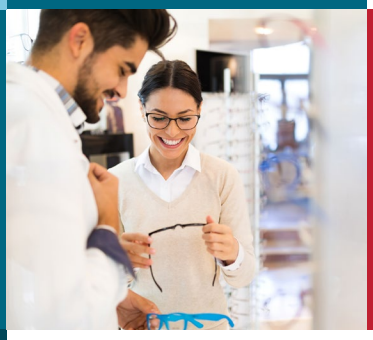
2025
2026

EMPLOYEE BENEFITS GUIDE

reepforbenefits.org



REEP for Benefits

MURRIETA VALLEY
UNIFIED SCHOOL DISTRICT

Employee Benefits Guide 2025-2026

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The information in this brochure is a general outline of the benefits offered under Murrieta Valley USD's benefits program. Specific details and plan limitations are provided in the Summary Plan Descriptions (SPD), which is based on the official Plan Documents that may include policies, contracts and plan procedures. The SPD and Plan Documents contain all the specific provisions of the plans. In the event the information in this brochure differs from the Plan Documents, the Plan Documents will prevail.

Contact Information

Below is a listing of the telephone numbers you can call with questions about the plans available to you. You can also use the website (if available) to access information from providers for the various plans.

Carrier	Phone Number	Website
REEP General		www.reepforbenefits.org
Medical		
• Kaiser	800-464-4000	choose.kaiserpermanente.org/reep
• Anthem	800-331-1476	www.anthem.com/ca
• Marathon	951-229-0708	https://marathon.health/
• Express Scripts	888-806-4969	www.express-scripts.com
• ComPsych EAP	800-557-1005	www.compsych.com/services
Dental		
• Delta Dental	800-448-3815	deltadentalins.com/members
• Anthem Dental	800-331-1476	www.anthem.com/ca
Vision		
• EyeMed	866-939-3633	member.eyemedvisioncare.com
Basic Life AD&D		
• Madison National	800-356-9601	
Ancillary		
• Simplicollege		https://www.simplicollege.com/
• Colonial	800-325-4368	ColonialLife.com
• Transcarent	844-643-0606	member.transcarent.com
• CompleteCare	877-872-4232	https://britehr.app/REEP
• Omada Wellness	888-987-8337	www.omadahealth.com/reep
• Metlife Legal	800-821-6400	members.legalplans.com
• Metlife Pet	800-438-6388	metlife.com/getpetquote
• American Fidelity	800-365-9180	americanfidelity.com

Murrieta Valley USD Online Benefits Enrollment is easy with BenefitBridge!

Need Help?

For all questions related to your benefits, please contact your employer's benefits administrator. For BenefitBridge technical assistance ***only***, please contact BenefitBridge Customer Care at 800.814.1862; Mon – Fri, 8:00 a.m. – 5:00 p.m., PST or email benefitbridge@keenan.com.

Here's what you can do on BenefitBridge:

- View Current Plan Year Benefits
- Compare Plan Options
- Enroll in Benefits
- Resource Center: Health Insurance Basics, Medicare, Glossary, Media Resources
- Add or Remove Dependents/ Beneficiaries
- Message Center
- Update My Account Info
- Available 24/7 via the Internet

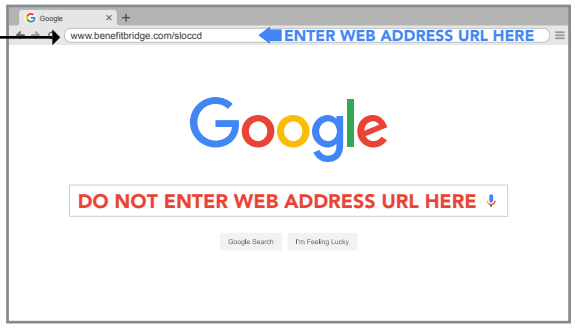
Registration and Login

Already have login credentials?

1. Login to **BenefitBridge** at www.benefitbridge.com/mvusd
2. Forgot your Username or Password? Click on **"Forgot Username/Password?"**
3. Please add or update your email address to receive an email confirmation of your enrollment approval.

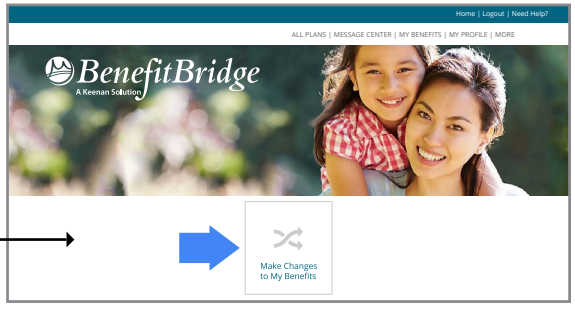
Need to create login credentials?

1. In the **address bar**, type www.benefitbridge.com/mvusd **(Not in the Google, Yahoo, Bing, etc. search engine field)**
2. Click the **Enter** key, then follow the instructions below to register:
   - **STEP 1:** Select **"Register"** to **Create an Account**
     - **You will need to create an account using your first and last names as they appear on your payroll statement.**
   - **STEP 2:** Create a **Username** and **Password**
   - **STEP 3:** Select a picture, as instructed
   - **STEP 4:** Select **"Continue"** to access **BenefitBridge**



Enrolling in Benefits

Access your enrollment via the **"Make Changes to My Benefits"** button



For BenefitBridge technical assistance only, please contact BenefitBridge Customer Care at

800.814.1862

Monday – Friday, 8:00 AM - 5:00 PM, PST or email benefitbridge@keenan.com.

2025-2026 Benefit Updates & Policy Changes

Once again, the REEP JPA has been hard at work, acting to implement plans and benefit enhancements designed to provide the REEP member districts with more options and reduce overall costs. Below is an overview of the updates and policy changes for the 2025-2026 plan year.

REEP Health Center for Anthem PPO, HSA and MVP Members

Our Health Center has updated its hours to better accommodate our members' schedules. Additionally, we have welcomed a new provider to our team, enhancing the quality of care available to our members. See the flyer on the Marathon Health Center on page 34 for additional information.

The Marathon Health Center covers up to 90% of your comprehensive and primary care needs with virtually no out-of-pocket costs ($0 copay for all preventive services for PPO and HSA plan participants. $0 copay for non-preventive services for PPO members and only a $10 copay for HSA plan participants). REEP participating school district/college employees and dependents on **PPO, HSA or MVP** plans can access Marathon Health services including virtual care and 24/7 access to your provider for emergencies.

Marathon Health Center services include, but are not limited to the following:

- Annual physical exams
- Chronic condition management
- Full-scope family medicine
- Men's and women's health
- Mental health screenings
- No cost onsite lab work
- School and sports physicals
- Select onsite medications at little to no cost
- Sick and urgent care
- Same and next day appointments
- 24/7 phone access to your care team for urgent needs

To learn more, visit https://marathon.health/

Plan Updates for 2025:

Anthem Medical Changes

This year, the Minimum Value Plan has been renamed to PPO MVP 5900 to align with traditional medical plans. The "5900" in the name signifies the deductible amount, ensuring clarity and consistency across our offerings.

Anthem and Kaiser Medical Changes

In compliance with federal mandates, we have updated the deductibles for our HSA plans. The HSA 1600 plan will now be known as HSA 1650.

There will be no changes to the PPO MVP 5900 benefits.

Change in EAP Provider

We are excited to announce a change in our Employee Assistance Program (EAP) carrier. Starting July 1st, 2025, ComPsych EAP will be providing our EAP services, offering enhanced support and resources for our employees.

If you are currently receiving care through an Anthem provider, your care will continue through the end of the authorized number of visits and you will need to receive a new referral through ComPhysch for any new EAP visits needed.

Additional information can be found on page 51

SimpliCollege

Schools that use SimpliCollege for their employees also get free accounts to give to all of their students and families! See flyer on page 56 for more information.

2025-2026 Benefit Updates & Policy Changes
(continued)

Change in Life Insurance Provider

We are pleased to announce effective July 1, 2025, your MetLife policies will become insured with Madison National Life. Madison National Life has been a trusted leader in the insurance business for over 60 years, providing superior service to more than 1,500 Public and Education clients. Madison National Life will provide all the essential benefits found in your current contract with no benefit changes. In addition, the rates are guaranteed until July 1, 2030. New certificates of coverage detailing your plan of benefits will be issued to you in the next few weeks.

If you are enrolled in the voluntary life and/or voluntary AD&D plan and wish to change your coverage, you can do so on BenefitBridge during open enrollment. If you are not enrolled in one of these plans and wish to enroll you can also elect to enroll in the voluntary life plan in BenefitBridge. Any employee wishing to increase or enroll in the voluntary life plan for the first time is required to complete a Statement of Health form and submit the form to Madison National Life for approval. Instructions for this process are included on the form.

Change in Pet Insurance Provider

MetLife Pet Insurance is the new REEP pet insurance carrier, effective April 1, 2025. MetLife Pet can help you be prepared for unexpected vet costs associated with injuries and illnesses and can also cover routine care. Pet parents have the power of choice to customize their pet insurance to protect their pet's health and well-being, while protecting their wallet.

Switching to MetLife Pet Insurance is easy.

Don't worry if your furry family members have previously covered pre-existing conditions already covered by Nationwide—they will still be covered if you switch to MetLife Pet Insurance.

Here's how it's done:

1. Don't cancel your coverage with your previous provider until after the start date of your MetLife Pet policy.
2. When enrolling, remember to select if your pet has insurance with another pet insurance provider.
3. Keep the declaration page or Explanation of Benefits (EOB) from your old policy as you will need this when submitting claims.

Additional information can be found on page 73.

If you would like to retain your coverage through Nationwide, you will have to contact Nationwide directly to convert your policy to an individual policy.

Anthem Dental

We are pleased to introduce new benefits to our dental plan at no additional cost. Whitening and occlusal guards will now be covered, aligning with the enhancements made to Delta Dental last year. Additionally, we are moving to a preferred platform to streamline services and improve member experience.

REEP Instagram Page

REEP has a new Instagram Page! Follow to stay up to date on REEP Employee Benefits!

Click the URL: https://www.instagram.com/reep_benefits/ , scan the QR code, or look us up on the app @reep_benefits to follow.

Bi-weekly random follower drawings for **$100!**

*Must fill out form in bio to enter

REEP_BENEFITS

CompleteCare®

Say GOOD-BYE to copays, CompleteCare has you covered!

CompleteCare is an innovate program that helps employees save money on medical expenses in a simple way. Here is how it works: if your spouse has a medical insurance plan through a non-REEP employer, you can enroll in their plan. If you enroll on your spouse's medical plan, CompleteCare will reimburse all approved medical expenses you have to payout of your own pocket, like copays, deductibles and coinsurance.

Imagine 100% Coverage

With CompleteCare, you can enjoy up to 100% coverage for your medical expenses. This is achieved through reimbursement for all approved copayments, coinsurance, and deductibles - up to the maximum out-of-pocket limits set by the Affordable Care Act. It is a simple way to gain peace of mind and financial security when it comes to healthcare. CompleteCare lets you focus on your health without worrying about surprise medical bills. Best of all, there is no employee premium deductions to join the CompleteCare program for eligible employees and their dependents.

Eligibility Requirements

You must be currently enrolled in a REEP health plan or be a new employee.

You are required to enroll in a non-REEP group medical plan, typically through a spouse or Registered Domestic Partner.

CompleteCare Benefits

Get reimbursed for medical costs: Complete Care will reimburse you for copays, deductibles and coinsurance costs up to $9,200 for individuals and $18,400 for families each year.

No paycheck deductions from your paycheck.

Premium reimbursement: If the premium for your spouse/domestic partner's plan is higher than what you would have paid for the REEP plan, CompleteCare will reimburse you up to $100 per month for individuals, $200 for two people, and $300 for family coverage.

Scan QR Code for More Info:

For more information, contact Catilize Health at 877-872-4232 or email us at completecare@catilizehealth.com.

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Catilize Health

Medical: Plan Options

Whether you have a common cold or will be undergoing surgery, medical benefits cover a range of services and can provide peace of mind to help you offset health care costs.

You have several health plans options to choose from under the REEP umbrella. The main difference between the plans are network of providers and copays for services. There is Kaiser plan options and Anthem HMO plan options to choose from.

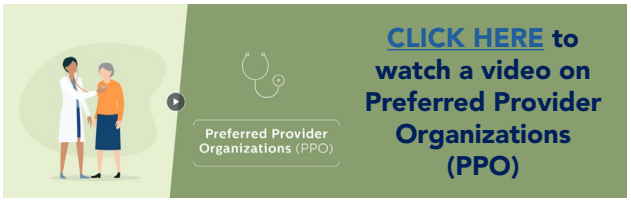
Kaiser Medical Plans		
• HMO 25	• Virtual Complete 2500	• MVP
• DHMO 500	• HSA	

Anthem Medical Plans		
• Anthem HMO 30	• Anthem HSA 1650	• Anthem PPO MVP 5900
• Anthem DHMO 500 Select	• Anthem HSA 3000	

Selecting a Plan that's Right for You

When choosing a health plan, it's important to consider several key factors:

- **Choice:** If you have preferred doctors, specialists, or medical facilities, ensure that the plan you select covers services from these providers. Some health plans limit your choice of providers, while others offer more flexibility.
- **Cost:** Cost is often a significant factor in selecting a plan. Be sure to look at various cost components such as deductibles, copayments, and coinsurance, as well as the amount deducted from your payroll for the plan.
- **Click links to View Rates Effective 7/1/25:**
  - **Classified:** Click Here or Scan Code Below
  - **Certificated/Management/Confidential:** Click Here or Scan Code Below



Anthem Plan Comparisons

Anthem HMO & DHMO Select

Below are all the REEP HMO/DHMO plan options. All REEP HMO/DHMO plans can add chiropractic coverage at a $10 copay which includes 30 visits/calendar year; provided through American Specialty Health.

	Anthem Blue Cross	
	HMO 30 - $15/40/80 Rx	DHMO 500 Select - $19/50/75 Rx
General Plan Information		
• Annual Deductible/Individual	$0	$500
• Annual Deductible/Family	$0	$1,000
• Coinsurance	100%	100%
• Office Visit/Exam	$30 copay	$40 copay
• Outpatient Specialist Visit	$30 copay	$40 copay
• Annual Out-of-Pocket Limit/Individual	$500 Rx not included	$1,500 Rx not included
• Annual Out-of-Pocket Limit/Family	$1,500 Rx not included	$4,500 Rx not included
• Lifetime Plan Maximum	Unlimited	Unlimited
Inpatient Hospital Services		
• Inpatient Hospitalization	100%	$250 admit fee after deductible is met
• Semi-Private Room & Board; Including Services and Supplies	100%	100%
Emergency Services		
• Emergency Room	$100 copay waived if admitted	$100 copay waived if admitted
Mental Health Benefits		
• Inpatient Care	100% (subject to utilization review; waived for emergency admissions)	100% (subject to utilization review; waived for emergency admissions)
• Outpatient Care	100% (Behavioral Health treatment for autism or pervasive development disorders require pre-service review.)	100% (Behavioral Health treatment for autism or pervasive development disorders require pre-service review.)

The information described on this page is only intended to be a summary of benefits. It does not describe or include all benefit provisions, limitations, exclusions, or qualifications for coverage. Please review plan documents for full details. If there are any conflicts with information provided on this page, the plan documents will prevail.

Anthem Plan Comparisons (continued)

	Anthem Blue Cross	
	HMO 30 - $15/40/80 Rx	DHMO 500 Select - $19/50/75 Rx
Substance Abuse		
Inpatient Care		
• Inpatient Hospitalization	100% (subject to utilization review; waived for emergency admissions)	100% (subject to utilization review; waived for emergency admissions)
• Inpatient Detoxification Services	100% (subject to utilization review; waived for emergency admissions)	100% (subject to utilization review; waived for emergency admissions)
Outpatient Care		
• Outpatient Services	100%	100%
Prescription Drug Benefits		
• Prescription Drug Deductible		
• Generic	$15 copay	$19 copay
	(see www.express-scripts.com for a list of pharmacies)	
• Brand *(Formulary/Preferred)*	$40 copay	$50 copay
	(see www.express-scripts.com for a list of pharmacies)	
• Brand *(Non-Formulary/ Non-preferred)*	$80 copay	$75 copay
	(see www.express-scripts.com for a list of pharmacies)	
• Number of Days Supply	30 days	30 days
Mail Order		
• Mail Order Mandatory		
• Generic	$30 copay provided by Express Scripts	$38 copay provided by Express Scripts
• Brand *(Formulary/Preferred)*	$80 copay provided by Express Scripts	$100 copay provided by Express Scripts
• Brand *(Non-Formulary/ Non-preferred)*	$160 copay provided by Express Scripts	$150 copay provided by Express Scripts
• Number of Days Supply for Mail Order	90 days	90 days

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Anthem Plan Comparisons (continued)

Anthem MVP 5900

Below is the REEP MVP 5900 plan option. The REEP MVP 5900 plans can add chiropractic coverage at a $10 copay which includes 30 visits/calendar year; provided through American Specialty Health.

	MVP 5900 - $19/50/75 Rx + Cost	
	In-Network	**Out-of-Network**
General Plan Information		
• Annual Deductible/Individual	$5,900	$11,800
• Annual Deductible/Family	$11,800	$23,600
• Coinsurance	100% after the deductible has been satisfied	50%
• Office Visit/Exam	$35 copay; deductible waived first 3 visits/combined services	50%
• Outpatient Specialist Visit	$35 copay; deductible waived first 3 visits/combined services	50%
• Annual Out-of-Pocket Limit/Individual	$6,100 Rx not included	$12,700 Rx not included
• Annual Out-of-Pocket Limit/Family	$12,200 Rx not included	$25,400 Rx not included
• Lifetime Plan Maximum	Unlimited	Unlimited
Inpatient Hospital Services		
• Inpatient Hospitalization	100% after the deductible has been satisfied	50% plus $500 admission fee after the deductible has been satisfied (waived for emergency)
• Semi-Private Room & Board; Including Services and Supplies	100% after the deductible has been satisfied	50% plus $500 admission fee after the deductible has been satisfied (waived for emergency)
Emergency Services		
• Emergency Room	100%	100%

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Anthem Plan Comparisons (continued)

	MVP 5900 - $19/50/75 Rx + Cost	
	In-Network	**Out-of-Network**
Mental Health Benefits		
• Inpatient Care	100% (subject to utilization review; waived for emergency admissions)	50% (subject to utilization review; waived for emergency admissions)
• Outpatient Care	$35 copay/visit with deductible waived for the first 3 visits (Behavioral Health treatment for Autism or Pervasive Development disorders require pre-service review)	50%
Alcohol Abuse		
Inpatient Care		
• Inpatient Hospitalization	100% (subject to utilization review; waived for emergency admissions)	50% plus $500 admission fee after the deductible has been satisfied (waived for emergency).
• Inpatient Detoxification Services	100% (subject to utilization review; waived for emergency admissions)	50% plus $500 admission fee after the deductible has been satisfied (waived for emergency).
Outpatient Care		
• Outpatient Services	$35 copay/visit with deductible waived for the first 3 visits	50%
• Outpatient Detoxification Services	$35 copay/visit with deductible waived for the first 3 visits	50%
Substance Abuse		
Inpatient Care		
• Inpatient Hospitalization	100% (subject to utilization review; waived for emergency admissions)	50% (subject to utilization review; waived for emergency admissions)
• Inpatient Detoxification Services	100% (subject to utilization review; waived for emergency admissions)	50% (subject to utilization review; waived for emergency admissions)
Outpatient Care		
• Outpatient Services	$35 copay/visit with deductible waived for the first 3 visits	50%
• Outpatient Detoxification Services	$35 copay/visit with deductible waived for the first 3 visits	50%

The information described on this page is only intended to be a summary of benefits. It does not describe or include all benefit provisions, limitations, exclusions, or qualifications for coverage. Please review plan documents for full details. If there are any conflicts with information provided on this page, the plan documents will prevail.

Anthem Plan Comparisons (continued)

	MVP 5900 - $19/50/75 Rx + Cost	
	In-Network	**Out-of-Network**
Prescription Drug Benefits		
• Generic	$19 copay/Tier 1 Pharmacy; $19 copay + $15/Tier 2 Pharmacy provided by ESI	50% + an additional $15 fee applies per prescription for a Tier 2 Pharmacy; provided by ESI
	(see www.express-scripts.com for a list of pharmacies)	
• Brand *(Formulary/Preferred)*	$50 copay/Tier 1 Pharmacy; $50 copay + $15/Tier 2 Pharmacy provided by ESI	50% + an additional $15 fee applies per prescription for a Tier 2 Pharmacy; provided by ESI
	(see www.express-scripts.com for a list of pharmacies)	
• Brand *(Non-Formulary/ Non-preferred)*	$75 copay/Tier 1 Pharmacy; $75 copay + $15/Tier 2 Pharmacy provided by ESI	50% + an additional $15 fee applies per prescription for a Tier 2 Pharmacy; provided by ESI
	(see www.express-scripts.com for a list of pharmacies)	
• Number of Days Supply	30 days	30 days
Mail Order		
• Generic	$38 copay provided by Express Scripts	Not covered
• Brand *(Formulary/Preferred)*	$100 copay provided by Express Scripts	Not covered
• Brand *(Non-Formulary/ Non-preferred)*	$150 copay provided by Express Scripts	Not covered
• Number of Days Supply for Mail Order	90 days	N/A

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Anthem Plan Comparisons (continued)

Anthem HSA

Below are all the REEP HSA plan options. All REEP HSA plans can add chiropractic coverage with 10% coinsurance after deductible which includes 30 visits/calendar year; provided through American Specialty Health.

	HSA 1650 - $15/40 Rx		HSA 3000 - $15/40 Rx	
	In-Network	Out-of-Network	In-Network	Out-of-Network
General Plan Information				
• Annual Deductible/Individual	$1,650 medical/prescription/MH-SA in/out of network combined	$1,650 medical/prescription/MH-SA in/out of network combined	$3,000 medical/prescription/MH-SA in/out of network combined	$3,000 medical/prescription/MH-SA in/out of network combined
• Annual Deductible/Family	$3,300 medical/prescription/MH-SA in/out of network combined	$3,300 medical/prescription/MH-SA in/out of network combined	$6,000 medical/prescription/MH-SA in/out of network combined	$6,000 medical/prescription/MH-SA in/out of network combined
• Coinsurance	90% after deductible	70% after deductible	90% after deductible	70% after deductible
• Office Visit/Exam	90%	70%	90%	70%
• Outpatient Specialist Visit	90%	70%	90%	70%
• Annual Out-of-Pocket Limit/Individual	$3,000	$9,000	$4,000	$9,000
• Annual Out-of-Pocket Limit/Family	$6,000	$18,000	$8,000	$18,000
• Lifetime Plan Maximum	Unlimited	Unlimited	Unlimited	Unlimited
Inpatient Hospital Services				
• Inpatient Hospitalization	90% plus $250 copay if prior authorization is not obtained from Anthem for non-emergency Inpatient admissions to non-network providers.	70% plus $500 copay per admission and 30% coinsurance after deductible	90%	70% plus $500 admission fee after the deductible has been satisfied (waived for emergency)
• Semi-Private Room & Board; Including Services and Supplies	90% plus $250 copay if prior authorization is not obtained from Anthem for non-emergency Inpatient admissions to non-network providers.	70% plus $500 copay per admission and 30% coinsurance after deductible	90%	70%
Emergency Services				
• Emergency Room	90%	90%	90%	90%

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Anthem Plan Comparisons (continued)

	HSA 1650 - $15/40 Rx		HSA 3000 - $15/40 Rx	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Mental Health Benefits				
• Inpatient Care	90% (subject to utilization review; waived for emergency admissions)	70% plus $500 copay per admission (waived for emergency); there is an additional $250 copay if a utilization review is not obtained	90% (subject to utilization review; waived for emergency admissions)	70% plus $500 admission fee after the deductible has been satisfied (waived for emergency)
• Outpatient Care	90%	70% facility care. Physician visits behavioral health treatment for autism or pervasive development disorders requires pre-service review.	90%	70% facility care. Physician visits behavioral health treatment for autism or pervasive development disorders requires pre-service review.
Alcohol Abuse				
Inpatient Care				
• Inpatient Hospitalization	90% (subject to utilization review; waived for emergency admissions)	70% plus $500 copay per admission (waived for emergency); there is an additional $250 copay if a utilization review is not obtained	90% (subject to utilization review; waived for emergency admissions)	70% plus $500 copay per admission (waived for emergency); there is an additional $250 copay if a utilization review is not obtained
• Inpatient Detoxification Services	90%	70% facility care. Physician visits behavioral health treatment for autism or pervasive development disorders requires pre-service review.	90% (subject to utilization review; waived for emergency admissions)	70% plus $500 copay per admission (waived for emergency); there is an additional $250 copay if a utilization review is not obtained
Outpatient Care				
• Outpatient Services	90%	70% facility care. Physician visits behavioral health treatment for autism or pervasive development disorders requires pre-service review.	90%	70% facility care. Physician visits behavioral health treatment for autism or pervasive development disorders requires pre-service review.
• Outpatient Detoxification Services	90%	70% facility care. Physician visits behavioral health treatment for autism or pervasive development disorders requires pre-service review.	90%	70% facility care. Physician visits behavioral health treatment for autism or pervasive development disorders requires pre-service review.

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Anthem Plan Comparisons (continued)

	HSA 1650 - $15/40 Rx		HSA 3000 - $15/40 Rx	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Substance Abuse				
Inpatient Care				
• Inpatient Hospitalization	90% (subject to utilization review; waived for emergency admissions)	70% plus $500 copay per admission (waived for emergency); there is an additional $250 copay if a utilization review is not obtained	90% (subject to utilization review; waived for emergency admissions)	70% plus $500 copay per admission (waived for emergency); there is an additional $250 copay if a utilization review is not obtained
• Inpatient Detoxification Services	90% (subject to utilization review; waived for emergency admissions)	70% plus $500 copay per admission (waived for emergency); there is an additional $250 copay if a utilization review is not obtained	90% (subject to utilization review; waived for emergency admissions)	70% plus $500 copay per admission (waived for emergency); there is an additional $250 copay if a utilization review is not obtained
Outpatient Care				
• Outpatient Services	90%	70% facility care. Physician visits behavioral health treatment for autism or pervasive development disorders requires pre-service review.	90%	70% facility care. Physician visits behavioral health treatment for autism or pervasive development disorders requires pre-service review.
• Outpatient Detoxification Services	90%	70% facility care. Physician visits behavioral health treatment for autism or pervasive development disorders requires pre-service review.	90%	70% facility care. Physician visits behavioral health treatment for autism or pervasive development disorders requires pre-service review.
Prescription Drug Benefits				
• Prescription Drug Deductible	$1,650 ind/$3,300 fam medical/prescription/MH-SA in/out of network combined	$1,650 ind/$3,300 fam medical/prescription/MH-SA in/out of network combined	$3,000 ind/$6,000 fam medical/prescription/MH-SA in/out of network combined	$3,000 ind/$6,000 fam medical/prescription/MH-SA in/out of network combined
• Generic	$15 after deductible Tier 1 Pharmacy $15 copay after deductible + $15/Tier 2 Pharmacy provided by ESI	50% after deductible + an additional $15 fee applies per prescription for a Tier 2 Pharmacy; provided by ESI	$10 after deductible Tier 1 Pharmacy; $10 copay after deductible + $15/Tier 2 Pharmacy provided by ESI	50% after deductible + an additional $15 fee applies per prescription for a Tier 2 Pharmacy; provided by ESI
	(see www.express-scripts.com for a list of pharmacies)			
• Brand *(Formulary/Preferred)*	$40 after deductible /Tier 1 Pharmacy $40 copay after deductible + $15/Tier 2 Pharmacy provided by ESI	50% after deductible + an additional $15 fee applies per prescription for a Tier 2 Pharmacy; provided by ESI	$80 after deductible/Tier 1 Pharmacy; $80 copay after deductible + $15/Tier 2 Pharmacy provided by ESI	50% after deductible + an additional $15 fee applies per prescription for a Tier 2 Pharmacy; provided by ESI
	(see www.express-scripts.com for a list of pharmacies)			

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Anthem Plan Comparisons (continued)

	HSA 1650 - $15/40 Rx		HSA 3000 - $15/40 Rx	
	In-Network	Out-of-Network	In-Network	Out-of-Network
• Brand *(Non-Formulary/ Non-preferred)*	$80 after deductible /Tier 1 Pharmacy $80 copay after deductible + $15/Tier 2 Pharmacy provided by ESI	50% after deductible + an additional $15 fee applies per prescription for a Tier 2 Pharmacy; provided by ESI	$30 after deductible/Tier 1 Pharmacy; $30 copay after deductible + $15/Tier 2 Pharmacy provided by ESI	50% after deductible + an additional $15 fee applies per prescription for a Tier 2 Pharmacy; provided by ESI
	(see www.express-scripts.com for a list of pharmacies)			
• Number of Days Supply	30 days	30 days	30 days	30 days
Mail Order				
• Generic	$30 copay after deductible; provided by Express Scripts	Not covered	$30 copay after deductible; provided by Express Scripts	Not covered
• Brand *(Formulary/Preferred)*	$80 copay after deductible; provided by Express Scripts	Not covered	$80 copay after deductible; provided by Express Scripts	Not covered
• Brand *(Non-Formulary/ Non-preferred)*	$160 copay after deductible; provided by Express Scripts	Not covered	$160 copay after deductible; provided by Express Scripts	Not covered
• Number of Days Supply for Mail Order	90 days	Not covered	90 days	Not covered

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Marathon Health

Everside Health is soon becoming Marathon Health

New name, same great experience, plus an improved app & portal!

Meet your provider: Abigail Kent, PA-C

Abigail received her Bachelor's degree in Biology from Concordia University Irvine and her Master's degree as a Physician Assistant from Marietta College in Marietta,Ohio. She has many years of experience as a PA in family practice, urgent care and emergency medicine. She enjoys forming relationships with her patients in order to help them achieve their health goals. She was born and raised in San Diego, and enjoys traveling, reading, cooking and spending time with her family, friends and pets.

Your onsite and virtual primary care services

- Annual physical exams
- Annual wellness review
- Condition management
- Diet, nutrition review, and counseling
- Labs and onsite testing
- Lab test recommendations
- Select medications at no cost
- School and sports physicals
- Sick and immediate care
- See a provider virtually through our secure portal
- 24/7 virtual access to manage your care
- More time with your provider

NEW Extended Hours

Mon. 7 am - 3:30 pm
Tues. 10 am - 7 pm
Wed. 10 am - 7 pm
Thur. 7 am - 3:30 pm
Fri. 7 am - 2 pm

REEP Health Center

25395 Hancock Ave.
Ste. 200
Murrieta,CA 92562
951-229-0708

Available for REEP members on Anthem PPO/HSA/MVP/HPN health plans!

Schedule an appointment
Call 951-229-0708
or visit **my.marathon.health**

Marathon Health

Virtual care services

Whether you're at home, at work, or feeling under the weather, **get the care you need, when you need it.**

How is a virtual visit different from an in-person visit?
Virtual care is great for healthcare needs that don't require a physical exam. Otherwise, it's very similar. Visits can be held on your smartphone or computer where your healthcare provider will ask questions about your health and focus on your main concern. If there are urgent health needs, you might be referred to the right level of care.

Primary and preventive care

- Routine check-ups and preventive screenings
- Condition management (diabetes, heart disease, COPD, and more)
- Mental health support (provider assessment for mental health concerns)
- Establishing care (getting to know your provider)
- Discussing medications or getting refills

Immediate & sick care

- Bronchitis
- Common cold and cough
- Constipation
- Diarrhea
- Eye infections
- Headache
- Joint pain
- Nausea and vomiting
- Nosebleed
- Sinus infections
- Skin infections
- Strep throat

Family care (ages <X+>)

- Minor injuries (cuts, scrapes, and minor burns)
- Sick care (fever, flu, vomiting, pink eye, cough, and more)

Schedule an appointment
Call 888-830-6538
or visit **my.marathon.health**

All visits are conducted through a secure platform to ensure patient confidentiality. The care you receive by Marathon Health is protected by state and federal law.

Kaiser Plan Comparisons

Kaiser HMO 25 Plan Comparison

Below is the REEP HMO plan option. All REEP HMO plans can add chiropractic coverage at a $10 copay which includes 30 visits/calendar year; provided through American Specialty Health.

	HMO 25
General Plan Information	
• Annual Deductible/Individual	$0
• Annual Deductible/Family	$0
• Coinsurance	100%
• Office Visit/Exam	$25 copay
• Outpatient Specialist Visit	$25 copay
• Annual Out-of-Pocket Limit/Individual	$1,500
• Annual Out-of-Pocket Limit/Family	$3,000
• Deductible Included in Out-of-Pocket Limits	N/A
• Lifetime Plan Maximum	Unlimited
• Primary Care Physician Election Required	Yes
Outpatient Services	
Preventive Services	
• Well-Child Care	100% through age 23 months
• Immunizations	100%
• Well Woman Exams	100%
• Mammograms	100%
• Adult Periodic Exams with Preventive Tests	100%
• Diagnostic X-Ray and Lab Tests	100% $25 copay for MRI/CT/PET

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Kaiser Plan Comparisons (continued)

	HMO 25
Maternity Care	
• Pregnancy and Maternity Care *(Pre-Natal Care)*	100%
Inpatient Hospital Services	
• Inpatient Hospitalization	100%
• Pre-Authorization of Services Required	Yes
• Semi-Private Room & Board; Including Services and Supplies	100%
Surgical Services	
• Outpatient Facility Charge	$25 copay per procedure
Emergency Services	
• Emergency Room	$100 copay waived if admitted
Ambulance	
• Air	100%
• Ground	100%
Urgent Care	
• Urgent Care Facility	$25 copay
Mental Health Benefits	
• Inpatient Care	100%
• Outpatient Care	$25 copay

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Kaiser Plan Comparisons (continued)

	HMO 25
Substance Abuse	
Inpatient Care	
• Inpatient Hospitalization	100%
• Inpatient Detoxification Services	100%
Outpatient Care	
• Outpatient Services	$25 copay
Prescription Drug Benefits	
• Generic	$15 copay
• Brand *(Formulary/Preferred)*	$35 copay
• Number of Days Supply	30 days
Mail Order	
• Generic	$30 copay
• Brand *(Formulary/Preferred)*	$70 copay
• Number of Days Supply for Mail Order	30 days
Other Services and Supplies	
• Durable Medical Equipment & Prosthetic Devices	100%
• Home Health Care	100% limited to 100 visits/calendar year
• Skilled Nursing or Extended Care Facility	100% limited to 100 days/benefit period
• Hospice Care	100%
• Acupuncture	Not covered

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Kaiser Plan Comparisons (continued)

Kaiser DHMO 500 & DHMO 2500 Virtual Complete

Below are all the REEP DHMO plan options. All REEP DHMO plans can add chiropractic coverage at a $10 copay which includes 30 visits/calendar year; provided through American Specialty Health.

	DHMO 500	DHMO 2500 Virtual Complete
General Plan Information		
• Annual Deductible/Individual	$500	$2,500
• Annual Deductible/Family	$1,000	$2,500 for each member in a family of two or more members. $5,000 for an entire family of two or more members.
• Coinsurance	80%	80%
• Office Visit/Exam	$20 copay	$40 copay after Plan Deductible (Plan Deductible doesn't apply to the first three visits combined for primary care, urgent care, mental health and substance use disorder treatment services.)
• Outpatient Specialist Visit	$20 copay	$40 copay after Plan Deductible
• Annual Out-of-Pocket Limit/Individual	$3,000	$5,500
• Annual Out-of-Pocket Limit/Family	$6,000	$5,500 for each member in a family of two or more members. $11,000 for an entire family of two or more members.
• Deductible Included in Out-of-Pocket Limits	Yes	Yes
• Lifetime Plan Maximum	Unlimited	Unlimited
• Primary Care Physician Election Required	No	No

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Kaiser Plan Comparisons (continued)

	DHMO 500	DHMO 2500 Virtual Complete
Outpatient Services		
Preventive Services		
• Well-Child Care	100% through age 23 months	100% through age 23 months
• Immunizations	100%	100%
• Well Woman Exams	100%	100%
• Mammograms	100% for preventive	100% for preventive
• Adult Periodic Exams with Preventive Tests	100%	100%
• Diagnostic X-Ray and Lab Tests	$10 copay per encounter after deductible; $50 copay per procedure for MRI/CT/PET after deductible	80% after deductible for most X-rays, and $15 per encounter for most lab tests
Maternity Care		
• Pregnancy and Maternity Care *(Pre-Natal Care)*	100%	100%
Inpatient Hospital Services		
• Inpatient Hospitalization	80% after deductible	80% after deductible
• Pre-Authorization of Services Required	Yes	Yes
• Semi-Private Room & Board; Including Services and Supplies	80% after deductible	80% after deductible
Surgical Services		
• Outpatient Facility Charge	80% after deductible	80% after deductible
Emergency Services		
• Emergency Room	80% after deductible	80% after deductible
Ambulance		
• Air	$150 copay per trip; after deductible	80% after deductible
• Ground	$150 copay per trip; after deductible	80% after deductible

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Kaiser Plan Comparisons (continued)

	DHMO 500	DHMO 2500 Virtual Complete
Urgent Care		
• Urgent Care Facility	$20 copay; deductible waived	$40 copay after deductible
Mental Health Benefits		
• Inpatient Care	80% after deductible	80% after deductible
• Outpatient Care	$20 copay; deductible waived	$40 per visit for individual and $20 per visit for group treatment
Substance Abuse		
Inpatient Care		
• Inpatient Hospitalization	80% after deductible	80% after deductible
• Inpatient Detoxification Services	80% after deductible	80% after deductible
Outpatient Care		
• Outpatient Services	$20 copay; deductible waived	$40 copay per visit for individual and $5 per visit for group treatment
Prescription Drug Benefits		
• Prescription Drug Deductible	$100 per Member/calendar year	
• Generic	$10 copay; deductible waived	$15 copay, deductible waived
• Brand *(Formulary/Preferred)*	$30 copay; after $100 prescription deductible	$40 copay after deductible
• Number of Days Supply	30 days	30 days
Mail Order		
• Generic	$20 copay; deductible waived	$30 copay; deductible waived
• Brand *(Formulary/Preferred)*	$60 copay; after $100 prescription deductible	$80 copay after deductible
• Number of Days Supply for Mail Order	100 days	100 days

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Kaiser Plan Comparisons (continued)

Kaiser DHMO HSA & HMO MVP

Below are all the REEP HMO/DHMO plan options. All REEP HMO/DHMO plans can add chiropractic coverage with 10% coinsurance after deductible which includes 30 visits/calendar year; provided through American Specialty Health.

	DHMO HSA	HMO MVP
General Plan Information		
• Annual Deductible/Individual	$1,650 medical/prescription combined	$4,500
• Annual Deductible/Family	$3,300 medical/prescription combined	$9,000
• Coinsurance	90%	60%
• Office Visit/Exam	90% after deductible	$50 copay; after deductible
• Outpatient Specialist Visit	90% after deductible	$50 copay; after deductible
• Annual Out-of-Pocket Limit/Individual	$3,000	$6,000
• Annual Out-of-Pocket Limit/Family	$6,000	$12,000
• Deductible Included in Out-of-Pocket Limits	Yes	Yes (except prescription drugs)
• Lifetime Plan Maximum	Unlimited	Unlimited
• Primary Care Physician Election Required	No	No
Outpatient Services		
Preventive Services		
• Well-Child Care	100% through age 23 months	100% through age 23 months
• Immunizations	100%	100%
• Well Woman Exams	100%	100%
• Mammograms	100% for preventive	100% for preventive
• Adult Periodic Exams with Preventive Tests	100%	100%
• Diagnostic X-Ray and Lab Tests	90% after deductible	60% after deductible

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Kaiser Plan Comparisons (continued)

	DHMO HSA	HMO MVP
Maternity Care		
• Pregnancy and Maternity Care *(Pre-Natal Care)*	100%	100%
Inpatient Hospital Services		
• Inpatient Hospitalization	90% after deductible	60% after deductible
• Pre-Authorization of Services Required	Yes	Yes
• Semi-Private Room & Board; Including Services and Supplies	90% after deductible	60% after deductible
Surgical Services		
• Outpatient Facility Charge	90% after deductible	60% after deductible
Emergency Services		
• Emergency Room	90% after deductible	$250 copay; after deductible
Ambulance		
• Air	90% after deductible	60% after deductible
• Ground	90% after deductible	60% after deductible
Urgent Care		
• Urgent Care Facility	90% after deductible	$50 copay; after deductible
Mental Health Benefits		
• Inpatient Care	90% after deductible	60% after deductible
• Outpatient Care	90% after deductible	$50 copay; after deductible
Substance Abuse		
Inpatient Care		
• Inpatient Hospitalization	90% after deductible	60% after deductible

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Kaiser Plan Comparisons (continued)

	DHMO HSA	HMO MVP
• Inpatient Detoxification Services	90% after deductible	60% after deductible
Outpatient Care		
• Outpatient Services	90% after deductible	$50 copay; after deductible
Prescription Drug Benefits		
• Prescription Drug Deductible	$1,650 ind/$3,300 fam; medical/prescription combined	
• Generic	$10 copay; after deductible	$15 copay; deductible waived
• Brand *(Formulary/Preferred)*	$30 copay; after deductible	$35 copay; after prescription deductible
• Number of Days Supply	30 days	30 days
Mail Order		
• Generic	$20 copay; after deductible	$30 copay; deductible waived
• Brand *(Formulary/Preferred)*	$20 copay; after deductible	$70 copay; after prescription deductible
• Number of Days Supply for Mail Order	100 days	100 days
Other Services and Supplies		
• Durable Medical Equipment & Prosthetic Devices	90% after deductible limited to $2,500 calendar year benefit	60% deductible waived
• Home Health Care	100% limited to 100 visits/calendar year	100% limited to 100 visits/calendar year
• Skilled Nursing or Extended Care Facility	90% after deductible; limited to 100 days/benefit period	60% after deductible; limited to 100 days/benefit period
• Hospice Care	100%	100%
• Acupuncture	Not covered	Not covered

The information described on this page is only intended to be a summary of benefits. It does not describe or include all benefit provisions, limitations, exclusions, or qualifications for coverage. Please review plan documents for full details. If there are any conflicts with information provided on this page, the plan documents will prevail.

Dental - Anthem

Anthem

Use the Find Care tool at **anthem.com/ca** to

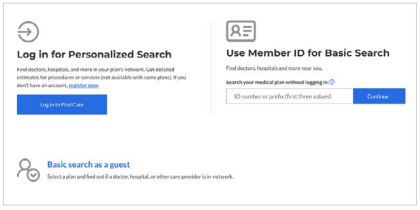
find a Dental Complete provider

Anthem's Find Care tool was created to make it easy to find the care you need. That includes dental care. Use this quick step-by-step guide to help you find the best dental providers where you live and work.

Step 1

Go to **anthem.com/ca/find-care** and select the **Find Care** button located at the top of the page.

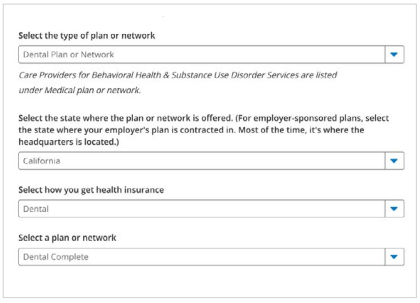
- For guests – Choose **Basic search as a guest**.
- For members – You can either select **Log in for Personalized Search** on the left or you can search without logging in by selecting **Use Member ID for Basic Search** on the right.



Step 2

Scroll down and complete the following fields:

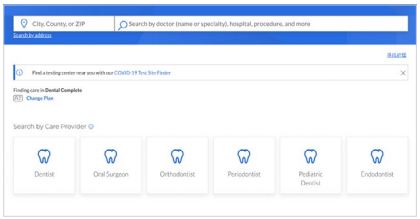
- Select the type of plan or network – Use the drop-down menu to select **Dental Plan or Network**.
- Select the state where the plan or network is located – Use the drop-down menu to select **California**.
- Select how you get health insurance – Use the drop-down menu to select **Dental**.
- Select a plan or network – Use the drop-down menu to select **Dental Complete**.
- Select the **Continue** button.



Step 3

Enter the city, county, or ZIP code in top left. You now have two options to narrow your search:

- Option 1 – Enter a dentist by name or specialty in the search box. The results will appear below the **search box**, where you can select the name for more details about the dentist.
- Option 2 – **Search by Care Provider**. Select the icon of the type of dental provider you're looking for. The results will appear on a new screen, and you can select the dentist's name for additional details.



Step 4

View your search results.

- Choose the printer icon to print the results of your search, or select the email icon to email the search results.
- Select a provider name to see more details.
- Choose the **Back to Find Care** button on the upper left or **Back** button at the bottom the screen to return to your results.

We are here to help

If you have questions, please call Member Services using the phone number listed on the back of your member ID card.

Mobile and online tools help make the most of your dental plan

sydney

Your dental plan includes digital tools and resources to help you learn about the health of your mouth and make dental care decisions that are right for you. These tools are available at no extra cost through our Sydney Health mobile app and anthem.com/ca.

Dental Health Assessment tool

Dental health conditions such as gum disease are common and can lead to more serious issues, including losing a tooth. Good dental habits can help reduce the risk of developing gum disease, tooth decay, and mouth cancer.

The **Dental Health Assessment** tool can help you **understand your own dental health and risk for disease**. To take the assessment, answer a few questions about dental health habits, such as brushing, flossing, and how often you see the dentist. You will receive a personalized report with dental health scores that show how you're doing and areas where you may need to improve. You can bring the report to your next dental appointment and talk with your dentist about the results.

Ask a Hygienist

If you have questions about your dental health, you can **ask them directly** to a licensed hygienist. To do so, log in to the Sydney Health app or anthem.com/ca and select **Ask a Hygienist**. You will receive an email response from a dental professional with expertise in preventing and treating diseases of the mouth, usually within 24 hours. They can help answer questions and offer dental health tips.

Help estimating dental costs in advance

With Anthem's **Find Care** tool, you can search for common dental treatments such as crowns and **compare estimated costs** at providers in your plan's network. This can help you make more informed choices before receiving care and potentially save money.

Discover solutions to help take charge of your dental health

To start using these digital tools, log in to the Sydney Health mobile app or visit anthem.com/ca.

Anthem

Your Summary of Benefits
Plan H
Anthem Dental Complete

WELCOME TO YOUR DENTAL PLAN!
This benefit summary outlines how your dental plan works and provides you with a quick reference of your dental plan benefits. For complete coverage details, please refer to your employee benefits booklet.

Dental coverage you can count on
Your Anthem dental plan lets you visit any licensed dentist or specialist you want – with costs that are normally lower when you choose one within our large network.

Savings beyond your dental plan benefits – you get more for your money.
You pay our negotiated rate for covered services from in-network dentists even if you exceed your annual benefit maximum.

YOUR DENTAL PLAN AT A GLANCE	In-Network	Out-of-Network
Annual Benefit Maximum – (Calendar Year) • Per insured person Annual Maximum Carryover	 $2,500 No	 $2,500 No
Orthodontic Lifetime Benefit Maximum • Per eligible person	Not Covered	Not Covered
Annual Deductible – (Calendar Year) • Per insured person • Family maximum	 $0 3x single member deductible	 $0 3x single member deductible
Deductible Waived for Diagnostic/Preventive Services	Yes	Yes
Out-of-Network Reimbursement	80th percentile	

Dental Services	In-Network Anthem Pays:	Out-of-Network Anthem Pays:	Waiting Period
Diagnostic and Preventive Services • Periodic oral exam • Teeth cleaning (prophylaxis) • Bitewing X-rays (once in 12 mos. for all ages) • Intraoral X-rays	100% coinsurance	100% coinsurance	No waiting period
Basic Services • Amalgam (silver-colored) Filling • Front composite (tooth-colored) Filling • Back Composite Filling, alternated to amalgam allowance • Simple Extractions	90% coinsurance	80% coinsurance	No waiting period
Endodontics • Root canal	90% coinsurance	80% coinsurance	No waiting period
Periodontics • Scaling and root planing	90% coinsurance	80% coinsurance	No waiting period
Oral Surgery • Surgical Extractions	90% coinsurance	80% coinsurance	No waiting period
Major Services • Crowns	60% coinsurance	50% coinsurance	No waiting period
Prosthodontics • Dentures • Bridges • Dental Implants	60% coinsurance	50% coinsurance	No waiting period
Prosthetic Repairs/Adjustments	90% coinsurance	80% coinsurance	No waiting period
Orthodontic Services • Adults and dependent children	Not Covered	Not Covered	N/A
Dental Accident Benefit*	100% coinsurance	100% coinsurance	No waiting period

*Applies to annual benefit maximum
This is not a contract; it is a partial listing of benefits and services. All covered services are subject to the conditions, limitations, exclusions, terms and provisions of your employee benefits booklet. In the event of a discrepancy between the information in this summary and the employee benefits booklet, the booklet will prevail. ABC_PCLG_ASO-Custom

Emergency dental treatment for the international traveler

As an Anthem dental member, you and your eligible, covered dependents automatically have access to the International Emergency Dental Program.** With this program, you may receive emergency dental care from our listing of credentialed dentists while traveling or working nearly anywhere in the world.

** The International Emergency Dental Program is managed by DeCare Dental, which is an independent company offering dental-management services to Anthem Blue Cross. To learn more about the program, please visit the International Emergency Dental Web site at www.decaredental.com/internationalDentalProgram.do.

Finding a dentist is easy.

To select a dentist by name or location, do one of the following:

- Go to anthem.com/ca/mydental
- Call Anthem dental customer service at the toll-free number listed on the back of your ID card.

TO CONTACT US:

Call	Write
Refer to the toll-free number indicated on the back of your plan ID card to speak with a U.S.-based customer service representative during normal business hours. Calling after hours? We may still be able to assist you with our interactive voice-response system.	Refer to the back of your plan ID card for the address.

Limitations & Exclusions

Limitations – Below is a partial listing of dental plan limitations when these services are covered under your plan. Please see your employee benefits booklet for a full list.

Diagnostic and Preventive Services

Oral evaluations (exam) Limited to two per Calendar Year

Teeth cleaning (prophylaxis) Limited to three per Calendar Year

Intraoral X-rays, single film Limited to four films per 12-month period

Complete series X-rays (panoramic or full-mouth) Limited to once every three years

Topical fluoride application Limited to once every 12 months for members through age 18

Sealants Limited to first and second molars once every 60 months per tooth for members through age 13; sealants may be covered under Diagnostic and Preventive or Basic Services.

Basic and/or Major Services

Fillings

Space Maintainers Limited to extracted primary posterior teeth once per lifetime per tooth for members through age 18; space maintainers may be covered under Diagnostic and Preventive or Basic Services.

Crowns Limited to once per tooth in a five-year period

Fixed or removable prosthodontics – dentures, partials, bridges, tooth implants

Covered once in any five-year period; benefits are provided for the replacement of an existing bridge, denture or partial for members age 16 or older if the appliance is five years old or older and cannot be made serviceable.

Root canal therapy Limited to once per 24 months per tooth; coverage is for permanent teeth only.

Periodontal surgery Limited to one complex service per single tooth or quadrant in any 36 months, and only if the pocket depth of the tooth is five millimeters or greater

Periodontal scaling and root planing Limited to once per quadrant in 24 months, when the tooth pocket has a depth of four millimeters or greater

Brush biopsy (Not covered)

ADDITIONAL LIMITATION FOR ORTHODONTIC SERVICES – *if Orthodontia is included as a benefit of your dental plan*

Orthodontia Limited to one course of treatment per member per lifetime

Exclusions – Below is a partial listing of noncovered services under your dental plan. Please see your employee benefits booklet for a full list.

Services provided before or after the term of this coverage Services received before your effective date or after your coverage ends, unless otherwise specified in the dental plan certificate

Orthodontics (unless included as part of your dental plan benefits) Orthodontic braces, appliances and all related services

Cosmetic dentistry Services provided by dentists solely for the purpose of improving the appearance of the tooth when tooth structure and function are satisfactory and no pathologic conditions (cavities) exist

Drugs and medications Intravenous conscious sedation, IV sedation and general anesthesia when performed with nonsurgical dental care

Analgesia, analgesic agents, anxiolysis nitrous oxide, therapeutic drug injections, medicines or drugs for nonsurgical or surgical dental care except that intravenous conscious sedation is eligible as a separate benefit when performed in conjunction with complex surgical services.

The in-network dental providers mentioned in this communication are independently contracted providers who exercise independent professional judgment. They are not agents or employees of Anthem Blue Cross Life and Health Insurance Company.

Dental - Delta Dental

DELTA DENTAL®

Resources at your fingertips

Go online to manage your plan

Whether you need to check your benefits or select a new dentist, you can do it all with Delta Dental's online tools.

Create an account

What you can do:

- Check your plan details and eligibility.
- Browse claim history.
- Download plan documents.
- Find an in-network dentist.
- View your member ID card or print a paper copy.
- Update your settings to go paperless.

Try it out: Go to **deltadentalins.com** and choose **Log in** to create an account or log in to your existing account.

Tip: Access your benefits info on mobile, tablet or desktop!

Find an in-network dentist

What you can do:

- Search by distance, specialty, language spoken, extended office hours, wheelchair accessibility and more.
- Browse Yelp ratings and reviews from real patients, and check out DentaQual scores for an objective quality metric based on actual claims data.

Try it out: Go to **deltadentalins.com**, enter your address or ZIP code and select your network. Not sure which network to choose? Log in to your account first and follow the prompts to find a dentist.

deltadentalins.com/members

Dental - Delta Dental (continued)

Understand your plan

What you can do:

- Browse answers to frequently asked questions.
- Get tips on planning for a dental visit.
- Find claim forms.
- Learn how to go paperless, sign up for a virtual dental visit and coordinate coverage with two or more plans.

Try it out: Visit **deltadentalins.com/members** for useful resources and tips.

Explore dental wellness

What you can do:

- Browse articles on everything from acid reflux to xylitol.
- Find delicious recipes for healthy meals.
- Check out videos on preventive care and common procedures.

Try it out: Visit **deltadentalins.com/wellness** to start learning.

Download the app

What you can do:

- Check your plan details and eligibility.
- Browse claim history.
- View your member ID card.
- Get a cost estimate.
- Find an in-network dentist.

Try it out: Search for Delta Dental in the App Store or Google Play.

Tip: Don't need another app? Just visit **deltadentalins.com** on your smartphone or tablet and log in to your account.

Our Delta Dental enterprise includes these companies in these states: Delta Dental of California — CA, Delta Dental of the District of Columbia — DC, Delta Dental of Pennsylvania — PA & MD, Delta Dental of West Virginia, Inc. — WV, Delta Dental of Delaware, Inc. — DE, Delta Dental of New York, Inc. — NY, Delta Dental Insurance Company — AL, DC, FL, GA, LA, MS, MT, NV, TX and UT.

Benefit Highlights: Delta Dental PPO ™

Plan Benefit Highlights for: Murrieta Valley Unified School District
(Certificated & Classified, Self-Paid Retirees, District Paid Retirees & COBRA)

Group No: 07100 - 07155, 07555, 07755 & 09155

Eligibility	For eligibility details, refer to the plan's Evidence/Certificate of Coverage (on file with your benefits administrator, plan sponsor or employer).			
Deductibles	**Delta Dental PPO dentists:** None **Non-Delta Dental PPO dentists:** $25 per person / $75 per family each calendar year			
Deductibles waived for Diagnostic & Preventive (D & P)?	**Delta Dental PPO dentists:** N/A **Non-Delta Dental PPO dentists:** No			
Deductible waived for Orthodontics?	**Delta Dental PPO dentists:** N/A **Non-Delta Dental PPO dentists:** Yes			
Maximums* **	**Delta Dental PPO dentists:** $3,000 per person each calendar year **Non-Delta Dental PPO dentists:** $1,000 per person each calendar year			
D & P counts toward maximum?	Yes			
Waiting Period(s)	Basic Services None	Major Services None	Prosthodontics None	Orthodontics None

Benefits and Covered Services*	**Delta Dental PPO dentists****	**Non-Delta Dental PPO dentists****
Diagnostic & Preventive Services (D & P) Exams, (2) cleanings and x-rays	100 %	50 %
Basic Services Fillings, posterior composites, sealants and bleaching	100 %	50 %
Endodontics (root canals) Covered Under Basic Services	100 %	50 %
Periodontics (gum treatment) Covered Under Basic Services	100 %	50 %
Oral Surgery Covered Under Basic Services	100 %	50 %
Major Services Crowns, onlays and cast restorations	100 %	50 %
Prosthodontics Bridges, dentures and implants	50 %	50 %
Implant Maximums	$1,500 Calendar Year	$1,500 Calendar Year
Orthodontic Benefits Adults and dependent children	100 %	100 %
Orthodontic Maximums	$2,500 Lifetime	$2,500 Lifetime
Occlusal Guard Benefits	50 %	50 %
Occlusal Guard Maximums	$500 Lifetime	$500 Lifetime
Dental Accident Benefits	100 % (Separate $1,000 maximum per person each calendar year)	

* Limitations or waiting periods may apply for some benefits; some services may be excluded from your plan. Reimbursement is based on Delta Dental maximum contract allowances and not necessarily each dentist's submitted fees.

** Reimbursement is based on PPO contracted fees for PPO dentists, Premier contracted fees for Premier dentists and program allowance for non-Delta Dental dentists.

*** Please refer to your employer EOC for details on Calendar Year Maximum Rollover provisions.

Delta Dental of California	**Customer Service**	**Claims Address**
560 Mission St., Suite 1300 San Francisco, CA 94105	866-499-3001	P.O. Box 997330 Sacramento, CA 95899-7330

deltadentalins.com

This benefit information is not intended or designed to replace or serve as the plan's Evidence of Coverage or Summary Plan Description. If you have specific questions regarding the benefits, limitations or exclusions for your plan, please consult your company's benefits representative.

Benefit Highlights: Delta Dental PPO ™

Plan Benefit Highlights for: Murrieta Valley Unified School District
(Certificated & Classified, Self-Paid Retirees, District Paid Retirees & COBRA)
Group No: 07100 - 07055, 07455, 07655 & 09055

In this incentive plan, 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, there will be a 10% decrease from the level attained the previous year. If an enrollee becomes ineligible for benefits and later regains eligibility, the percentage will drop back to 70%.

Eligibility	For eligibility details, refer to the plan's Evidence/Certificate of Coverage (on file with your benefits administrator, plan sponsor or employer).			
Deductibles	None			
Maximums* **	**Delta Dental PPO dentists:** $1,200 per person each calendar year **Non-Delta Dental PPO dentists:** $1,000 per person each calendar year			
D & P counts toward maximum?	Yes			
Waiting Period(s)	Basic Services None	Major Services None	Prosthodontics None	Orthodontics None

Benefits and Covered Services*	**Delta Dental PPO dentists****	**Non-Delta Dental PPO dentists****
Diagnostic & Preventive Services (D & P) Exams, (2) cleanings and x-rays	70 - 100 %	70 - 100 %
Basic Services Fillings, posterior composites, sealants and bleaching	70 - 100 %	70 - 100 %
Endodontics (root canals) Covered Under Basic Services	70 - 100 %	70 - 100 %
Periodontics (gum treatment) Covered Under Basic Services	70 - 100 %	70 - 100 %
Oral Surgery Covered Under Basic Services	70 - 100 %	70 - 100 %
Major Services Crowns, onlays and cast restorations	70 - 100 %	70 - 100 %
Prosthodontics Bridges, dentures and implants	50 %	50 %
Implant Maximums	$1,500 Calendar Year	$1,500 Calendar Year
Orthodontic Benefits Adults and dependent children	75 %	75 %
Orthodontic Maximums	$2,750 Lifetime	$2,750 Lifetime
Occlusal Guard Benefits	50 %	50 %
Occlusal Guard Maximums	$500 Lifetime	$500 Lifetime
Dental Accident Benefits	100 % (Separate $1,000 maximum per person each calendar year)	

* Limitations or waiting periods may apply for some benefits; some services may be excluded from your plan. 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 program allowance for non-Delta Dental dentists.

*** Please refer to your employer EOC for details on Calendar Year Maximum Rollover provisions.

Delta Dental of California	**Customer Service**	**Claims Address**
560 Mission St., Suite 1300 San Francisco, CA 94105	866-499-3001	P.O. Box 997330 Sacramento, CA 95899-7330

deltadentalins.com

Vision - EyeMed

EXPERIENCE MORE: EVERYDAY ACCESS

HOW TO: see an easy road ahead

USING YOUR EYEMED BENEFITS

It's official – you received your EyeMed Welcome Kit. Time to get the eyewear you love! But how does it work? Even if you're a vision benefits rookie, the process is a snap. Tailor-made for paperwork-phobes and freedom fans.

1. KNOW THE BENEFITS

Your Welcome Kit spells out all the great stuff that's covered. All the savings opportunities. All the choices you have. It's a pretty fun read.

2. CHOOSE A DOC

You're probably surrounded by in-network doctors: thousands of independent providers, popular retail stores and even online options. Find your ideal fit on eyemed.com or on the EyeMed Members App.

3. SET A DATE

Just call your eye doctor for an appointment. Even better, some let you schedule online with our Provider Locator. If you need weekend or evening hours, you'll find plenty of those, too.

4. COME ON IN

As an EyeMed member, it's easy to get your eye exam and get on with your day. No claim to file. No hassles. We take it from here.

5. FIND YOUR PERFECTION

Have fun picking out your favorite frames or contacts. Browse loads of designer brands; you decide which price point works best for you. With EyeMed, there's more in the store to adore.

* At select in-network providers

SEE THE GOOD STUFF

Register on eyemed.com or grab the member app (App Store or Google Play) now.

INDEPENDENT PROVIDER NETWORK + LENSCRAFTERS PEARLE VISION OPTICAL sears OPTICAL

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Vision - EyeMed (continued)

EXPERIENCE MORE: MOBILE ACCESS

HOW TO: mobilize your vision plan

EYEMED MEMBERS APP

Our member app was the first of its kind. But innovation – like your life – never stops. The EyeMed Members App is packed with ahead-of-the-game resources wherever you are. Before, during and after your eye appointment.

Get the latest EyeMed Members App:

1. **DOWNLOAD** – Search "EyeMed Members" in your App store, iTunes or Google Play.
2. **OPEN** – You can use some features right away; others unlock once you register.
3. **REGISTER** – You'll need your member ID or the last four digits of your social security number.
4. **LOG IN** – If you've already registered on eyemed.com, you can log onto the app the same way.

	Ready when you download	Unlocked when you register
Find nearby network providers	●	
On-the-fly appointment scheduling	●	
Turn by turn directions and map	●	
Eye exam and contact lens reminders		●
Electronic ID card for office visits		●
Save vision prescriptions*		●
Benefit plan details		●
Answers to common questions	●	
Special offers and discounts		●
Direct line to EyeMed support	●	

SEE THE GOOD STUFF

Register on eyemed.com or grab the member app (App Store or Google Play) now.

** Take a picture of your prescription and store it in your app. No need to type in the numbers.*

INDEPENDENT PROVIDER NETWORK + LENSCRAFTERS PEARLE VISION TARGET OPTICAL sears OPTICAL

PDF-1801-M-13S

Benefit Highlights: Delta Dental PPO ™

Plan Benefit Highlights for: Murrieta Valley Unified School District
(Certificated & Classified, Self-Paid Retirees, District Paid Retirees & COBRA)
Group No: 07100 - 07055, 07455, 07655 & 09055

In this incentive plan, 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, there will be a 10% decrease from the level attained the previous year. If an enrollee becomes ineligible for benefits and later regains eligibility, the percentage will drop back to 70%.

Eligibility	For eligibility details, refer to the plan's Evidence/Certificate of Coverage (on file with your benefits administrator, plan sponsor or employer).			
Deductibles	None			
Maximums* **	**Delta Dental PPO dentists:** $1,200 per person each calendar year **Non-Delta Dental PPO dentists:** $1,000 per person each calendar year			
D & P counts toward maximum?	Yes			
Waiting Period(s)	Basic Services None	Major Services None	Prosthodontics None	Orthodontics None

Benefits and Covered Services*	**Delta Dental PPO dentists****	**Non-Delta Dental PPO dentists****
Diagnostic & Preventive Services (D & P) Exams, (2) cleanings and x-rays	70 - 100 %	70 - 100 %
Basic Services Fillings, posterior composites, sealants and bleaching	70 - 100 %	70 - 100 %
Endodontics (root canals) Covered Under Basic Services	70 - 100 %	70 - 100 %
Periodontics (gum treatment) Covered Under Basic Services	70 - 100 %	70 - 100 %
Oral Surgery Covered Under Basic Services	70 - 100 %	70 - 100 %
Major Services Crowns, onlays and cast restorations	70 - 100 %	70 - 100 %
Prosthodontics Bridges, dentures and implants	50 %	50 %
Implant Maximums	$1,500 Calendar Year	$1,500 Calendar Year
Orthodontic Benefits Adults and dependent children	75 %	75 %
Orthodontic Maximums	$2,750 Lifetime	$2,750 Lifetime
Occlusal Guard Benefits	50 %	50 %
Occlusal Guard Maximums	$500 Lifetime	$500 Lifetime
Dental Accident Benefits	100 % (Separate $1,000 maximum per person each calendar year)	

* Limitations or waiting periods may apply for some benefits; some services may be excluded from your plan. Reimbursement is based on Delta Dental contract allowances and not necessarily each dentist's actual fees.

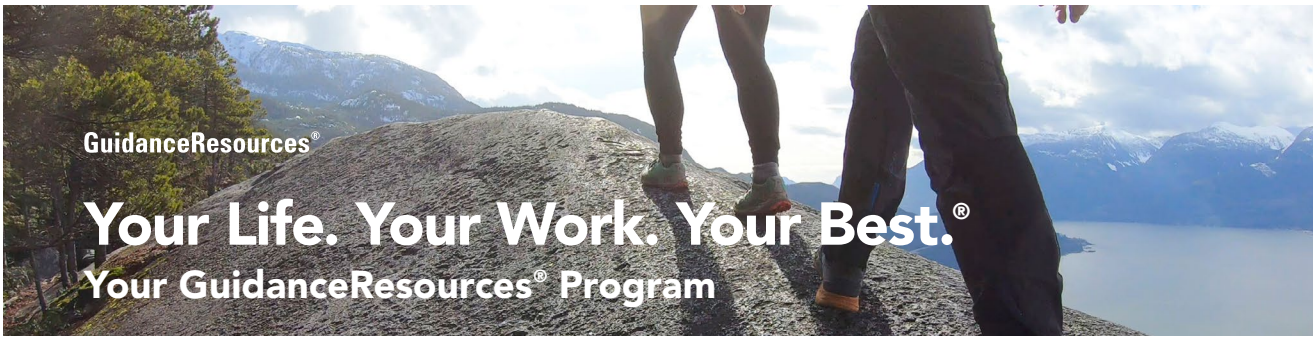
** Reimbursement is based on PPO contracted fees for PPO dentists, Premier contracted fees for Premier dentists and program allowance for non-Delta Dental dentists.

*** Please refer to your employer EOC for details on Calendar Year Maximum Rollover provisions.

Delta Dental of California	**Customer Service**	**Claims Address**
560 Mission St., Suite 1300 San Francisco, CA 94105	866-499-3001	P.O. Box 997330 Sacramento, CA 95899-7330

deltadentalins.com

Employee Assistance Programs (EAP)



Sometimes life can feel overwhelming. It doesn't have to. Your ComPsych® GuidanceResources® program provides confidential counseling, expert guidance and valuable resources to help you handle any of life's challenges, big or small.

Life is challenging. We can help. Confidential 24/7 support.

Services:

Confidential Emotional Support
- Anxiety, depression, stress
- Grief, loss and life adjustments
- Relationship/marital conflicts

Work and Lifestyle Support
- Child, elder and pet care
- Moving and relocation
- Shelter and government assistance

Legal Guidance
- Divorce, adoption and family law
- Wills, trusts and estate planning
- Free consultation and discounted local representation

Financial Resources
- Retirement planning, taxes
- Relocation, mortgages, insurance
- Budgeting, debt, bankruptcy and more

Digital Support
- Connect to counseling, work-life support or other services
- Tap into an array of articles, podcasts, videos, slideshows
- Improve your skills with On-Demand trainings

Interactive Digital Tools
- Self-care platform offers guided health programs
- Tackle anxiety, depression, stress
- Improve mindfulness, sleep, and more

Wellness Support
- Make positive lifestyle changes with health coaching
- Improve your nutrition, exercise habits, weight loss efforts
- Get help with smoking cessation, back care, resiliency and more

COMPSYCH® GuidanceResources® Worldwide

Coming Soon!
July 1, 2025

24/7 Live Assistance Online or by Phone

REEP Wellness

REEP Wellness Program Overview 2025-2026

Participate in the 2025/26 REEP Wellness Program to Incentivize and Optimize Your Health!

REEP continues to offer a streamlined program with wellness offerings for both Anthem Blue Cross and Kaiser Permanente medical plan members this year.

2025/26 REEP Wellness Program Overview

REEP continues to offer digital lifestyle change programs that focus on pre-diabetes, pre-hypertension, diabetes, hypertension and joint and muscle health management provided through **Omada Health**.

- REEP will cover the entire cost of the program if you or your spouse, domestic partner, or adult dependent aged 18 and older are enrolled in a REEP Anthem Blue Cross or Kaiser Permanente medical plan, and apply, qualify, and meet the eligibility requirements.
- All eligible REEP employee members who enroll in a REEP Omada Health diabetes, hypertension, or joint and muscle condition management program are eligible for a **$150 e-gift card**.*
- All eligible REEP employee members who apply will be entered into a monthly **$100 e-gift card** drawing sponsored by REEP. 3 winners are randomly selected each month.
- All Omada program participants will receive free smart devices such as a wireless smart scale, cellular glucometer, cellular blood pressure monitor, glucose monitors, or a MSK kit.*
- ***Please refer to the Omada program flyers for more information.***

Two (2) **online wellness challenges** provided through Health Enhancement Systems (HES) to motivate healthy behaviors across all REEP Anthem Blue Cross and Kaiser Permanente medical plan members.

- Incentives will be provided to promote member enrollment and engagement.
- Incentivized participation competitions will be held among school districts.
- Wellness program coordinators will determine the challenge themes.

We are accepting applications for those interested in the **REEP Wellness Program District Coordinators Group**. The group provides coordinators with more involvement in making decisions for the wellness program offerings. Interested? Contact Vanessa Torres, at vtorres@keenan.com.

Anthem BlueCross omada KAISER PERMANENTE KeenanWell

omada®

REEP Wellness

Access a health program built just for you

REEP is offering Omada® to help members manage diabetes and lower blood pressure with one-on-one personal coaching and the tools needed to make long-lasting health changes.

The best part: the program is no cost to you if you're eligible to join.

Omada helps members

- **See smart device readings in the Omada app after each use**
- **Eat healthier without counting calories or cutting out favorite foods**
- **Get up and move—yes, solo dance parties totally count**

Join Omada for access to

- One-on-one support from a health coach
- Easy monitoring with smart devices and tools
- Expert guidance from a clinical specialist

All Omada members receive a welcome kit*

With easy-to-use devices, based on your needs, shipped to your door and yours to keep. All at no cost to you.

- Two continuous glucose monitor sensors (CGMs)†
- Blood glucose meter
- Blood pressure monitor
- Ongoing supply of test strips and lancets
- Smart scale

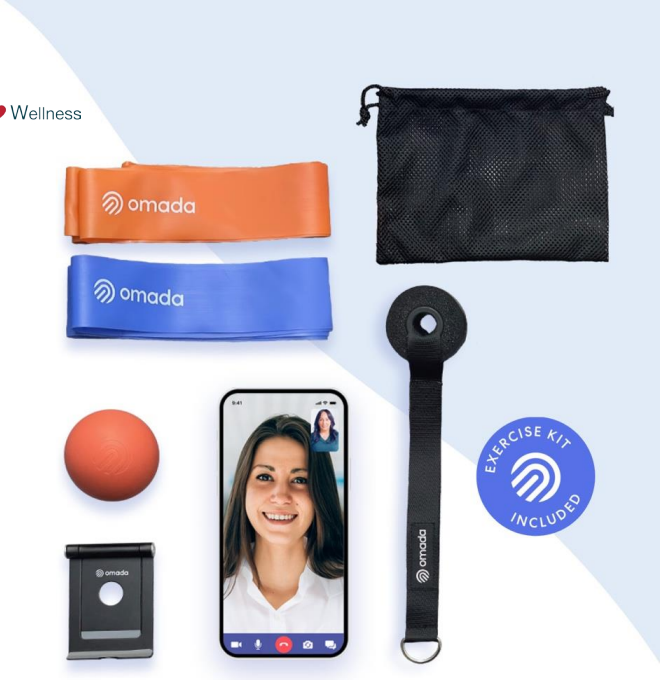
Claim my welcome kit:
omadahealth.com/reep

REEP will cover the entire cost of the program if you or your spouse, domestic partner, or adult dependent aged 18 and older are enrolled in a REEP Anthem Blue Cross or Kaiser Permanente medical plan, and apply, qualify, and meet the eligibility requirements.

*Certain features and smart devices are only available if you meet program and clinical eligibility requirements.
†The no cost CGM excludes Medicare, Medicaid, and other government payers. The Abbott FreeStyle Libre 14 day system is available to eligible participants with a valid prescription and compatible smartphone. Setup is required for continuous glucose monitoring. The circular shape of the sensor housing, FreeStyle, Libre, and related brand marks are marks of Abbott. FreeStyle Libre 14 day system: Failure to use FreeStyle Libre 14 day system as instructed in labeling may result in missing a severe low or high glucose event and/or making a treatment decision, resulting in injury. If readings do not match symptoms or expectations, use a finger stick value from a blood glucose meter for treatment decisions. Seek medical attention when appropriate or contact Abbott at 855-632-8658 or FreeStyleLibre.us for safety info.
Images, including apps, do not reflect real members or information about a specific person.

omada for Joint & Muscle Health

REEP Wellness



Live life without pain

Thanks to REEP, you have access to a virtual physical therapy program.

Sign up for Omada for Joint & Muscle Health® and **meet your physical therapist as early as tomorrow**—all from your smartphone or tablet.*

What's included in your benefit:†

- Dedicated licensed physical therapist
- Unlimited video visits
- Customized care plan
- App-based tools like virtual form detection
- Exercise kit with resistance bands

Specialized programs


Chronic Pain


Women's Health


Ergonomics


Surgery Navigation


Work Conditioning

"Virtual visits were more convenient and less stressful than taking time off work."

- Betsy, Omada member

Claim your benefit at:
msk.omadahealth.com/reep

REEP will cover the entire cost of the program if you or your spouse, domestic partner, or adult dependent aged 18 and older are enrolled in a REEP Anthem Blue Cross or Kaiser Permanente medical plan, and apply, qualify, and meet the eligibility requirements.

*Your home state may require a referral from a physician. Omada can facilitate this with a video visit with a physician, but this may delay your initial physical therapy consultation. Requirement of video referral in limited jurisdictions may delay time to meet a physical therapist.

†The program features described are specific to the Recovery and Women's Health versions of Omada® for Joint & Muscle Health®. Members not experiencing a relevant injury or musculoskeletal condition may instead receive a preventive version of the program, which includes different features and does not include a physical therapist.

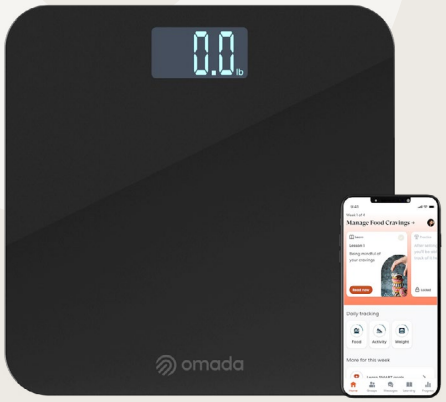
Testimonials are based on the member's real experiences and individual results. Results may vary based on individual and demographic factors. We do not claim that these are typical results that members will generally achieve.

App images are fictionalized samples and do not reflect information about a specific person.

Physical therapy is only available in states where it is allowed by law.

omada

REEP Wellness



Access a health program built just for you

REEP is offering Omada® to help members lose weight with one-on-one personal coaching and the tools needed to make long-lasting health changes.

The best part: the program—is no cost to you if you're eligible to join.

Omada helps members

- **See smart scale readings in the Omada app after each use**
- **Eat healthier without counting calories or cutting out favorite foods**
- **Get up and move—yes, solo dance parties totally count**

Join Omada for access to

- One-on-one support from a health coach
- Easy monitoring with a smart scale and tools

All Omada members receive a welcome kit

With easy-to-use devices, based on your needs, shipped to your door and yours to keep. All at no cost to you.

- Readings sync automatically
- See how habit changes can impact weight over time
- Get a personalized plan based on progress

Claim my welcome kit:
omadahealth.com/reep

REEP will cover the entire cost of the program if you or your spouse, domestic partner, or adult dependent aged 18 and older are enrolled in a REEP Anthem Blue Cross or Kaiser Permanente medical plan, and apply, qualify, and meet the eligibility requirements.

Images, including apps, do not reflect real members or information about a specific person.

REEP for Benefits

Members, activate your free account today!

You get exclusive access to:

- **The Financial Roadmap:** Simplicollege's proprietary approach to get the biggest return on investment for college.
- **Help with every part of the college process:** Choosing a career, finding a college, paying for school, getting in, and getting the most from the college experience.
- **Exclusive access** to the College Budget Calculator, The College Checkup, and The Career Factors for Students.
- Schools that use SimpliCollege for their employees also get **free accounts** to give to all of their students and families!

Why that matters to you:

- **$500+ billion** spent on college expenses annually
- **40% of students** do not graduate
- **43 million** parents & students paying off college debt
- **5 1/2 years** average time to graduate with a 4-year degree
- **$130+ billion** of new debt created each year
- **1 of 3 students** transfer or drop out within 24 months
- **$1.7 trillion** total college debt nationwide
- **3 times** average student changes their major

What can SimpliCollege do for your family?

- Reduce stress and anxiety
- Provide strategies for lowering the cost of college
- Help you make confident decisions
- How to choose a college & a major
- Help prevent costly mistakes
- Help find grants & scholarships
- Teach you how to appeal for additional financial aid
- And much more!

simplicollege

SimpliCollege will simplify your college journey.

Be Clear

Get rid of the confusion that comes with planning for college and have clarity in what steps you need to take next.

Be Confident

Rest knowing that you're making the best financial decisions for your student's future, saving more, and stressing less.

Be Proud

You can be excited for the future! Celebrate your success instead of being overwhelmed by anxiety and stress.

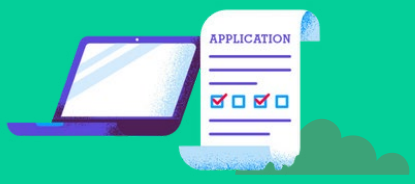
YOUR COLLEGE JOURNEY simplified

Lower the cost of college

We've uncovered the most effective strategies to help you lower the cost of college. Explore what options you have to pay for an education and how to make it an affordable decision for your family.

Make confident decisions

We're here to arm you with the tools and resources you need to make the best decisions for your future. You will make confident choices, knowing that you have the best information available today.



Stress Less

Sending a child to college doesn't have to be overwhelming, complex, and time consuming. We simplify the process, providing all the tools you need in one place so your journey is clearly defined and easy to navigate.

simplicollege

Colonial Life
The benefits of good hard work.

REEP for Benefits

How Do I Enroll?

A Colonial Life Advisor will assist you via a screen share enrollment which requires access to a computer and Internet.

Prepare for your appointment:

Be sure to bring social security numbers and dates of birth for any dependents that will be covered.

Click or Scan the QR code to schedule an appointment.

35 YEARS • 1989-2024
MURRIETA VALLEY
UNIFIED SCHOOL DISTRICT

Click the icon to the right to watch a short video on the claims process. The URL at the bottom of the page takes you to the Policy Holder website.

GROUP MEDICAL BRIDGE

Pays cash amounts to help with the non-covered expenses of a hospital stay.

www.ColonialLife.com/individuals

Madison National Life

Madison National Life has been selected to provide life insurance to our employees. This change in carrier will take place on July 1, 2025. The essential benefits of your coverage will automatically transfer to Madison National Life. There is no need to complete new enrollment forms.

In the event of your death, Life Insurance will provide your family members or other beneficiaries with financial protection and security. Additionally, if your death is a result of an accident or if you become dismembered, your Accidental Death & Dismemberment (AD&D) coverage may apply.

Basic Life & Accidental Death & Dismemberment (AD&D)

District paid benefit to cover each eligible employee with this term group life and AD&D insurance. Madison National Life underwrites this insurance policy.

The Accidental Death & Dismemberment (AD&D), included in the Basic Life plan, is available to you even if you already have accident insurance. It provides benefits beyond your disability or life insurance for losses due to covered accidents — while commuting, traveling by public or private transportation and during business trips.

Voluntary Life & Voluntary Accidental Death & Dismemberment

If you would like to supplement your employer paid insurance, additional Life coverage for you and/or your dependents is available for purchase through Madison National Life. Premiums will be deducted from employee's paycheck. Enrollments can be made using the BenefitBridge platform. Evidence of Insurability (EOI) may be required for newly elected amounts of coverage.

Select Your Beneficiary

Beneficiaries are individuals or entities that you select to receive benefits from your policy.

- **You can change your beneficiary designation at any time.**
- **You may designate a sole beneficiary or multiple beneficiaries to receive payment in the amount you specify.**
- **Make any changes via Benefit Bridge.**

MetLife | Pet Insurance

Happy pets, means happy pet parents.

MetLife Pet is here to help keep your BFFs happy and healthy.

MetLife Pet Insurance can help cover the cost of unexpected accidents and illnesses and routine care. Help protect your pet's health and your wallet.

- The freedom to visit any U.S. licensed veterinarian
- Flexible plans with no breed exclusions
- Covered exam fees for accidents and illnesses
- Optional Preventive Care coverage for wellness needs
- Savings up to 30%[1]
- 24/7 live vet chat[2]

Get a quote today.

Visit metlife.com/getpetquote

or scan the QR code

Enter or say "REEP" as your employer.

Call **1-800-GET-MET8.**

1. When using multiple discounts, discounts cannot exceed 30%. Each discount may not be available in all states. Please contact MetLife Pet for further details.
2. Virtual veterinary services are available through the MetLife Pet app and are provided entirely by AskVet, a third-party partner; MetLife is not responsible for any pet guidance or advice provided or taken. Veterinarians providing virtual veterinary services cannot prescribe medication or answer questions about the pet policy.

Coverage issued by Metropolitan General Insurance Company, a Rhode Island insurance company headquartered at 700 Quaker Lane, Warwick, RI 02886. Availability is subject to regulatory approval. Coverage subject to restrictions, exclusions and limitations and application is subject to underwriting. See policy or contact MetLife Pet Insurance Solutions LLC ("MetLife Pet") for details. MetLife Pet is the policy administrator. It may operate under an alternate or fictitious name in certain jurisdictions, including MetLife Pet Insurance Services LLC (New York and Minnesota) and MetLife Pet Insurance Solutions Agency LLC (Illinois).

MetLife | Pet Insurance

REEP for Benefits

Enroll All Year Round

FOR REEP MEMBERS :

Help protect your BFF with discounted pet insurance[1]

Are you a current or future pet parent?
If so, check out this great benefit for REEP members.

MetLife Pet Insurance helps protect your pet's health and your wallet

- **Discounts of up to 30%**[1]
- **Up to 90% coverage** if your pet becomes sick or injured[2]
- **Optional Preventive Care coverage** for routine wellness
- Freedom to visit any licensed vet in the U.S.
- Multiple pets can be covered on the same policy[3]
- No breed exclusions or upper age limits[4]

Plus, if you already have pet insurance, any pre-existing conditions that were covered by your previous pet insurance provider will be covered by MetLife Pet Insurance, too![5]

You can enroll in Pet Insurance through REEP at MetLife all year round!

Visit metlife.com/getpetquote
Or call **855-698-6134**
Enter or say "REEP" as your employer.

[1] Must be eligible for applicable discount. When using multiple discounts, discounts cannot exceed 30%. Each discount may not be available in all states. Please contact MetLife Pet for further details.
[2] Reimbursement options include: 50%, 70%, 80% and 90%. Pet age restrictions may apply.
[3] Family plan policies are limited to dogs age 12 and under and cats age 14 and under. Multi-policy discount is not available with Family Plans.
[4] Coverage options may be limited for certain ages.
[5] Applies to individuals that have purchased MetLife pet insurance as part of an employer group benefit offering.

Pet Insurance coverage issued by Metropolitan General Insurance Company, a Rhode Island insurance company headquartered at 700 Quaker Lane, Warwick, RI 02886. Availability is subject to regulatory approval. Coverage subject to restrictions, exclusions and limitations and application is subject to underwriting. See policy or contact MetLife Pet Insurance Solutions LLC ("MetLife Pet") for details. MetLife Pet is the policy administrator. It may operate under an alternate or fictitious name in certain jurisdictions, including MetLife Pet Insurance Services LLC (New York and Minnesota) and MetLife Pet Insurance Solutions Agency LLC (Illinois).

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ID Theft

24/7 Peace of Mind

ID Theft Protector offers unlimited identity theft restoration services for you and your family to help easily recover from identity theft.

24/7 "real time" access to credit bureau records allow specially trained and certified fraud resolution specialists to identify the crime, respond quickly to stop additional damage, remove fraudulent activity from the victim's name and regain control of your credit history.

With ID Theft Protector, resolution services happen much more quickly than with competitive programs. Whenever and wherever a victim's identity is stolen, ID Theft Protector begins to make it better right away - with only one call to our 24/7 emergency assistance center.

Backed by Industry Leaders

ID Theft Protector is backed by industry leaders to help 24/7 at home or when you are traveling. The product is backed by two of the largest and most experienced companies of their type in the identity protection business: CLC, Incorporated, who provides Legal, Financial and Identity Theft protection services to over 27 million households and over 25,000 corporations, and Trans Union/True Credit, a leading provider of business intelligence, consumer information and Web-based services helping consumers prevent and resolve credit fraud and identity theft issues, supported by more than 3,600 employees in 25 countries worldwide.

$1,000,000 Cash Asset and Expense Reimbursement

Unlimited restoration and up to $1,000,000 in identity theft insurance with a zero deductible for unauthorized electronic funds transfers from personal checking and savings accounts as well as certain fraud-related expenses, such as lost wages, reasonable attorney's fees (appointed by the insurance company) along with other out-of-pocket expenses that are related to the recovery of your identity. To establish eligibility you must enroll in Identity Theft Monitoring.

Key Service Features

Instant Alerts
Get immediate alerts of questionable activity

Quick Response
Experts will work to assess any situation 24/7

Quick Restore
Your identity is restored in record time

Quick Relief
Get life back to normal as soon as possible

For any product-related questions, please contact your Account Executive or Benefits Administrator!

If you are already a member of ID Theft Protector powered by ID Theft Assist and have any activation questions or suspect your identity is compromised in any way, immediately call 1-866-262-5844.

Keenan & Associates
CA License No. 0451271

American Fidelity Flexible Spending Accounts (FSA)

Medical FSA and Dependent Care FSA will require you to complete your enrollment for the new plan year – **even if you are electing the same dollar amount, you must re-enroll in the FSA each year**. To do this, you will need to schedule an in-person or virtual meetings by calling American Fidelity 800-365-9180.

Important Reminders

1. Governmental regulations require all employees carry medical insurance. Therefore, any employee who declines group medical insurance **MUST** denote on ***BenefitBridge*** that you are waiving medical insurance, electing not to enroll in the plan(s) offered by the district.
2. Once you make your plan elections, you cannot change to a different plan until the next open enrollment period without a qualifying event. A loss or change of provider is not considered a qualifying event. If your physician is no longer an eligible provider for the plan you have chosen, you must choose a new participating provider, or the carrier will select one on your behalf.
3. Eligible dependents include your spouse, registered domestic partner, and your children up to their 26th birthday (or your dependent child(ren) of any age who is totally disabled prior to age 26). This includes natural children, step-children, adopted children and children for whom you are a court appointed guardian. This also includes any child for whom you are required to provide coverage under a Qualified Medical Child Support Order (QMCSD).

Medical - Anthem

Find a doctor online

We believe that finding a doctor online is one of the top reasons many of you visit our website. That's why we keep working on our Find a Doctor tool to make it better. Here's how you can get information about doctors in your area.

1. Go to http://www.anthem.com/ca
2. Click on Find Care
3. Click on BASIC SEARCH AS A GUEST
4. Under SELECT THE TYPE OF PLAN OR NETWORK, select MEDICAL PLAN OR NETWORK
5. Under SELECT THE STATE WHERE THE PLAN OR NETWORK IS OFFERED, select CALIFORNIA
6. Under SELECT HOW YOU GET HEALTH INSURANCE, select MEDICAL - EMPLOYER-SPONSORED

    A. **California Members** - Under SELECT A PLAN OR NETWORK:

        1) **HMO Full Network:** Select Blue Cross HMO (CACARE) – Large Group
        2) **Select or Priority Select HMO Network:** Select Select HMO or Priority Select HMO
        3) **PPO and Anthem PPO HSA-California:** Select Blue Cross PPO (Prudent Buyer) – Large Group

    B. **Non-California Members** – Select a Non-California State.

        1) **PPO/Anthem PPO HSA/Lumenos HSA-Non-California:** Select National PPO (Blue Card PPO)

7. Click CONTINUE
8. Next, Enter the CITY, COUNTY or ZIP
9. Next, choose who you like to see. You can search for a doctor nearby or use the doctors name
10. Next, select a provider to see more details

    ***Primary Medical Group/Primary Care Physician code is located under PCP ID/ENROLLMENT ID. Code is either a 3 or 6 digit code**

Anthem

The Sydney Health mobile app makes healthcare easier

Access personalized health and wellness information wherever you are

Use Sydney℠ Health to keep track of your health and benefits — all in one place. With a few taps, you can quickly access your plan details, Member Services, virtual care, and wellness resources. Sydney Health stays one step ahead — moving your health forward by building a world of wellness around you.

Find Care

Search for doctors, hospitals, and other healthcare professionals in your plan's network and compare costs. You can filter providers by what is most important to you, such as gender, languages spoken, or location. You'll be matched with the best results based on your personal needs.

My Health Dashboard

Use My Health Dashboard to find news on health topics that interest you, health and wellness tips, and personalized action plans that can help you reach your goals. It also offers a customized experience just for you, such as syncing your fitness tracker and scanning and tracking your meals.

Chat

If you have questions about your benefits or need information, Sydney Health can help you quickly find what you're looking for and connect you to an Anthem representative.

Virtual Care

Connect directly to care from the convenience of home. Assess your symptoms quickly using the Symptom Checker or talk to a doctor via chat or video session.

Community Resources

This resource center helps you connect with organizations offering no-cost and reduced-cost programs to help with challenges such as food, transportation, and child care.

My Health Records

See a full picture of your family's health in one secure place. Use a single profile to view, download, and share information such as health histories and electronic medical records directly from your smartphone or computer.

¿Prefieres obtener información en español?

Tienes opciones. Si tu teléfono móvil ya está configurado en español, la aplicación Sydney Health también estará en español. Si no es así, selecciona el **menú** dentro de la aplicación Sydney Health y elige **el idioma de la aplicación**. También puedes visitar anthem.com/es/ca.

Download the Sydney Health app today

Use the app anytime to:

- Find care and compare costs.
- See what's covered and check claims.
- View and use digital ID cards.
- Check your plan progress.
- Fill prescriptions.

Scan the QR code to download the Sydney Health app.

You can also set up an account at anthem.com/ca/register to access most of the same features from your computer.

In addition to using a telehealth service, you can receive in-person or virtual care from your own doctor or another healthcare provider in your plan's network. If you receive care from a doctor or healthcare provider not in your plan's network, your share of the costs may be higher. You may also receive a bill for any charges not covered by your health plan.

Sydney Health is offered through an arrangement with Carelon Digital Platforms, a separate company offering mobile application services on behalf of your health plan. ©2024 The Virtual Primary Care experience is offered through an arrangement with Hydrogen Health.

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Anthem

Receive virtual care and support 24/7 with our Sydney Health app

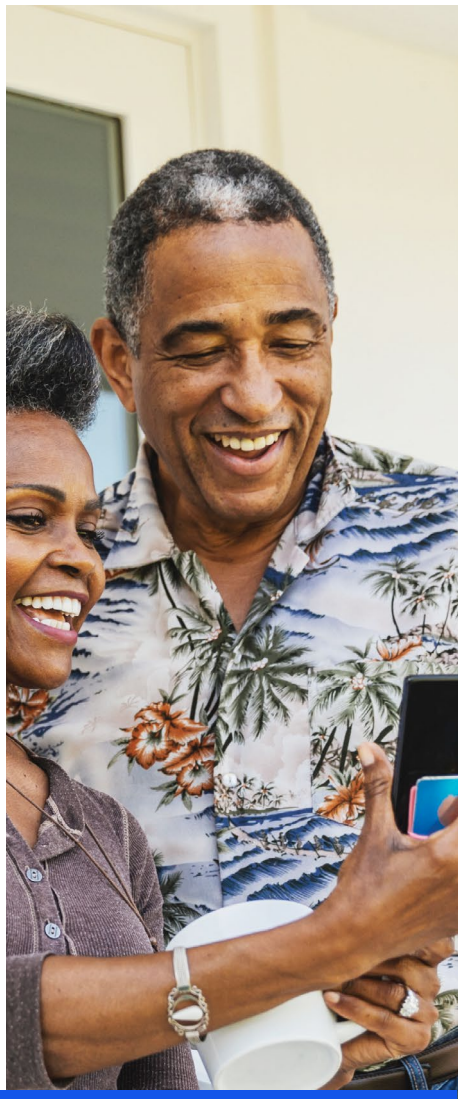
Now you can connect more easily to the care you need through our **Sydney℠ Health** app. Have a video visit with a doctor on your mobile device or computer with a camera, 24/7.

Visit with a doctor for common health concerns

Doctors are available anytime, with no appointments or long wait times. They can help you with these types of conditions:

- COVID-19
- Flu
- Cold and fever
- Minor rashes
- Sore throat
- Headaches

During your video visit, the doctor will assess your condition, provide a treatment plan, and send prescriptions to the pharmacy of your choice, if needed.[1]



What people say about virtual care visits[2]

89% said the doctor they saw was professional and helpful

92% thought the doctor understood their concerns

92% were able to book a virtual visit sooner than an in-person visit

How to download our Sydney Health app:

sydney℠

Download on the App Store

GET IT ON Google Play

Scan the QR code with your phone's camera or visit the App Store® or Google Play™.

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Medical - Anthem (continued)

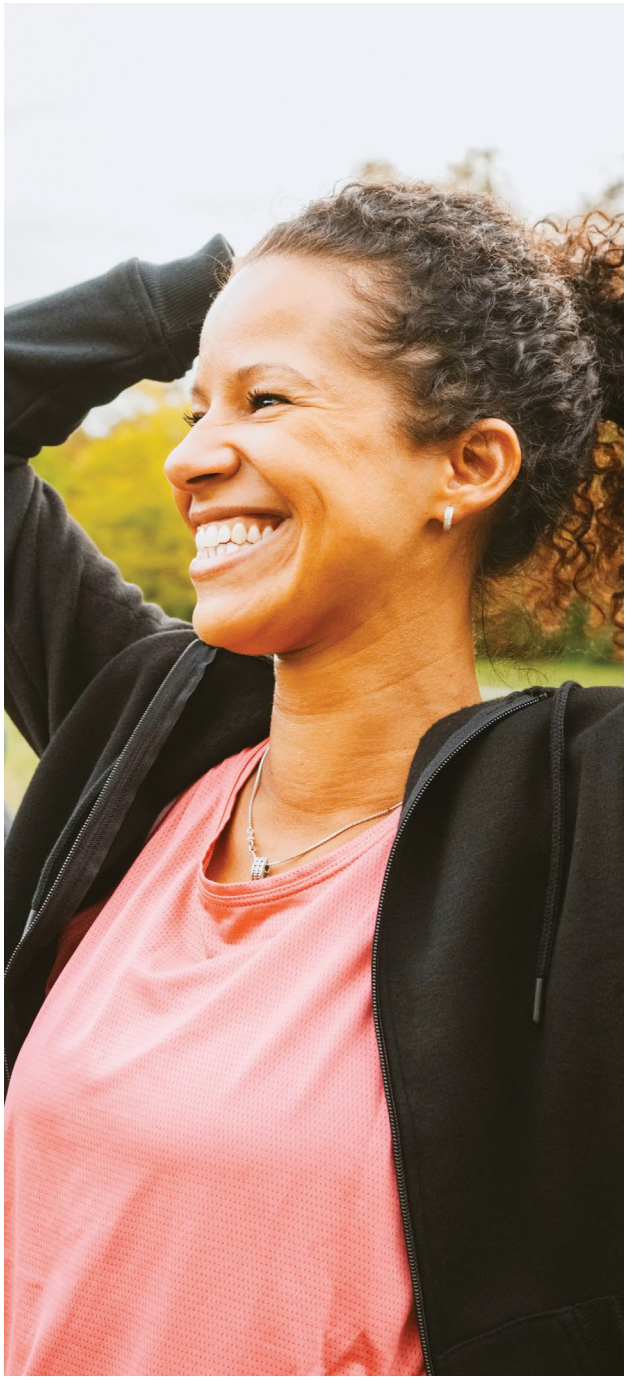
Here's how to access the program through virtual care:

Download our no-cost **Sydney Health** app.

1. Register (if you haven't yet) and log in.
2. Once you register, your username and password are the same for our app and **anthem.com/ca**.
3. Select **Care** and then select **Virtual Care**.

Visit **anthem.com/ca**.

1. Register (if you haven't yet) and log in.
2. Once you register, your username and password are the same for **anthem.com/ca** and our **Sydney Health** app.
3. From the **Care** tab, select **Virtual Care** in the drop down menu. Then, click **Video Visit Options**.



1 Prescription availability is defined by physician judgment.

2 Based on Sydney Health utilization trends from top national clients.

In addition to using a telehealth service, you can receive in-person or virtual care from your own doctor or another healthcare provider in your plan's network. If you receive care from a doctor or healthcare provider not in your plan's network, your share of the costs may be higher. You may also receive a bill for any charges not covered by your health plan.

LiveHealth Online is the trade name of Health Management Corporation, a separate company, providing telehealth services on behalf of Anthem Blue Cross.

Sydney Health is offered through an arrangement with Carelon Digital Platforms, a separate company offering mobile application services on behalf of your health plan. ©2024 The Virtual Primary Care experience is offered through an arrangement with Hydrogen Health.

Anthem Blue Cross is the trade name of Blue Cross of California. Anthem Blue Cross and Anthem Blue Cross Life and Health Insurance Company are independent licensees of the Blue Cross Association. Anthem is a registered trademark of Anthem Insurance Companies, Inc.

Save money

with SpecialOffers and discounts

As part of your health plan, you qualify for discounts on products and services that help promote better health and well-being. These discounts are available through SpecialOffers, which can help you save money while taking care of your health.

Dental, hearing, and vision

Dental

RefreshaDent

Save on premium dentures sent direct to your home. You can receive a 50% discount on a lifetime warranty. This program includes a lifetime digital record of your dentures for easy replacement.

Hearing

NationsHearing®

Receive hearing screenings and in-home service at no additional cost. You also can receive hearing aids at a discounted rate.

Hearing Care Solutions

Receive no-cost hearing exams and discounts on hearing aids. Hearing Care Solutions has 3,100 locations and eight manufacturers, and offers a three-year warranty, batteries for two years, and unlimited visits for one year.

Amplifon

Save on top-quality care and ongoing service and support for your hearing aids.

Eyewear

Glasses.com® and 1-800 CONTACTS®

Shop for the latest brand-name frames at a fraction of the cost of similar frames from other retailers. You also can receive additional savings on orders of $100 or more, plus no-cost shipping and returns.

EyeMed

Take advantage of discounts on new glasses, nonprescription sunglasses, and eyewear accessories.

LASIK

Premier LASIK Network

Save on LASIK when you choose any featured Premier LASIK Network provider.

TruVision

Save on LASIK eye surgery at over 1,000 locations.

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Anthem

Medical - Anthem (continued)

Health and fitness

Health

BREVENA

Enjoy a discount on BREVENA skin care creams and balms for smooth, rejuvenated skin from head to toe.

ChooseHealthy®

Discounts are available on acupuncture, chiropractic, massage, podiatry, physical therapy, and nutritional services. You also have discounts on fitness equipment, wearable health trackers, and health products such as vitamins and nutrition bars.

LifeMart®

Receive deals on beauty and skin care, diet plans, fitness club memberships and plans, personal care, spa services, yoga classes, sports gear, and vision care.

Fitness

Active&Fit Direct™

Choose from more than 12,000 participating fitness centers and 5,800 premium exercise studios nationwide and receive a discounted membership. This program is offered through American Specialty Health Fitness, Inc.

Fitbit®

Work toward your fitness goals with Fitbit trackers and smartwatches that fit your lifestyle and budget.

Garmin®

Discounts are available on select Garmin wellness devices.

Husk Wellness

Discounts are available for gym memberships, fitness equipment and technology, and fitness and nutrition coaching.

Family and home

Family

23andMe®

Save on health and ancestry kits to learn about your wellness, ancestry, and more.

WINFertility®

Save up to 40% on infertility treatment. WINFertility helps make quality treatment more affordable.

Home

Nationwide® Pet Insurance

Receive discounts when you enroll through your company or organization. Additional savings are available when you enroll multiple pets.

ASPCA® Pet Health Insurance

Find reduced rates on pet insurance and choose from three levels of care, including flexible deductibles and custom reimbursements.

Medicine and treatment

Medicine

Puritan's Pride®

Choose from a large selection of discounted vitamins, minerals, and supplements.

Allergy Control Products and National Allergy Supply™

Save on select doctor-recommended products, such as allergy-friendly bedding, air purifiers and filters, and asthma products. Some orders qualify for no-cost ground shipping within the contiguous U.S.

Treatment

The Living Well Courses

Choose one of the online wellness programs and save on coaching to help you lose weight, stop smoking, manage stress or diabetes, restore sound sleep, or address alcohol or substance dependence.

▷ Learn more about SpecialOffers

Log in to anthem.com/ca, choose **Care**, and select **Discounts**.

BROUGHT TO YOU BY REEP for Benefits

transcarent

When you choose Transcarent for surgery you may be eligible for a taxable care allowance of $1,650 or $3,300 if you are enrolled in an HSA Plan.

Need Surgery?

Thanks to REEP for Benefits, surgery through Transcarent costs you $0.* If surgery is in your future take these 5 simple steps to get the care you need through Transcarent.

Connect with your Care Team

Download the Transcarent app to message the Care Team or connect by phone.

Discuss care options

Your Care Team can help you determine the best next steps in your care plan.

Select a surgeon

You'll be matched with a selection of top-quality providers that have delivered exceptional results; you'll choose where to have your surgery.

Prep for surgery

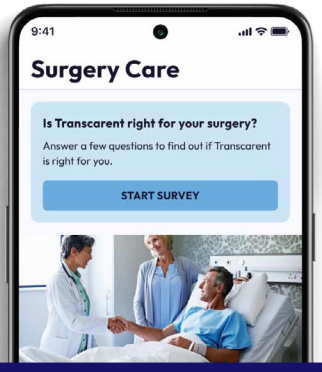
All arrangements will be made for you in advance—all you have to do is show up.

Recover

Get back to yourself—we'll check on you after your procedure!

Available surgical procedures

- Bariatric
- Cardiac
- General
- Neurological
- Orthopedic
- Spine
- Vascular
- Women's Health



Contact Transcarent today

member.transcarent.com

844-643-0606

Scan here to download the app

*PPO plan members pay $0 for surgery. If you are enrolled in a high deductible plan, you pay $0 after your deductible has been met. Your surgery costs, one pre-operative appointment, one post-operative appointment, anesthesia, surgical site fees, and medications given in the facility for your procedure are covered under this benefit. If a local surgeon is not available and travel is required, travel expenses for the patient and an adult companion, including airfare, lodging, and meals allowance are also covered when arranged through Transcarent.

Note: Qualifying medical travel expenses, such as meals and incidentals and lodging expenses, benefiting both employee Members and non-employee Members, may be considered taxable income and subject to taxation by the Employer/Plan. Transcarent does not provide tax advice.

Understanding your Surgery Care benefit

Your Personal Care Coordinator	From concierge support for billing, medical records collection, and questions we've got you covered. Your Care Coordinator manages the entire surgery process, while keeping you informed and in charge at every step.
Your Coverage	**PPO Plan** Surgery costs are covered at 100%. There is no deductible or coinsurance when you choose your provider though Transcarent. No surprise bills. **High Deductible Plan** Surgery costs are covered at 100% after you meet your deductible. There is no coinsurance when you choose your provider through Transcarent. We'll coordinate with your health plan to verify any remaining deductible amount prior to surgery, payable by credit card.
What's Included	Your surgery benefit includes: • Preoperative surgeon appointment • Surgery (all facility, anesthesia, surgical staff, and surgeon charges) • In-patient services, if a hospital stay is required • Postoperative surgeon appointment **Medical expenses that occur before your first and last surgery appointment will be covered under the usual terms of your health plan.**

If Travel is Required	If travel of over 100 miles (one way) from your primary residence is required to get you to a top surgeon for your procedure, we'll pay the travel expenses for you and a companion, including:
	• Airfare (coach unless first class is medically necessary)
	• Lodging (one double occupancy room)
	• Meals and incidentals allowance:
	  - $50 per day for the patient when not admitted (days 1-14)
	  - $50 per day for a companion (days 1-14)
	  - $125 per week per person after 14 days (days 15+)
	To receive this benefit, airfare and lodging must be arranged by your Care Coordinator. Any travel companion must be at least 18 years of age.
	Qualifying medical travel expenses, such as meals and incidentals and lodging expenses, benefiting both employee Members and non-employee Members, may be considered taxable income and subject to taxation by the Employer/Plan. Transcarent does not provide tax advice.

Covered Surgical Procedures	Bariatric, Orthopedic, Women's Health, General, Vascular, Cardiac, Neurological, and Spine. **Procedures not available through Transcarent:** Emergency, pediatric (under age 13), cancer, cosmetic, dental, diagnostic, vision and transplant procedures.
Care Allowance	When you choose a Transcarent provider, REEP for Benefits provides a taxable care allowance to assist with care and recovery expenses. PPO plan participants are not eligible for a Care Allowance. • HSA Plan 1 - you receive a $1,650 Care Allowance • HSA Plan 2 - you receive a $3,300 Care Allowance *This update is a Summary of Material Modifications to your Summary Plan Description (SPD) as required by ERISA. Any related taxes associated with this payment are your responsibility. Transcarent does not provide tax advice.*

member.transcarent.com **844-643-0606**

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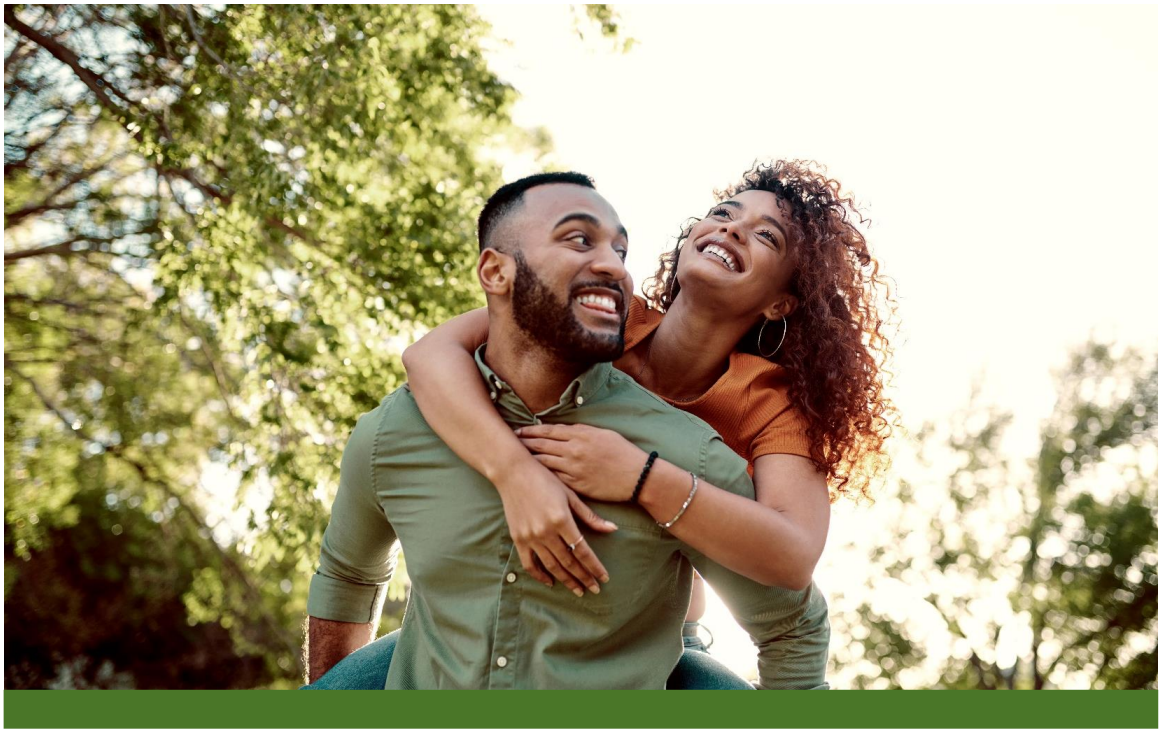
Medical - Kaiser

KAISER PERMANENTE MICROSITE



Rediscover Kaiser Permanente on a website just for **REEP for Benefits Members**

Whether you are a current member or considering Kaiser Permanente for the first time, you can get all the information you need at choose.kaiserpermanente.org/reep.

- View detailed information about your health plan benefits
- Wellness Tools and Resources
- Personal telephonic wellness coaching
- See how easy it is to stay on top of your health online
- Fitness program discount
- On-demand videos

KAISER PERMANENTE®

Explore health and wellness resources

You deserve support for your total health – mind, body, and spirit. These resources can help you reach your health goals and improve your overall well-being. It's care made easy, designed to help you live well and thrive.

For your mental wellness

Members can get help with depression, anxiety, addiction, and mental or emotional health – without a referral for mental health care within Kaiser Permanente.

Access resources to help you feel your best

Share your concerns with anyone on your care team at any time, and they can connect you to the support you need, including:

- Individual or group therapy
- Medication
- Self-care resources
- Mental wellness apps[1]

kp.org/mentalhealth

KAISER PERMANENTE®

For your physical health

Take advantage of these convenient perks – from personal health coaching to reduced rates on alternative medical therapies.

Live healthier with helpful resources[2]

Get tools, tips, and information to help you create positive changes in your life. Our complimentary resources can help you:

- Eat healthier
- Quit smoking
- Reduce stress
- Manage ongoing conditions like diabetes or depression

kp.org/health-wellness
kp.org/salud-bienestar (en español)

Connect to a wellness coach

If you need more support, we offer Wellness Coaching by Phone at no cost. You'll work one-on-one with your personal coach to make a plan to help you reach your health goals.

kp.org/wellnesscoach

Join health classes

With all kinds of health classes and support groups offered at our facilities, there's something for everyone. Classes vary at each location, and some may require a fee.

kp.org/classes
kp.org/clases (en español)

Achieve your fitness goals

Get help reaching your health goals with a fitness membership from One Pass Select Affinity from Optum.[1] Choose your plan and get unlimited access to a large nationwide network of gyms and boutique studios.

You'll also get access to Optum's affinity musculoskeletal program. Enjoy 20% off chiropractor, acupuncture, and therapeutic massage services at participating providers.

kp.org/exercise

Getting great care is easy

Are you new to Kaiser Permanente? Thinking about joining? It's simple to get started with your new plan.

Get started with Kaiser Permanente at **kp.org/newmember**.

1. The services described above are not covered under your health plan benefits and are not subject to the terms set forth in your *Evidence of Coverage* or other plan documents. These services may be discontinued at any time without notice. **2.** This value-added service is an extra service provided by entities other than Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. (KFHP-MAS), and is neither offered nor guaranteed under any KFHP-MAS contract. This entity may change or discontinue offering this service at any time. KFHP-MAS disclaims any liability for the service provided by this entity.

Colorado state law requires that an access plan be available that describes Kaiser Foundation Health Plan of Colorado's network of provider services. To obtain a copy, please call Member Services or visit kp.org.

Services covered under your health plan are provided and/or arranged by Kaiser Permanente health plans around the country: Kaiser Foundation Health Plan, Inc., in Northern and Southern California and Hawaii • Kaiser Foundation Health Plan of Colorado • Kaiser Foundation Health Plan of Georgia, Inc., Nine Piedmont Center, 3495 Piedmont Road NE, Atlanta, GA 30305 • Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc., in Maryland, Virginia, and Washington, D.C., 2101 E. Jefferson St., Rockville, MD 20852 • Kaiser Foundation Health Plan of the Northwest, 500 NE Multnomah St., Suite 100, Portland, OR 97232 • Kaiser Foundation Health Plan of Washington or Kaiser Foundation Health Plan of Washington Options, Inc., 2715 Naches Ave. SW, Renton, WA 98057

KAISER PERMANENTE®

1474202105 October 2024

Caring for the whole you

Mental health and addiction care services

Mental health care goes hand-in-hand with all the care we provide.

Primary care

Talk to your primary care doctor about any mental health or substance use concerns anytime. Your doctor can assess your needs and connect you with the right care.

Specialty care

Visit **kp.org/mentalhealthservices** for information on available options and how to make an appointment with a Kaiser Permanente mental health care professional – no referral needed. This includes dedicated help for those struggling with alcohol or drugs. If you or someone you love needs support, talk to your doctor or visit **kp.org/addiction**.

Self-care and wellness resources

You have access to many tools including self-care apps that can help with stress, anxiety, and sleep – available at no cost. You can also try wellness coaching, join a health class,[1] and take online self-assessments. Visit **kp.org/wellnessresources** to learn more.

Connected care

Your entire Kaiser Permanente care team is connected to each other, and to you, through your electronic health record. So, it's easy for our doctors to consult with one another about your care. Your team may include many health professionals to support you, including:

- Primary care doctors
- Psychiatrists
- Therapists
- Addiction medicine specialists

Common conditions

We provide assessment and treatment for a variety of mental, emotional, and substance use issues, including but not limited to:

- Anxiety and stress
- Attention deficit hyperactivity disorder (ADHD)
- Autism spectrum disorders
- Bipolar disorder
- Depression
- Eating disorders
- Obsessive-compulsive disorder (OCD)
- Personality disorders
- Postpartum depression
- Post-traumatic stress disorder (PTSD)
- Schizophrenia
- Sleep problems
- Substance use disorders

(continued on back)

Learn more at **kp.org/mentalhealth**

KAISER PERMANENTE®

Medical - Kaiser (continued)

(continued from front)

Support and resources

You can count on us to help guide you throughout your journey with a wide range of treatment. These include but aren't limited to:

- Classes and support groups[1]
- Digital wellness resources
- Healthy lifestyle programs
- Integration with primary care
- Intensive outpatient services
- Inpatient services
- Outpatient services
- Preventive care
- Recovery and social support
- Self-care apps
- Wellness coaching

Self-care at your fingertips

It's common to struggle with everyday life sometimes. These no-cost self-care apps can help you with stress, sleep, depression, and more.[2,3]

Calm is the number one app for sleep, meditation, and relaxation.[4]

Headspace Care provides 1-on-1 emotional support coaching by text and self-care activities to help with many common challenges.[5]

Many ways to get care

You can connect with a mental health or substance use professional when and where it works for you.

- **24/7 advice:** Speak to licensed care professionals who can help connect you with a clinician, schedule appointments, and offer immediate care guidance
- **Video visit:** Face-to-face care from a clinician on your smartphone or computer[6]
- **E-visit:** Online questionnaire to provide a personalized care plan[7]
- **Phone appointment:** High-quality care over the phone – just like an in-person visit[6]
- **Email:** Message your Kaiser Permanente doctor's office with nonurgent health questions anytime
- **In-person:** Meet with a clinician for personalized care

No matter how you reach out, you can get connected to the right care.

To understand your care options and connect to the support you need, visit **kp.org/mentalhealthservices**.

For emergency care

If you think you have a medical or psychiatric emergency, call 911 or go to the nearest hospital.[8]

1. Some classes may require a fee. **2.** The apps and services described above are not covered under your health plan benefits, are not a Medicare-covered benefit, and are not subject to the terms set forth in your *Evidence of Coverage* or other plan documents. The apps and services may be discontinued at any time. **3.** Calm can be used by members 13 and over. The Headspace Care app and services are not available to any members under 18 years old. **4.** Calm is the number one app for sleep, meditation, and relaxation. Learn more at calm.com/blog/about. **5.** Eligible Kaiser Permanente members can text with a coach using the Headspace Care app for 90 days per year. After the 90 days, members can continue to access the other services available on the Headspace Care app for the remainder of the year at no cost. **6.** When appropriate and available. **7.** Mental health e-visits are not currently available in Colorado. **8.** If you believe you have an emergency medical condition, call 911 or go to the nearest hospital. For the complete definition of an emergency medical condition, please refer to your *Evidence of Coverage* or other coverage documents.

Kaiser Foundation Health Plan, Inc., 1950 Franklin St., Oakland, CA 94612. Kaiser Foundation Health Plan, Inc., 393 E. Walnut St., Pasadena, CA 91188. Kaiser Foundation Health Plan, Inc., 711 Kapiolani Blvd., Honolulu, HI 96813. Kaiser Foundation Health Plan of the Northwest, 500 NE Multnomah St., Suite 100, Portland, OR 97232. Kaiser Foundation Health Plan of Colorado, 10350 E. Dakota Ave., Denver, CO 80247. Kaiser Foundation Health Plan of Georgia, Inc., Nine Piedmont Center, 3495 Piedmont Road NE, Atlanta, GA 30305. Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc., 2101 E. Jefferson St., Rockville, MD 20852. Kaiser Foundation Health Plan of Washington or Kaiser Foundation Health Plan of Washington Options, Inc., 2715 Naches Ave. SW, Renton, WA 98057.

Learn more at **kp.org/mentalhealth**

KAISER PERMANENTE®

1335504011 April 2024

When you have a health issue, you have many easy ways to get care when and where it works for you.

E-visit

Answer a few questions online or in our app for 24/7 self-care advice. In some cases, a Kaiser Permanente clinician will get back to you with a care plan – usually within 2 hours.

24/7 virtual care

Fast, personalized support around the clock -- no appointment needed. Get 24/7 care by phone or video from a Kaiser Permanente clinician across the U.S.[1,2]

Phone or video visit

Schedule time to talk with a doctor or nurse by phone or video.[1] On most plans, there's no cost.[2]

24/7 advice

Speak to a licensed medical professional anytime, day or night. Call **1-833-574-2273** (TTY **711**).

E-mail

Message your Kaiser Permanente doctor's office with nonurgent questions and get a reply usually within 2 business days.

Care is a call or click away

- To get care – in person, by phone, or online – simply sign in at **kp.org** or use our app.
- You can also call **1-833-574-2273** (TTY **711**), **24 hours a day, 7 days a week.**

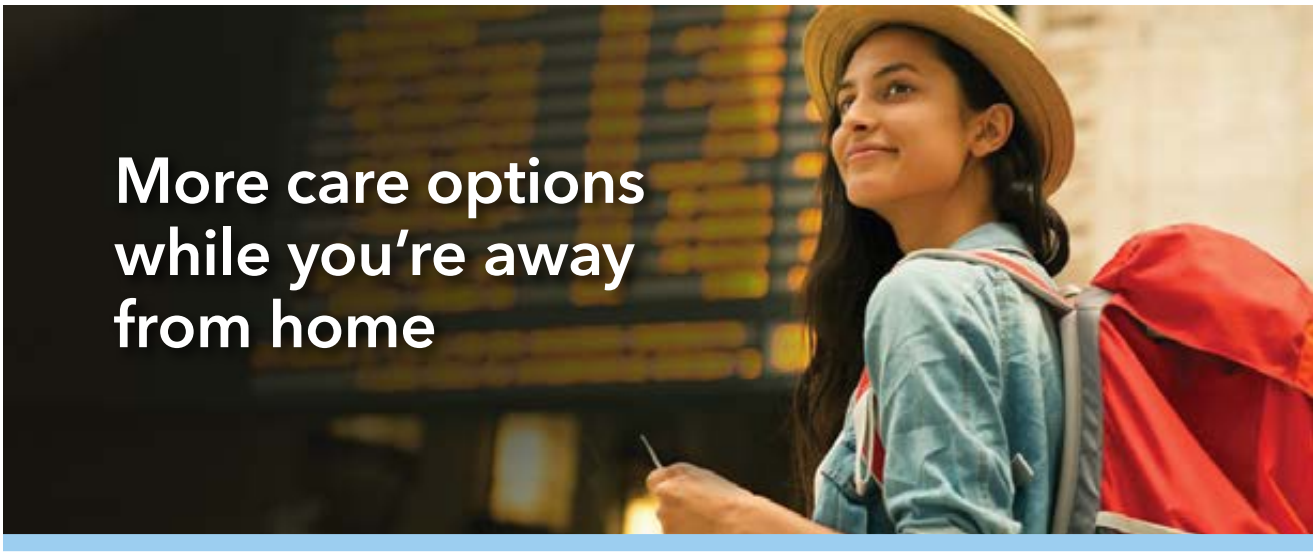
Learn more

- Learn more about your care options at **kp.org/getcare.**

1. When appropriate and available. If you travel out of state, phone appointments and video visits may not be available in select states due to licensing laws. Laws differ by state.**2.**If you have an HSA-qualified deductible plan, you may need to pay the full charge for scheduled phone appointments and video visits until you reach your deductible. Once you reach your deductible, you won't pay anything for scheduled phone appointments and video visits.

KAISER PERMANENTE®

1019677924 February 2023



No matter where life takes you, Kaiser Permanente has you covered. If something unexpected happens while you're away from home, it's easier than ever to get care.

Nonurgent care

Use your **kp.org** account or the Kaiser Permanente app across the U.S. to:

- Get 24/7 care and advice from Kaiser Permanente clinicians by phone or online
- Access care by phone,[1] video,[1] or e-visit – usually at no cost[2]
- Email nonurgent questions to your doctor's office

Urgent care[3]

You can get urgent care anywhere in the world. At many locations outside Kaiser Permanente states, you'll only pay your copay or coinsurance for care or prescriptions[4] related to your urgent care visit – no need to file a claim later:

- Cigna PPO Network[5]
- MinuteClinic, including pharmacies[6]
- Concentra Urgent Care[6]
- The Little Clinic, including pharmacies[6]

At all other locations, you must pay the full cost of care upfront and file a claim for reimbursement later.

Emergency care[7]

No matter where you are, you can simply go to the nearest hospital emergency room. If it's a Kaiser Permanente location or Cigna PPO provider, you'll only pay your normal copay or coinsurance.

Support while you're away

Need help finding care or learning what's covered while you're away? Call the Away from Home Travel Line at **951-268-3900** (TTY **711**)[8] or visit **kp.org/travel**.

Learn more at **kp.org/travel**

KAISER PERMANENTE®

1020222594 January 2023

Important Notices

No Surprises Act Notice

Our medical plans are subject to the No Surprises Act, which limits the amount covered persons may have to pay for some out-of-network surprise medical bills. More information about surprise billing requirements included under the No Surprises Act and similar state laws can be found on the medical insurance company's website or the Plan Sponsor's website. Additional information may be found in your Explanation of Benefits for any affected claims.

Discrimination is Against the Law

Murrieta Valley Unified School District complies with the applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin (including limited English proficiency and primary language), age, disability, or sex (including pregnancy, sexual orientation, gender identity, and sex characteristics). Murrieta Valley Unified School District does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Newborns' and Mothers' Health Protection Act (NMHPA)

Benefits for pregnancy hospital stay (for delivery) for a mother and her newborn may not be restricted to less than 48 hours following a vaginal delivery or 96 hours following a cesarean section. Also, any utilization review requirements for inpatient hospital admissions will not apply to this minimum length of stay. Early discharge is permitted only if the attending health care provider, in consultation with the mother, decides an earlier discharge is appropriate.

Women's Health and Cancer Rights Act (WHCRA) Annual Notice

Your plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services, including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema. For more information, you should review the Summary Plan Description or call your Plan Administrator at 951.696.1600.

Patient Protections

The medical plan requires the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. Until you make this designation, the plan will designate one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, please contact Anthem or Kaiser Customer Service phone number on the back of your Member ID card.

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

You do not need prior authorization from the plan or any other person (including a primary care provider) to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, please contact Anthem or Kaiser Customer Service art h phone number on the back of your Member ID card.

Networks/Claims/Appeals

The major medical plans described in this booklet have provider networks with . The listing of provider networks will be available to you automatically and free of charge. A list of network providers can be accessed immediately by using the Internet address found in the Summary of Benefits and Coverage that relates to the Plan. You have a right to appeal denials of claims and a right to a response within a reasonable amount of time. Claims that are not submitted within a reasonable time may be denied. Please review your Summary Plan Description or contact the Plan Administrator for more details.

Notice of Extended Coverage to Children Covered as Students

Michelle's Law generally extends eligibility for group health benefit plan coverage to a dependent child over the age of 26, who, as a condition of coverage, is enrolled in an institution of higher education. Please review the following information with respect to your dependent child's rights in the event student status is lost.

Michelle's Law requires the Plan to allow extended eligibility in some cases for a covered child over age 26, who would lose eligibility for Plan coverage due to loss of full-time student status.

There are two definitions that are important for purposes of determining whether the Michelle's Law extension of eligibility applies to a particular child:

- *A dependent child means a child over the age of 26 who is a dependent of a plan participant and who is eligible under the terms of the Plan based on their student status and enrollment at a post-secondary educational institution immediately before the first day of a medically necessary leave of absence.*
- *Medically necessary leave of absence means a leave of absence or any other change in enrollment:*
  - of a dependent child from a post-secondary educational institution that begins while the child is suffering from a serious illness or injury;
  - Which is medically necessary; and,
  - Which causes the dependent child to lose student status under the terms of the Plan.

The dependent child's treating physician must provide written certification of medical necessity (i.e., a certification that the dependent child suffers from a serious illness or injury that necessitates a leave of absence or other enrollment change that would otherwise cause loss of eligibility).

If a dependent child qualifies for the Michelle's Law extension of eligibility, the Plan will treat the dependent child as eligible for coverage until the earlier of:

- *One year after the first day of the leave of absence; or*
- *The date that Plan coverage would otherwise terminate (for reasons other than failure to be a full-time student).*

A dependent child on a medically necessary leave of absence is entitled to receive the same Plan benefits as other dependent children covered under the Plan. Further, any change to Plan coverage that occurs during the Michelle's Law extension of eligibility will apply to the dependent child to the same extent as it applies to other dependent children covered under the Plan.

COBRA Continuation Coverage

This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under covered medical, dental, and vision plans (the "Plan"). **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

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

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

WHAT IS COBRA CONTINUATION COVERAGE?

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

If you are an employee, you will become a Qualified Beneficiary if you lose coverage under the Plan because of the following Qualifying Events:

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

If you are the spouse of an employee, you will become a Qualified Beneficiary if you lose your coverage under the Plan because of the following Qualifying Events:

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

Your dependent children will become Qualified Beneficiaries if they lose coverage under the Plan because of the following Qualifying Events:

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

WHEN IS COBRA CONTINUATION COVERAGE AVAILABLE?

The Plan will offer COBRA continuation coverage to Qualified Beneficiaries only after the Plan Administrator has been notified of a Qualifying Event:

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

For all other Qualifying Events (e.g., divorce or legal separation of the employee and spouse, or a dependent child's losing eligibility for coverage as a dependent child, etc.), you must notify the Plan Administrator within 60 days after the Qualifying Event occurs. You must provide this notice to your employer.

Life insurance, accidental death and dismemberment benefits, and weekly income or long-term disability benefits (if part of the employer's plan), are not eligible for continuation under COBRA.

NOTICE AND ELECTION PROCEDURES

Each type of notice or election to be provided by a covered employee or a Qualified Beneficiary under this COBRA Continuation Coverage Section must be in writing, must be signed and dated, and must be mailed or hand-delivered to the Plan Administrator, properly addressed, or as otherwise permitted by the COBRA administrator, no later than the date specified in the election form, and properly submitted to the Plan Administrator.

Each notice must include all of the following items: the covered employee's full name, address, phone number, and Social Security Number; the full name, address, phone number, and Social Security Number of each affected dependent, as well as each dependent's relationship to the covered employee; a description of the Qualifying Event or disability determination that has occurred; the date the Qualifying Event or disability determination occurred; a copy of the Social Security Administration's written disability determination, if applicable; and the name of this Plan. The Plan Administrator may establish specific forms that must be used to provide a notice or election.

ELECTION AND ELECTION PERIOD

COBRA continuation coverage may be elected during the period beginning on the date Plan coverage would otherwise terminate due to a Qualifying Event and ending on the later of the following: (1) 60 days after coverage ends due to a Qualifying Event, or (2) 60 days after the notice of the COBRA continuation coverage rights is provided to the Qualified Beneficiary.

If, during the election period, a Qualified Beneficiary waives COBRA continuation coverage rights, the waiver can be revoked at any time before the end of the election period. Revocation of the waiver will be an election of COBRA continuation coverage. However, if a waiver is revoked, coverage need not be provided retroactively (that is, from the date of the loss of coverage until the waiver is revoked). Waivers and revocations of waivers are made on the date they are sent to the employer or Plan Administrator.

HOW IS COBRA CONTINUATION COVERAGE PROVIDED?

Once the Plan Administrator receives notice that a Qualifying Event has occurred, COBRA continuation coverage will be offered to each of the Qualified Beneficiaries. Each Qualified Beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation on behalf of their dependent children.

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

Important Notices (continued)

DISABILITY EXTENSION OF THE 18-MONTH PERIOD OF COBRA CONTINUATION COVERAGE

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. This disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage. (See Notice and Election Procedures.)

SECOND QUALIFYING EVENT EXTENSION OF 18-MONTH PERIOD OF COBRA CONTINUATION COVERAGE

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

OTHER OPTIONS BESIDES COBRA CONTINUATION COVERAGE

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

ENROLLMENT IN MEDICARE INSTEAD OF COBRA

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period[1] to sign up for Medicare Part A or B, beginning on the earlier of:

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

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

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

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

IF YOU HAVE QUESTIONS

For more information about the Marketplace, visit www.healthcare.gov.

The U.S. Department of Health and Human Services (HHS), through the Centers for Medicare & Medicaid Services (CMS), has jurisdiction with respect to the COBRA continuation coverage requirements of the Public Health Service Act (PHSA) that apply to state and local government employers, including counties, municipalities, public school districts, and the group health plans that they sponsor (Public Sector COBRA). COBRA can be a daunting and complex area of federal law. If you have any questions or issues regarding Public Sector COBRA, you may contact the Plan Administrator or email HHS at phig@cms.hhs.gov.

[1] https://www.medicare.gov/basics/get-started-with-medicare/sign-up/when-does-medicare-coverage-start

KEEP YOUR PLAN INFORMED OF ADDRESS CHANGES

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

EFFECTIVE DATE OF COVERAGE

COBRA continuation coverage, if elected within the period allowed for such election, is effective retroactively to the date coverage would otherwise have terminated due to the Qualifying Event, and the Qualified Beneficiary will be charged for coverage in this retroactive period.

COST OF CONTINUATION COVERAGE

The cost of COBRA continuation coverage will not exceed 102% of the Plan's full cost of coverage during the same period for similarly situated non-COBRA beneficiaries to whom a Qualifying Event has not occurred. The "full cost" includes any part of the cost which is paid by the employer for non-COBRA beneficiaries.

The initial payment must be made within 45 days after the date of the COBRA election by the Qualified Beneficiary. Payment must cover the period of coverage from the date of the COBRA election retroactive to the date of loss of coverage due to the Qualifying Event (or the date a COBRA waiver was revoked, if applicable). The first and subsequent payments must be submitted and made payable to the Plan Administrator or COBRA Administrator. Payments for successive periods of coverage are due on the first of each month thereafter, with a 30-day grace period allowed for payment. Where an employee organization or any other entity that provides Plan benefits on behalf of the Plan Administrator permits a billing grace period greater than the 30 days stated above, such period shall apply in lieu of the 30 days. Payment is to be made on the date it is sent to the Plan or Plan Administrator.

The Plan will allow the payment for COBRA continuation coverage to be made in monthly installments, but the Plan can also allow for payment at other intervals. The Plan is not obligated to send monthly premium notices.

The Plan will notify the Qualified Beneficiary, in writing, of any termination of COBRA coverage based on the criteria stated in this Section that occurs prior to the end of the Qualified Beneficiary's applicable maximum coverage period. Notice will be given within 30 days of the Plan's decision to terminate.

Such notice shall include the reason that continuation coverage has terminated earlier than the end of the maximum coverage period for such Qualifying Event and the date of termination of continuation coverage.

See the Summary Plan Description or contact the Plan Administrator for more information.

Uniformed Services Employment and Reemployment Rights Act (USERRA)

If you leave your job to perform military service, you have the right to elect to continue your existing employer-based health plan coverage for you and your dependents (including your spouse) for up to 24 months while in the military. Even if you do not elect to continue coverage during your military service, you have the right to be reinstated in your employer's health plan when you are reemployed, generally without any waiting periods or exclusions for pre-existing conditions except for service-connected injuries or illnesses.

Flexible Spending Accounts (FSAs) – Termination and Claims Submission Deadlines

Note: If you lose eligibility for any reason during the Plan Year, your contributions to your Health and/or Dependent Care FSAs will end as of the date your eligibility terminates. You may submit claims for reimbursement from your FSAs for expenses incurred during the Plan Year prior to your eligibility termination. You must submit claims for reimbursement from your Health and/or Dependent Care FSAs no later than 90 days after the date your eligibility terminates. Any balance remaining in your FSAs will be forfeited after claims submitted prior to this date have been processed.

Special Enrollment Rights Notice

CHANGES TO YOUR HEALTH PLAN ELECTIONS

Once you make your benefits elections, they cannot be changed until the next Open Enrollment. Open Enrollment is held once a year.

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if there is a loss of other coverage. However, you must request enrollment no later than 30 days after that other coverage ends.

If you declined coverage while Medicaid or the Children's Health Insurance Program (CHIP) is in effect, you may be able to enroll yourself and/or your dependents in this plan if you or your dependents lose eligibility for that other coverage. However, you must request enrollment no later than 60 days after Medicaid or CHIP coverage ends.

If you or your dependents become eligible for Medicaid or CHIP premium assistance, you may be able to enroll yourself and/or your dependents into this plan. However, you must request enrollment no later than 60 days after the determination to remain eligible for such assistance.

If you have a change in family status such as a new dependent resulting from marriage, birth, adoption or placement for adoption, divorce (including legal separation and annulment), death, or Qualified Medical Child Support Order, you may be able to enroll yourself and/or your dependents. However, you must request enrollment no later than 30 days after the marriage, birth, adoption, or placement for adoption or divorce (including legal separation and annulment).

For information about Special Enrollment Rights, please contact:

Hilaree Pugh
Coordinator, Human Resources
benefits@murrieta.k12.ca.us

Availability of Health Insurance Portability and Accountability Act (HIPAA) Notice of Privacy Practices

Murrieta Valley Unified School District Group Health Plan (Plan) maintains a Notice of Privacy Practices that provides information to individuals whose protected health information (PHI) will be used or maintained by the Plan. If you would like a copy of the Plan's Notice of Privacy Practices, please contact Hilaree Pugh at 951.696.1600 ext.1015.

Wellness – Alternative Standards

Your health plan is committed to helping you achieve your best health. Rewards for participating in a wellness program are available to all participating employees. If you think you might be unable to meet a standard for a reward under the wellness program, you might qualify for an opportunity to earn the same reward by different means. Contact us at 951.696.1600 and we will work with you (and, if requested, with your doctor) to find a wellness program with the same reward that is right for you with regard to your health status.

Important Notice Regarding Wellness Information

The REEP Wellness Program is a voluntary program available to employees who participate in Anthem and Kaiser medical plans and is subject to federal law including the Americans with Disabilities Act and the Genetic Information Nondiscrimination Act.

If you choose to participate, you may be asked to complete a voluntary health risk assessment that asks questions about your health-related activities and behaviors and whether you have or had certain medical conditions. You may also be asked to complete a voluntary biometric screening which includes cholesterol, glucose, blood pressure, BMI and Body Fat.

The information gathered from your health risk assessment and/or biometric screening will be used to provide you with information to help you understand your current health, potential risks, and may also be used to offer you services through the wellness program. You are also encouraged to share your results or concerns with your own doctor.

The law requires us to maintain the privacy and security of your personally identifiable health information. Although the wellness program and Murrieta Valley Unified School District may use aggregate, non-employee-specific information to design a program to address health risks in the workplace, your personally identifiable information will never be disclosed publicly or to your employer. Medical information that personally identifies you in connection with the wellness program will not be disclosed to your supervisors or managers and will never be used to make decisions regarding your employment. Anyone (e.g., a registered nurse, a doctor, a health coach, etc.) who receives information about you for the purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements.

All medical information obtained through the wellness program will be confidential.

If you have any questions or concerns, please contact Hilaree Pugh at 951.696.1600 ext. 1015.

Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: GENERAL INFORMATION

This notice provides you with information about Murrieta Valley Unified School District in the event you wish to apply for coverage on the Health Insurance Marketplace. All the information you need from Human Resources is listed in this notice. If you wish to have someone assist you in the application process or have questions about subsidies that you may be eligible to receive, (for California residents only) you can contact KeenanDirect at 855-653-3626 or at www.KeenanDirect.com, or (for everyone) contact the Health Insurance Marketplace directly at www.Healthcare.gov.

WHAT IS THE HEALTH INSURANCE MARKETPLACE?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget by offering "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a tax credit that lowers your monthly premium right away.

Open Enrollment for health insurance coverage through Covered California will begin on November 1, 2025, and end on January 31, 2026. For more information on Open Enrollment and other opportunities to enroll, visit www.coveredca.com or KeenanDirect at 855-653-3626 or www.KeenanDirect.com.

Open Enrollment for most other states begins on November 1 and closes on January 15 of each year. For more information on Open Enrollment and other opportunities to enroll, visit www.healthcare.gov.

CAN I SAVE MONEY ON MY HEALTH INSURANCE PREMIUMS IN THE MARKETPLACE?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer you coverage, offers medical coverage that is not "Affordable," or does not provide "Minimum Value." If the lowest cost plan from your employer that would cover you (and not any other members of your family) is more than 8.39% (for 2024) of your household income for the year, then that coverage for you is not Affordable. **Note**: The IRS will update the applicable percentage for 2025. Affordability for dependent family members is determined separately and is based on the total cost of family coverage. Moreover, if the medical coverage offered covers less than 60% of the benefits costs, then the plan does not provide Minimum Value.

DOES EMPLOYER HEALTH COVERAGE AFFECT ELIGIBILITY FOR PREMIUM SAVINGS THROUGH THE MARKETPLACE?

Yes. If you have an offer of medical coverage from your employer that is both Affordable and provides Minimum Value, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's medical plan. If you receive premium savings for Marketplace coverage, the IRS may seek reimbursement of those funds.

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered medical coverage. Also, this employer contribution, as well as your employee contribution to employer-offered coverage, is often excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

STATES WITH INDIVIDUAL MANDATE

Taxpayers in CA, DC, MA, NJ, RI, and VT (this list is neither complete nor exhaustive) are reminded that your state imposes an individual mandate penalty (tax) should you, your spouse, and children choose to not have (and keep) medical/Rx coverage for each tax year. Please consult your tax advisor for how a non-election for health coverage may affect your tax situation.

PART B: INFORMATION ABOUT HEALTH COVERAGE OFFERED BY YOUR EMPLOYER

In the event you wish to apply for coverage on the Exchange, all the information you need from Human Resources is listed below. If you are located in California and wish to have someone assist you in the application process or have questions about subsidies that you may be eligible to receive, you can contact KeenanDirect at 855-653-3626 or at www.KeenanDirect.com. The information is numbered to correspond to the Marketplace application.

3. Employer name Murrieta Valley Unified School District	**4. Employer Identification Number (EIN)** 33-0666881	
5. Employer address 41870 McAlby Court	**6. Employer phone number** 951.696.1600	
7. City Murrieta	**8. State** CA	**9. ZIP code** 92562
10. Who can we contact about employee health coverage at this job? Hilaree Pugh, Coordinator, Human Resources		
11. Phone number (if different from above) 951.696.1600 ext 1015	**12. Email address** benefits@murrieta.k12.ca.us	

As your employer, we offer coverage that meets the minimum value standard to the employees as described in this Guide. The coverage offered to you meets the minimum value standard and the cost of this coverage to you is intended to be affordable based on employee wages.

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

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

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

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

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

If you live in one of the following States, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2024. Contact your State for more information on eligibility.

ALABAMA – Medicaid
Website: http://myalhipp.com/
Phone: 855-692-5447

ALASKA – Medicaid
The AK Health Insurance Premium Payment Program
Website: http://myakhipp.com/
Phone: 866-251-4861
Email: CustomerService@MyAKHIPP.com
Medicaid Eligibility:
https://health.alaska.gov/dpa/Pages/default.aspx

ARKANSAS – Medicaid
Website: http://myarhipp.com/
Phone: 855-MyARHIPP (855-692-7447)

CALIFORNIA – Medicaid
Health Insurance Premium Payment (HIPP) Program Website:
http://dhcs.ca.gov/hipp
Phone: 916-445-8322
Fax: 916-440-5676
Email: hipp@dhcs.ca.gov

COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHIP+)
Health First Colorado Website:
https://www.healthfirstcolorado.com/
Health First Colorado Member Contact Center:
800-221-3943 | TTY: Colorado relay 711
CHP+: https://hcpf.colorado.gov/child-health-plan-plus
CHP+ Customer Service:
800-359-1991 | TTY: Colorado relay 711
Health Insurance Buy-In Program (HIBI):
https://www.mycohibi.com/
HIBI Customer Service: 855-692-6442

FLORIDA – Medicaid
Website:
http://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html
Phone: 877-357-3268

GEORGIA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp/
Phone: 678-564-1162, press 1
GA CHIPRA Website:
https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra
Phone: 678-564-1162, press 2

INDIANA – Medicaid
Website: https://www.in.gov/medicaid/
Or http://www.in.gov/fssa/dfr/
Family and Social Services Administration
Phone: 800-403-0864
Member Services Phone: 800-457-4584

IOWA – Medicaid and CHIP (Hawki)
Medicaid Website: https://hhs.iowa.gov/programs/welcome-iowa-medicaid
Medicaid Phone: 800-338-8366
Hawki Website: http://hhs.iowa.gov/programs/welcome-iowa-medicaid/iowa-health-link/hawki
Hawki Phone: 800-257-8563
HIPP Website:
https://hhs.iowa.gov/programs/welcome-iowa-medicaid/free-service/hipp
HIPP Phone: 888-346-9562

KANSAS – Medicaid
Website: https://www.kancare.ks.gov/
Phone: 800-792-4884
HIPPA Phone: 800-967-4660

KENTUCKY – Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website:
https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx
Phone: 855-459-6328
Email: KIHIPP.PROGRAM@ky.gov
KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx
Phone: 877-524-4718
Medicaid Website: https://chfs.ky.gov/agencies/dms

LOUISIANA – Medicaid
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp
Phone: 888-342-6207 (Medicaid hotline) or
855-618-5488 (LaHIPP)

MAINE – Medicaid
Enrollment Website:
https://www.mymaineconnection.gov/benefits/s/?language=en_US
Phone: 800-442-6003 | TTY: Maine relay 711
Private Health Insurance Premium Webpage:
https://www.maine.gov/dhhs/ofi/applications-forms
Phone: 800-977-6740 | TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP
Website: https://www.mass.gov/masshealth/pa
Phone: 800-862-4840 | TTY: Massachusetts relay 711
Email: masspremassistance@accenture.com

MINNESOTA – Medicaid
Website: https://mn.gov/dhs/health-care-coverage/
Phone: 800-657-3672

MISSOURI – Medicaid
Website:
https://www.dss.mo.gov/mhd/participants/pages/hipp.htm
Phone: 573-751-2005

MONTANA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: 800-694-3084
Email: HHSHIPPProgram@mt.gov

NEBRASKA – Medicaid
Website: http://www.ACCESSNebraska.ne.gov
Phone: 855-632-7633
Lincoln: 402-473-7000
Omaha: 402-595-1178

NEVADA – Medicaid
Medicaid Website: http://dhcfp.nv.gov/
Medicaid Phone: 800-992-0900

NEW HAMPSHIRE – Medicaid
Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program
Phone: 603-271-5218
Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov
HIPP Program Toll-Free Phone: 800-852-3345, ext. 5218

NEW JERSEY – Medicaid and CHIP
Medicaid Website:
http://www.state.nj.us/humanservices/dmahs/clients/medicaid/
Phone: 800-356-1561
CHIP Premium Assistance Phone: 609-631-2392
CHIP Website: http://www.njfamilycare.org/index.html
CHIP Phone: 800-701-0710 (TTY: 711)

NEW YORK – Medicaid
Website: https://www.health.ny.gov/health_care/medicaid/
Phone: 800-541-2831

NORTH CAROLINA – Medicaid
Website: https://medicaid.ncdhhs.gov/
Phone: 919-855-4100

NORTH DAKOTA – Medicaid
Website: https://www.hhs.nd.gov/healthcare
Phone: 844-854-4825

OKLAHOMA – Medicaid and CHIP
Website: http://www.insureoklahoma.org
Phone: 888-365-3742

OREGON – Medicaid
Websites: http://healthcare.oregon.gov/Pages/index.aspx
Phone: 800-699-9075

PENNSYLVANIA – Medicaid and CHIP
Website: https://www.dhs.pa.gov/en/services/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html
Phone: 800-692-7462
CHIP Website: https://www.dhs.pa.gov/CHIP/Pages/CHIP.aspx
CHIP Phone: 800-986-KIDS (5437)

Important Notices (continued)

RHODE ISLAND – Medicaid and CHIP
Website: http://www.eohhs.ri.gov/
Phone: 855-697-4347 or 401-462-0311 (Direct RIte Share Line)

SOUTH CAROLINA – Medicaid
Website: https://www.scdhhs.gov
Phone: 888-549-0820

SOUTH DAKOTA – Medicaid
Website: http://dss.sd.gov
Phone: 888-828-0059

TEXAS – Medicaid
Website: https://www.hhs.texas.gov/services/financial/health-insurance-premium-payment-hipp-program
Phone: 800-440-0493

UTAH – Medicaid and CHIP
Utah's Premium Partnership for Health Insurance (UPP)
Website: https://medicaid.utah.gov/upp/
Email: upp@utah.gov
Phone 888-222-2542
Adult Expansion Website: https://medicaid.utah.gov/expansion/

Utah Medicaid Buyout Program
Website: https://medicaid.utah.gov/buyout-program/
CHIP Website: https://chip.utah.gov/

VERMONT – Medicaid
Website: https://dvha.vermont.gov/members/medicaid/hipp-program
Phone: 800-250-8427

VIRGINIA – Medicaid and CHIP
Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select
https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs
Medicaid Phone: 800-432-5924
CHIP Phone: 800-432-5924

WASHINGTON – Medicaid
Website: https://www.hca.wa.gov/
Phone: 800-562-3022

WEST VIRGINIA – Medicaid and CHIP
Website: https://dhhr.wv.gov/bms/
http://mywvhipp.com/
Medicaid Phone: 304-558-1700
CHIP Toll-Free Phone: 855-MyWVHIPP (855-699-8447)

WISCONSIN – Medicaid and CHIP
Website:
https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm
Phone: 800-362-3002

WYOMING – Medicaid
Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/
Phone: 800-251-1269

To see if any other states have added a premium assistance program since July 31, 2024, or for more information on special enrollment rights, contact either:

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

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

Important Notice from Murrieta Valley Unified School District About Your Prescription Drug Coverage and Medicare

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

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

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

WHEN CAN YOU JOIN A MEDICARE DRUG PLAN?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

WHAT HAPPENS TO YOUR CURRENT COVERAGE IF YOU DECIDE TO JOIN A MEDICARE DRUG PLAN?

If you decide to join a Medicare drug plan, your current Murrieta Valley Unified School District coverage will not be affected. If you keep this coverage and elect Medicare, the Murrieta Valley Unified School District coverage will coordinate with Part D coverage.

If you do decide to join a Medicare drug plan and drop your current Murrieta Valley Unified School District coverage, be aware that you and your dependents will be able to get this coverage back.

WHEN WILL YOU PAY A HIGHER PREMIUM (PENALTY) TO JOIN A MEDICARE DRUG PLAN?

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

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

FOR MORE INFORMATION ABOUT THIS NOTICE OR YOUR CURRENT PRESCRIPTION DRUG COVERAGE…

Contact the person listed below for further information.

NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Murrieta Valley Unified School District changes. You also may request a copy of this notice at any time.

Date:	April 2025
Name of Entity / Sender:	Murrieta Valley Unified School District
Contact:	Hilaree Pugh
Address:	41870 McAlby Court Murrieta, CA 92562
Phone:	951.696.1600 ext. 1015

FOR MORE INFORMATION ABOUT YOUR OPTIONS UNDER MEDICARE PRESCRIPTION DRUG COVERAGE…

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

For more information about Medicare prescription drug coverage:

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

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

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

Glossary

Affordable Care Act and Patient Protection (ACA)

Also called Health Care Reform, the ACA requires health plans to comply with certain requirements. The ACA became law in March 2010. Since then, the ACA has required some changes to medical coverage—like covering dependent children to age 26, no lifetime limits on medical benefits, covering preventive care without cost-sharing, etc, among other requirements.

Allowed Amount

Maximum amount on which payment is based for covered health care services. This may be called "eligible expense," "payment allowance" or "negotiated rate." If your provider charges more than the allowed amount, you may have to pay the difference. (See Balance Billing.)

Balance Billing

When a provider bills you for the difference between the provider's charge and the allowed amount. For example, if the provider's charge is $100 and the allowed amount is $70, the provider may bill you for the remaining $30. A preferred provider may not balance bill you.

Brand Name Drug

The original manufacturer's version of a particular drug. Because the research and development costs that went into developing these drugs are reflected in the price, brand name drugs cost more than generic drugs.

COBRA (Consolidated Omnibus Budget Reconciliation Act)

The Consolidated Omnibus Budget Reconciliation Act allows people who lose their jobs to continue their employer-sponsored insurance coverage for up to 18 months.

Children's Health Insurance Program (CHIP)

The government program that provides free or low-cost health coverage for children up to age 19 in families whose income is too high to qualify for Medicaid but too low to afford private insurance. CHIP covers U.S. citizens and eligible immigrants. In some states, CHIP covers pregnant people. CHIP goes by different names in some states.

Claim

A request for payment that you or your health care provider submits to your health insurer to be paid or reimbursed for items or services you have received. Most often, you will not be responsible for making claim requests. Usually, billing and claims specialists employed by the health care provider (e.g. primary care office, hospital) will make the claim on your behalf.

Coinsurance

A percentage of costs you pay "out-of-pocket" for covered expenses after you meet the deductible.

Copayment (Copay)

A fee you have to pay "out-of-pocket" for certain services, such as a doctor's office visit or prescription drug.

Comprehensive Coverage

A health insurance plan that covers the full range of care that you may need. This may include preventive services (like flu shots), physical exams, prescription drugs, and doctor or hospital care.

Deductible

The amount you pay "out-of-pocket" before the health plan will start to pay its share of covered expenses.

Formulary

A list of prescription drugs covered by the health plan, often structured in tiers that subsidize low-cost generics at a higher percentage than more expensive brand-name or specialty drugs.

Generic Drug

Lower-cost alternative to a brand name drug that has the same active ingredients and works the same way.

High-Deductible Health Plan (HDHP)

High-deductible health plans (HDHPs) are health insurance plans with lower premiums and higher deductibles than traditional health plans. Only those enrolled in an HDHP are eligible to open and contribute tax-free to a health savings account (HSA).

Glossary (continued)

Health Savings Account (HSA)

A health savings account (HSA) is a portable savings account that allows you to set aside money for health care expenses on a tax-free basis. State taxes may apply. You must be enrolled in a high-deductible health plan in order to open an HSA. An HSA rolls over from year to year, pays interest, can be invested, and is owned by you—even if you leave the company.

Health Reimbursement Arrangements (HRAs)

Unlike HSAs, only an employer may fund an HRA and the funds revert back to the employer when the employee leaves the organization. HRAs are not subject to the same contribution limits as HSAs, and they may be paired with either high-deductible plans or traditional health plans.

In-Network

Doctors, clinics, hospitals and other providers with whom the health plan has an agreement to care for its members. Health plans cover a greater share of the cost for in-network health providers than for providers who are out-of-network.

Non-Preferred Provider

A provider who doesn't have a contract with your health insurer or plan to provide services to you. You'll pay more to see a non-preferred provider.

Out-of-Pocket Maximum

The most you pay each year "out-of-pocket" for covered expenses. Once you've reached the out-of-pocket maximum, the health plan pays 100% for covered expenses.

Out-Of-Network

A health plan may not cover treatment for doctors, clinics, hospitals and other providers who are out-of-network, but covered employees will pay more out-of-pocket to use out-of-network providers than for in-network providers.

Out-Of-Pocket Limit

The most an employee could pay during a coverage period (usually one year) for his or her share of the costs of covered services, including co-payments and co-insurance.

Plan Year

The year for which the benefits you choose during Annual Enrollment remain in effect. If you're a new employee, your benefits remain in effect for the remainder of the plan year in which you enroll, and you enroll for the next plan year during the next Annual Enrollment.

Preferred Provider

A provider who has a contract with your health insurer or plan to provide services to you at a discount.

Premium

The amount that must be paid for a health insurance plan by covered employees, by their employer, or shared by both. A covered employee's share of the annual premium is generally paid periodically, such as monthly, and deducted from his or her paycheck.

Preventive Care

Health care services you receive when you are not sick or injured— so that you will stay healthy. These include annual checkups, gender- and age-appropriate health screenings, well-baby care, and immunizations recommended by the American Medical Association.

Qualifying Life Event

A change in your life that can make you eligible for a Special Enrollment Period to enroll in health coverage. Examples of qualifying life events include moving to a new state, certain changes in your income, and changes in your family size.

Skilled Nursing Care

Services from licensed nurses in your own home or in a nursing home. Skilled care services are from technicians and therapists in your own home or in a nursing home.

Urgent Care

Care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room care.