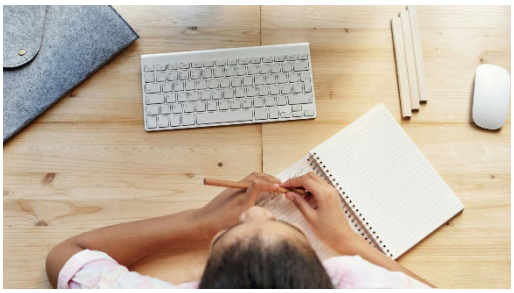
2026-2027

Employee Benefits Overview



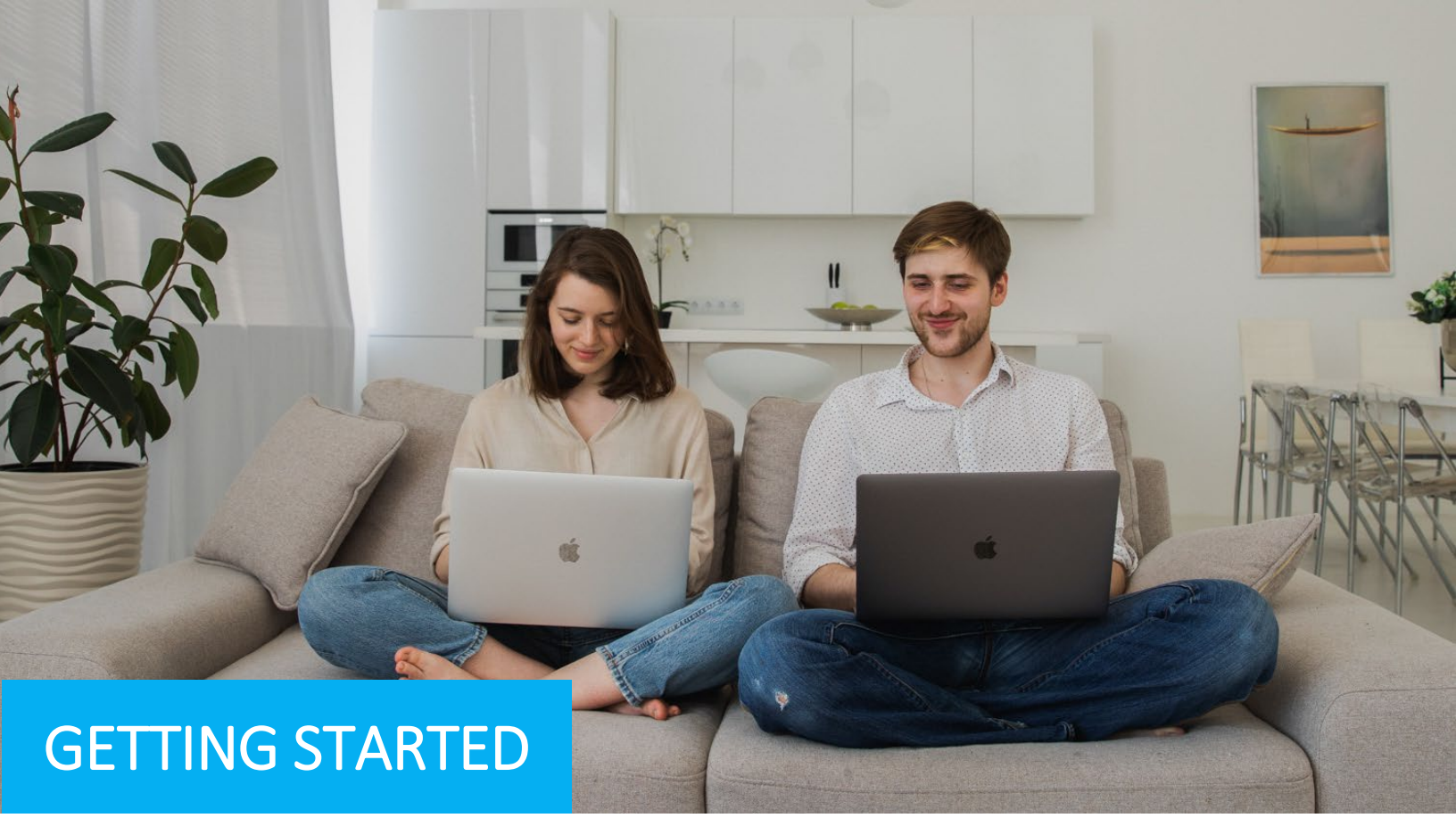
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MEDICARE PART D NOTICE

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.

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GETTING STARTED

2026 - 2027 BENEFITS

October 1, 2026
through
September 30, 2027

What's New?

- VSP LightCare
- SB 7229 Fertility Benefit (California HMO Plans)

For more details about What's New, please turn to pg. 4.

Whether you're enrolling in benefits for the first time, nearing retirement, or somewhere in between, Pasadena USD 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 insurance, 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.



WHAT'S NEW?

What's New for 2026-2027?

VSP LightCare:

- VSP's LightCare benefit allows members to use their vision benefit toward non-prescription sunglasses or blue light filtering glasses from participating VSP providers, even if they don't need prescription eyewear. It's a great option for making the most of your vision benefit!

SB 7229 Fertility Benefit (California HMO Plans):

- In accordance with California Senate Bill (SB) 729, eligible HMO plans now include expanded coverage for the diagnosis and treatment of infertility and fertility services. Covered services may include infertility evaluations, fertility treatments, and assisted reproductive technology (including IVF), subject to plan requirements, medical necessity, and prior authorization. Coverage is available through participating providers as of 10/1/26.

Enrollment Instructions





Note: When you elect your medical coverage, you will be provided a link to download or print a SISC enrollment/change form. You must print and complete this form if you are enrolling in a medical plan for the first time or if you are making changes to your current medical election. You will be required to provide the completed SISC enrollment/change form, along with dependent verification documents, to the Benefits Office or through Plansource.

The online enrollment platform will be open for Open Enrollment elections beginning Monday, August 3, 2026, and will be available until close of business on Friday, August 21, 2026.

SSN Requirements: The Centers for Medicare and Medicaid Services (CMS) requires that group health plans provide social security numbers (SSN) for enrolled dependents. During the online enrollment process and on the SISC enrollment forms, you are REQUIRED to enter SSN information for all of your enrolled dependents. If you do not provide this information, your dependents will not be eligible for benefits.

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.

Open Enrollment Instructions

1. Go to **benefits.plansource.com**
2. The username is the first letter of your first name followed by the first 6 letters of your last name and the last four of your social security number. For example, if your name is Joe Anderson and the last four of your social security number are 1234, your login id would be janders1234.
3. The password will be your birthdate in the YYYYMMDD format. For example, if you were born on April 5, 2017, your password would be 20170405. You will be prompted to create a new password the first time you log in.
4. You can then review your current benefit elections and make any needed changes.
5. If any changes are made to your medical plan you will need to upload and submit any corresponding enrollment form and/or other required documents.

When Can I Enroll?



You can enroll in benefits as a new hire or during the annual open enrollment period. New hire coverage begins on the first of the month following date of hire You must enroll within 30 days of becoming eligible. If you are a part time employee and become full time, your coverage will begin on the first of the month following change in status.

If you miss the enrollment deadline, you'll need to wait until the next open enrollment (the one time each year that you can make changes to your benefits for any reason).

Important Reminder

All employees who wish to enroll in benefits or make changes to their current benefit elections are **REQUIRED** to enroll online **AND** submit a SISC medical enrollment/change form.

- **Spouse** – you will need to provide a copy of an official state issued marriage certificate; also, you will need to provide a copy of the first page of your most recent federal tax return. A tax return is not required if you are enrolling before your first tax filing as a married couple.
- **Domestic partner** – you will need to provide a copy of the "Declaration of Domestic Partnership" certificate approved by the state of California. Notarized applications that have not been state approved will not be accepted.
- **Child(ren)** – you will need to provide a copy of the official state issued birth certificate, court issued and approved adoption paperwork, or proof of legal guardianship for each child. Hospital Certificates of Birth will not be accepted unless the child was born within the last 30 days. Dependent children are eligible for coverage until the age of 26.



Who Can You Cover?

WHO IS ELIGIBLE?

If you are an employee working 75% or more and have a monthly assignment, you are eligible under the District's health benefit program, as well as other optional plans. Your coverage for health benefits will be effective on the first of the month following date of hire. Enrollment and changes made during the open enrollment period will be effective October 1st.

For Certificated Employees represented by UTP:

According to the agreement signed between PUSD and UTP, every benefit eligible member is required to enroll in the benefits program (medical and dental), which is offered by the district, within 30 days of their hire date. Payroll deductions for your fringe benefits will be retroactive back to the date of eligibility.

Note: UTP members whose spouse or domestic partner is also a UTP member shall not be required to enroll in one of the health or dental plans provided he/she is covered in the health plan of his/her spouse or domestic partner.

For Classified and Management Employees represented by CSEA and APSA:

Classified and Management employees may choose to waive their benefits as long as they complete a "Waiver Form" and provide proof of other health plan coverage.

DEPENDENT ELIGIBILITY:

Your eligible dependents include:

- Your legally wed spouse as defined by state law. Proof of marriage will be required.
- Your same sex domestic partner age 18 and older and opposite sex domestic partner when one or the other is age 62 or older. The employee/retiree must provide a certified copy of the Declaration of Domestic Partnership that was filed with the California Secretary of State.
- Child/Child of Domestic Partner: A natural child or step-child from birth to age 26; a legally adopted child or a child who is in the process of being adopted; a child for whom the member has legal and physical custody/guardianship to age 18. Proof of eligibility will be required.
- Disabled Dependent: A disabled dependent may be eligible to continue coverage beyond age 26 if unmarried and a dependent for federal income tax purposes. Proof will be required.
- Child named in a Qualified Medical Child Support Order (QMCSO) as defined by federal law.

If you are enrolling your dependents, you will be required to provide proof of your dependents' status at the time of your enrollment. See page 4 for a list of acceptable documents or contact the Benefits Office.

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.

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.).

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 -** including marriage, divorce, legal separation, annulment, and death of a spouse
- **Change in number of dependents or dependent eligibility status -** including birth, adoption, placement for adoption, or death of a dependent child
- **Change in employment status that affects eligibility for you, your spouse, or dependent child(ren) -** including the start or termination of employment by you, your spouse, or your dependent child
- **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 -**resulting from a divorce, legal separation, annulment, or change in legal custody (including a Qualified Medical Child Support 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 are also responsible for notifying the Benefits Office of dependent(s) that become INELIGIBLE as a result of divorce or becoming an overage dependent of the plan, within 60 days of the event. Failure to do so may jeopardize your dependent's right to elect COBRA.

Know Where To Go

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

Type	Appropriate for	Examples	Access	Cost
Nurseline 	Quick answers from a trained nurse	▪ Identifying symptoms ▪ Decide if immediate care is needed ▪ Home treatment options and advice	24/7	$0
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	$$$$$



Making the Most of Your Benefits Program

MDLIVE 24/7
(Blue Shield members only)

MDLIVE provides all SISC Blue Shield PPO and HMO members with access to doctors and pediatricians who can answer their health-related questions conveniently over the phone, via online video or secure e-mail. This program is available 24/7, 365 days a year including holidays. The service is secure, confidential and compliant with all medical privacy regulations. To begin using this benefit, members must first register by calling MDLIVE at 1-888-632-2738 or by going online at **mdlive.com/sisc.** Members will need to have their member ID number and the name, address and phone number of the covered member who needs medical assistance. There is a $10 per consultation fee for this service regardless of the plan's office visit co-pay. This service is not available to Kaiser members.

Doctors sometimes refer patients to other providers. It is the member's responsibility to make sure all providers are in-network (i.e. physicians, labs, radiology, pharmacy etc.). This is true whether members access care through a regular physician or MDLIVE.

ANTHEM EMPLOYEE ASSISTANCE PROGRAM (EAP)

The SISC medical plans provide an Employee Assistance (EAP) program. The Program is designed to help you with everyday concerns and questions, both big and small, which impact you or anyone residing in your household. The EAP also serves more serious concerns such as alcohol and drug Problems, family violence and threats of suicide.

This program is available to all enrolled employees (includes Blue Shield and Kaiser members) at no cost to the employee.
The EAP can be accessed two ways:

- Call the toll free number 24/7 - (800) 999-7222
- Register on the EAP website at **anthemeap.com**; program name is SISC.

HEALTH SMARTS

SISC's health improvement program for members and their families. Through Health Smarts, members and their families have access to onsite biometric screening events and flu vaccine clinics. Health Smarts is voluntary, confidential and offered at no cost to our members. Please visit the Health Smarts web page for additional information or call the SISC office at (661) 636-4410 and speak to your Account Management Team.

SISC EXPERT MEDICAL OPINION SERVICE
(Formerly Advance Medical)

The SISC Expert Medical Opinion program allows all SISC members to obtain an expert medical opinion on their medical condition and treatment plan. Members speak directly with a Teladoc physician at no cost. No question is too big or too small. Expert Medical Opinion ensures members are getting the right care. They collect all relevant medical records, retest pathology, engage leading experts, complete the expert report for the member, review the report with the member and answer any remaining questions they may have. Members may call Teladoc Medical Experts at 1-800-835-2362 or visit **www.teladoc.com/sisc**



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 Pasadena USD 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 Plans

Medical coverage provides you with benefits that help 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.

Pasadena Unified School District gives you a choice between two HMO medical plans through Kaiser and Blue Shield of California and a PPO medical plan through Blue Shield.

	Kaiser Permanente HMO (SISC)	Blue Shield of California HMO (SISC)
	In-Network	In-Network
Annual Deductible	None	None
Annual Out-of-Pocket Max	$1,500 individual $3,000 family	$1,000 individual $2,000 family
Lifetime Max	Unlimited	Unlimited
Office Visit		
Primary Provider	$10 copay	$10 copay
Specialist	$10 copay	$10 copay ($30 Access+ Specialist)
MDLive 24/7	n/a	$5 copay
Preventive Services	Plan pays 100%	Plan pays 100%
Chiropractic Care	$10 copay (30 visits per calendar year combined with acupuncture)	$10 copay (30 visits per calendar year combined with acupuncture)
Lab and X-ray	Plan pays 100%	Plan pays 100%
Inpatient Hospitalization	Plan pays 100%	Plan pays 100%
Outpatient Surgery	$10 copay	Plan pays 100%
Urgent Care	$10 copay	$10 copay
Emergency Room	$100 copay (copay waived if admitted)	$100 copay (copay waived if admitted)

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

Medical Plans, Continued

	Blue Shield of California PPO (SISC) 80-E		Blue Shield of California PPO (SISC) 90-A	
	In-Network	**Out-Of-Network**	**In-Network**	**Out-Of-Network**
Annual Deductible[1,2] Individual Coverage Family Coverage	$300 individual $600 family	$300 individual $600 family	$100 individual $300 family	$100 individual $300 family
Annual Out-of-Pocket Maximum[1,2] Individual Coverage Family Coverage	$1,000 individual $3,000 family	$1,000 individual $3,000 family	$1,000 individual $3,000 family	$1,000 individual $3,000 family
Lifetime Max	Unlimited	Unlimited	Unlimited	Unlimited
Office Visit Primary Care/Specialist Online/Telehealth	$20 copay/ $20 copay $5 copay	Plan pays 50% N/A	$20 copay/ $20 copay	Plan pays 50%
Preventive Services	Plan pays 100%	Not covered	Not covered	Not covered
Chiropractic	Plan pays 80% (up to 20 visits per year)	Not covered	Plan pays 90% (up to 20 visits per year)	Not covered
Lab and Imaging Basic/Complex	Plan pays 80%	Not covered	Plan pays 90%	Not Covered
Inpatient Hospitalization	Plan pays 80%[2]	Plan pays 100% up to $600 per day (non-emergency) [2]	Plan pays 90%	Plan pays 100% up to $600 per day
Outpatient Surgery	Plan pays 80%[2]	Plan pays 100% up to $350 per day (non-emergency) [2]	Plan pays 90%	Plan pays 100% up to $350 per day
Urgent Care	$20 copay	Plan pays 50%[2]	$20 copay	Plan pays 50%
Emergency Room	$100 copay + 20% (copay waived if admitted)	$100 copay + 20% (copay waived if admitted)	$100 copay + 10% (copay waived if admitted)	$100 copay + 10% (copay waived if admitted)

[1]This family maximum is embedded, meaning that the plan will cover 100% for a member once they reach their individual maximum.
[2]All covered expenses including your medical deductibles and prescription copays accumulate towards the out-of-pocket maximum.



Prescription Drugs

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

If you enroll in medical coverage, you will automatically receive coverage for prescription drugs. If you enrolled in Kaiser, your prescription benefits will be provided by Kaiser. If you enrolled in Blue Shield, your prescription benefits will be provided by Navitus.

	Kaiser Permanente HMO (SISC)	Blue Shield of California HMO (SISC)
	In-Network	In-Network
Prescription Drug Deductible	$0	$0
Annual Out-of-Pocket Limit	Combined with Medical OOPM	$1,500 individual $2,500 family
Pharmacy		
Generic	$10 copay	$0 copay at Costco $5 copay at other
Preferred Brand	$10 copay	$20 copay at Costco $20 copay at other
Supply Limit	100 days	30 days
Mail Order		
Generic	$10 copay	$0 copay at Costco
Preferred Brand	$10 copay	$50 copay at Costco
Supply Limit	100 days	30 days Navitus 90 days Costco
Specialty Drug Supply Limit	$10 Copay 30 Days	$20 at Navitus 30 Days

Prescription Drugs, Continued

	Blue Shield of California PPO (SISC) 80-E		Blue Shield of California PPO (SISC) 90-A	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Prescription Drug Deductible	$0	$0	$0	$0
Annual Out-of-Pocket Limit	$1,500 individual $2,500 family	$1,500 individual $2,500 family	$1,500 individual $2,500 family	$1,500 individual $2,500 family
Pharmacy				
Generic	$0 copay at Costco $5 copay at other	Member must pay the entire cost up front and apply for reimbursement. Net cost may be greater than if member uses an in-network provider	$0 copay at Costco $5 copay at other	Member must pay the entire cost up front and apply for reimbursement. Net cost may be greater than if member uses an in-network provider
Preferred Brand	$20 copay at Costco $20 copay at other		$20 copay at Costco $20 copay at other	
Supply Limit	30 days		30 days	
Mail Order				
Generic	$0 copay	Not covered	$0 copay	Not covered
Preferred Brand	$50 copay		$50 at Costco	
Supply Limit	30 days Navitus 90 days Costco		30 days Navitus 90 days Costco	
Specialty Drug Supply Limit	$20 at Navitus 30 Days	Not Covered	$20 Navitus 30 Days	Not covered

Dental

Regular visits to your dentist can protect more than your smile; they can help protect your health. Recent studies have linked gum disease to damage elsewhere in the body and dentists are able to screen for oral symptoms of many other diseases including cancer, diabetes, and heart disease.

Pasadena Unified School District provides you with comprehensive coverage through Delta Dental of California.

With the incentive plans, Delta Dental pays 70% of the PPO contract allowance for covered diagnostic, preventive and basic services and 70% of the PPO contract allowance for major services during the first year of eligibility. The coinsurance percentage will increase by 10% each year (to a maximum of 100%) for each enrollee if that person 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 level attained the previous year. If an enrollee becomes ineligible for benefits and later regains eligibility, the percentage will drop back to 70%.

	APSA Delta Dental PPO (ACSIG)		UTP Delta Dental PPO (ACSIG)	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**
Calendar Year Deductible	None	None	None	None
Annual Plan Maximum	$1,700 per person	$1,500 per person	$1,700 per person	$1,500 per person
Waiting Period	None	None	None	None
Diagnostic & Preventive	Plan pays 70-100%	Plan pays 70-100%	Plan pays 70-100% (Services do not count towards annual plan maximum)	Plan pays 70-100%
Basic Services Fillings Root Canals Periodontics	 Plan pays 70-100% Plan pays 70-100% Plan pays 70-100%	 Plan pays 70-100% Plan pays 70-100% Plan pays 70-100%	 Plan pays 70-100% Plan pays 70-100% Plan pays 70-100%	 Plan pays 70-100% Plan pays 70-100% Plan pays 70-100%
Major Services	Plan pays 70-100%	Plan pays 70-100%	Plan pays 70-100%	Plan pays 70-100%
Prosthodontics	Plan pays 70%	Plan pays 70%	Plan pays 70%	Plan pays 70%
Orthodontia Adults Children	 Plan pays 50% Plan pays 50%	 Plan pays 50% Plan pays 50%	 Plan pays 50% Plan pays 50%	 Plan pays 50% Plan pays 50%
Ortho Lifetime Max	$2,000	$2,000	$2,000	$2,000



Dental, Continued

	Delta Dental PPO (ACSIG) CSEA	
	In-Network	**Out-of-Network**
Calendar Year Deductible	None	None
Annual Plan Maximum	$1,700 per person (applies to basic and major services only)	$1,500 per person (applies to basic and major services only)
Waiting Period	None	None
Diagnostic & Preventive	Plan pays 70-100% (services do not count towards annual plan maximum)	Plan pays 70-100%
Basic Services Fillings Root Canals Periodontics	 Plan pays 70-100% Plan pays 70-100% Plan pays 70-100%	 Plan pays 70-100% Plan pays 70-100% Plan pays 70-100%
Major Services	Plan pays 70-100%	Plan pays 70-100%
Prosthodontics	Plan pays 70%	Plan pays 70%
Orthodontia Adults Children	 Plan pays 50% Plan pays 50%	 Plan pays 50% Plan pays 50%
Ortho Lifetime Max	$2,000	$2,000

Vision

Routine vision exams are important, not only for correcting vision but because they can detect other serious health conditions. Pasadena Unified School District gives you a choice between two vision plans through Vision Service Plan or UHC.

	Vision Service Plan		UHC	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**
Examination				
Benefit	$5 copay then plan pays 100%	Plan pays up to $45	$0 copay	Plan pays up to $40
Frequency	Once every 12 months	Once every 12 months	Once every 12 months	Once every 12 months
Materials	$5 copay (combined with exam copay)	See schedule below	$0 copay	See schedule below
Eyeglass Lenses				
Single Vision Lens	Plan pays 100% of basic lens	Plan pays up to $30	Plan pays 100% of basic lens	Plan pays up to $40
Bifocal Lens	Plan pays 100% of basic lens	Plan pays up to $50	Plan pays 100% of basic lens	Plan pays up to $60
Trifocal Lens	Plan pays 100% of basic lens	Plan pays up to $65	Plan pays 100% of basic lens	Plan pays up to $80
Frequency	Once every 12 months	Once every 12 months	Once every 12 months	Once every 12 months
Frames				
Benefit	Plan pays up to $130 allowance (plus 20% off the amount over your allowance)	Plan pays up to $70	Plan pays up to $130 allowance	Up to $45
LightCare	Plan pays up to $130 allowance for ready-made non-prescription lenses		Not Available	Not Available
Frequency	Once every 12 months	Once every 12 months	Once every 12 months	Once every 12 months
Contacts (Elective)				
Benefit	Plan pays up to $130 (Up to $60 copay for fitting & evaluation)	Plan pays up to $105	Covered in full	Plan pays up to $105

SISC Value Added Services

Take advantage of these value-added services available to SISC plan members to help you get and stay healthy.

Benefit Highlights	Availability & How To Get Started	
24/7 Help with Personal Concerns **SISC Employee Assistance Program** Access free, confidential resources for help with emotional, marital, financial, addiction, legal, or stress issues.	*All eligible employees* **Call** (800) 999-7222 **Visit** anthemEAP.com/SISC	
Online Counseling and Therapy **Talkspace** Digital platform that supports behavioral health and emotional wellness needs from a secure, HIPAA-compliant app. Up to 6 counseling sessions per situation.	*All eligible employees* **Call** (800) 999-7222 **Visit** talkspace.com/associatecare and enter SISC as your organization name	
Expert Medical Opinions **Teladoc Medical Experts** Get answers to health care questions and second opinions from world-leading experts. Specialists can review your diagnosis and treatment plan to help you make informed decisions.	*All eligible employees* **Call** (800) 835-2362 **Visit** teladochealth.com/SISC	
Personal Health Coaching & Therapy **Vida Health** Get one-on-one health coaching, therapy, chronic condition management, health trackers and other tools and resources online or via phone.	*Blue Shield members* **Call** (855) 442-5885 **Visit** vida.com/sisc	
24/7 Physician Access—Anytime, Anywhere **MDLive** Access to virtual visits with psychiatrists and therapists for members age 10 and up. Virtual urgent care services are available to all members. Physicians can prescribe medication when appropriate.	*Blue Shield members* **Call** (800) 657-6169 **Visit** mdlive.com/sisc	
Free Generic Medications **Costco**[1] Get most generic prescriptions at no cost through Costco retail or mail-order pharmacies - no Costco membership required. Enjoy free home delivery from your local Costco via Instacart, with a text sent once your prescription is ready.	*Blue Shield members* **Call** (800) 774-2678 (press 1) **Visit** rx.costco.com	

[1] A deductible may apply for HSA members.

Members on HSA & MEC are eligible. Per IRS guidelines, in person services are subject to deductible for HSA members.

SISC Value Added Services, Cont.

Benefit Highlights	Availability & How To Get Started
Virtual Menopause Care **Midi Health**[1] Expert menopause care from home. Get personalized treatment plans, prescriptions when appropriate, and lifestyle support through virtual visits.	*Blue Shield PPO members* **Visit** joinmidi.com/sisc
Physical Therapy for Back or Joint Pain **Hinge Health** Conquer pain and restore mobility with personalized exercises and one-on-one guidance from a physical therapist. Plus, access to orthopedic specialists for extra support.	*Blue Shield PPO members* **Call** (855) 902-2777 **Visit** hingehealth.com/sisc
24/7 Virtual Primary Care Doctor **Centivo Care** Skip the waiting room and get quick answers with primary care in your pocket. Use the Centivo app for same-day appointments, prescriptions, and follow-up care through secure video or live chat.	*Blue Shield PPO members* **Visit** centivocare.com/sisc/ or download the app
24/7 Access to Virtual Maternity & Postpartum Support **Maven** Connect with specialists and a care advocate from pregnancy to postpartum, and enjoy a free 6-month diaper subscription when you enroll before your third trimester.	*Blue Shield PPO members* **Visit** mavenclinic.com/join/SISC
Hip, Knee, & Spine Surgical Benefit **Carrum Health**[1] Consult top-quality surgeons on hip and knee replacements and certain spine surgeries. Benefit covers all related travel and medical bills.	*Blue Shield PPO members* **Call** (888) 855-7806 **Visit** info.carrumhealth.com/sisc
Enhanced Cancer Benefit **Lantern Cancer Care** Get help from a personal oncology nurse who can partner with you on every step of your cancer journey, including a review of your initial diagnosis and development of a care plan.	*Blue Shield PPO members* **Visit** lanterncare.com
Autoimmune Support **WellTheory** Take control of your autoimmune health. Work with expert coaches to fill gaps left by medications and ease chronic symptoms like pain, fatigue, and digestive issues.	*Blue Shield PPO members* **Visit** welltheory.com/partner/sisc

[1] A deductible may apply for HSA members.

Members on HSA & MEC are eligible. Per IRS guidelines, in person services are subject to deductible for HSA members.



LIFE INSURANCE

Is your family protected?

Life and AD&D insurance can fill a number of financial gaps due to a temporary or permanent reduction of income. Consider what your family would need to cover day-to-day living expenses and medical bills during a pregnancy or illness-related disability leave, or how you would manage large expenses (rent or mortgage, children's education, student loans, consumer debt, etc.) after the death of a spouse or partner.

Basic Life And AD&D Insurance



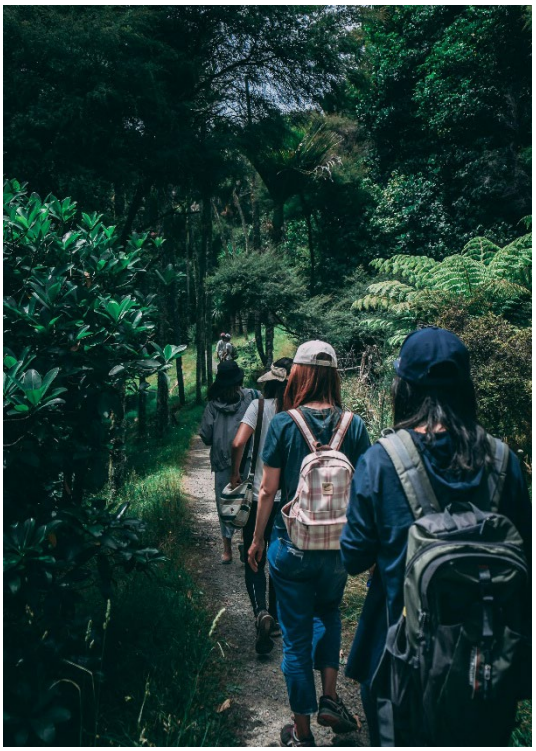
Basic Life Insurance pays your beneficiary a lump sum if you die. AD&D (Accidental Death & Dismemberment) coverage provides a benefit to you if you suffer from loss of a limb, speech, sight, or hearing, or to your beneficiary if you have a fatal accident. Coverage is provided by Unum.

Unum Basic Life and AD&D	
Basic Life Amount	$10,000
Basic AD&D Amount	$10,000

YOUR BENEFICIARY = WHO GETS PAID

If the worst happens, your beneficiary—the person (or people) on record with the life insurance carrier—receives the benefit. Make sure that you name at least one beneficiary for your life insurance benefit, and change your beneficiary as needed if your situation changes.

Voluntary Life And AD&D Insurance



GUARANTEED ISSUE

If you purchase life insurance coverage above a certain limit (the "guaranteed issue" amount) or after your initial eligibility period, you will need to submit Evidence of Insurability with additional information about your health in order for the insurance company to approve the amount of coverage.

Protecting those you leave behind

Voluntary Life Insurance allows you to purchase additional life insurance to protect your family's financial security. Coverage is provided by Unum and available for your spouse and/or child(ren).

Unum Voluntary Life

Employee	Increments of $10,000 up to the lesser of 5x your annual salary or $500,000 Guaranteed Issue: $200,000
Spouse	Increments of $10,000 up to the lesser of 100% of the employee's benefit amount or $500,000 Guaranteed Issue: $50,000
Child(ren)	Increments of $5,000 up to the amount of $10,000.

Note: Benefit amount start to reduce at age 70.

In the event of a serious or fatal accident

Voluntary AD&D Insurance allows you to purchase accidental death and dismemberment coverage that pays your beneficiary if you have a fatal accident. If you experience a serious injury such as a loss of a limb, speech, sight or hearing, the plan pays a benefit to you.

Coverage is provided by Unum and is available for your spouse and child(ren).

Unum Voluntary AD&D

Employee	Increments of $10,000 up to the lesser of 5x your annual salary or $500,000
Spouse*	Increments of $10,000 up to $500,000
Child(ren)*	Increments of $5,000 up to $10,000

* Delayed Effective Date: If your spouse or child has a serious injury, sickness, or disorder, or is confined, their coverage may not take effect. Payment of premium does not guarantee coverage.

Evidence of Insurability (EOI)

If you select coverage above a certain limit (the "guaranteed issue" amount) **or after your initial eligibility period**, you will need to submit an Evidence of Insurability, which involves providing the insurance company with additional information about your health. The instructions will be in PlanSource when you enroll.

Healthcare Flexible Spending Account (FSA)

Click to play video



ARE YOU ELIGIBLE?

You don't have to enroll in one of our medical plans to participate in the healthcare FSA. **Find out more**

- Eligible Expenses – now include more over-the-counter items!

Set aside healthcare dollars for the coming year

A healthcare FSA allows you to set aside tax-free money to pay for healthcare expenses you expect to have over the coming year. This program is administered through American Fidelity.

How the American Fidelity FSA Plan works

- You estimate what you and your family's out-of-pocket costs will be for the coming year. Think about what out-of-pocket costs you expect to have for eligible expenses such as office visits, surgery, dental and vision expenses, prescriptions, even eligible drugstore items.
- You can contribute up to $3,400, the 2026 annual limit set by the IRS, with a minimum contributions of at least $120. Contributions are deducted from your pay pre-tax, meaning no federal or state tax on that amount.
- During the year, when you have an eligible expense, simply complete an FSA claim form. The form can be found and/ or submitted on their website at afadvantage.com, by calling 800-325-0654, or by contacting the benefits office.
- Expenses must be incurred between 10/01/2026 and 9/30/2027 and claims must be submitted for reimbursement no later than 12/31/2026. If you don't spend all the money in your account, you can rollover up to $680 to use the following year. Any additional remaining balance will be forfeited.
- Elections cannot be changed during the plan year, unless you experience a qualifying event.
- You must re-enroll in this program each year.

Dependent Care FSA



Estimate carefully! You can't change your FSA election amount mid-year unless you experience a qualifying event. Money contributed to a dependent care FSA must be used for expenses incurred during the same plan year. Unspent funds will be forfeited.

How the American Fidelity DFSA Plan works

A dependent care Flexible Spending Account (FSA) can help families save potentially hundreds of dollars per year on day care. This program is administered by American fidelity.

You set aside money from your paycheck, before taxes, to pay for work-related day care expenses. Eligible expenses include not only childcare, but also before and after school care programs, preschool, and summer day camp for children under age 13. The account can also be used for day care for a spouse or other adult dependent who lives with you and is physically or mentally incapable of self-care.

You can set aside up to $7,500 per household per year. If you are married but filing separately, federal regulations limit the use of Dependent Care FSA to $3,750 each year. You can pay your dependent care provider directly from your FSA account, or you can submit claims to get reimbursed for eligible dependent care expenses you pay out of pocket.

Wellness Programs





Kaiser Members

Active&Fit

The Active&Fit Direct program allows you to choose from 9,000+ participating fitness centers and YMCAs nationwide for $28 a month (plus a $28 enrollment fee and applicable taxes). To enroll, visit kp.org/choosehealthy, select your area, click the "Choose Healthy" link, and click "Learn More".

myStrength

myStrength is designed to help navigate life's challenges, make positive changes, and support your overall well-being. The app can help you set goals and work towards them in the ways that work best for you. You can get myStrength at kp.org/selfcareapps and choose the mental health and wellness areas you want to focus on.

ClassPass

Kaiser has teamed up with fitness industry leader ClassPass to make it easier for you to exercise from the comfort of your home or local gym/studio. Kaiser Permanente members can get on demand video workouts at no cost and reduced rates on livestream and in-person fitness classes. To get started, visit kp.org/exercise.

Blue Shield Members

Fitness Your way

Experience fitness in a whole different way. Fitness your way is a flexible, no-excuse fitness discount program. Enroll in a flexible gym package to work out at multiple gyms where you live, work and travel and take virtual classes. Gym packages star at just $19 a month, with a one-time enrollment fee of $19 and allow access to thousands of gyms nationwide with no long-term contracts. There are also at home plans to allow you to work out at home attend live virtual classes including cardio, boot camps, barre, yoga and so much more. Go to **fitnessyourway.tivityhealth.com/bsc** to enroll in your preferred gym package and get your member ID number.

Key Terms

-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-

Balance Billing
In-network providers are not allowed to bill you for more than the plan's allowable charge, but out-of-network providers are. This is called balance billing. For example, if the provider's fee is $100 but the plan's allowable charge is only $70, an out-of-network provider may bill YOU for the $30 difference (the balance).

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.

Grandfathered
A medical plan that is exempt from certain provisions of the Affordable Care Act (ACA).

-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.

Key Terms

-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 Notices and Documents

CURRENT HEALTH PLAN NOTICES

Notices must be provided to plan participants on an annual basis and are available on our benefits website at benefits.plansource.com and include:

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.

Notice of Choice of Providers

Notifies you about the plan's requirement that you name a Primary Care Physician (PCP).

Children's Health Insurance Program Reauthorization Act (CHIPRA)

Describes availability of premium assistance for Medicaid eligible dependents.

CURRENT PLAN DOCUMENTS

Important documents for our health plan are available on our benefits website at benefits.plansource.com and include:

Summary Plan Descriptions (SPDs)

A Summary Plan Description, or SPD, is the legal document for describing benefits provided under the plan as well as plan rights and obligations to participants and beneficiaries. The Summary Plan descriptions for each of the plans outlined in this guide are available at eb-portals.com/PUSD.

Summary of Benefits and Coverage (SBCs)

A Summary of Benefits and Coverage (SBC) is a document required by the Affordable Care Act (ACA) that presents benefit plan features in a standardized format. The following SBCs are available on the benefits website at benefits.plansource.com:

- Kaiser HMO
- Blue Shield HMO
- Blue Shield PPO

Paper copies of these documents and notices are available if requested. If you would like a paper copy, please contact the Benefits Office at (626) 396-3600 extension 88144.

Statement of Material Modifications

This enrollment guide constitutes a summary of Material Modifications (SMM) to the Pasadena Unified School District Group Health Plan. 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.

Open Enrollment FAQ's

Q- IF I DO NOT NEED TO MAKE CHANGES TO MY INSURANCE, DO I NEED TO DO ANYTHING?

A- No action is needed if you are not making changes. Your current coverage will continue for the next plan year unchanged.

Q- I COMPLETED THE ONLINE PROCESS AND IT SAYS I AM NOT ELIGIBLE FOR COVERAGE OR DECLINED, WAS MY ENROLLMENT PROCESSED?

A- Since all changes require documents to make changes the system may put your change into a pending status. Once the required documents are received, the system will be updated to no longer show as pending.

Q- CAN I MAKE AN APPOINTMENT TO GET HELP ENROLLING IN MY BENEFITS?

A- Yes. You can setup an appointment with an American Fidelity representative from 8 am to 5 pm Monday through Friday during Open Enrollment. You can also access the enrollment system 24 hours a day on any computer/device with internet access to make changes without assistance.

Q- I COMPLETED THE ONLINE ENROLLMENT, IS THAT IT?

A- Not necessarily. All changes require a form to be turned into the Benefits Office by August 21 2026, in order for the online changes to take effect.

Q- WHAT ADDITIONAL DOCUMENTATION DO I NEED?

A- For adding a spouse, a state issued marriage certificate and top page of the latest 1040 tax form filed will be required. For adding children, state issued birth certificates for each dependent are required. Divorce and adoption require official court paperwork. For any change to a medical plan, an enrollment/change form is required.

Q- IF I MAKE A CHANGE NOW, CAN I CHANGE IT AGAIN BEFORE OCTOBER 1, 2026?

A- No. Changes can only be made during the Open Enrollment period. All changes made as of August 21, 2026, are final until the next Open Enrollment unless your experience a qualifying life event.

Q- CAN I BRING IN THE ADDITIONAL DOCUMENTS AFTER AUGUST 21, 2026?

A- No. Any change made without the proper documents turned in by August 21, 2026, will not be processed even if the online portion was completed.

Q- HOW DO I KNOW IF I NEED TO TURN IN BACKUP DOCUMENTATION?

A- Any and all changes require a form to be turned in after the online enrollment. Any addition of a dependent will require additional documents. The PUSD website will have a list of documents needed for various types of changes.

Q- WHY ARE WE REQUIRED TO PROVIDE THE BACKUP DOCUMENTS?

A- Blue Shield and Kaiser have set certain guidelines for insuring dependents. The District must abide by those guidelines. These are not PUSD requirements, they are insurance carrier requirements.

Q- THIS IS NOT WHAT I HAD TO DO LAST TIME, IS THIS NEW?

A- Benefits laws and requirements are constantly changing. Enrollment rules can change every year, sometimes more than once a year. Please do not assume that each year is the same, this could lead to losing coverage or missing a new required step.

Open Enrollment FAQ cont.

Q- MY CO-WORKER SAID I HAD TO DO SOMETHING DIFFERENT, IS THAT TRUE?

A- Please do not seek benefit advice from co-workers that do not work in the Benefits Department. Although advice from co-workers may have good intentions, many times the information may be outdated, incorrect, or specific to that member's situation. If you have questions regarding your benefits please consult someone in the Benefits Department only.

Q- I MADE A CHANGE TO MY PLANS, WHY AM I STILL BEING DEDUCTED THE SAME AMOUNT ON MY AUGUST/SEPTEMBER PAYCHECK?

A- Changes made during open enrollment, including the new deduction amounts, will take effect in October 2026. For classified employees, changes will begin on your September 30 paycheck and for certificated employees, changes will begin on your October 1 paycheck.

Q- HOW DO I KNOW IF I COMPLETED THE ONLINE PROCESS?

A- When you complete the process you will have the option to email yourself a confirmation of the changes you made. You can keep this confirmation as proof that you made a change online. Please note, this will not serve as proof that all required documents were received, only that the online portion was completed. There is still action needed after the online portion.





For Assistance

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

Plan Type	Provider	Phone Number	Website
Medical	Kaiser	(800) 464-4000	kaiserpermanente.org
Medical	Blue Shield of California	(855) 256-9404	blueshieldca.com/sisc
Prescription Drugs (Blue Shield Members)	Navitus Health Solutions	(866) 333-2757	navitus.com
Dental	Delta Dental	(800) 765-6003	deltadental.com
Vision	VSP	(800) 877-7195	vsp.com
Vision	UHC	(800) 638-3120	myuhcvision.com
Employee Assistance Program	Anthem/SISC	(800) 999-7222	anthemeap.com Program Name: SISC
Life Insurance (District Paid)	Unum	(800) 421-0344	unum.com
Life Insurance (Voluntary)	Unum	(800) 421-0344	unum.com
Flexible Spending Accounts	American Fidelity	(800) 323-3748	afadvantage.com
MDLIVE (Blue Shield Members)	SISC	(888) 632-2738	MDLIVE.com/sisc
Health Smarts	SISC	(661) 636-4410	sischealth.com
SISC Expert Medical Opinion Service	SISC	(800) 835-2362	teladoc.com/sisc
Pasadena Benefits Office	(626) 396-3600 Ext 88144		pusd.us

Early Retirement Plan

CERTIFICATED/UPT EMPLOYEES

Early Retiree Medical Plan

Eligibility:

- Must have at least 15 years of service in PUSD.
- Must be at least 55 years of age as of September 1st of the year of retirement
- Must be at the maximum step of his/her salary column placement at the time of retirement

The District will agree to pay a percentage of health insurance premiums depending on the age at the time of retirement. The plan will continue until the age of 65 or the employee becomes eligible for Medicare, whichever occurs first.

After termination of Early Retirement Medical Plan, employee may elect a self-pay Medicare plan option.

a) Medicare Parts A and B are required and must be effective the month in which the retiree turns 65. Not doing so will result in the member being charged additional premium surcharges.

b) Suggestion: Please contact Social Security Office to find out whether you are eligible for Part A or B and how many quarters you have currently earned.

*****Once the health coverage terminates or is waived, there is no opportunity of extending or electing coverage. This is also true to adding dependents. Once retirement elections have been selected, dependent elections cannot be altered.**

Early retirees may elect to continue their dental coverage with Delta Dental through a self-pay plan. Upon turning the age of 65, the retiree will be transferred to an over 65 Delta Dental plan if coverage is elected to continue.

CLASSIFIED/CERTIFICATED APSA

Early Retirement-Medical Plan

Eligibility:

- Must have at least of 8 years of service in PUSD
- Must be at least 55 years of age.

The District agrees to pay a percentage of individual's health insurance premium. The plan will continue until the age of 65 or the employee becomes eligible for Medicare, whichever occurs first.

After termination of Early Retirement Medical Plan, employee may elect a self-pay Medicare plan option.

a) Medicare Parts A and B are required and must be effective the month in which the retiree turns 65. Not doing so will result in the member being charged additional premium surcharges.

b) Suggestion: Please contact Social Security Office to find out whether you are eligible for Part A or B and how many quarters you have currently earned.

*****Once the health coverage terminates or is waived, there is no opportunity of extending or electing coverage. This is also true to adding dependents. Once retirement elections have been selected, dependent elections cannot be altered.**

Early retirees may elect to continue their dental coverage with Delta Dental through a self-pay plan. Upon turning the age of 65, the retiree will be transferred to an over 65 Delta Dental plan if coverage is elected to continue.



Early Retirement Plan

CLASSIFIED CSEA/TEAMSTER EMPLOYEES

Early Retirement-Medical Plan

Eligibility:

- If age 60 or above must have minimum 15 continuous years of service in PUSD**.**
- If age 55-59 must have 25 continuous years of service in PUSD.
- Must be enrolled in a health plan currently offered by the District.

District agrees to pay 80% of individual's health insurance premium.

The plan will continue until the age of 65 or the employee becomes eligible for Medicare, whichever occurs first.

After termination of Early Retirement Medical Plan, employee may elect a self-pay Medicare plan option.

a) Medicare Parts A and B are required and must be effective the month in which the retiree turns 65. Not doing so will result in the member being charged additional premium surcharges.

b) Suggestion: Please contact Social Security Office to find out whether you are eligible for Part A or B and how many quarters you have currently earned.

*****Once the health coverage terminates or is waived, there is no opportunity of extending or electing coverage. This is also true to adding dependents. Once retirement elections have been selected, dependent elections cannot be altered.**

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