

2027

Benefits Guide



MEDICAL

DENTAL

VISION

WELLNESS

EAP

LIFE

DISABILITY

LEGAL

FSA

RETIREMENT



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Represents California Schools Voluntary Employee Benefits Association (VEBA) programs.

VEBA is a joint labor-management trust formed for the purpose of purchasing health care benefits for school district employees and their families.



Represents San Diego County Office of Education Fringe Benefits Consortium (FBC) programs.

The FBC offers its member districts a wide variety of fringe benefits for their employees at a lower cost than districts can get on their own or with other groups.

BENEFITS ELIGIBILITY

Benefits eligibility is determined by the nature of your contract (full-time or part-time) and bargaining unit (Certificated, Classified or Administrative). Additional information regarding eligibility for benefits is found in bargaining unit contracts.

When you become eligible for benefits, be sure you enroll yourself and the eligible dependents you wish to cover within 30 days. Otherwise, you must wait until the next Open Enrollment period. This is your opportunity to be sure you and your eligible dependents are enrolled. Refer to [Enrollment Rights](#) for more information.

Part-time employees who choose to purchase insurance for their dependents will pay dependent premiums through payroll deductions. Deductions for dependent coverage are made in eleven equal deductions.

EMPLOYER-Paid Benefits	CVEA Certificated			CSEA Classified			CVAA Administration	
	51%+	50%	<50%	6.75-8 hr	4-6.74 hr	<4 hr	51%+	<50%
EAP, Optum (VEBA)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Health, Dental (employee + dependents)	Yes	N/A	No	Yes	N/A	No	Yes	No
Health, Dental (employee + dependents option)	N/A	Yes	No	N/A	Yes	No	N/A	N/A
Income Protection	Yes	Yes	Yes (40+FTE)	Yes	Yes	Yes (15+ hrs+/wk)	No	No
EMPLOYEE-Paid Benefits								
Health premium copay (mandatory)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
ACH: Electronic Direct Payroll Deposit	Yes	Yes	No	Yes	Yes	No	Yes	No
EyeMed Vision Benefit	Yes	Yes	No	Yes	Yes	No	Yes	No
Hartford Term Life, MetLife Legal	Yes	Yes	No	Yes	Yes	No	Yes	No
Health, Dental (dependents)	N/A	Yes	No	N/A	Yes	No	Yes	No
Investments (TSA, 403b, 457b)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Section 125 Flexible Benefits Plans	Yes	Yes	No	Yes	Yes	No	Yes	No

ENROLLMENT RIGHTS

Enrolling in Benefits

You can enroll in coverage during your initial eligibility period and during the annual Open Enrollment period.

Included with your benefits package are Section 125 services and additional voluntary benefits that may be of interest for you and your family. Section 125 is part of the IRS Code that allows employees to convert a taxable cash benefit (salary) into non-taxable benefits. Section 125 must be offered and affirmed for all new employees. This is an important step as a new hire as it helps you become more familiar with the CVUSD benefits package and helps the district stay in compliance.

Schedule your appointment 30 days within your hire date here: enroll.americanfidelity.com/B5956CE6

Making Changes to Your Benefits

During Open Enrollment: You may change your elections before the enrollment deadline, but you may not make any changes after the deadline unless you have a qualifying status change.

During the Year: Due to IRS rules, you may not make any changes during the year unless you have a qualifying status change. **Any qualifying event change (as listed below) must be made within 30 days of the event. You will need to submit appropriate documentation.**

Qualifying changes in status are defined by the Internal Revenue Code as follows:

- Change in marital or domestic partnership status
- Change in number of dependents (birth, adoption, death)
- Dependent child turns 26
- Change in spouse or dependent's eligibility under their employer's plan
- Change including a reduction or increase in hours of employment by the employee, spouse or dependent, including a switch between part-time and full-time, or commencement or return from an unpaid leave of absence
- Change in residency that affects accessibility to current plan
- Becoming eligible for or losing coverage under a state's premium assistance program through Medicaid/CHIP



Eligible Dependents

Eligible dependents are defined as:

- Legally married spouses
- Registered Domestic Partners
- Children to age 26
- Stepchildren
- Legally adopted children
- Children or grandchildren for whom the member has been awarded court appointed guardianship
- Disabled children (Social Security determination required; no age maximum)
- Children of qualified Domestic Partnerships
- A child for whom a Qualified Medical Child Support Order (QMCSO) that complies with all applicable laws has been issued

Legal documentation of dependents is required (i.e. birth certificate, Declaration of Domestic Partnership and tax forms, etc.).

MEDICAL: KAISER HMO PLANS



How it works...

Kaiser's truly integrated health care delivery system includes the health plan, doctors, hospitals, labs, and pharmacies all in one organization. Members enjoy the convenience of one-stop shopping because most Kaiser facilities feature a hospital, medical offices, labs and pharmacies all in one location.

- Medical information is readily available when needed because all facilities are connected.
- Physicians and pharmacies are electronically linked enhancing patient safety by alerting caregivers to drug allergies or interactions.

Each member chooses a PCP who directs your care and will refer you to specialists or other providers when needed. Your PCP and locations can be different than your covered dependents—though you must all enroll in a Kaiser HMO plan.

Physicians have electronic access to evidence-based best practices for treatment shared by all Kaiser doctors. Patients can use their computer or mobile device to contact their doctor, order prescription refills and make appointments.

Find a PCP: kp.org

Kaiser HMO Medical Benefits...

	CVEA CVAA HMO 10 – 30 day Rx	CSEA HMO 10 – 100 day Rx
Deductible (individual family)	None	None
Out-of-Pocket Maximum (individual family)	\$1,500 \$3,000	\$1,500 \$3,000
Office Visits (Primary Care Specialist)	\$10 copay	\$10 copay
Virtual Visits	No charge	No charge
Urgent Care Visits	\$10 copay	\$10 copay
Preventive Care Exams & Screenings	No charge	No charge
Routine Diagnostic Lab & X-Rays	No charge	No charge
Complex Imaging & Scans (MRI, CT, PET, etc.)	No charge	No charge
Inpatient Hospitalization	No charge	No charge
Outpatient Surgery	\$10 copay	\$10 copay
Emergency Room Visits (waived if admitted)	\$100 copay	\$100 copay
Outpatient Physical/Rehabilitation Therapy	\$10 copay	\$10 copay
Outpatient Mental Health & Substance Abuse Visits	\$10 copay	\$10 copay
Chiropractic & Acupuncture (refer to page 10)	\$10 copay	\$10 copay

Pharmacy Benefits...

	Retail	Mail Order	Retail	Mail Order
Brand & Specialty Deductible	None		None	
Out-of-Pocket Maximum (individual family)	Included in health plan maximum		Included in health plan maximum	
Days Supply	Up to 30	Up to 100	Up to 100	Up to 100
Generic Drugs	\$10 copay	\$20	\$10 copay	\$10 copay
Brand Name Drugs	\$20 copay	\$40	\$10 copay	\$10 copay

MEDICAL: UHC HMO PLANS



Know Your Options...

The UnitedHealthcare (UHC) HMO plans offer you access to certain physician groups that have contracted with one or more HMO network. You and dependents must choose the same network—but your PCPs can be different. The charts here show the amount you can expect to pay when accessing care within your medical group and/or at the direction of your Primary Care Physician (PCP).

All Groups
[VEBA Direct HMO 10](#)

Find a PCP:
calveba.org/veba-direct

Search for a Provider

Sharp Rees-Stealy
Sharp Community
UCSD Medical Group
Rady Children's

All Groups
[Alliance HMO 20/30](#)

Find a PCP:
whyuhc.com/csveba

Search for a Provider

Scripps Clinic
Scripps Coastal
UCSD Medical Group
Greater Tri-Cities
Rady Children's

HMO Medical Benefits...

Deductible (individual family)	None	None
Out-of-Pocket Maximum (individual family)	\$1,500 \$3,000	\$3,000 \$6,000
Office Visits (Primary Care Specialist)	\$10 \$10 copay	\$20 \$30 copay
Virtual Visits (see below)	No charge	No charge
Urgent Care Visits	\$10 copay	\$20 copay
Preventive Care Exams & Screenings	No charge	No charge
Routine Diagnostic Lab & X-Rays	No charge	No charge
Complex Imaging & Scans (MRI, CT, PET, etc.)	No charge	\$200 copay
Inpatient Hospitalization	No charge	\$500 copay
Outpatient Surgery	No charge	\$250 copay
Emergency Room Visits (waived if admitted)	\$100 copay	\$150 copay
Outpatient Physical/Rehabilitation Therapy	\$10 copay	\$20 copay
Outpatient Mental Health & Substance Abuse Visits	\$10 copay	\$20 copay
Chiropractic & Acupuncture (refer to page 10)	\$10 copay	\$20 copay
Prescription Drug Benefits	Refer to Express Scripts Prescription Drug Plan on page 9	

Virtual Visits

Doctors can treat a wide range of health conditions and may even prescribe medications if needed. Consider Virtual Visits for these common conditions:

- Allergies
- Flu
- Sore throat
- Bronchitis
- Migraine
- Stomachache
- Eye Infection
- Rash
- and more

All UHC members have a \$0 copay when accessing 24/7 Virtual Visits through one of these providers:

Optum **amwell** **dr. on demand** **Teladoc HEALTH**

Sign in at myuhc.com/virtualvisits

Call 888.586.6365

Journey Plans

The Journey plans are consumer driven health plans that include deductibles but have been paired with Health Reimbursement Accounts (HRA) that VEBA funds annually. The HRAs are designed to help you meet your deductible and pay for other expenses when accessing care including medical plan copays, pharmacy and chiropractic costs.

Find a PCP:

whyuhc.com/csveba

Search for a Provider

All Groups Journey Plan - Alliance

*Scripps Clinic
Scripps Coastal
UCSD Medical Group
Greater Tri-Cities
Rady Children's*

All Groups Journey Plan - Harmony

*Sharp Rees-Stealy
Sharp Community*

UHC Journey HMO Medical Benefits...

Deductible (individual family)	\$2,000 \$4,000	\$2,000 \$4,000
Out-of-Pocket Maximum (individual family)	\$3,500 \$7,000	\$3,500 \$7,000
Office Visits (Primary Care Specialist)	\$25 \$40 copay	\$25 \$40 copay
Virtual Visits (refer to the bottom of page 6)	No charge	No charge
Urgent Care Visits	\$25 copay	\$25 copay
Preventive Care Exams & Screenings	No charge	No charge
Routine Diagnostic Lab & X-Rays	No charge	No charge
Complex Imaging & Scans (MRI, CT, PET, etc.)	\$100 copay	\$100 copay
Inpatient Hospitalization	20% after deductible	20% after deductible
Outpatient Surgery	20% after deductible	20% after deductible
Emergency Room Visits (waived if admitted)	20% after deductible	20% after deductible
Outpatient Physical/Rehabilitation Therapy	\$25 copay	\$25 copay
Outpatient Mental Health & Substance Abuse Visits	\$25 copay	\$25 copay
Chiropractic & Acupuncture (refer to page 10)	\$30 copay	\$30 copay
Prescription Drug Benefits	Refer to Express Scripts Prescription Drug Plan on page 9	

Annual HRA Funds...

Subscriber Only	\$500	\$1,000
Subscriber + 1 Dependent	\$1,000	\$1,600
Subscriber + 2 or More Dependents	\$1,600	\$2,200

If enrolled in one of the Journey plans, ANY unused HRA balance can be rolled over for the following calendar year and it is portable.

MEDICAL: UMR UHC NEXUS ACO PPO



How it works...

The **Nexus ACO** (Accountable Care Organization) Preferred Provider Organization (PPO) plan requires that each family member designates a Primary Care Physician (PCP) from Tier 1, however members have the freedom to choose any recognized provider or hospital when accessing care from Tier 1, 2 or out-of-network.

The freedom of choice empowers you to use higher quality, more efficient providers and rewarding you by costing less. There are significant cost advantages when utilizing the Nexus ACO providers (Tier 1) and Select Plus PPO providers (Tier 2). The amounts facilities charge for standard services can vary greatly based on where that service is delivered. The chart below shows the level of coverage you can expect when accessing care at each tier.

Find a PCP and/or Participating Providers: [Nexus ACO Network](#)



This Plan is Available to All Groups

	Tier 1 - ACO	Tier 2 – Select Plus	Out-of-Network ⁽¹⁾
	Sharp Rees-Stealy Sharp Community	Select Plus PPO Providers	Non-Contracted Providers
UMR UHC Nexus ACO PPO Medical Benefits...			
Deductible (individual family)	\$1,000 \$2,000	\$2,000 \$4,000	\$4,000 \$8,000
Out-of-Pocket Maximum (individual family)	\$2,500 \$5,000	\$5,000 \$10,000	\$7,500 \$14,500
Office Visits (Primary Care Specialist)	\$30 \$50 copay	20% after deductible	50% after deductible
Virtual Visits (refer to the bottom of page 6)	No charge	No charge	Not covered
Urgent Care Visits	\$50 copay	\$50 copay	50% after deductible
Preventive Care Exams & Screenings	No charge	No charge	Not covered
Routine Diagnostic Lab & X-Rays	No charge ⁽²⁾	20%	50% after deductible
Complex Imaging & Scans (MRI, CT, PET, etc.)	20% after deductible	40% after deductible	50% after deductible
Inpatient Hospitalization	20% after deductible	40% after deductible	50% after deductible ⁽³⁾
Outpatient Surgery	20% after deductible ⁽²⁾	40% after deductible ⁽²⁾	50% after deductible ⁽³⁾
Emergency Room Visits (waived if admitted)	\$100 copay	\$100 copay	\$100 copay
Outpatient Physical/Rehabilitation Therapy	\$30 copay	20% after deductible	50% after deductible
Outpatient Mental Health & Substance Abuse Visits	\$30 copay	20% after deductible	50% after deductible
Inpatient Mental Health & Substance Abuse Visits	20% after deductible		50% after deductible
Chiropractic & Acupuncture (refer to page 10)	\$30 copay	\$30 copay	50% after deductible
Prescription Drug Benefits	Refer to Express Scripts Prescription Drug Plan on page 9		

(1) Out-of-Network Providers set their own prices, and you may be responsible for and balance billed for amounts higher than the Select Plus PPO negotiated rate.

(2) Additional charges apply at hospital-based lab, radiology center or surgical center..

(3) Pre-authorization required.

MEDICAL: EXPRESS SCRIPTS PRESCRIPTION DRUG PLAN



Plan Overview

If you are enrolled in the one of the UHC HMO plans or the UMR Nexus ACO PPO plan, your prescription drug benefits are through Express Scripts (ESI). Within the ESI network, some pharmacies have negotiated special pricing establishing smaller, more cost-effective options. Your prescription drug plan will reward you with lower copays when using these more cost-effective pharmacies.

Find an ESI Pharmacy:

express-scripts.com

Smart 90⁽¹⁾

Sharp Rees-Stealy

Costco Rite Aid

ESI Mail Order

ESI Advantage (EAN)

Supermarkets

Drug Stores

Many Independents

Other ESI Pharmacies

Walgreens

CVS

Some Independents

UHC Performance Plan A Network 1 HMO	Generic	Brand	NP ⁽²⁾	Generic	Brand	NP ⁽²⁾	Generic	Brand	NP ⁽²⁾
Short Term Drugs (up to 30-day supply)	\$5	\$25	50%	\$5	\$25	50%	\$10	\$30	50%
Maintenance Drugs (up to 90-day supply) ⁽³⁾	\$10	\$50	50%	\$10	\$50	50%	Not available		
Out-of-Pocket Maximum (individual family)	Combined with medical								

Alliance HMO 20/30, Journey HMOs & UMR Nexus ACO PPO

Short Term Drugs (up to 30-day supply)	\$10	\$30	50%	\$10	\$30	50%	\$15	\$35	50%
Maintenance Drugs (up to 90-day supply) ⁽³⁾	\$20	\$60	50%	\$20	\$60	50%	Not available		
Out-of-Pocket Maximum (individual family)	Combined with medical								

(1) \$0 copays for preferred generic cholesterol, hypertension and oral hypoglycemic drugs at Smart90 pharmacies and mail order.

(2) Non-Preferred (NP) short-term drugs are subject to \$40 minimum and \$175 maximum copays and maintenance are subject to \$80 minimum and \$350 maximum copays.

(3) The 4th and following fills of maintenance drugs must be through a Smart90 pharmacy or Express Scripts Home Delivery to avoid a penalty of two times the short-term drug copay.



Your Pharmacy ID Card

You must show your Express Scripts ID card when you go to the pharmacy. Do NOT show your UHC ID card at the pharmacy, that card is only for doctor and hospital visits. You get two (2) ID Cards in the mail for your entire family. If needed, you can print additional ID cards when you register at express-scripts.com.

Price Assure through GoodRx

Price Assure is a collaboration between ESI and GoodRx, that provides access to lower prices for brand and generic medications, allowing you to pay the lowest possible cost. You automatically save on generic medications when filled at ESI pharmacies that also accept GoodRx. If the GoodRx price is lower than the copay, you pay the lower price while applying the cost to your deductible, and out-of-pocket maximum.

MEDICAL: CHIROPRACTIC & ACUPUNCTURE BENEFITS



How it Works...

If you are enrolled in one of the Kaiser or UHC medical HMO or PPO plans, you receive chiropractic and acupuncture benefits as long as you receive care from participating OptumHealth Physical Health of California (OptumHealth) providers. Your benefits include:

- Unlimited visits (subject to medical necessity)
- Copays that align with your PCP office visit copay
- X-rays as authorized
- Coverage for durable medical equipment up to \$50
- No PCP referral necessary

At the time of your appointment: Your provider will verify your eligibility using your Optum ID card and you pay the office visit copay (depending upon your medical plan). If you don't have an ID card, you can still access services by telling your provider you are a VEBA member and to verify your benefits with Optum. Your provider may have you complete a Patient Summary Form that enables you to share information about your condition. When submitted to Optum, you and your provider may receive a recovery milestone document that represents a number of treatments most patients with a similar condition have recovered. This is not a limit on the number of treatments available; it simply helps your provider set a point when your condition should be reviewed again to determine the level of improvement. If you need additional treatment, your provider will advise you and Optum.

Find a Network Provider

Only OptumHealth chiropractors and acupuncturists are eligible for reimbursement under the plan. So, before you receive services, please verify that your provider participates with OptumHealth.

Your health plan coverage gives you access to more than 3,000 network providers in California. There are several ways to find a contracted provider near you:

Go to:

myoptumhealthphysicalhealthofca.com

To find a network provider, look for "VEBA" in the list in the column headed "Participating Provider for:"

Call Optum: 800.428.6337

Or call the provider directly to schedule an appointment, and verify they are part of the Optum network for VEBA.



MEDICAL: SIMNSA CROSS-BORDER HMO



Plan Overview

Sistemas Medicos Nacionales, S.A. de C.V. (SIMNSA) is a comprehensive health care service plan and is one of the leading HMO programs in Northern Mexico. The network extends through the border cities of Tijuana, Tecate and Mexicali. In addition, the plan:

- Provides an affordable and culturally sensitive across-the-border option
- Requires that routine services must be received in Mexico
- Provides worldwide emergency and urgent care services
- Has medical providers in Tijuana, Mexicali and Tecate including over 200 physicians along the U.S.-Mexico Border, two SIMNSA medical clinics in close proximity to the U.S. border
- Access to Interlab, one of the most modern and technologically advanced labs in Mexico
- Clinics are open 7 days a week
- Grupo MEDYCA in Tijuana is open until midnight
- No appointments needed, walk-ins welcome
- Clinic wait time is reduced by use of an electronic monitoring system
- Patients can cross back FASTER using the medical pass lane
- No PCP election required
- Is subject to Health Care Reform mandates including no copays for extensive list of preventive care services
- Meets ACA requirements of a Minimum Value Plan and Essential Health Benefits

SIMNSA Website: www.simnsa.com

Visit the website for more information, including a list of providers, full benefits summary, evidence of coverage, forms and wellness information.

	All Groups HMO Plan 5/5
<i>Cross-Border HMO Medical Benefits...</i>	
Deductible (individual family)	None
Out-of-Pocket Maximum (individual family)	\$6,350 \$12,700
Office Visits (Primary Care Specialist)	\$5 copay
Virtual Visits	Not covered
Urgent Care Visits	\$25 copay
Preventive Care Exams & Screenings	No charge
Routine Diagnostic Lab & X-Rays	No charge
Complex Imaging & Scans (MRI, CT, PET, etc.)	No charge
Inpatient Hospitalization	No charge
Outpatient Surgery	No charge
Emergency Room Visits (waived if admitted)	\$250 copay
Outpatient Physical/Rehabilitation Therapy	\$5 copay
Outpatient Mental Health & Substance Abuse Visits	\$5 copay

<i>Cross-Border Pharmacy Benefits...</i>	
Brand & Specialty Deductible	None
Days Supply	Up to 30
Generic Drugs	\$5 copay
Brand Name Drugs	\$5 copay

Who Can Join SIMNSA Health Plan

Employees and their eligible dependents who live in San Diego County or Tijuana and meet the following definition of "Mexican National" may enroll in the SIMNSA HMO plan:

- A person born in Mexico
- A person born in another country with a Mexican father or a Mexican mother, or both
- A foreign woman or man who marries a Mexican man or woman and lives in Mexico
- A foreigner who becomes naturalized in Mexico



Advocacy Contact
Call **888.276.0250** or
vebaonline.com/contact

Post 65 Member Services
Call **619.961.2047** or email:
post65inquiries@vebaonline.com

VEBA Advocacy

What It is: Don't sit on hold. Get help navigating the health care system. When you contact VEBA Advocacy, you'll be connected with a dedicated specialist who will help you get answers to your questions, resolve benefits-related issues, make appointments, and get more information about recommended tests, treatments and prescribed medications.

Wondering about your eligibility or enrollment request?

During Open Enrollment, the operations department expects a 10-15 business day waiting period after enrollment is submitted to VEBA by the district, before benefits are active with the carrier.

In addition, any eligibility or enrollment-based questions sent to the Advocacy team will be immediately sent over to the Operations team for prompt resolution. However, the increased volume of requests during Open Enrollment may cause delays.

Should a member call Advocacy to change their address or phone number? No. Members should contact the benefit office or HR department to make any demographic changes. We cannot make any changes to a member's account without something in writing directly from the employer. Once our Operations department receives the change request from the District, they will update the account and send the information to the insurance carrier.

Should a member call Advocacy to order an ID card? No. We do not generate or mail out ID cards, they come directly from the insurance provider. The member should call the insurance carrier to request a new ID card.

Should a member call Advocacy to change Primary Care Physicians? No. While Advocacy is happy to assist you with the process of locating an in-network provider, in order to change your PCP you will need to contact your insurance carrier directly.

VEBA Resource Center

The VEBA Resource Center (VRC) is a caring and safe environment that supports VEBA Members as they define their path to well-being. Everyone's health care journey is unique, so we help our Members find the resources that work for them. The VRC is centered around each Member.

Most health care systems are designed for efficiencies, which does not give people the space they need to explore their most pressing issues. At the VRC, we look at chronic disease more often as the symptom of greater underlying challenges, as opposed to the singular challenge to solve. Our team of providers helps identify those challenges and provides personalized, holistic approaches to healing.

vebaresourcecenter.com



OPTUM EMPLOYEE ASSISTANCE PROGRAM



Understanding Your EAP

The EAP is **confidential** counseling and referral services that provides you and members of your household no-cost support and resources for life's everyday challenges. Whether you need in the moment emotional support, short-term counseling to get you through a challenging life event or access to financial and legal advice, your EAP can be your first place to start. The EAP can provide support on a variety of issues, such as:

- Emotional and stress-related problems
- Marital conflicts
- Parenting or child issues
- Alcoholism and other forms of substance abuse
- Financial difficulties
- Legal assistance
- Child, elder and pet care referrals
- Identity theft

You have 24-hour access to professional assistance. **You and each of your household members can utilize up to five (5) counseling sessions at no cost to you.**

To access the EAP benefits, you may contact the EAP 24 hours a day, 7 days a week by phone. During the initial telephone call, it is important to give the specialist as much information as possible including any preferences you have regarding a counselor. You will be given the contact information of a counselor(s) in your area that you may contact to schedule an appointment.

The EAP only contracts with licensed professionals. What you discuss is held in strictest confidence in accordance with professional ethics and state law. Counseling sessions are conducted away from work to ensure confidentiality and privacy.

Optum

Call 888-625-4809 or visit liveandworkwell.com

Code: VEBA

The **Calm** app — help to stress less and feel better



Get meditations, breathing exercises, Sleep Stories, daily tips and more. All designed to help you stress less, sleep more and live mindfully.



DENTAL: DELTA DENTAL INCENTIVE PPO



CVUSD offers you and your family a comprehensive PPO dental plan administered by Delta Dental and encourages good dental health. The [Delta Dental Incentive PPO plan](#) is a traditional dental plan that allows you to use any dentist you choose in or out-of-network. In general, you will pay less when seeking care from a Delta Dental dentist.

Plan Highlights

The Delta Dental Incentive PPO plan pays 70% of the PPO contract allowance for most services during the first year of enrollment. The coinsurance percentage will increase by 10% each year (to a maximum of 100%) for each enrollee if that individual visits the dentist at least once during the year. If an enrollee does not use the plan during the calendar year, the percentage remains at the same level attained the previous year. If an enrollee becomes ineligible for benefits and later regains eligibility, the percentage will drop back to 70%.

Selecting A Dentist

Visit a dentist in the PPO network to maximize your savings. These dentists have agreed to reduced fees, and you won't get charged more than your expected share of the bill. You can still visit any licensed dentist, but your out-of-pocket costs may be higher if you choose a non-PPO dentist. Network dentists are paid contracted fees. You are responsible for coinsurance, amounts over annual or lifetime maximums and charges for non-covered services. Out-of-network dentists may bill the difference between their usual fee and Delta Dental's maximum contract allowance.

Find a PPO dentist:
deltadentalins.com

Find a dentist

Review the chart below for level of coverage available under each year on the PPO dental plan.

<i>Dental Incentive PPO Member Benefits</i> ⁽¹⁾	<i>In-Network</i> ⁽²⁾				<i>Out-of-Network</i> ⁽²⁾			
	Year 1	Year 2	Year 3	Year 4	Year 1	Year 2	Year 3	Year 4
Annual Deductible	None							
Annual Benefit Maximum	\$2,500 per person							
Diagnostic (<i>exam & x-rays</i>)	30%	20%	10%	0%	30%	20%	10%	0%
Preventive (<i>3 cleanings per year & fluoride</i>)	30%	20%	10%	0%	30%	20%	10%	0%
Endodontics (<i>root canals</i>)	30%	20%	10%	0%	30%	20%	10%	0%
Periodontics (<i>gum treatments</i>)	30%	20%	10%	0%	30%	20%	10%	0%
Oral Surgery	30%	20%	10%	0%	30%	20%	10%	0%
Major Restorations (<i>crowns, inlays & onlays</i>)	30%	20%	10%	0%	30%	20%	10%	0%
Prosthodontics (<i>bridges, dentures & implants</i>) ⁽³⁾	40%	40%	40%	40%	50%	50%	50%	50%
Dental Accident	No charge up to \$1,000 maximum benefit per person, per year							
Orthodontics (<i>adult child</i>)	Not covered							

(1) Limitations or waiting periods may apply for some benefits; some services may be excluded from your plan.

(2) Reimbursement is based on Delta Dental contract allowances and not necessarily each dentist's actual fees. Reimbursement is based on PPO contracted fees for PPO dentists, Premier contracted fees for Premier dentists and the program allowance for non-Delta Dental dentists.

(3) Implants (appliances inserted into bone or soft tissue in the jaw, usually to anchor a denture) are not covered by your plan. However, if implants are provided along with a covered prosthodontic appliance, Delta Dental will allow the cost of a standard partial or complete denture toward the cost of the implants and the prosthodontic appliances when the prosthetic appliance is completed. If Delta Dental makes such an allowance, they will not pay for any replacement for five years following the completion of the service.

DENTAL: DELTACARE USA DENTAL HMO

CVUSD offers the [DeltaCare USA Dental HMO](#) (DHMO) plan. When you enroll in the DHMO plan, you'll choose a primary care dentist from the network of carefully screened private practice dentists. You must visit your primary care dentist to receive benefits.

Plan Highlights

The DHMO plan encourages regular dental care with an extensive list of covered services to help you stay healthy. There are no surprises. You'll know your copayments and your out-of-pocket costs as they are clearly defined before treatment begins.

- [Low or no copayments for cleanings and exams](#)
- [No deductibles or maximums for covered services](#)
- [Pay only your copayment](#) (if any) at the time of treatment – full list of copayments can be found in the [DeltaCare USA Benefits Summary](#)
- [Adult and child orthodontia coverage](#)
- No restrictions on pre-existing conditions (except work in progress)
- Access to specialty care and out-of-area emergency convenient services
- Access plan information online
- Change your primary care dentist by phone or online
- No claim forms to complete and no plan ID card is required to receive treatment

Selecting A Dentist

When you enroll, you must select a primary care dentist from the DeltaCare USA network. If you cover any family members, each person can select his or her own primary care dentist.

You can request to change your primary care dentist at any time. Simply log on to your Online Services account or call Customer Service. Change requests received by the 21st of the month will become effective the first day of the following month.

Find a DHMO dentist:
deltadentalins.com

 **Find a dentist**

Full List of DHMO Plan Copays:
[DeltaCare USA Benefits Summary](#)



EYEMED VISION

Vision Plan Highlights

There's so much more to your vision benefits than copays and coverage. Get ready to see the good stuff for yourself. Members already save using their EyeMed benefits, but our long list of special offers takes benefits even further. Additional discounts include:

- 40% off complete pair of prescription eyeglasses
- 20% off non-prescription sunglasses
- 20% off remaining balance beyond plan coverage

Selecting a Provider

See who you want, when you want. You have thousands of providers to choose from — independent eye doctors, your favorite retail stores, even online options. Your vision benefits are offered through EyeMed, a network that gives you lots of choices and flexibility. No matter which provider you choose, your plan is designed to be easy-to-use and help you access the care you need.

When you receive services or purchase materials from an out-of-network provider, the member reimbursement levels will be based on the reduced plan allowances.

Find an EyeMed provider:
[eyemed.com](https://www.eyemed.com) or
call 866.723.0596

Lasik or PRK from U.S. Laser Network: call 800.988.4221

Hearing care from Amplifon:
call 877.203.0675

Benefits when using an EyeMed Provider...

Routine Exam	\$10 copay
Retinal Imaging	Plan pays up to \$39

Contact Lens Fit & Follow-up

Fit & Follow-up – Standard	Plan pays up to \$55 ⁽¹⁾
Fit & Follow-up – Premium	10% off retail price

Frames

Frame	\$150 allowance
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Standard Plastic Lenses

Single Vision Bifocal Trifocal	\$25 copay
Lenticular	20% off retail price
Progressive	\$90 copay ⁽²⁾

Lens Options

Anti-Reflective Coating – Standard	\$45
Anti-Reflective Coating – Premium	20% off retail price
Polycarbonate – Standard	\$40
Scratch Coating – Standard Plastic	\$15
Tint – Solid and Gradient	\$15
UV Treatment	\$15
All Other Lens Options	20% off retail price

Contact Lenses

Conventional	15% off > \$150 allowance
Disposable	\$150 allowance
Medically Necessary	No charge

Frequency of Benefits

Exam:	Every 12 months from the date of service
Frame:	Every 24 months from the date of service
Lenses:	Every 12 months from the date of service
Contact Lenses:	Every 12 months from the date of service

(1) Includes two follow up visits

(2) Premium Progressive: \$90 copay; 30% off retail price less \$120 allowance

SECTION 125:

FLEXIBLE SPENDING ACCOUNTS



The FSAs are IRC Section 125 plans that allow for money to be taken out of your paycheck before taxes and set aside—so you don't pay taxes on the contributions. The money is then later used to reimburse you for your eligible health care and dependent care expenses. This is a great way to lower your tax liability and bring home more of your paycheck. American Fidelity is the FSA Plan Administrator. Employees interested in signing up for either a dependent day care account or a medical expense reimbursement account must meet with an American Fidelity representative annually to complete their enrollment. If you would like to learn more information view this short video here on [Section 125](#).

How it works

There are 2 separate accounts that you can contribute to – the Health Care Account and the Dependent Care Account. Each year during Open Enrollment you decide how much to set aside in your accounts for the following year. The amount you contribute to the accounts is divided up into equal payroll deductions made throughout the year. Be thoughtful in your planning of the amount you wish to set aside into the FSA. The IRS "Use It or Lose It Rule" requires that you forfeit any money left in your account at the end of the plan year. You have 90 days after the plan year ends to file claims for expenses incurred during the plan year, but unused amounts will be forfeited. Also, no changes will be permitted at any time other than Open Enrollment unless there is an IRS qualified status change.

Eligible Expenses

The IRS determines what expenses are eligible and ineligible. It's important to keep receipts and other supporting documentation related to your FSA expenses and reimbursement requests. The IRS requires appropriate documentation for all FSA reimbursements.

- **Health Care Account:** You can set aside up to \$3,400 (in 2026) per year in the Health Care Account for your out-of-pocket expenses including copayments, deductibles, coinsurance, and some services that your medical, dental and vision plans may not cover.
- **Dependent Care Account:** If you pay a licensed professional to care for your qualified dependents while you work, you can contribute up to \$7,500 per year in the Dependent Care Account. Eligible expenses include before/after school care, au pair services, extended day programs, preschool or nursery school, summer day camp, and elder daycare.

How do I Access My Funds?

Your **Flex Card** works like a typical debit card but is used as a credit card for eligible health and dependent care expenses, based on the funds available in your benefits account. Rather than paying out-of-pocket and waiting to be reimbursed, the Flex Card allows you to pay for eligible health care account expenses when the service is provided (or when an eligible product is purchased).

You may also pay for services with your own money and request reimbursement any time a qualified expense has been incurred. The service related to the expense needs only to have taken place; it need not be paid before requesting reimbursement. It is your responsibility to comply with these guidelines and to avoid submitting duplicate or ineligible requests for reimbursement:

- incurred during the applicable plan year
 - incurred by eligible plan participants
 - not reimbursed previously under this or any other benefits plan
 - not claimed as an income tax deduction.
1. **Mobile App** provides the simplest and quickest method to request a reimbursement. Simply enter the required information as prompted and attach your receipt to the Request for Reimbursement by taking a photo using your mobile device camera.
 2. **Online Request for Reimbursement** is another easy way to submit for reimbursement requests along with substantiation.
 3. **Mail or Fax** in your personalized Request for Reimbursement form.

americanfidelity.com

American Fidelity offers online and mobile tools to you help manage your Flexible Spending Accounts

THE STANDARD DISABILITY

Disability Income Protection is disability insurance for non-administrative certificated and classified employees with contacts of at least 15 hours per week. The District provides this disability insurance for employees in lieu of State Disability Insurance (SDI).

Plan Features

There is a 7 day waiting period during which the employee must be totally disabled and absent from work by order of a Physician. Income protection benefits have been designed to supplement employee income while on disability leave. The Payroll Department processes disability claim forms; it is the employee's responsibility to initiate the claim by contacting the Payroll Department.

METLIFE LEGAL ASSISTANCE



Finding an affordably priced attorney to represent you when you have trouble with creditors, buy or sell your home, or even prepare your last will and testament can be a challenge. Through MetLife, you can enroll in a legal services plan that provides legal representation for you, your spouse, and dependents at a price that won't break your budget.

Plan Features

The plan provides resources for important, legal services for a wide range of matters, including:

- Documentation review and preparation (mortgages, deeds, immigration)
- Debt collection defense
- Identity theft defense
- Wills and living trusts
- Real estate matters

The MetLife Legal Plan provides access to a nationwide network of participating attorneys from which to choose. Attorneys have met stringent selection criteria and have an average of 25 years or more of legal experience.

HARTFORD VOLUNTARY LIFE



Employee-paid Term life insurance is available for yourself and your eligible family members.

Guarantee Issue: No medical questions necessary for employee coverage up to \$150,000, spouse coverage up to \$50,000 or for any amount of supplemental child life.

Employee: Increments of \$10,000 up to \$300,000 not to exceed 5 times your annual earnings.

Spouse: 50% of employee voluntary life insurance, in increments of \$5,000, to a maximum of \$100,000. Coverage terminates at age 70. You may not elect coverage for your spouse if they are in active full-time military service or is already covered as an employee under this policy.

Child(ren): If you elect voluntary life insurance for yourself, you can choose \$2,500, \$5,000 or \$10,000 for each child.



DEFERRED COMPENSATION PLANS



403(b), 457(b) & ROTH 403(b) plans

Sections 403(b) and 457(b) of the IRS code allows employees of governmental organizations to save part of their income on a pre-tax basis. This lowers taxable income and helps long term savings grow faster. Contributions to the plan are invested in mutual funds, bond funds, or other investment vehicles and grow tax free until withdrawn.

The ROTH 403(b) plan enables you to save part of your income on an after-tax basis. Your ROTH 403(b) Savings may be withdrawn tax-free.

How much money can I defer into these plans?

For the 2027 tax year the elective deferral contribution limit for employees who participate in 403(b) and 457(b) plans is projected to be \$25,000 or \$25,500 (set annually by the IRS).

What are “catch-up” contributions?

The catch-up contribution provision allows you to save up to an additional \$8,000 or (projected) 8,500 during the 2027 tax year if you are over age 50. Furthermore, if you have 15 years of service with the District, you may also be eligible to make an additional \$3,000 catch-up contribution to the 403(b) plan and if you are in your final 3 years prior to reaching Normal Retirement Age, you may be eligible to contribute up to an additional \$19,500 to the 457(b) plan.

When can I withdraw the money?

You will be able to withdraw or rollover your 403(b) assets when you terminate employment, retire, reach 59 1/2 years of age or become 100% disabled. While you are still employed, you are also eligible to take out a plan loan and/or financial hardship or unforeseeable emergency withdrawal in certain circumstances.

There are many online resources and tools available to you that can help plan your retirement strategy. You will find plan and investment information including plan forms, account access, financial products overview and investment options at:

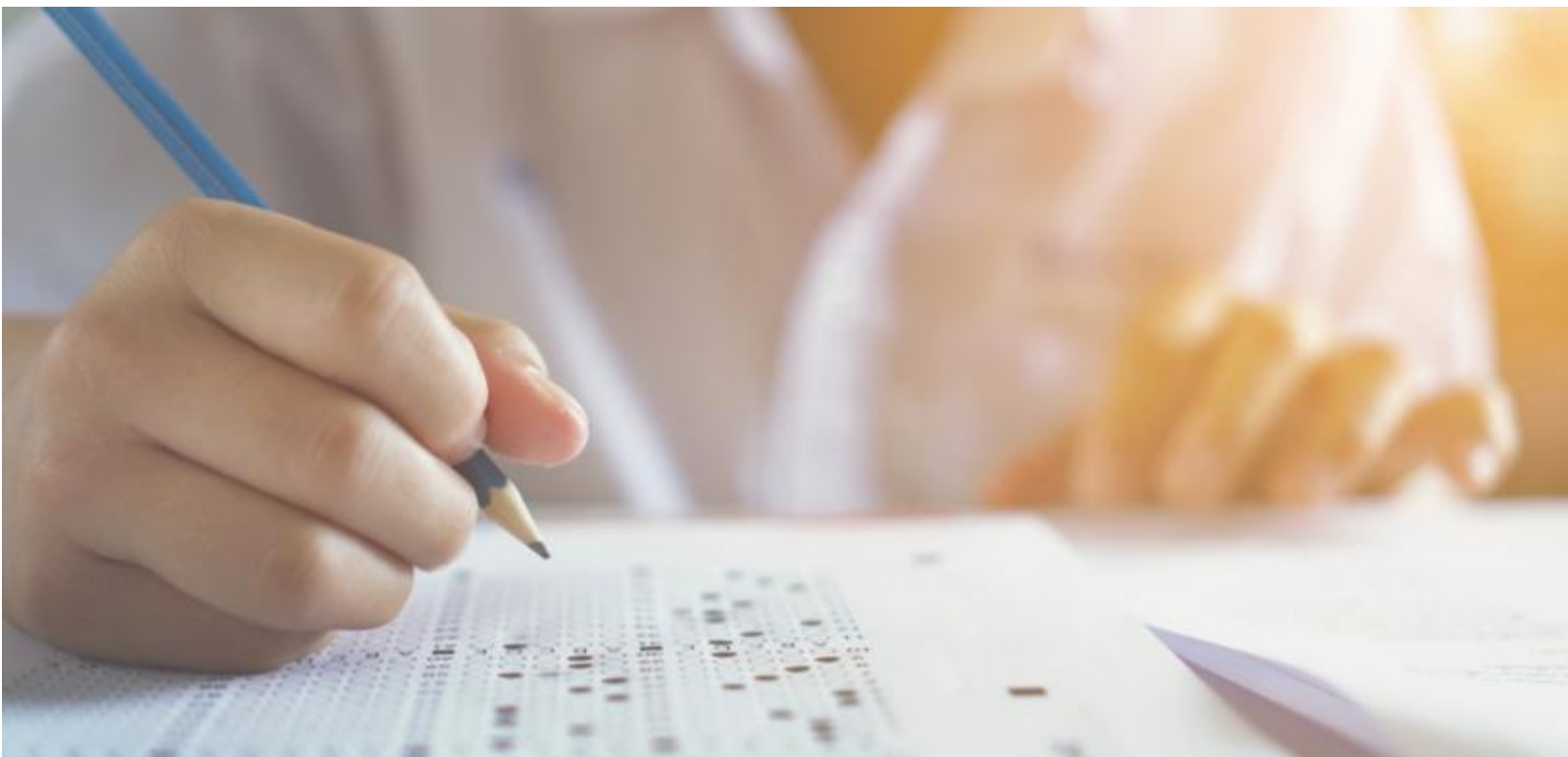
Retirement Resource Center:
[FBCModelPlan.com](https://fbcmodelplan.com)

FBC Retirement Plan Advisor:

Phone: (833) 752-6322

Email: support@fbcmodelplan.com

Retirement Specialists are salaried and noncommissioned, and will make no offer to sell any products, thereby maintaining focus strictly on the program.



EMPLOYEE CO-PREMIUMS



Rates effective December 2026 – November 2027 for Coverage effective January – December 2027

Eleven monthly medical and dental insurance premiums are deducted from your paycheck during the months of August through June, as negotiated by each bargaining unit. If you are part-time and choose to pay for dependent coverage, premiums are also deducted in eleven monthly payments, August through June. Vision premiums are deducted in ten monthly payments, September through June. To determine your benefit eligibility, refer to the eligibility chart in Enrollment Guide. Governing Board and Personnel Commission pay the CVAA rates. Retired employees pay the rate corresponding to their position at the time of retirement. Rates are shown below by bargaining unit.

	Full Time Co-Premium (11 monthly payments)			Part Time Co-Premium (11 monthly payments)		
Cajon Valley Education Association – CVEA	Single	2-Party	Family	Single	2-Party	Family
Kaiser 10/20 HMO	\$271.91	\$536.18	\$756.00	\$271.91	\$1,329.00	\$2,208.27
VEBA Direct HMO	\$336.27	\$671.45	\$931.64	\$336.27	\$1,464.27	\$2,383.91
UHC Alliance HMO 20/30	\$431.18	\$704.18	\$966.55	\$431.18	\$1,497.00	\$2,418.82
UHC PPO Nexus ACO Select 80/50	\$1,673.72	\$3,290.72	\$4,602.55	\$1,673.72	\$4,083.54	\$6,054.82
UHC Journey Harmony	\$205.36	\$344.18	\$461.45	\$205.36	\$1,137.00	\$1,913.72
UHC Journey Alliance	\$215.18	\$391.09	\$537.82	\$215.18	\$1,183.91	\$1,990.09
SIMNSA HMO	\$88.09	\$153.55	\$225.00	\$88.09	\$349.91	\$635.73
Delta Dental PPO	\$0.00	\$0.00	\$0.00	\$0.00	\$52.74	\$95.24
DeltaCare USA	\$0.00	\$0.00	\$0.00	\$0.00	\$12.25	\$25.26
Eyemed Vision	\$9.07	\$17.13	\$25.11	\$9.07	\$17.13	\$25.11

California School Employees Association – CSEA

Kaiser 10/10 HMO	\$279.00	\$550.36	\$775.36	\$279.00	\$1,364.45	\$2,264.45
VEBA Direct HMO	\$288.00	\$570.00	\$799.91	\$288.00	\$1,416.00	\$2,335.64
UHC Alliance HMO 20/30	\$409.91	\$661.64	\$908.46	\$409.91	\$1,475.73	\$2,397.55
UHC PPO Nexus ACO Select 80/50	\$1,652.45	\$3,248.18	\$4,544.46	\$1,652.45	\$4,062.27	\$6,033.55
UHC Journey Harmony	\$184.09	\$301.64	\$403.36	\$184.09	\$1,115.73	\$1,892.45
UHC Journey Alliance	\$193.91	\$348.55	\$479.73	\$193.91	\$1,162.64	\$1,968.82
SIMNSA HMO*	\$88.09	\$153.55	\$225.00	\$88.09	\$349.91	\$635.73
Delta Dental PPO	\$0.00	\$0.00	\$0.00	\$0.00	\$52.74	\$95.24
DeltaCare USA	\$0.00	\$0.00	\$0.00	\$0.00	\$12.25	\$25.26
Eyemed Vision	\$9.07	\$17.13	\$25.11	\$9.07	\$17.13	\$25.11

Cajon Valley Administrators Association – CVAA

Kaiser 10/20 HMO	\$326.29	\$643.42	\$907.20
VEBA Direct HMO	\$390.65	\$778.69	\$1,082.84
UHC Alliance HMO 20/30	\$485.56	\$811.42	\$1,117.75
UHC PPO Nexus ACO Select 80/50	\$1,728.10	\$3,397.96	\$4,753.75
UHC Journey Harmony	\$259.74	\$451.42	\$612.65
UHC Journey Alliance	\$269.56	\$498.33	\$689.02
SIMNSA HMO*	\$24.67	\$42.99	\$63.00
Delta Dental PPO	\$0.00	\$0.00	\$0.00
DeltaCare USA	\$0.00	\$0.00	\$0.00
Eyemed Vision	\$9.07	\$17.13	\$25.11

No part-time employees

*Cross-Border Mexico plan: Must meet plan requirements to enroll.

PAYROLL & OPT-OUTS

ACH: Electronic Direct Deposit

You may have your pay automatically deposited into your bank or credit union. Direct Deposit information is available in the Payroll Department on CVUSD website under "Departments" then "Payroll" then "Payroll Forms" or [HERE](#).

The earliest your ACH will start is the second payday after signing up. If you change or close your bank account, notify Payroll IMMEDIATELY to prevent problems with your payroll deposit. If you choose not to use ACH, your check will be available for pick up in the Payroll Department on pay day. Paychecks not picked up in payroll are mailed home the following business day.

MyPayNow provides on-demand, near real-time access to your earned wages as an employee benefit of the CVUSD. It is not a loan, has no hidden fees or interest charges, and doesn't need a credit check. All CVUSD contracted employees (full and part-time) are eligible.

Near Real-Time Access and Flexibility

You can get up to \$1,000 of your earnings credited to your East County Schools Federal Credit Union e-checking or checking account.

One Benefit, Many Services

As a MyPayNow user, you have access to many services to help you navigate your financial goals: learning resources, financial counseling, budgeting and savings.

Savings in More Ways Than One

Avoid unfair fees from lenders and other financial institutions. All who are enrolled can also access prescription discounts.



Download the PayActiv App to Get Started

ECSFU Support:

Call or Text 619-588-1515 or email mypaynow@eastcountyschools.org

App Support 24/7:

Call: 877-937-6966 or
Online chat: payactiv.com/help
Email support@payactive.com

Medical Plan Waiver

The medical insurance waiver option is available to employees who have alternate health coverage and do not require to be enrolled in a District health plan. **You remain eligible for other District-paid benefits when you choose medical insurance waiver payments. Employees do not receive financial compensation when choosing to waive enrollment in a District health plan.**

Employees who wish to participate must submit a Medical Insurance Opt-Out/Waiver form (found [HERE](#)) to the Benefits Department during Open Enrollment every year or within 30 days of experiencing a qualifying event. Proof of alternate health insurance coverage is required to determine eligibility for a waiver.

Medical Plan Opt-Out Payments

A \$1,200 annual incentive is paid to employees who opt-out of medical insurance benefits for themselves and their entire family. You remain eligible for other District-paid benefits when you choose health opt-out payments.

This option is only available to those who are already receiving a medical insurance opt-out payment. The District's health insurance provider no longer permits opt-outs, and only those who have been receiving an opt-out payment are permitted to continue.

Employees must be currently receiving opt-out payments to exercise this option and must submit documentation that verifies medical insurance through an outside entity every year. Once a "grandfathered" employee ceases to opt-out of medical benefits, they may not return to the opt-out status in the future.

Employees who wish to participate must complete and submit a Medical Insurance Opt-out/Waiver form (found [HERE](#)) to the Benefits Department during Open Enrollment every year. The medical insurance opt-out stipend will end December 31st if paperwork is not submitted.

No retro-active stipends will be paid for time prior to the date paperwork is received by the Payroll Department. Employees who do not submit the opt-out enrollment form and other required documentation within the Open Enrollment period, will receive stipend payments from the date the paperwork is received.

REQUIRED NOTICES

ERISA and various other state and federal laws require that employers provide disclosure and annual notices to their plan participants. CVUSD provides all federally required annual notices; below are summary descriptions of each notice and disclosure. Copies of the full disclosures can be obtained by contacting the Benefits Department.

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

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

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

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

Availability of Privacy Practices Notice states that we maintain, and you may obtain a copy of the Notice of Privacy Practices by contacting Human Resources.

Notice of Choice of Providers states that you have the right to designate any primary care provider who participates in the network and who is available to accept you or your family members. Until you make this designation, the medical carrier designates one for you. For children, you may designate a pediatrician as the primary care provider. You do not need prior authorization in order to obtain access to obstetrical or gynecological care from a health care professional in our network.

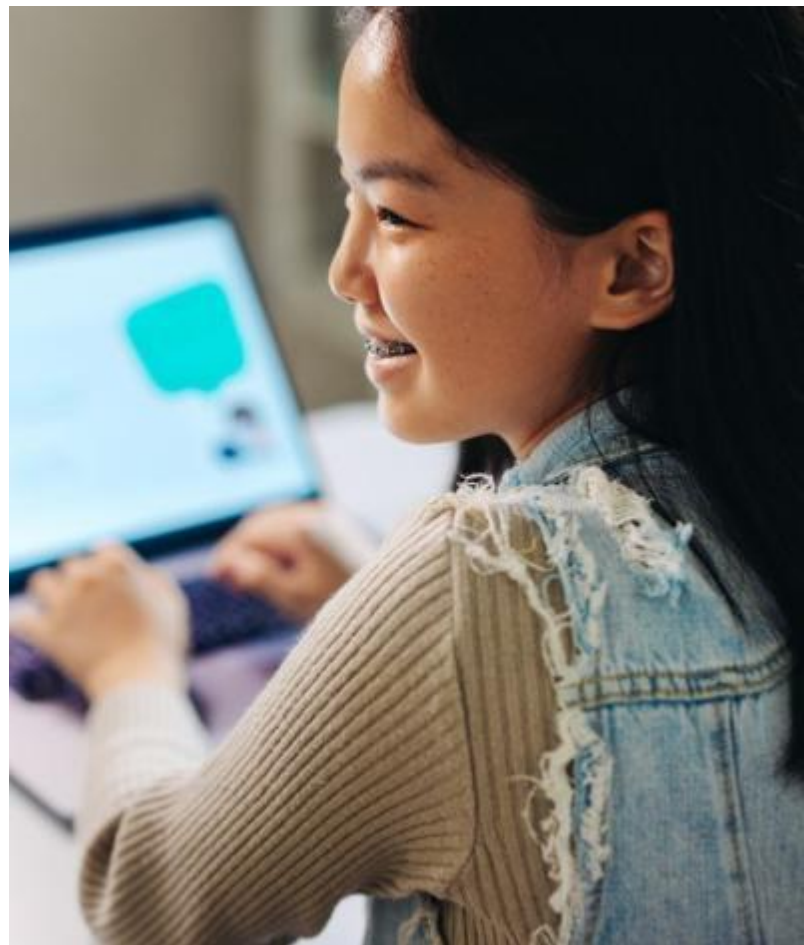
Premium Assistance under Medicaid and the Children's Health Insurance Program (CHIP) provides information on how to contact your state Medicaid office (where applicable to receive information on assistance if you are eligible for health coverage from your employer but are unable to afford the premiums).

ACA Disclaimer states that the offer of coverage may disqualify you from receiving government subsidies for an Exchange plan even if you choose not to enroll.

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. Out-of-network providers or emergency facilities may ask you to sign a notice and consent form before providing certain non-emergency services. 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.

General Notice of COBRA Rights explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.

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



DISTRICT BENEFITS CONTACTS

	Phone	Website Email
HMO Kaiser Permanente Member Services Optum Chiropractic & Acupuncture Mental Health Appointments Away from Home Travel Line	800.464.4000 800.428.6337 833.579.4848 951.268.3900	kp.org myoptumhealthphysicalhealthofca.com
HMO UnitedHealthcare Member Services HMO VEBA Direct Medpoint Member Services Express Scripts – Pharmacy Member Services Optum – Chiropractic & Acupuncture HealthInvest HRA Bank AbleTo – Self Care Wellness Resources	800.624.8822 800.918.8011 800.428.6337 844.342.5505 866.287.1802	whyuhc.com/csveba calveba.org/veba-direct expressscripts.com myoptumhealthphysicalhealthofca.com healthinvestHRA.com member.ableto.com/begin whyuhc.com/csveba/wellness-resources
PPO UMR Member Services Find a Provider – UHC Nexus ACO Network Express Scripts – Pharmacy Member Services Carrum Health – Specialty Medical & Surgery	800.826.9781 800.918.8011 888.855.7806	umr.com connect.werally.com/medicalProvider/root expressscripts.com info.carrumhealth.com/csveba
Fertility, Family Building & Menopause Kindbody (UHC HMO, PPO & Kaiser Members)	855-950-2053	kindbody.com/activate Access Code: KINDCSVEBA employeebenefits@kindbody.com
Cross-Border HMO SIMNSA	800.424.4652	simnsa.com
Medical Expert Opinion Teladoc	800.835.2362	teladoc.com/medical-experts
Employee Assistance Program Optum	888.625.4809	liveandworkwell.com
VEBA Advocacy Resource Center	888.276.0250 619.398.4220	vebaonline.com/contact vebaresourcecenter.com
Dental Delta Dental PPO Member Services DeltaCare DHMO	866.499.3001 800.422.4234	deltadentalins.com
Vision EyeMed	866.723.0596	member.eyemedvisioncare.com/member
Flexible Spending Accounts American Fidelity	800.365.9180	americanfidelity.com
Disability The Standard Claims	800.522.0406	standard.com/eforms/3379cta.pdf
Legal Plan MetLife	800.821.6400	Info.legalplans.com Code: 1680005
Life and AD&D The Hartford Claims	888.563.1124	thehartford.com/employee-benefits/claims
Deferred Compensation SDCOE FBC FBC Model Plan	833.752.6322	FBCModelPlan.com support@fbcmodelplan.com
ACH Direct Deposit PayActiv East County Schools Federal Credit Union	877.937.6966 619.588.1515	payactiv.com/help or email: support@payactive.com eastcountyschools.org
Association of California School Administrators	800.672.3494	www.acsa.org
Payroll & Benefits CVUSD	619.588.3070	do-payroll@cajonvalley.net



CAJON VALLEY

UNION SCHOOL DISTRICT

The information in this Benefits Summary is presented for illustrative purposes and is based on information provided by the employer and the insurance carriers. The text contained in this booklet was taken from various summary plan descriptions and benefit information. While every effort was taken to accurately report your benefits, discrepancies or errors are always possible.

In case of discrepancy between the booklet and the actual plan documents, the actual plan documents will prevail. All information is confidential, pursuant to the Health Insurance Portability and Accountability Act (HIPAAA) of 1996. If you have any questions about this booklet, contact the District's Employee Benefits Department.