrollment portal from a tablet or smartphone.

Before you enroll

- Know the date of birth, social security number, and address for each dependent you will cover.
- Review your enrollment materials to understand your benefit options and costs for the coming year.

Getting started

- Log in to PlanSource using the following link: PlanSource Login

  Username: Your SAUSD email.

  Password: Your birthdate in YYYYMMDD format.

  Example: A birthdate of August 14, 1962, would result in the password "19620814".
- Please note, the first time you log in, you will be prompted to change your password.
- Click and follow for instructions on next steps: How to PlanSource.pdf

PLANSOURCE

For additional assistance:

support@thebenefitsupportcenter.com

Or call 888-909-0166

CHANGING YOUR BENEFITS

Click to play video

LIFE HAPPENS

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

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

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

You must submit your change within 30 days after the event.

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

1. Any change you make must be consistent with the change in status.
2. You must make the change within 30 days of the date the event occurs.
3. All proper documentation is required to cover dependents(marriage certificates, birth certificates, etc.).

HEALTHCARE

MAKE TIME FOR HEALTH

OUR COMMITMENT

We believe that our employees should have access to healthcare coverage that promotes preventive care and helps cover the cost of illness.

Eligible employees and their eligible dependents can enroll in medical, dental, and vision coverage through the SAUSD benefits program.

Medical

We offer 4 medical plans. Preventive care is fully covered under all plans if obtained in-network. Your costs for other services will depend on which plan you choose. Review the network provider information and out-of-pocket costs such as deductible, coinsurance and prescription drugs so you can choose the best fit for your health concerns and budget.

Dental

Some people don’t like going to the dentist, but no one likes big dental bills. Regular checkups and cleanings are fully covered and can identify issues before they become serious. And if you do need dental services, insurance helps cover the cost for fillings, gum disease, orthodontia, and more.

Vision

An eye exam can uncover health conditions you may not know you have, such as glaucoma, or even high blood pressure. Our vision plan help cover the cost of eye exams, eyeglasses, and contact lenses to ensure you’re seeing and feeling your best.

MEDICAL HMO COVERAGE

Medical coverage provides you with benefits that keep you healthy like Preventive care screenings and access to urgent care. It also provides important financial protection if you have a serious medical condition. The following chart shows the medical HMO plans offered to SAUSD employees. You always pay the deductible and copayment ($).

	HMO Plans		
	Blue Shield Trio ACO HMO	**Blue Shield Access+ HMO**	**Kaiser Permanente HMO**
Calendar Year Deductible[1]	None	None	None
Calendar Year Out-of-Pocket Maximum[1] Individual Family	$1,000 $3,000 Embedded[2]	$1,000 $3,000 Embedded[2]	$1,500 $3,000 Embedded[2]
Office Visit Primary Care Specialist	$20 copay $20 copay	$20 copay $20 copay ($30 copay self-referral)	$20 copay $20 copay
Preventive Services	No Charge	No Charge	No Charge
Chiropractic	$10 copay (up to 30 visits per year)	$10 copay (up to 30 visits per year)	Not Covered
Lab and X-ray	No Charge	No Charge	No Charge
Urgent Care	$20 copay	$20 copay	$20 copay
Emergency Room	$100 copay (waived if admitted)	$100 copay (waived if admitted)	$100 copay (waived if admitted)
Inpatient Hospitalization	$250 copay per admission	$250 copay per admission	$250 copay per admission
Outpatient Surgery	No charge	No Charge	$20 copay per admission
PRESCRIPTION DRUGS	**Express Scripts**		**Kaiser Pharmacy**
Calendar Year Deductible	$150 per person (for brand name Rx)	$150 per person (for brand name Rx)	None
Out-of-Pocket Maximum Individual Family	$5,600 $10,200	$5,600 $10,200	Combined with Medical
Pharmacy Generic Preferred Brand Name Non-Preferred Brand Name Specialty Supply Limit	$15 copay $30 copay (after Rx deductible) $50 copay (after Rx deductible) 20% ($100 max) 30 days	$15 copay $30 copay (after Rx deductible) $50 copay (after Rx deductible) 20% ($100 max) 30 days	$10 copay $20 copay Not Covered $20 copay 30 days
Mail Order Generic Preferred Brand Name Non-Preferred Brand Name Supply Limit	$30 copay $60 copay (after Rx deductible) $100 copay (after Rx deductible) 90 days	$30 copay $60 copay (after Rx deductible) $100 copay (after Rx deductible) 90 days	$20 copay $40 copay Not Covered 100 Days

[1]Deductibles and out-of-pocket maximums accumulate on a calendar year from January 1 – December 31.
[2] An embedded family maximum means the plan will cover 100% for an individual member as soon as they reach their individual maximum.

MEDICAL PPO COVERAGE

Medical coverage provides you with benefits that keep you healthy like Preventive care screenings and access to urgent care. It also provides important financial protection if you have a serious medical condition. The following chart shows the medical PPO plan offered to SAUSD employees. You always pay the deductible and copayment ($). The coinsurance (%) shows what the plan pays after the deductible.

	Blue Shield PPO	
	In-Network	Out-of-Network
Calendar Year Deductible[1] Individual Family	$300 $600	$600 $1,200
Calendar Year Out-of-Pocket Maximum[1] Individual Family	$1,300 $2,600	$2,600 $5,200
Office Visit Primary Care Specialist	$20 copay $20 copay	Plan pays 70%[2] Plan pays 70%[2]
Preventive Services	Plan pays 100%	Not Covered
Chiropractic (up to 50 visits/year)	Plan pays 80%[2]	Plan pays 70%[2]
Lab and X-ray	Plan pays 80%[2]	Plan pays 70%[2]
Urgent Care	$20 copay	Plan pays 70%[2]
Emergency Room	$100 copay (waived if admitted) +10% physician services fee[2]	$100 copay (waived if admitted) +10% physician services fee[2]
Inpatient Hospitalization	Plan pays 90%[2]	Plan pays 70%[2] up to $1,500/day
Outpatient Surgery	Plan pays 90%[2]	Plan pays 70%[2] up to $1,500/day
PRESCRIPTION DRUGS (Express Scripts)		
Calendar Year Deductible	$150 per person	$150 per person
Out-of-Pocket Maximum Individual Family	$5,300 $10,600	Not Applicable Not Applicable
Retail- 30 Day Supply Generic Preferred Brand Name Non-Preferred Brand Name Specialty	$15 copay $30 copay[2] $50 copay[2] 20% ($100 max)	$15 copay +25% coinsurance $30 copay[2] +25% coinsurance $50 copay[2] +25% coinsurance
Mail Order- 90 Day Supply Generic Preferred Brand Name Non-Preferred Brand Name Specialty	$30 copay $60 copay[2] $100 copay[2] 20% ($100 max)	Not Covered Not Covered Not Covered Not Covered

[1]Deductibles and out-of-pocket maximums accumulate on a calendar year from January 1 – December 31.
[2]After deductible.

PRESCRIPTION DRUGS – Express Scripts (Blue Shield Only)

EXPRESS SCRIPTS APP
You can also use the Express Scripts pharmacy mobile app to search for providers. Download from the App Store or Google Play.

Blue Shield members have access to prescription drug coverage through Express Scripts. Below is some information to keep in mind regarding this coverage:

Advantage Plus Utilization Management Program

Express Scripts uses these strategies to help manage the high-cost and high-utilization of specialty and non-specialty medications. Employees may be required to participate in the following programs when filling their prescriptions.

Drug Quantity Management

Drug quantity management is required medications prescribed "as needed" for which the days of supply cannot be inferred from the prescription (migraine medications, inhalers, creams, and ointments).

Step-Therapy

Step-therapy is required for most non-specialty drugs, including therapies for diabetes, high-blood pressure, depression and ulcers.

Prior Authorization

Prior authorization is required for most specialty drugs. To ensure safe and appropriate use of medications, prior authorization may apply for certain medications. For definitions on what each of these mean, please refer to the Glossary section.

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	$
Online 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	$$$$$

DENTAL PPO COVERAGE

SAUSD gives you a choice of two dental PPO plans. When you enroll in a Delta Dental DPPO plan, you have the choice of visiting any dentist you choose, including in-network preferred providers and non-network premier providers. Members receive the highest level of benefits when they visit an in-network preferred provider.

Contact Delta Dental at (866) 499-3001 or visit their website at www.deltadentalins.com to find to provider near you.

	Delta Dental Incentive DPPO		Delta Dental Network DPPO	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Annual Deductible	None	$25 per person $75 per family (waived for diagnostic and preventative)	None	None
Annual Plan Maximum	$2,000 per person	$1,500 per person	$2,000 per person	$1,200 per person
Waiting Period	None	None	None	None
Diagnostic & Preventive	Plan pays 70-100%	Plan pays 70-100%	Plan pays 100%	Plan pays 50%
Basic Services Fillings Root Canals	Plan pays 70-100%	Plan pays 70-100%	Plan pays 100% Plan pays 100%	Plan pays 50% Plan pays 50%
Major Services Prosthodontics Implants Other Major Services	Plan pays 50% Plan pays 50% Plan pays 70-100%	Plan pays 50% Plan pays 50% Plan pays 70-100%	Plan pays 50% Plan pays 50% Plan pays 100%	Plan pays 50% Plan pays 50% Plan pays 50%
Orthodontia Adults and Dependent Children	Plan pays 50%	Plan pays 50%	Plan pays 50%	Plan pays 50%
Ortho Lifetime Max	$500	$500	$1,000	$1,000

Rates for Classified COBRA Subscribers

	Incentive DPPO	Network DPPO
Single **Cost for Employee only**	$54.72 Per month	$43.77 Per month
Two-Party **Cost for Employee +1 dependent**	$152.10 Per month	$121.68 Per month
Family **Cost for Employee +2 or more dependents**	$206.90 Per month	$165.48 Per month

DENTAL HMO COVERAGE

Delta Care is a dental HMO plan and automatically assigns you and your dependents a dentist when you enroll. You can always change your dentist by calling Delta Care at (800) 422-4234 and letting them know the office you prefer within their DHMO network.

	Delta Care USA DHMO
Annual Deductible	None
Annual Plan Maximum	Unlimited
Waiting Period	None
Diagnostic & Preventive	$0 - $45 copay
Basic Services Fillings Root Canals	 Plan pays 100% $45 - $205 copay
Prosthodontics	$0 - $195 copay
Major Services	$0 - $195 copay
Orthodontia Child – up to age 19 Adult – over 19	 $1,700 $1,900 copay*
Ortho Lifetime Max	Unlimited

*copay covers up to 24 months of active treatment

Rates for Classified COBRA Subscribers

Single **Cost for Employee only**	$19.36 Per month
Two-Party **Cost for Employee +1 dependent**	$31.96 Per month
Family **Cost for Employee +2 or more dependents**	$47.25 Per month

VISION

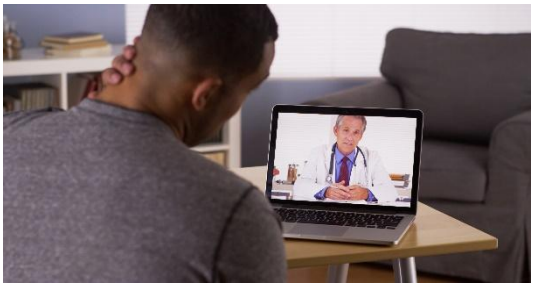
All SAUSD employees and family members enrolled in our medical plans, including Kaiser members, will receive vision benefits from Vision Service Plans (VSP). Routine vision exams are important, not only for correcting vision but because they can detect other serious health conditions.

VSP has a large network of optometrist you can choose from for your vision needs. Visit www.vsp.com to find a VSP provider near you.

	VSP Vision Plan	
	In-Network	**Out-of-Network**
Exams		
Benefit	$15 copay	$45 copay
Frequency	Once every 12 months	Once every 12 months
Eyeglass Lenses		
Single Vision Lens	Plan pays 100%	Plan pays up to $30
Bifocal Lens	Plan pays 100%	Plan pays up to $50
Trifocal Lens	Plan pays 100%	Plan pays up to $65
Frequency	Once every 12 months	Once every 12 months
Lenses Enhancements		
Standard Progressive	Plan pays 100%	Plan pays up to $50
Premium Progressive	$95 - $105 copay	Not Covered
Custom Progressive	$150 - $175	Not Covered
Frequency	Once every 12 months	Once every 12 months
Frames		
VSP Select frames	Plan pays up to $150*	Plan pays up to $70
VSP featured frames	Plan pays up to $170*	Not Applicable
Costco frames	Plan pays up to $80	Not Applicable
Frequency	Once every 24 months	Once every 24 months
Contacts (Elective)		
Contact Allowance	Plan pays up to $150	Plan pays up to $105
Fitting and Evaluation	$0 - $60 copay	Not Applicable
Frequency	Once every 12 months	Once every 12 months

*20% savings on amount over allowance

WHEN YOU NEED CARE NOW



GET THE CARE YOU NEED

Teladoc Health doctors can treat many medical conditions, including:

- Cold & flu symptoms
- Allergies
- Sinus problems
- Urinary tract infection
- Respiratory infection
- Skin problems
- And more!

Blue Shield Members - Teladoc

Talk to a doctor anytime

Teladoc Health gives you 24/7/365 access to U.S. board-certified doctors through the convenience of phone, video or mobile app visits. It's an affordable alternative to costly urgent care and ER visits when you need care now.

Meet our doctors

Teladoc Health is simply a new way to access qualified doctors.

All Teladoc Health doctors:

- Are practicing PCPs, pediatricians, and family medicine physicians
- Average 20 years' experience
- Are U.S. board-certified and licensed in your state
- Are credentialed every three years, meeting NCQA standards

When should you use Teladoc Health?

Teladoc Health does not replace your primary physician. It is a convenient and affordable option for quality care.

- When you need care now
- If you're considering the ER or urgent care for a non-emergency
- When on vacation, a business trip or away from home
- For short-term prescription refills

Teladoc Health

Teladoc.com/bsc

800-835-2362

Kaiser Permanente Members

Get care from a doctor where they are. If your have a minor health condition or need a follow-up, you may be able to talk to a doctor by video or phone.

You need an in-person appointment and need to register on kp.org before you can receive a video or phone appointment.

Kaiser Member Services

Monday through Friday

7am to 7pm

833-574-2273

EMPLOYEE ASSISTANCE PROGRAM (EAP)

CONTACT THE EAP

Blue Shield Life Referrals 24/7
800-985-2405

Kaiser Behavioral Health Hotline
800-900-3277

Kaiser Wellness Coaching
866-862-4295

Wellness Resources & Discounts

Throughout the years, SAUSD collaborates with various wellness vendors such as Gemini Timing for the 5k walk/run, Feet First and their Amazing Race, and HealthyWage with their team challenges. Visit the employee wellness website at www.sausd.us/ahealthieru for more resources and event information.

Blue Shield Life Referrals 24/7

Because we want our employees to have a well-balanced life, Blue Shield members will receive EAP benefits through Blue Shield's Life Referrals 24/7 program. This program provides referrals to professional counselors for up the 3 free face-to-face confidential visits every 6-months and live 60-minutes telephone consultations.

You can access this program 24 hours, 365 days to help you resolve emotional, health, family and work issues.

This benefit is included in your Blue Shield medical plan and is available to all household members

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

Kaiser Behavioral Health

Kaiser takes care of the whole you. Your personal physician coordinates your care with a mental health specialist, or team, that can diagnose mental health issues that affect your health and well-being.
Depending on your needs, you can choose from a wide range of services:

- Call or email your doctor
- Make non-urgent appointments
- Make therapy appointments
- Make counseling appointments
- Talk to an advice nurse
- Speak with a wellness coach
- Enroll to take a class

Blue Shield Perks

Visit www.blueshieldca.com/sausd to access a hospital comparison tool, symptom checker, condition management information and resources, along with information specific to your health. Blue shield also offers various discounts including gym memberships. Register with Blue Shield online for additional wellness resources.

Kaiser Perks

Visit kp.org to access information on living healthy, managing conditions and diseases, and to obtain information about natural medicines and remedies. Kaiser also offers customized plans for healthier living, classes, and various specialty health services. Visit www.kp.org/choosehealthy for more information about available services including various discounts.

TURNING 65? UNDERSTAND YOUR MEDICARE OPTIONS

Alliant Medicare Solutions is a no cost service available to you, your family members, and friends nearing age 65.

Alliant Medicare Solutions is provided by Insuractive LLC, a Nebraska resident insurance agency. Insuractive LLC is wholly owned by Alliant Insurance Services, Inc.

Whether you retire or continue to work, choosing the right healthcare option is an important decision when you reach age 65

Most people become eligible for Medicare at age 65. When that happens, you'll probably have some time-sensitive decisions to make, based on your individual situation.

Introducing Alliant Medicare Solutions

Medicare can be complicated. Figuring out the rules—not to mention how Medicare works with or compares to your employer-provided medical coverage—can be a headache. That's why we are offering Alliant Medicare Solutions. The licensed insurance agents at AMS can help you understand Medicare, what is and isn't covered, and how to choose the best coverage for your situation.

How does it work?

1. Call Alliant Medicare Solutions at **(877) 888-0165** to speak to a licensed insurance agent. Have your current medical coverage information available when you call.
2. Discuss with Alliant Medicare Solutions your existing insurance coverage, your Medicare options, and which of those plans might work the best for you.
3. If Medicare is the best option, Alliant Medicare Solutions helps you enroll immediately or emails policy materials for you to review and enroll at a later date.

IMPORTANT PLAN INFORMATION

In this section, you'll find important plan information, including:

- Your benefit contributions
- Contact information for our benefit carriers and vendors
- A Benefits Glossary to help you understand important insurance terms
- A summary of the health plan notices you are entitled to receive annually, and where to find them

RATES SUMMARY

All SAUSD employees pay for their medical insurance coverage. Be sure to look at the appropriate chart for your specific rates.

The total amount that you pay for your benefits coverage depends on the plans you choose, how many dependents you cover, and for medical coverage. Your contributions are to be paid on a month-to-month basis.

Rates are effective July 1, 2026, through June 30, 2027

Monthly Rates for Classified COBRA Subscribers

	Medical Rates				Dental Rates		
	Blue Shield Access+ HMO	Blue Shield PPO	Blue Shield Trio ACO HMO	Kaiser Permanente HMO	Delta Care USA DHMO	Delta Dental Incentive DPPO	Delta Dental Network DPPO
Single (Cost for Employee only coverage)							
Total Plan Cost	$1,012.25	$1,424.05	$817.23	$909.17	$19.36	$54.72	$43.77
Two-Party (Cost for Employee +1 Dependent coverage)							
Total Plan Cost	$2,079.22	$2,960.63	$1,691.29	$1,814.63	$31.96	$152.10	$121.68
Family (Cost for Employee +2 or more dependents coverage)							
Total Plan Cost	$2,993.08	$4,249.68	$2,435.20	$2,571.38	$47.25	$206.90	$165.48

PLAN CONTACTS

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

Plan Type	Provider	Phone Number	Website	Group #
Medical	Blue Shield of California	Trio members 855-747-5800 Access+ & PPO members 800-393-6130	www.blueshieldca.com/sausd	W0051532
Medical	Kaiser Permanente	833-574-2273	www.kp.org	132731
Dental	Delta Dental	866-499-3001 – DPPO 800-422-4234 - DHMO	Deltadentalins.com	75969
Vision	VSP	800-877-7195	www.vsp.com	30098994
Pharmacy	Express Scripts – BS members only	877-474-1136	www.express-scripts.com	4117379
Voluntary Benefits	American Fidelity	800-365-9180	www.americanfidelity.com	N/A
Supplemental Cancer Insurance	Washington National (American Fidelity)	800-662-1113	www.washingtonnational.com	N/A
Wellness - Blue Shield members only	Blue Shield Mental Health	877-263-9952	www.blueshieldca.com/wellnessdiscounts www.wellvolution.com	W0051532
Wellness – Kaiser members only	Kaiser Wellness Coaching	866-862-4295	www.kp.org/coaching	132731
EAP- Blue Shield members only	Blue Shield Life Referrals 24/7	800-985-2405	www.blueshieldca.com/sausd	W0051532
EAP– Kaiser members only	Kaiser Behavioral Health	800-900-3277	www.kp.org	132731
Telemedicine - Blue Shield members only	Teladoc	800-835-2362	Member.Teladoc.com/bsc	W0051532
Medicare Services	Alliant Medicare Solutions	877- 888-0165	N/A	N/A
PlanSource	Enrollment Platform	888-909-0166	support@thebenefitsupportcenter.com	N/A
Employee Union for eligible Classified personnel	C.S.E.A	714-532-3766	www.csea.com/web	
Employee Union for eligible Certificated personnel	S.A.E.A	714-542-6758	www.santaanaeducators.com	
Employee retirement system for Certificated personnel	S.T.R.S	800-228-5453	www.calstrs.com	
Third party administrator of additional retirement accounts	Schools First	714-258-4000	www.schoolsfirst.org	

GLOSSARY

-A-

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

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

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

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

-B-

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

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

-C-

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

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

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

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

-D-

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

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

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

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

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

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

-E-

Eligible Expense
A service or product that is covered by your plan. Your plan will not cover any of the cost if the expense is not eligible.

Excluded Service
A service that your health plan doesn't pay for or cover.

-F-

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

-G-

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

-H-

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

GLOSSARY

-I-

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

-L-

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

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

-M-

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

-O-

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

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

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

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

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

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

-P-

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

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

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

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

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

-S-

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

-T-

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

-U-

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

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

-V-

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

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

Important Plan Information

Health Plan Notices

These notices must be provided to plan participants on an annual basis and are available in the Annual Notices document, located at the end of this booklet.

- **Medicare Part D Notice:** Describes options to access prescription drug coverage for Medicare eligible individuals
- **Women's Health and Cancer Rights Act:** Describes benefits available to those that will or have undergone a mastectomy
- **Newborns' and Mothers' Health Protection Act:** Describes the rights of mother and newborn to stay in the hospital 48-96 hours after delivery
- **HIPAA Notice of Special Enrollment Rights:** Describes when you can enroll yourself and/or dependents in health coverage outside of open enrollment
- **HIPAA Notice of Privacy Practices:** Describes how health information about you may be used and disclosed
- **Notice of Choice of Providers:** Notifies you that your plan requires you to name a Primary Care Physician (PCP) or provides for you to select one
- **Michelle's Law:** Describes right to extend dependent medical coverage during student leaves
- **The 'No Surprises' Rules:** Explains rules that protect you from surprise medical bills
- **Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP):** Describes availability of premium assistance for Medicaid eligible dependents
- **Illinois Consumer Coverage Disclosure Act**: Provides to Illinois employees a list that compares the essential health insurance benefits offered by the employer's group health plan with the essential health benefits regulated by the State of Illinois

COBRA Continuation Coverage

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

Plan Documents

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

Summary Plan Descriptions (SPD)

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

Summary Of Benefits and Coverage (SBC)

A document required by the Affordable Care Act (ACA) that presents benefit plan features in a standardized format. SBC documents are available at www.sausd.us/benefits.

- Blue Shield Access+ HMO
- Blue Shield PPO
- Blue Shield Trio ACO HMO
- Kaiser Permanente HMO

Statement Of Material Modifications

This enrollment guide constitutes a Summary of Material Modifications (SMM) to the Santa Ana Unified School District. It is meant to supplement and/or replace certain information in the SPD, so retain it for future reference along with your SPD. Please share these materials with your covered family members.

Medicare Part D Notice

Important Notice from Santa Ana Unified 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 Santa Ana Unified 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. Santa Ana Unified School District has determined that the prescription drug coverage offered by the plans are, 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, your Santa Ana Unified School District coverage will not be affected. See below for more information about what happens to your current coverage if you join a Medicare drug plan. **Important Note for Retiree Plans:** Certain retiree plans will terminate RX coverage when an individual enrolls in Medicare Part D and individuals might not be able to re-enroll in that coverage.

Since the existing prescription drug coverage under our plans is creditable (e.g., as good as Medicare coverage), you can retain your existing prescription drug coverage and choose not to enroll in a Part D plan; or you can enroll in a Part D plan as a supplement to, or in lieu of, your existing prescription drug coverage.

If you do decide to join a Medicare drug plan and drop your Santa Ana Unified School District prescription drug coverage, be aware that you and your dependents can only get this coverage back at open enrollment or if you experience an event that gives rise to a HIPAA Special Enrollment Right.

If you do decide to join a Medicare drug plan and drop your Santa Ana Unified School District prescription drug coverage, be aware that you and your dependents can only get this coverage back at open enrollment or if you experience an event that gives rise to a HIPAA Special Enrollment Right.

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 Santa Ana Unified 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 Santa Ana Unified 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 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 800-MEDICARE (800-633-4227). TTY users should call 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 socialsecurity.gov, or call them at 800-772-1213 (TTY 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:	July 1, 2026
Name of Entity/Sender:	Santa Ana Unified School District
Contact-Position/Office:	Employee Benefits Office
Address:	1601 East Chestnut Avenue, Santa Ana, California 92701
Phone Number:	714-558-5686

Women's Health and Cancer Rights Act

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under our plans. If you would like more information on WHCRA benefits, call your plan administrator (Blue Shield of California or Kaiser Permanente).

Newborns' and Mothers' Health Protection Act

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 a 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). If you would like more information on maternity benefits, call your plan administrator (Blue Shield of California or Kaiser Permanente).

HIPAA Notice of Special Enrollment Rights

If you decline enrollment in Santa Ana Unified School District's health plan for you or your dependents (including your spouse) because of other health insurance or group health plan coverage, you or your dependents may be able to enroll in Santa Ana Unified School District's health plan without waiting for the next open enrollment period if you:

- Lose other health insurance or group health plan coverage. You must request enrollment within 30 days after the loss of other coverage.
- Gain a new dependent as a result of marriage, birth, adoption, or placement for adoption. You must request health plan enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.
- Lose Medicaid or Children's Health Insurance Program (CHIP) coverage because you are no longer eligible. You must request medical plan enrollment within 60 days after the loss of such coverage.

If you request a change due to a special enrollment event within the 30-day timeframe, coverage will be effective the date of birth, adoption or placement for adoption. For all other events, coverage will be effective the first of the month following your request for enrollment. In addition, you may enroll in Santa Ana Unified School District's health plan if you become eligible for a state premium assistance program under Medicaid or CHIP. You must request enrollment within 60 days after you gain eligibility for medical plan coverage. If you request this change, coverage will be effective the first of the month following your request for enrollment. Specific restrictions may apply, depending on federal and state law.

Note: If your dependent becomes eligible for a special enrollment right, you may add the dependent to your current coverage or change to another health plan.

Availability of Privacy Practices Notice

We maintain the HIPAA Notice of Privacy Practices for Santa Ana Unified School District describing how health information about you may be used and disclosed. You may obtain a copy of the Notice of Privacy Practices by contacting Santa Ana Unified School District Human Resources Department.

Notice of Choice of Providers

The HMO plans generally requires the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. Until you make this designation, the HMO plans will designate one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the insurance provider (Blue shield of California and Kaiser Permanente).

For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from the plans or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the insurance provider (Blue shield of California and Kaiser Permanente).

Michelle's Law

The Santa Ana Unified School District plans may extend medical coverage for dependent children if they lose eligibility for coverage because of a medically necessary leave of absence from school. Coverage may continue for up to a year, unless your child's eligibility would end earlier for another reason.

Extended coverage is available if a child's leave of absence from school — or change in school enrollment status (for example, switching from full-time to part-time status) — starts while the child has a serious illness or injury, is medically necessary and otherwise causes eligibility for student coverage under the plan to end. Written certification from the child's physician stating that the child suffers from a serious illness or injury and the leave of absence is medically necessary may be required.

If your child will lose eligibility for coverage because of a medically necessary leave of absence from school and you want his or her coverage to be extended, notify Santa Ana Unified School District Human Resources Department in writing as soon as the need for the leave is recognized. In addition, contact your child's health plan to see if any state laws requiring extended coverage may apply to his or her benefits.

ACA Disclaimer

This offer of coverage may disqualify you from receiving government subsidies for an Exchange plan even if you choose not to enroll. To be subsidy eligible you would have to establish that this offer is unaffordable for you, meaning that the required contribution for employee only coverage under our base plan exceeds 8.39% in 2024 (9.02% in 2025) of your modified adjusted household income.

The 'No Surprises' Rules

The "No Surprises" rules protect you from surprise medical bills in situations where you can't easily choose a provider who's in your health plan network. This is especially common in an emergency situation, when you may get care from out-of-network providers. Out-of-network providers or emergency facilities may ask you to sign a notice and consent form before providing certain services after you're no longer in need of emergency care. These are called "post-stabilization services." You shouldn't get this notice and consent form if you're getting emergency services other than post-stabilization services. You may also be asked to sign a notice and consent form if you schedule certain non-emergency services with an out-of-network provider at an in-network hospital or ambulatory surgical center.

The notice and consent form informs you about your protections from unexpected medical bills, gives you the option to give up those protections and pay more for out-of-network care, and provides an estimate of what your out-of-network care might cost. You aren't required to sign the form and shouldn't sign the form if you didn't have a choice of health care provider or facility before scheduling care. If you don't sign, you may have to reschedule your care with a provider or facility in your health plan's network.

View a sample notice and consent form (PDF).

This applies to you if you're a participant, beneficiary, enrollee, or covered individual in a group health plan or group or individual health insurance coverage, including a Federal Employees Health Benefits (FEHB) plan.

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 **January 31, 2026**. Contact your State for more information on eligibility—

ALABAMA – Medicaid
Website: http://myalhipp.com/ | Phone: 1-855-692-5447
ALASKA – Medicaid
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
Website: http://myarhipp.com/ | Phone: 1-855-MyARHIPP (855-692-7447)
CALIFORNIA – Medicaid
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+)
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
FLORIDA – Medicaid
Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

GEORGIA – 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
INDIANA – Medicaid
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: (800) 403-0864 | Member Services Phone: (800) 457-4584
IOWA – Medicaid and CHIP (Hawki)
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
KANSAS – Medicaid
Website: https://www.kancare.ks.gov/ | Phone: 1-800-792-4884 | HIPP Phone: 1-800-967-4660
KENTUCKY – 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
LOUISIANA – Medicaid
Louisiana Medicaid Website: https://www.ldh.la.gov/healthy-louisiana Medicaid Customer Service Line: 1-888-342-6207 | Louisiana Medicaid email: healthy@la.gov Louisiana Health Insurance Premium Program (LaHIPP) Website: https://www.ldh.la.gov/lahipp LaHIPP phone: 1-877-697-6703 | LaHIPP email: La.HIPP@la.gov | LaHIPP fax: 1-888-716-9787 LaHIPP mailing address: 100 Crescent Centre Parkway, Suite 1000 Tucker, GA 30084
MAINE – Medicaid
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: 800-977-6740 | TTY: Maine relay 711
MASSACHUSETTS – Medicaid and CHIP
Website: https://www.mass.gov/masshealth/pa | Phone: 1-800-862-4840 | TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid
Website: https://mn.gov/dhs/health-care-coverage/ | Phone: 1-800-657-3672
MISSOURI – Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm | Phone: 573-751-2005
MONTANA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 | email: HHSHIPPProgram@mt.gov
NEBRASKA – Medicaid
Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 | Lincoln: 402-473-7000 | Omaha: 402-595-1178
NEVADA – Medicaid
Medicaid Website: http://dhcfp.nv.gov | Medicaid Phone: 1-800-992-0900

NEW HAMPSHIRE – Medicaid
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
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ | Phone: 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)
NEW YORK – Medicaid
Website: https://www.health.ny.gov/health_care/medicaid/ | Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid
Website: https://medicaid.ncdhhs.gov/ | Phone: 919-855-4100
NORTH DAKOTA – Medicaid
Website: https://www.hhs.nd.gov/healthcare | Phone: 1-866-614-6005
OKLAHOMA – Medicaid and CHIP
Website: http://www.insureoklahoma.org | Phone: 1-888-365-3742
OREGON – Medicaid and CHIP
Website: http://healthcare.oregon.gov/Pages/index.aspx | Phone: 1-800-699-9075
PENNSYLVANIA – 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)
RHODE ISLAND – Medicaid and CHIP
Website: http://www.eohhs.ri.gov/ | Phone: 1-855-697-4347 or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid
Website: https://www.scdhhs.gov | Phone: 1-888-549-0820
SOUTH DAKOTA – Medicaid
Website: http://dss.sd.gov | Phone: 1-888-828-0059
TEXAS – Medicaid
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493
UTAH – Medicaid and CHIP
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
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427
VIRGINIA – Medicaid and CHIP
Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select or https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924

WASHINGTON – Medicaid
Website: https://www.hca.wa.gov/ | Phone: 1-800-562-3022
WEST VIRGINIA – Medicaid and CHIP
Website: https://dhhr.wv.gov/bms/ or http://mywvhipp.com/ Medicaid Phone: 304-558-1700 | CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm | Phone: 1-800-362-3002
WYOMING – Medicaid
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 **January 31, 2026**, 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

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

Illinois Consumer Coverage Disclosure Act

The Consumer Coverage Disclosure Act requires employers to notify Illinois employees which of the Essential Health Benefits listed below are and are not covered by their employer-provided group health insurance coverage. Refer to the Access to Care and Treatment Benchmark Plan and the Pediatric Dental Plan to reference the pages listed below.

Employer Name:	Santa Ana Unified School District
Employer State of Situs:	CA
Name of Issuer:	Blue Shield of California
Plan Marketing Name:	Blue Shield Access+ HMO, Blue Shield PPO, Blue Shield Trio ACO HMO
Plan Year:	7/1/2026

Ten (10) Essential Health Benefit (EHB) Categories:

- Ambulatory patient services (outpatient care you get without being admitted to a hospital)
- Emergency services
- Hospitalization (like surgery and overnight stays)
- Laboratory services
- Mental health and substance use disorder (MH/SUD) services, including behavioral health treatment (this includes counseling and psychotherapy)
- Pediatric services, including oral and vision care (but adult dental and vision coverage aren't essential health benefits)
- Pregnancy, maternity, and newborn care (both before and after birth)
- Prescription drugs
- Preventive and wellness services and chronic disease management
- Rehabilitative and habilitative services and devices (services and devices to help people with injuries, disabilities, or chronic conditions gain or recover mental and physical skills)

2020-2023 Illinois Essential Health Benefit (EHB) Listing (P.A. 102-0630)				**Employer Plan Covered Benefit?**
Item	**EHB Benefit**	**EHB Category**	**Benchmark Page # Reference**	
1	Accidental Injury—Dental	Ambulatory	Pgs. 10 & 17	
2	Allergy Injections and Testing	Ambulatory	Pg. 11	
3	Bone anchored hearing aids	Ambulatory	Pgs. 17 & 35	
4	Durable Medical Equipment	Ambulatory	Pg. 13	
5	Hospice	Ambulatory	Pg. 28	
6	Infertility (Fertility) Treatment	Ambulatory	Pgs. 23–24	
7	Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	Ambulatory	Pg. 21	
8	Outpatient Surgery Physician/Surgical Services (Ambulatory Patient Services)	Ambulatory	Pgs. 15–16	
9	Private-Duty Nursing	Ambulatory	Pgs. 17 & 34	
10	Prosthetics/Orthotics	Ambulatory	Pg. 13	
11	Sterilization (vasectomy men)	Ambulatory	Pg. 10	
12	Temporomandibular Joint Disorder (TMJ)	Ambulatory	Pgs. 13 & 24	
13	Emergency Room Services (Includes MH/SUD Emergency)	Emergency services	Pg. 7	
14	Emergency Transportation/ Ambulance	Emergency services	Pgs. 4 & 17	

15	Bariatric Surgery (Obesity)	Hospitalization	Pg. 21	
16	Breast Reconstruction After Mastectomy	Hospitalization	Pgs. 24–25	
17	Reconstructive Surgery	Hospitalization	Pgs. 25–26 & 35	
18	Inpatient Hospital Services (e.g., Hospital Stay)	Hospitalization	Pg. 15	
19	Skilled Nursing Facility	Hospitalization	Pg. 21	
20	Transplants—Human Organ Transplants (Including transportation & lodging)	Hospitalization	Pgs. 18 & 31	
21	Diagnostic Services	Laboratory services	Pgs. 6 & 12	
22	Intranasal opioid reversal agent associated with opioid prescriptions	MH/SUD	Pg. 32	
23	Mental (Behavioral) Health Treatment (Including Inpatient Treatment)	MH/SUD	Pgs. 8–9, 21	
24	Opioid Medically Assisted Treatment (MAT)	MH/SUD	Pg. 21	
25	Substance Use Disorders (Including Inpatient Treatment)	MH/SUD	Pgs. 9 & 21	
26	Tele-Psychiatry	MH/SUD	Pg. 11	
27	Topical Anti-Inflammatory acute and chronic pain medication	MH/SUD	Pg. 32	
28	Pediatric Dental Care	Pediatric Oral and Vision Care	See AllKids Pediatric Dental Document	
29	Pediatric Vision Coverage	Pediatric Oral and Vision Care	Pgs. 26–27	
30	Maternity Service	Pregnancy, Maternity, and Newborn Care	Pgs. 8 & 22	
31	Outpatient Prescription Drugs	Prescription drugs	Pgs. 29–34	
32	Colorectal Cancer Examination and Screening	Preventive and Wellness Services	Pgs. 12 & 16	
33	Contraceptive/Birth Control Services	Preventive and Wellness Services	Pgs. 13 & 16	
34	Diabetes Self-Management Training and Education	Preventive and Wellness Services	Pgs. 11 & 35	
35	Diabetic Supplies for Treatment of Diabetes	Preventive and Wellness Services	Pgs. 31–32	
36	Mammography—Screening	Preventive and Wellness Services	Pgs. 12, 15 & 24	
37	Osteoporosis—Bone Mass Measurement	Preventive and Wellness Services	Pgs. 12 & 16	
38	Pap Tests/ Prostate—Specific Antigen Tests/ Ovarian Cancer Surveillance Test	Preventive and Wellness Services	Pg. 16	
39	Preventive Care Services	Preventive and Wellness Services	Pg. 18	
40	Sterilization (women)	Preventive and Wellness Services	Pgs. 10 & 19	
41	Chiropractic & Osteopathic Manipulation	Rehabilitative and Habilitative Services and Devices	Pgs. 12–13	
42	Habilitative and Rehabilitative Services	Rehabilitative and Habilitative Services and Devices	Pgs. 8, 9, 11, 12, 22 & 35	

Special Note: Under Pub. Act 102-0104, eff. July 22, 2021, any EHBs listed above that are clinically appropriate and medically necessary to deliver via telehealth services must be covered in the same manner as when those EHBs are delivered in person.

Illinois Consumer Coverage Disclosure Act

The Consumer Coverage Disclosure Act requires employers to notify Illinois employees which of the Essential Health Benefits listed below are and are not covered by their employer-provided group health insurance coverage. Refer to the Access to Care and Treatment Benchmark Plan and the Pediatric Dental Plan to reference the pages listed below.

Employer Name:	Santa Ana Unified School District
Employer State of Situs:	CA
Name of Issuer:	Kaiser Permanente
Plan Marketing Name:	Kaiser Permanente HMO
Plan Year:	7/1/2026

Ten (10) Essential Health Benefit (EHB) Categories:

- Ambulatory patient services (outpatient care you get without being admitted to a hospital)
- Emergency services
- Hospitalization (like surgery and overnight stays)
- Laboratory services
- Mental health and substance use disorder (MH/SUD) services, including behavioral health treatment (this includes counseling and psychotherapy)
- Pediatric services, including oral and vision care (but adult dental and vision coverage aren't essential health benefits)
- Pregnancy, maternity, and newborn care (both before and after birth)
- Prescription drugs
- Preventive and wellness services and chronic disease management
- Rehabilitative and habilitative services and devices (services and devices to help people with injuries, disabilities, or chronic conditions gain or recover mental and physical skills)

2020-2023 Illinois Essential Health Benefit (EHB) Listing (P.A. 102-0630)				**Employer Plan Covered Benefit?**
Item	**EHB Benefit**	**EHB Category**	**Benchmark Page # Reference**	
1	Accidental Injury—Dental	Ambulatory	Pgs. 10 & 17	
2	Allergy Injections and Testing	Ambulatory	Pg. 11	
3	Bone anchored hearing aids	Ambulatory	Pgs. 17 & 35	
4	Durable Medical Equipment	Ambulatory	Pg. 13	
5	Hospice	Ambulatory	Pg. 28	
6	Infertility (Fertility) Treatment	Ambulatory	Pgs. 23–24	
7	Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	Ambulatory	Pg. 21	
8	Outpatient Surgery Physician/Surgical Services (Ambulatory Patient Services)	Ambulatory	Pgs. 15–16	
9	Private-Duty Nursing	Ambulatory	Pgs. 17 & 34	
10	Prosthetics/Orthotics	Ambulatory	Pg. 13	
11	Sterilization (vasectomy men)	Ambulatory	Pg. 10	
12	Temporomandibular Joint Disorder (TMJ)	Ambulatory	Pgs. 13 & 24	
13	Emergency Room Services (Includes MH/SUD Emergency)	Emergency services	Pg. 7	
14	Emergency Transportation/ Ambulance	Emergency services	Pgs. 4 & 17	

15	Bariatric Surgery (Obesity)	Hospitalization	Pg. 21	
16	Breast Reconstruction After Mastectomy	Hospitalization	Pgs. 24–25	
17	Reconstructive Surgery	Hospitalization	Pgs. 25–26 & 35	
18	Inpatient Hospital Services (e.g., Hospital Stay)	Hospitalization	Pg. 15	
19	Skilled Nursing Facility	Hospitalization	Pg. 21	
20	Transplants—Human Organ Transplants (Including transportation & lodging)	Hospitalization	Pgs. 18 & 31	
21	Diagnostic Services	Laboratory services	Pgs. 6 & 12	
22	Intranasal opioid reversal agent associated with opioid prescriptions	MH/SUD	Pg. 32	
23	Mental (Behavioral) Health Treatment (Including Inpatient Treatment)	MH/SUD	Pgs. 8–9, 21	
24	Opioid Medically Assisted Treatment (MAT)	MH/SUD	Pg. 21	
25	Substance Use Disorders (Including Inpatient Treatment)	MH/SUD	Pgs. 9 & 21	
26	Tele-Psychiatry	MH/SUD	Pg. 11	
27	Topical Anti-Inflammatory acute and chronic pain medication	MH/SUD	Pg. 32	
28	Pediatric Dental Care	Pediatric Oral and Vision Care	See AllKids Pediatric Dental Document	
29	Pediatric Vision Coverage	Pediatric Oral and Vision Care	Pgs. 26–27	
30	Maternity Service	Pregnancy, Maternity, and Newborn Care	Pgs. 8 & 22	
31	Outpatient Prescription Drugs	Prescription drugs	Pgs. 29–34	
32	Colorectal Cancer Examination and Screening	Preventive and Wellness Services	Pgs. 12 & 16	
33	Contraceptive/Birth Control Services	Preventive and Wellness Services	Pgs. 13 & 16	
34	Diabetes Self-Management Training and Education	Preventive and Wellness Services	Pgs. 11 & 35	
35	Diabetic Supplies for Treatment of Diabetes	Preventive and Wellness Services	Pgs. 31–32	
36	Mammography—Screening	Preventive and Wellness Services	Pgs. 12, 15 & 24	
37	Osteoporosis—Bone Mass Measurement	Preventive and Wellness Services	Pgs. 12 & 16	
38	Pap Tests/ Prostate—Specific Antigen Tests/ Ovarian Cancer Surveillance Test	Preventive and Wellness Services	Pg. 16	
39	Preventive Care Services	Preventive and Wellness Services	Pg. 18	
40	Sterilization (women)	Preventive and Wellness Services	Pgs. 10 & 19	
41	Chiropractic & Osteopathic Manipulation	Rehabilitative and Habilitative Services and Devices	Pgs. 12–13	
42	Habilitative and Rehabilitative Services	Rehabilitative and Habilitative Services and Devices	Pgs. 8, 9, 11, 12, 22 & 35	

Special Note: Under Pub. Act 102-0104, eff. July 22, 2021, any EHBs listed above that are clinically appropriate and medically necessary to deliver via telehealth services must be covered in the same manner as when those EHBs are delivered in person.

SANTA ANA UNIFIED SCHOOL DISTRICT

benefits