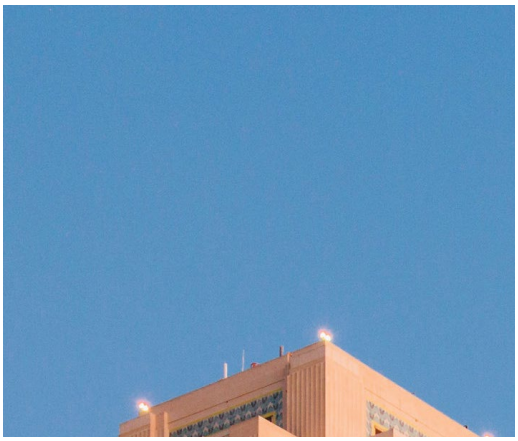
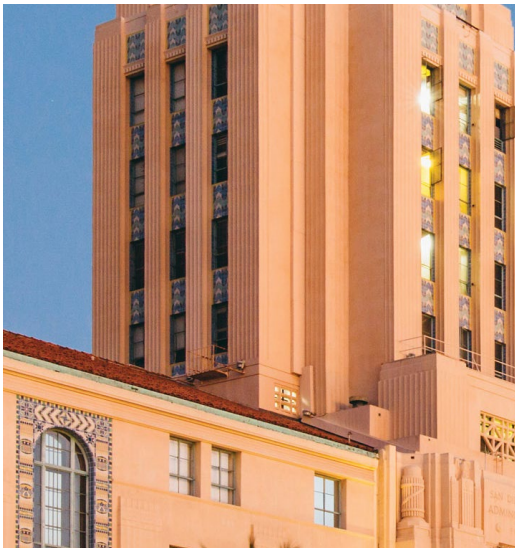
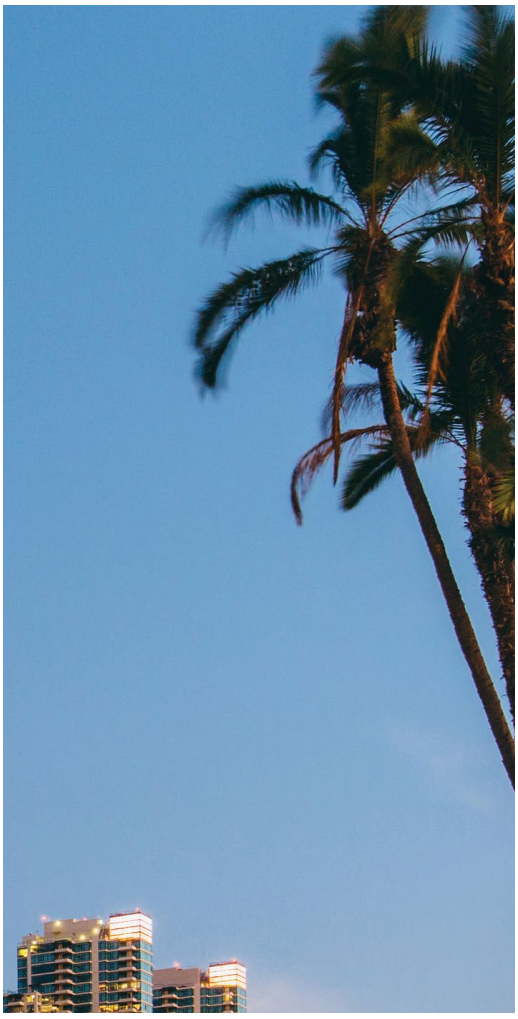
2026 EMPLOYEE BENEFITS GUIDE

COUNTY OF SAN DIEGO







Your Benefits

Learn-Plan-Choose

Learn: What's New For 2026

Open Enrollment for your 2026 benefits is **Monday, October 6 to Thursday, October 30, 2025**. This is your annual opportunity to review benefit plan options, consider your coverage needs, and make benefit elections for the next calendar year. The following changes are effective January 1, 2026.

Flex Credits Increase

Flex Credits are a pay period allowance that reflects the County's contribution toward your benefit plan premiums, lowering your out-of-pocket costs for insurance. Flex Credits are increasing 5% to 6% for 2026.

Medical, Dental, and Vision Plan Contributions

Healthcare costs are rising nationwide, and the County's costs have gone up along with them. However, the County helps cover part of these increases by increasing your Flex Credits and working hard to keep the impact on your paycheck as low as possible.

You will notice an increase in premiums for all medical plans.

There is no change in premiums for dental coverage under the Delta Dental PPO and DeltaCare USA HMO plans.

Contributions for the Vision Service Plan (VSP) will decrease slightly for 2026.

NEW! Kaiser Permanente Medical Plan – Everyday Care HMO

The County is introducing a new Kaiser Permanente medical plan option – the Everyday Care HMO – featuring lower copays for office visits, higher copays on more expensive services such as the emergency room (ER), and a deductible that applies only to inpatient hospital and outpatient services. This plan offers lower premiums than the Kaiser Permanente HMO plan, helping you save on medical costs while maintaining quality coverage.

NEW! Name Change for UHC SignatureValue Performance HMO – Network 1

The plan name for UHC SignatureValue Performance HMO – Network 1 is changing, but the plan's benefits and features remain the same. You will now see the plan referred to as UHC CS VEBA Performance HMO.

UHC SignatureValue Performance HMO – Network 1 ⋯→ **UHC CS VEBA Performance HMO**

NEW! Expanded HMO Fertility Coverage

Starting January 1, 2026, all County HMO medical plans will include in-network coverage for in vitro fertilization (IVF) treatment and other family-building services, in line with California's new requirements (California Senate Bill (S.B.) 729).

This means IVF services will now be available directly through your HMO medical plan provider network. If you're currently receiving fertility treatment through Kindbody, a Continuity of Care option will be available so you can finish your treatment.

If you are a VEBA or UnitedHealthcare/UMR Select Plus PPO member, you will continue to access your fertility benefits through Kindbody.

Kindbody will still offer menopause services to all VEBA participants.

Additional information on Continuation of Care through Kindbody

If you're in the middle of fertility treatment when our IVF coverage changes on January 1, 2026, you may be able to keep working with Kindbody for a short time to finish your current cycle.

Who qualifies?

You may be eligible if, before January 1, 2026, you:

- Are currently taking stimulation medications for an upcoming retrieval or transfer.
- Are scheduled for a retrieval, egg/embryo freezing, or IVF procedure.
- Have already prepared for an embryo transfer (for example, had a pelvic sonogram or uterine lining check).
- Have Kindbody authorization for fertility treatment (such as IVF, egg freezing, or IUI) that will take place within 90 days.

How it works:

- If your cycle started **before January 1, 2026**, you'll have until March 31, 2026 to finish that cycle with Kindbody. Your care and costs will follow Kindbody's current benefit rules.
- If your cycle starts **on or after January 1, 2026**, your medical plan will handle your fertility benefits, authorizations, and claims based on the plan's benefit design.

Increased Deductibles and Out-of-Pocket Maximums for Kaiser Permanente HDHP with HSA

The IRS has increased the minimum deductibles and out-of-pocket maximums for HDHPs and you will see the following changes to the **Kaiser HDHP with HSA**:

Plan Feature	Change for 2026
Deductible	
Employee Only	$1,700
Individual within a Family	$3,400
Family	$3,400
Out-of-Pocket Maximum	
Employee Only	$3,400
Individual within a Family	$3,400
Family	$6,800

Increased Deductibles and Out-of-Pocket Maximums for UHC Harmony HDHP

The IRS has increased the minimum deductibles and out-of-pocket maximums for HDHPs and you will see the following changes to the **UHC Harmony HDHP**:

Plan Feature	Change for 2026
Deductible	
Individual within a Family	$3,400
Family	$3,400
Out-of-Pocket Maximum	
Individual	$3,400

Enhanced VSP LightCare Benefits

There is a $250 allowance for in-network and a $45 allowance for out-of-network ready-made non-prescription sunglasses or blue light filtering glasses, which can be used in lieu of prescription glasses or contact lenses.

Increased Maximums for Lincoln STD and PFL

The weekly maximum benefit for short-term disability and PFL benefits will increase to $1,750 for employees who are NON-CA/SDI participants.

NEW! Accident and Hospital Indemnity Plans

Accident and Hospital Indemnity Insurance is now being offered by Lincoln Financial Group. These plans are employee-paid and not eligible for payment through Flex Credits.

Accident Insurance

Lincoln Financial Group's Accident Insurance provides additional coverage for injuries, medical services, and hospitalization, covering more than 150 types of accidents. In the case of an accident, you receive a lump-sum payment to use at your discretion.

Hospital Indemnity Insurance

Lincoln Financial Group's Hospital Indemnity Insurance helps cover out-of-pocket expenses during your hospital stay and recovery, easing the financial burden as you heal. It provides coverage for services and treatments resulting from accidents, illnesses, or childbirth.

Your Benefits | *Learn-Plan-Choose*

Health Savings Accounts (HSA)

Maximum Contribution Increases – The maximum amounts you can contribute to a Health Savings Account in 2026 are:

- $4,400 for individual coverage
- $8,750 for family coverage

Flexible Spending Accounts (FSA)

You can roll over up to a combined amount of $660 from your 2025 Health Care FSA and HRA balances in 2026.

- Dependent Care FSA will not have a rollover to 2026. Any leftover balances in the 2025 account will be forfeited.
- You have until March 31, 2026 to submit claims for eligible health care and dependent care expenses incurred in 2025.

Increased Health Care FSA Contribution Maximum – The federal government has increased the annual Health Care FSA contribution maximum to $3,300.

NEW! Increased Dependent Care FSA Contribution Maximum – The federal government has increased the annual Dependent Care FSA contribution maximum to $7,500. If you are married and filing jointly, the combined maximum you can contribute to a Dependent Care FSA between both spouses is $7,500. If you are married and you and your spouse file separate federal income tax returns, the most each of you can contribute to a Dependent Care FSA is $3,750 (for a combined total of $7,500).

2026 OPEN ENROLLMENT

Monday, October 6 – Thursday, October 30, 2025

DO I HAVE TO TAKE ACTION During Open Enrollment?

YES! If Making Changes

If you want to make changes to your benefit elections for 2026…

YES! If Waiving Medical

If you want to waive or continue waiving your medical insurance in 2026…

YES! If Contributing to an HSA or FSA

If you want to contribute to your Health Savings Account (HSA) or participate in a Health Care or Dependent Care Flexible Spending Account (FSA) in 2026…

…THEN you must go to PeopleSoft Self Service **by Thursday, October 30, 2025** to make your changes, waive medical coverage, or indicate your FSA or HSA contributions. See "How to Enroll in PeopleSoft Self Service" on page 3 for details.

Useful Things to Know!

Primary Care Providers

For newly enrolled UnitedHealthcare HMO members, including those selecting the UHC Harmony HDHP, a PCP will be auto-assigned. If you would like to choose another provider, call UnitedHealthcare in late December 2025 to have your PCP changed. UnitedHealthcare can be reached at 888-586-6365.

SIMNSA Mexico HMO will not assign a PCP for its members. Instead, you may go to any in-network provider you choose.

New DeltaCare DHMO members will be assigned a dentist at their first visit with their selected PCD.

Waiving Medical Insurance

- If you currently waive medical insurance and want to continue waiving, you must actively select a waive reason in PeopleSoft Self Service during Open Enrollment.
  - Proof of other coverage is not required.
  - If you do not waive your medical election during Open Enrollment, you will be enrolled in the Kaiser HMO with Employee Only coverage and the County will direct any excess Flex Credits to the appropriate Spending Account.

Re-Elect Spending Accounts

- Health Care and Dependent Care Flexible Spending Accounts and Health Savings Accounts must be re-elected annually. Current annual pledges will not carry over into the new plan year.

Beneficiary Management

- Access the MetLife website if you would like to update or designate your Life Insurance beneficiaries.
- What do you need?
  - The beneficiary's full name, address, phone number and date of birth (and SSN, if available).
  - For trusts, you need the trust name, address, phone number, and trust date.
- How is this done?
  - Visit MetLife's website to register: **https://online.metlife.com/edge/web/public/uslogin?grpNumber=158540**
- Need help?
  - Call MetLife Record Keeping for assistance at 866-492-6983.

Increasing Supplemental Life Insurance

- Supplemental Life Insurance is available from 1-6 times salary.
  - A Statement of Health is required for new enrollments and for any increased amounts requested. After Open Enrollment ends, MetLife will email you an invitation to complete an electronic Statement of Health, which must be returned within 60 days.
  - Eligibility will be reviewed and determined by MetLife. New enrollments or increases will be effective January 1 or the 1st of the month after MetLife approval, whichever is later.

Your Benefits | *Learn-Plan-Choose*

The County of San Diego provides a comprehensive flexible benefits program for eligible employees and their dependents. You enroll in the benefits you want and waive coverage you do not want! This guide walks you through the general information about your County of San Diego benefits.

CONTENTS

This guide provides general benefit plan information only. For specific details, conditions, and exclusions please refer to the official Summary Plan Descriptions (SPD). If there is a discrepancy between this guide and official SPDs, the official documents will govern.

Enrolling in Your Benefits

Preparing for Enrollment

- **Review all your enrollment materials,** including this guide, to become familiar with your options.
- **Gather your dependents' information.**
  - Social Security numbers and dates of birth for eligible spouse, domestic partner, and children up to age 26.
  - Carriers require this information for dependents enrolling in County benefit plans; without this information, we cannot process the enrollment.
- **Have your** supporting documents ready to show proof of relationship (e.g., marriage certificate for a spouse and birth certificates for children).
- **Gather information about each of your beneficiaries.**
  - For individuals, you need the beneficiary's full name and date of birth (and SSN, if available).
  - For trusts, you need the trust name, address, phone number, and trust date.
  - You will designate your beneficiaries through MetLife at **https://online.metlife. com/edge/web/public/uslogin?grpNumber=158540**
- **Determine how much – if anything – you want to contribute** to a Flexible Spending Account and/or Health Savings Account.
- **Make sure** you have County Single Sign On access to PeopleSoft Self Service.
- **Get assistance** by contacting your assigned Help Desk:
  - DA Help Desk: 619-531-4104
  - County Help Desk: 888-298-1222
  - Sheriff's Help Desk: 858-256-2100
- **Update your mailing address** in Self Service for any communications related to your coverage.

Supporting Documentation for Dependents

When you enroll your dependents in County benefits, you must provide documentation verifying eligibility for the coverage.

Action/Change	Required Documentation (copy of document only; keep the original)
Enroll or add spouse	• Marriage certificate
Enroll or add domestic partner	• Registered Domestic Partnership Certification • Affidavit for Enrollment of Domestic Partners
Enroll or add a dependent child	• Birth certificate • Adoption papers • Custody award papers • Court order requiring coverage for the child
Drop spouse coverage due to divorce or legal separation[1]	• Divorce decree entered by the judge • Legal separation papers entered by the judge
Drop domestic partner coverage due to termination of domestic partnership[1]	• Statement of Termination of Domestic Partnership

[1] You will not receive COBRA paperwork for any dependents removed during the disenrollment process.

How to Submit Supporting Documentation

Have a copy of the scanned documents ready in PDF format. Upload your documents in PeopleSoft by selecting Benefit Details, and Document Upload.

If you need assistance or are having difficulty uploading documents, please email DHRBenefits.FGG@sdcounty.ca.gov.

How to Enroll in PeopleSoft Self Service

Enrolling in your County benefits is an easy three-step process. Here is what you need to do:

Step 1: Log In	Step 2: Enroll	Step 3: Submit
• Access PeopleSoft. • On the Self Service Page, Click on the Open Enrollment Tile (see image below). 	• Click the "Review" button on the right of the benefit plan for each plan you want to change or enroll in. • Follow the instructions on the screen to complete your changes and return to the Benefits Enrollment Summary page. • For details on how to enroll, select "Enrollment Instructions."	• Once you have completed your elections, click on "Next" at the bottom of the Benefits Enrollment Summary page. • Click "Next" on the top right. Print or save a copy of your Enrollment summary for your records. Note: You will not receive an enrollment confirmation email.

Login Assistance

Make sure you have County Single Sign On access to PeopleSoft Self Service.

Get assistance by contacting your help desk.

DA Help Desk:
619-531-4104

County Help Desk:
888-298-1222

Sheriff's Help Desk:
858-256-2100

Qualifying Life Events

Making Changes During the Year

You have 60 days from the date of the event to submit documentation and make changes to your benefit elections. If you miss this window, your next opportunity to make changes will be during Open Enrollment.

Effective Dates

Birth Events – New elections due to the birth of a child will be effective the 1st of the month following the date of birth.

All Other Qualifying Life Events – New elections for all other Qualifying Life Events will be effective the 1st of the month after documentation of the event is provided.

Qualifying Life Events May Include the Following

- Birth of a Child
- Adoption, Placement for Adoption, or Guardianship
- Marriage
- Divorce
- Adding or Removing a Domestic Partner
- Gain or Loss of Coverage
- Dependent Moving Into or Out of the Area
- Loss of a Dependent
- Changes to Spending Accounts
- Spouse's or Parent's Open Enrollment

Any benefit change you make must be consistent with the qualifying life event change. For example, if you have a baby, you can enroll your child in County Health plans; however, if you are not currently enrolled in dental coverage, but would like to add it, you must also add your new child to the plan to newly enroll.

Supporting Documentation

If you add a dependent for the first time to any health plans (medical, dental, vision or critical illness), the County requires that you provide supporting documentation to show proof of relationship – such as **a marriage certificate for a spouse and a birth certificate for a child**.

Spending Accounts

It is important to note that Qualifying Life Events can often result in changes to County funded Spending Accounts.

Tag Along Rule

Please note that the County follows the "Tag Along rule" for qualifying life events. The Tag Along rule allows all eligible dependents to be enrolled for coverage upon a qualifying life event. For example, if you have a baby, you will be allowed to enroll your newborn, as well as your spouse and all other eligible children, for medical coverage.

Who Is Eligible

You

You are eligible for benefits if you are:

- An active employee of the County of San Diego who is authorized to work 20 or more hours per week
- An elected official of the County of San Diego

Your Dependents

You may also enroll your dependents if they are:

- Your legal spouse or domestic partner (same-sex, opposite sex, or non-binary)
- Your child(ren)* or your spouse/domestic partner's child(ren)* who are under the age of 26
- Your child(ren)* or your spouse/domestic partner's child(ren)* of any age if:
  - They are incapable of self-sustaining employment because of a physical or mental disability that occurred before they reached the age limit for the plan, **and**
  - You provide proof of the child's incapacity and dependency within 60 days after the insurance carrier requests the Disabled Dependent Certification.

** Children also include stepchildren, legally adopted children, children placed with you for adoption, children for whom you have been appointed legal guardian, and children for whom you are required to provide coverage under a Qualified Medical Child Support Order (QMCSO) up to the age limit for the plan.*

Domestic Partners

If you want to enroll your domestic partner:

- They must be at least 18 years of age or older and mentally competent to consent to the domestic partnership.
- You must share a close personal relationship and be responsible for each other's common welfare.
- You must be each other's sole domestic partner.
- You cannot be married to anyone or have another domestic partner within the prior six months.
- You must not be related to each other by blood to a degree that would prohibit legal marriage in the State of California.
- You must share the same regular and permanent residence with the current intent to continue doing so indefinitely.
- You must be mutually financially responsible for each other's "basic living expenses."
- You must complete an **affidavit** or email your registered domestic partner certificate issued by the State to **dhrbenefits.fgg@sdcounty.ca.gov**.

Are Your Dependents County of San Diego Employees?

If you and your spouse, domestic partner, or parent are County employees, both County employees are eligible to participate in health care benefits.

Flex Credit Allowance

Flex Credits

The County of San Diego provides you with a pay period* allowance, known as Flex Credits, that you can use toward benefit elections. To see the Flex Credit amount available to each job classification, go to the **Benefit Summary**. To opt out of Flex Credits, contact Employee Benefits at 888-550-2203.

Things you should know about Flex Credits:

- They carry no cash value.
- Flex Credit amount is based on your medical coverage selection. If you choose to waive medical coverage or elect employee only coverage, your Flex Credit will be based on the Employee Only selection.
- They are applied to your coverages in the order of the elections listed in PeopleSoft , Benefit Details, View Current Benefits.
- Any amounts over the Flex Credits is your out-of-pocket expense.

** Based on 24 pay periods in the year/twice monthly deductions.*

Domestic Partner Flex Credit

You can receive the full Flex Credit when you enroll your domestic partner, but their portion of the premium will be taxed.

Excess Flex Credits

Where Do Excess Flex Credits Go When Waiving Medical Coverage?

You may have excess Flex Credits when waiving health care coverage or if you elect a medical plan that costs less than your Flex Credit allowance. Any excess Flex Credits will be directed to the respective Spending Account based on your reason for waiving.

Things to note:

- You do not have to elect a Spending Account in which to place your excess Flex Credits. They will be allocated to the appropriate Spending Account based on your medical enrollment selection or waive reason.
- Excess Flex Credits applied to a Health Care FSA have a $500 annual limit.
- If you would like any excess Flex Credits to go toward a Dependent Care FSA, you must actively elect a Dependent Care FSA during Open Enrollment and select an annual pledge. Prior Dependent Care FSA elections will not continue and you will not be able to move funds between accounts.

Reminder: Employees who want to waive medical coverage for the plan year must complete their waiver election in PeopleSoft Self Service annually. Your excess Flex Credits must total a minimum of $5 a pay period and $120 annually to be placed in a Spending Account.

Excess Flex Credits

The following table shows how the excess Flex Credits will be allocated when waiving medical coverage:

	Health Savings Account (HSA)[1]	Health Reimbursement Account (HRA)[2]	Health Care Flexible Spending Account (HCFSA)	Dependent Care Flexible Spending Account (DCFSA)
If You Are Waiving County Medical Coverage and...				
...You Have TRICARE; Medicare; Covered California; Medi Cal; or Any Other Individual Plan **or** **...You Have Chosen Not to Disclose Your Waive Reason**	N/A	N/A	**HCFSA** – You may receive up to **$500** excess Flex Credits, which will be defaulted to this account. You may elect out-of-pocket contributions up to a maximum of $2,800 (resulting in a combined annual contribution of $3,300).	**DCFSA** – You can contribute out-of-pocket money or elect excess Flex Credits to this account, up to a $7,500 contribution limit.
...You Have Other Group Health Plan Coverage (Non-HDHP)	N/A	**HRA** – All excess Flex Credits will be defaulted to this account, up to a maximum of $5,000.	**HCFSA** – You can elect out-of-pocket contributions up to $3,300.[3]	**DCFSA** – You can contribute out-of-pocket money or elect excess Flex Credits to this account, up to a $7,500 contribution limit.
...You Have Other Group Health Plan Coverage That Is a High Deductible Health Plan (HDHP)	**HSA** – All excess Flex Credits will be defaulted to this account up to the HSA family limit of $8,750[1] You may also elect out-of-pocket contributions combined with excess Flex Credits up to the limit.	N/A	**Limited Purpose HCFSA** – You may elect out-of-pocket contributions up to $3,300.[4]	**DCFSA** – You can contribute out-of-pocket money or elect excess Flex Credits to this account, up to a $7,500 contribution limit.
If You Are Electing County Medical Coverage...				
...Under a County Medical Plan (Non-HDHP)	N/A	**HRA** – Excess Flex Credits will be defaulted to this account up to a maximum of $5,000.	**HCFSA** – You can elect out-of-pocket contributions up to $3,300.[3]	**DCFSA** – You can contribute out-of-pocket money or elect excess Flex Credits to this account, up to a $7,500 contribution limit.
...Under the County HDHP Medical Plan	**HSA** – All excess Flex Credits will be defaulted to this account up to the HSA limit based on the level of coverage that you elect (employee only or family).[1] Note: You can elect out-of-pocket contributions combined with excess Flex Credits up to the limit.	N/A	**Limited Purpose HCFSA** – You may elect out-of-pocket contributions up to $3,300.[4]	**DCFSA** – You can contribute out-of-pocket money or elect excess Flex Credits to this account, up to a $7,500 contribution limit.

Your excess Flex Credits must total a minimum of $5 a pay period and $120 annually to be placed in a Spending Account.

[1] 2026 HSA contribution limits: Employee only coverage: $4,400; Employee + 1 or more coverage: $8,750. If you are not eligible to contribute to the HSA family limit due to outside contributions, contact Employee Benefits at 888-550-2203. NOTE: You cannot contribute to an HSA if you have a balance in a standard (not a limited) Health Care FSA account.

[2] HRA funds can be used for yourself and qualified dependents.

[3] The combination of HRA and HCFSA cannot exceed $5,000. If your HCFSA election amount causes the combined account total to be more than $5,000, the HCFSA will be reduced.

[4] A Limited Purpose HCFSA can be used for dental and vision expenses only.

2026 Rates for Medical, Dental, and Vision Plans

The following shows the per pay period* costs for County Medical, Dental, and Vision plans, and is based on 24 pay periods per year. The amounts below do not include Flex Credits contributions.

Plan	Coverage Level		
	Employee Only	Employee + 1	Employee + 2 or more
MEDICAL			
Kaiser Permanente HMO	$424.72	$849.44	$1,201.96
Kaiser Permanente Everyday Care HMO	$389.72	$779.44	$1,102.91
Kaiser Permanente HDHP with HSA	$331.54	$663.08	$938.26
UnitedHealthcare CS VEBA Performance HMO	$460.83	$921.30	$1,303.45
UnitedHealthcare SignatureValue CS VEBA Alliance HMO	$442.13	$883.90	$1,250.53
UnitedHealthcare/UMR Select Plus PPO	$845.53	$1,691.07	$2,392.92
UnitedHealthcare Harmony HDHP	$280.74	$558.25	$787.26
SIMNSA Mexico HMO	$144.31	$253.48	$372.59
DENTAL			
Delta Dental PPO	$23.88	$47.74	$68.16
DeltaCare USA DHMO	$9.07	$16.39	$21.00
VISION			
VSP Vision Service Plan	$4.07	$9.41	$12.76

** Based on 24 pay periods in the year/twice a month deductions.*

Medical Plans

Your selection of medical plans are administered by UnitedHealthcare (UHC and UHC/UMR), Kaiser Permanente, SIMNSA, and the VEBA Advocacy Center.

Plan	Major In-Network Providers	Available Coverage	HSA Available?
UnitedHealthcare CS VEBA Performance HMO	• Sharp • Rady	In-Network Only	No
UnitedHealthcare SignatureValue CS VEBA Alliance HMO	• Scripps • UCSD • Rady	In-Network Only	No
Kaiser Permanente HMO	Kaiser	In-Network Only	No
Kaiser Permanente Everyday Care HMO	Kaiser	In-Network Only	No
SIMNSA Mexico HMO	• SIMNSA Mexicali • SIMNSA Tecate • SIMNSA Tijuana	In-Network Only	No
UnitedHealthcare/UMR Select Plus PPO	Various; please consult the online provider directory (see page 10)	• In-Network • Out-of-Network	No
UnitedHealthcare Harmony HDHP	• Sharp • UCSD	In-Network Only	Yes
Kaiser Permanente HDHP with HSA	Kaiser	In-Network Only	Yes

Preventive Care

In-network preventive care is 100% covered under all of our medical plans.

What is Preventive Care?

Preventive care services are based on guidelines for your age. Ask your doctors about the right preventive care for you. Some common preventive care services include:

- Annual physicals
- Immunizations
- Medical/family history and physical exam
- Blood pressure checks
- Cholesterol checks
- Other screenings and exams by age and gender

For a complete list of covered preventive services, visit **https://www.healthcare.gov/coverage/preventive-care-benefits/**.

ID Cards

UHC and UHC/UMR ID Cards

All newly enrolled UHC HMO members, which includes those enrolled in the UHC Harmony HDHP, will be issued two digital ID cards: one medical ID card from UnitedHealthcare and a separate prescription drug ID card from Express Scripts.

UHC/UMR PPO newly enrolled members will be issued one ID card for medical and prescriptions combined.

You can access your digital ID card anytime. See Medical Plans for instructions on how to access your digital ID card.

Prescriptions under the UHC plans are covered by Express Scripts.

UHC HMO: 888-586-6365

UHC/UMR PPO: 800-826-9781

Express Scripts: 800-918-8011

Kaiser ID Card

All newly enrolled participants will receive an ID card from Kaiser, which you will use for both medical care and prescription drugs at Kaiser facilities.

Kaiser Permanente: 800-464-4000

SIMNSA ID Card

All newly enrolled participants will be issued one digital ID card from SIMNSA to be used both for medical care and prescription drugs at in-network providers and pharmacies.

You can access your digital ID card anytime. See Medical Plans for instructions on how to access your digital ID card.

SIMNSA: 800-424-4652

Using Your Card

You must present your card when you go to the doctor or fill a prescription at a new pharmacy.

If you need medical care before your card is available, your doctor's office or pharmacist can confirm with your insurance carrier that you are in the system.

Health Maintenance Organizations (HMOs)

The HMO plan provides cost-effective comprehensive medical care with no deductible and no claim forms to file. You select a primary care physician (PCP) who will coordinate your care and refer you to specialists, if necessary. To receive benefits, you use the HMO facilities and providers as referred by your PCP. Most services are covered at 100% after your copay. **An entire family enrolls in the same network but may choose different medical groups within the network.**

Doctors/Other Medical Care Providers: You can only use doctors, hospitals, and pharmacies that participate in the HMO network. There is no coverage if you go to out-of-network providers, except for emergency services.

Annual Deductible: There is no annual deductible.

Copays: You pay a set dollar amount when you receive medical care.

Annual Out-of-Pocket Maximum: The HMO plans include an annual out-of-pocket maximum. Once you reach the out-of-pocket maximum, the plan pays 100% of covered charges for the remainder of the plan year.

Your HMO Options

- UnitedHealthcare (UHC) CS VEBA Performance HMO (Sharp/Rady)
- UnitedHealthcare (UHC) SignatureValue CS VEBA Alliance HMO (Scripps/UCSD/Rady)
- Kaiser Permanente HMO
- Kaiser Permanente Everyday Care HMO
- SIMNSA Mexico HMO (SIMNSA Mexicali, Tecate, and Tijuana)

Selecting PCPs

If you are enrolling in an HMO plan, you need to designate a Primary Care Physician (PCP).

UHC CS VEBA Performance HMO or UHC SignatureValue CS VEBA Alliance HMO:

1. Go to the **UHC site**.
2. Click the "Search the provider network" blue button under the plan you wish to search, then click the blue pop-up "Continue" button.
3. On the next page, click the blue "Continue" button at the bottom of the screen. Now you can search by provider, service, or condition.
4. If your location is different from what's shown, click "Change Location," enter your location information and click "Update Location."
5. For newly enrolled UHC members, a Primary Care Physician will be auto-assigned; to choose another provider, call UHC at 888-586-6365.

Kaiser Permanente HMO and Everyday Care HMO:

1. Go to the **Kaiser site**.
2. Search by clicking "Doctor" or "Location."
3. Choose your region or enter your ZIP code or city.
4. Click the blue "Search" button.

SIMNSA Mexico HMO:

1. Go to **https://simnsa.com/**.
2. Under PROVIDER SEARCH, select the network location, the type of provider, and the provider speciality.
3. Click "Start Search."

The SIMNSA Mexico HMO

This HMO plan is very affordable. It has the lowest cost for coverage and low or no copays. But there are some requirements:

1. You must work in San Diego County, Imperial County, or Tijuana;
2. You must use a SIMNSA network provider in Mexicali, Tecate, or Tijuana. All medical prescriptions must be purchased and picked up in Mexico; and
3. You must meet one of the qualifications for a Mexican National.

   A "Mexican National" is defined as one or more of the following:

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

Preferred Provider Organization (PPO)

Doctors/Health Care Providers: You can choose any doctor, hospital, or pharmacy and pay less when you use a provider or facility that participates in network.

Annual Deductible: You generally pay an annual deductible before the plan begins to pay for a portion of covered medical services. Services that do not require a deductible first are preventive care, office visits, and prescription drugs.

Paying for Care: There are two ways you pay for services:

- **Copays:** You pay a set dollar amount when going to an in-network doctor for an office visit, the emergency room, or picking up a prescription. (You may need to pay the annual deductible first before the copay applies.)
- **Coinsurance:** When services are received, you pay a percentage of the cost of the service, and the plan pays the remaining percentage. (You will need to pay the annual deductible first before coinsurance applies.)

Annual Out-of-Pocket Maximum: This is the maximum amount you pay annually (under the applicable coinsurance percentage) after meeting the deductible. Once you reach the out-of-pocket maximum, the plan pays 100% of covered charges for the remainder of the plan year. **Please note:** Your annual out-of-pocket maximum will be lower when you use in-network providers.

Your PPO Option:

- UnitedHealthcare (UHC)/UMR Select Plus PPO

High Deductible Health Plans (HDHP) with an option for a Health Savings Account (HSA)

The High Deductible Health Plan (HDHP) is a unique medical plan that puts you in control of your health care spending and gives you the opportunity to enroll in a Health Savings Account.

Medical Plan

Doctors/Health Care Providers:

- **UnitedHealthcare (UHC) Harmony HDHP:** You can only use doctors, hospitals, and pharmacies that participate in the Harmony network. There is no coverage if you go to out-of-network providers, except for emergency services. Providers in the Rady's network are NOT part of the UHC Harmony Network HDHP.
- **Kaiser Permanente HDHP with HSA:** You must use Kaiser Permanente's network of providers. This network is the same network used with the Kaiser Permanente HMO.

Preventive Care: Preventive care is 100% covered for in-network providers.

Annual Deductible: You pay an annual deductible before the plan begins to pay for a portion of covered medical services. This includes office visits and prescription drugs. The only services that don't require you to pay a deductible first are preventive care.

Coinsurance: Once your annual deductible is met, you pay a percentage of the cost of the medical service, and the plan pays the remaining percentage.

Annual Out-of-Pocket Maximum: This is the maximum amount you must pay for the annual deductible and coinsurance combined. Once you reach the out-of-pocket maximum, the plan pays 100% of covered charges for the remainder of the plan year.

Embedded Deductible Limits for HDHP Plans: Any individual covered under a plan with dependent(s) will have a maximum deductible of $3,300. This means that no individual member's expenses will exceed the embedded individual deductible amount of $3,300 or the embedded individual out-of-pocket maximum amount of $3,300.

Your HDHP Options

- UHC Harmony HDHP (Sharp/UCSD)
- Kaiser Permanente HDHP with HSA

Important! Not Everyone Can Open an HSA

All employees are eligible to enroll in a High Deductible Health Plan (HDHP).

However, you may not be eligible to open or contribute to an HSA if you:

- Are enrolled in Medicare or receiving health benefits under TRICARE
- Can be claimed as a dependent on another individual's tax return
- Are considered active military
- Have a balance in a standard (not a limited) Health Care FSA account or Health Reimbursement Arrangement (HRA)

Health Savings Account (HSA)

The Health Savings Account is a key part of the High Deductible Health Plan (HDHP) that allows you to save toward out-of-pocket expenses now and in the future in an HSA bank account. You can use HSA funds for any IRS qualified Medical, Dental, and Vision expenses.

The County may also contribute to your HSA if you have excess Flex Credits. If you enroll in an HDHP, excess Flex Credits are automatically placed in your HSA. Unspent funds accumulate tax-free and roll over from year-to-year. There is no "use it or lose it" rule. The HSA is your bank account, and you can take it with you wherever you go.

If you want to contribute to your HSA through payroll deductions, you must set up your HSA bank account through Optum Bank. Optum Bank will mail a welcome kit with enrollment instructions to your home. The HSA is not established or administered by the County.

In 2026, here is how much you can contribute to an HSA:

- Employee only coverage: $4,400
- Employee + 1 or more coverage: $8,750 (this includes any spousal contributions)

Note: If you are age 55 or older, you can make additional "catch-up" contributions of up to $1,000 above the amounts listed.

The limits above include both contributions from you and the County.

How to Set Up and Use Your Health Savings Account (HSA)

Follow the four easy steps below to get started.

Step 1

Enroll in the Health Savings Account Plan in PeopleSoft Self Service to allocate any out-of-pocket contributions.

Step 2

Optum Bank will send a Welcome Kit to your home address. This kit includes details of the HSA account, where to find a list of qualified expenses, and any fees associated with the account. Complete the online account set-up process with Optum.

Step 3

Use your HSA debit card at the point of sale or when receiving qualified services.

Step 4

Save your receipts. If you are audited, you must provide proof that you have used the funds in your HSA according to IRS guidelines.

Questions?

Go to **www.optumbank.com** or call **866-234-8913**.

Domestic Partners and Health Savings Accounts (HSAs)

If you enroll in an HDHP and have an HSA, your domestic partner must set up their own HSA.

If you both set up HSAs, you can each contribute up to the maximum amount allowed each year by the IRS.

Health Savings Account Maintenance Fees

The HSA maintenance fee is $2.75 per month.

Ask About Generics

If you need medication, ask your doctor if the prescription can be filled with a generic brand. The Food and Drug Administration requires that generic drugs have the same active chemical composition, have the same strength, and be offered in the same dosage form as their brand-name counterparts. Competitive pricing by the different generic drug manufacturers keeps the prices down, which means generic drugs cost a lot less.

Prescription Drug Benefits

When you enroll in a medical plan, you will automatically receive prescription drug coverage. Here are some tips for making the most of your coverage:

- **Opt for generics, whenever possible:** Generic drugs have the same active ingredients as their brand-name counterparts, but cost less.
- **Mail order program:** Express Scripts and Kaiser each offer a mail order pharmacy that provides the convenience of home delivery, refill reminders, and added savings on maintenance medications. You will be able to obtain up to a 90-day supply of your long-term medication through home delivery.
- **Check your plan's formulary list:** A formulary is a list of approved drugs covered by your plan. This list can change during the plan year – with some drugs removed, new drugs added, and restrictions added or removed. Keeping up-to-date on your plan's formulary will help you save money on prescription medications.
- **Take advantage of preventive medications:** Preventive medications can help you avert or manage illness and better manage chronic conditions. Consult your doctor about preventive medications appropriate for your needs.

For more information about your prescription drug coverage, refer to your medical plan's prescription drug website listed below.

Medical Plan	Website
Kaiser Permanente HMO	https://healthy.kaiserpermanente.org/southern-california/health-wellness/drug-formulary?kp_shortcut_referrer=kp.org/formulary
Kaiser Permanente Everyday Care HMO	https://healthy.kaiserpermanente.org/southern-california/health-wellness/drug-formulary?kp_shortcut_referrer=kp.org/formulary
Kaiser Permanente HDHP with HSA	https://healthy.kaiserpermanente.org/southern-california/health-wellness/drug-formulary?kp_shortcut_referrer=kp.org/formulary
UnitedHealthcare CS VEBA Performance HMO	www.express-scripts.com/csvebaplan28
UnitedHealthcare SignatureValue CS VEBA Alliance HMO	www.express-scripts.com/csvebaplan28
UnitedHealthcare/UMR Select Plus PPO	www.express-scripts.com/csvebaplan30
UnitedHealthcare Harmony HDHP	www.express-scripts.com/csvebaplan40
SIMNSA Mexico HMO	English: https://simnsa.com/wp-content/uploads/2020/09/Plan7-10-250-ENG.pdf Spanish: https://simnsa.com/wp-content/uploads/2020/09/PLAN7-10-250-esp.pdf

VEBA Advocacy Center

UnitedHealthcare (UHC and UHC/UMR) and SIMNSA Plan Members Only

How do I contact the VEBA Advocacy Center?

The toll-free number is 888-276-0250. You can also visit **vebaonline.com/contact/** to submit a request.

What does the VEBA Advocacy Center do?

The VEBA Advocacy Center is there to help guide UHC, UHC/UMR, and SIMNSA members through the medical system and utilize their VEBA benefits, including support on issues such as:

- Helping members choose a health network
- Accessing care and emergency prescription drugs
- Transitioning care
- Suggestions on quality of care or access to a timely appointment
- Navigating complex health issues
- Assist with pharmacy and medical billing questions
  - If inquiring about a billing issue, the following information is required in order for the VEBA Advocacy Center to help: a copy of the full bill that contains the date of service, dollar amount, type of treatment, provider name, and phone number.
  - If inquiring about a prescription or pharmacy issue, provide the name of prescription, dosage and supply, name of pharmacy, date filled or attempted to fill, and dollar amount.

The VEBA Advocacy Center will need to verify personal information for the member, including first and last name, date of birth or full SSN, and contact information.

Fertility and Menopause Benefits through Kindbody

UnitedHealthcare/UMR Select Plus PPO Plan members will be able to access fertility and other family-building services, including one round of in vitro fertilization (IVF), through Kindbody. Members can also access Kindbody's menopause support program, including lifestyle assessment, hormone testing, and more.

Kindbody also offers wellness and therapy sessions for a range of needs, such as fertility care, parenting, and postpartum anxiety and depression. For details, visit **https://kindbody.com/**.

SIMNSA Plan members will access IVF services directly through the HMO provider network. Starting January 1, 2026, all County HMO medical plans will include in-network coverage for in vitro fertilization (IVF) treatment and other family-building services, in line with California's new requirements (California Senate Bill (S.B.) 729).

Is VEBA Advocacy Center assistance confidential?

Yes. VEBA Advocacy Center follows HIPAA guidelines and will not share any member's information unless authorized by you. They may have to contact your insurance provider or doctor's office to assist you, but will only do so with your permission. In some cases, they may ask you to sign a HIPAA authorization form giving them permission to access your information from your insurance carrier or doctor in order to better assist you.

Digital ID Cards for UnitedHealthcare, UnitedHealthcare/ UMR, Express Scripts, and SIMNSA

You can access your ID card at your fingertips digitally, anytime, anywhere. See **Medical Plans** for instructions on how to access each digital ID card. If you have trouble accessing your ID card and need help, contact the VEBA Advocacy Center at 888-276-0250.

Medical Plans at a Glance

The following charts provide a comparison of costs and benefits for the County of San Diego medical plans.

Benefit Features	UHC CS VEBA Performance HMO	UHC SignatureValue CS VEBA Alliance HMO	Kaiser Permanente (HMO)	Kaiser Permanente Everyday Care (HMO)	SIMNSA Mexico HMO
	HMO Network PCP Referred (within HMO medical group)	**UHC Network** PCP Referred (within HMO medical group)	**HMO Network** PCP Referred (within Kaiser network)	**HMO Network** PCP Referred (within Kaiser network)	**SIMNSA Network** PCP Referred (within SIMNSA network)
Provider Networks	Sharp, Rady	Scripps, Rady, UCSD	Kaiser	Kaiser	Mexico Only
ANNUAL DEDUCTIBLE[1]					
• **Individual**	None	None	None	$2,000	None
• **Maximum Per Family**	None	None	None	$4,000	None
ANNUAL OUT-OF-POCKET MAXIMUM (INCLUDES DEDUCTIBLE)					
• **Individual**	$2,000	$2,000	$1,500	$2,000	$6,350
• **Family**	$6,000	$6,000	$3,000	$4,000	$12,700
OUT-OF-HOSPITAL SERVICES					
• **Office Visits**	You pay $25 copay	You pay $25 copay	You pay $25 copay	You pay $10 copay	You pay $7 copay
• **Specialist Visits**	You pay $25 copay	You pay $40 copay	You pay $25 copay	You pay $10 copay	You pay $7 copay
• **Urgent Care Facility**	You pay $25 copay	You pay $25 copay	You pay $25 copay	You pay $10 copay	If care received in Mexico: $25 copay; If care received in U.S.: $50 copay
PREVENTIVE CARE					
• **Well-Baby/Well-Child**	No copay	No copay	No copay	No copay	No copay
• **Adult Physical Exam**	No copay	No copay	No copay	No copay	No copay
• **Well-Woman Care**	No copay	No copay	No copay	No copay	No copay
• **Prostate Cancer Screening**	No copay	No copay	No copay	No copay	No copay
• **Colorectal Cancer Screenings**	No copay	No copay	No copay	No copay	No copay
LAB/X-RAYS/ DIAGNOSTICS					
• **Preventive Diagnostic X-Ray/ Lab**	100% covered	100% covered	No copay	Preventive: No copay Lab: $10 copay X-Ray: $50 copay	No copay
• **Outpatient CT, PET, MRI, MRA, and Nuclear Medicine**	No copay	No copay	No copay	MRI, CT, PET: $500 copay	No copay
IN-HOSPITAL SERVICES					
• **Semiprivate Room and Board (Precertification required)**	You pay $200 per admission	You pay $200 per admission	You pay $100 per admission	$0 after deductible	No copay
• **Emergency Room**	You pay $125 (waived if admitted)	You pay $125 (waived if admitted)	You pay $125 (waived if admitted)	You pay $500 copay	You pay $250 copay (waived if admitted)
OTHER SERVICES					
• **Outpatient Surgery**	No copay	You pay $100 copay	You pay $25 per procedure	$0 after deductible	No copay
• **Durable Medical Equipment**	No copay	No copay	No copay	50% coinsurance (deductible doesn't apply)	No copay
• **Skilled Nursing Facility**	No copay; maximum 100 days a year	No copay; maximum 100 days a year	No copay; maximum 100 days a year	$0 after deductible; maximum 100 days a year	You pay $10 copay; available on the SIMNSA campus only; no maximum days limit
• **Physical/ Occupational/ Speech Therapy**	You pay $25 copay	You pay $25 copay	You pay $25 copay	You pay $10 copay	You pay $10 copay
• **Chiropractic Care/ Acupuncture**	You pay $20 copay; unlimited visits	You pay $20; unlimited visits	Not covered; discounts available through **https://healthy.kaiserpermanente.org/health-wellness/fitness-offerings**	Not covered; discounts available through **https://healthy.kaiserpermanente.org/health-wellness/fitness-offerings**	Chiropractic care not covered; Acupuncture: You pay $10 copay; unlimited visits

[1] All references to "annual" and "per year" on this chart refer to policy year of January 1 through December 31, 2026.

Benefit Features	UHC CS VEBA Performance HMO	UHC SignatureValue CS VEBA Alliance HMO	Kaiser Permanente (HMO)	Kaiser Permanente Everyday Care (HMO)	SIMNSA Mexico HMO
	HMO Network PCP Referred (within HMO medical group)	**UHC Network** PCP Referred (within HMO medical group)	**HMO Network** PCP Referred (within Kaiser network)	**HMO Network** PCP Referred (within Kaiser network)	**SIMNSA Network** PCP Referred (within SIMNSA network)
MENTAL HEALTH & SUBSTANCE ABUSE					
• **Outpatient Physician Visits**	You pay $25 copay for physician No charge for SA	You pay $25 per visit No charge for SA	$25 copay per individual visit $12 copay per group visit for MH $5 copay per group visit for SA	You pay $10 copay	You pay $7 copay for physician
• **Inpatient Physician Visits**	You pay $200 per admission	You pay $200 per admission	You pay $100 per admission	$0 after deductible	No copay
PRESCRIPTION DRUG BENEFITS: RETAIL (UP TO 30-DAY SUPPLY)					
• **Tier 1/Generics**	You pay $10 copay		You pay $10 copay	You pay $10 for a 30-day supply	You pay $10 copay
• **Tier 2/Brand**	You pay $20 copay		You pay $25 copay	You pay $50 for a 30-day supply	You pay $10 copay
• **Tier 3/Brand Non-Formulary**	You pay $35 copay		If prescribed by KP physician, covered at the brand copay	If prescribed by KP physician, covered at the brand copay	You pay $10 copay
• **Tier 4/Specialty**	Above applicable copays apply		You pay $25 copay	You pay $250 copay	You pay $10 copay
PRESCRIPTION DRUG BENEFITS: MAIL-ORDER					
• **Tier 1/Generics**	You pay $20 copay for up to 90-day supply		You pay $20 copay for up to 100-day supply	You pay $20 for a 100-day supply	Not covered
• **Tier 2/Brand**	You pay $40 copay for up to 90-day supply		100-day supply	You pay $100 for a 100-day supply	
• **Tier 3/Brand Non-Formulary**	You pay $60 copay for up to 90-day supply		You pay $50 copay for up to 100 day supply	Not covered	
• **Tier 4/Specialty**	Above applicable copays apply		You pay $25 copay for up to 30 days	You pay $250 copay for up to 30 days	
COST FOR COVERAGE (PER PAY PERIOD)[2]					
• **Employee Only**	$460.83	$442.13	$424.72	$389.72	$144.31
• **Employee +1 Dependent**	$921.30	$883.90	$849.44	$779.44	$253.48
• **Employee +2 or more Dependents**	$1,303.45	$1,250.53	$1,201.96	$1,102.91	$372.59

[2] Based on 24 pay periods in the year/twice a month deductions.

THIS COMPARISON CHART IS NOT A CONTRACT

The Comparison Chart is a summary of general benefits available to County of San Diego eligible employees. Wherever conflicts occur between the contents of this Comparison Chart and the Plan terms, than the Evidence of Coverage (EOC) plan document shall prevail. Space does not permit listing all limitations and exclusions that apply to each plan. Before using your benefits, call the insurance carrier for more information.

Benefit Features	UHC/UMR Select Plus Plan PPO		UnitedHealthcare (UHC) Harmony HDHP with Health Savings Account (HSA) Option	Kaiser Permanente HDHP with Health Savings Account (HSA) Option
	PPO Network Self-referred (within UHC PPO network)	**Out-of-Network** Self-referred (outside PPO network)	**UHC Harmony HDHP Network** PCP Referred (within the UHC Harmony HDHP network)	**Kaiser Permanente Network** PCP Referred (within the Kaiser network)
Choice of Provider			Must receive services from your Primary Care Physician (PCP) or be referred by your PCP to specialist within the same medical group. PCP must be a member of the UHC Harmony HDHP Network: Sharp, UCSD	Your choice of Kaiser Permanente physicians and providers. Must receive services from your Primary Care Physician (PCP) or be referred by your PCP to specialist within the same medical group.
ANNUAL DEDUCTIBLE[1]				
• **Employee Only Coverage (Annual Deductible includes Medical Care and copay Drug Benefits)**	$300	$600	$2,700	$1,700
• **Employee + Family Coverage (Annual Deductible includes Medical Care and copay Drug Benefits)**	$600	$1,200	$3,400 per individual $3,400 per family[2]	$3,400 per individual $3,400 per family[2]
ANNUAL OUT-OF-POCKET MAXIMUM (INCLUDES DEDUCTIBLE)				
• **Individual**	$2,300	$4,600	$3,400	$3,400
• **Family**	$4,600	$9,200	$6,000	$6,800
OUT-OF-HOSPITAL SERVICES				
• **Office Visits**	You pay $20 per visit (deductible waived)	You pay 40% after deductible	You pay 10% after deductible	You pay 10% after deductible
• **Specialist Visits**	You pay $40 per visit (deductible waived)	You pay 40% after deductible	You pay 10% after deductible	You pay 10% after deductible
• **Urgent Care Facility**	$75 copay (deductible waived)	You pay 40% after deductible	You pay 10% after deductible	You pay 10% after deductible
PREVENTIVE CARE				
• **Well-Baby/Well-Child**	No copay	You pay 40% after deductible	No copay or deductible	No copay or deductible
• **Adult Physical Exam**	No copay		No copay or deductible	No copay or deductible
• **Well-Woman Care**	No copay		No copay or deductible	No copay or deductible
• **Prostate Cancer Screening**	No copay		No copay or deductible	No copay or deductible
• **Colorectal Cancer Screenings**	No copay		No copay or deductible	No copay or deductible
• **Diagnostic X-Rays & Lab Tests**	100% covered		No copay or deductible	No copay or deductible
IN-HOSPITAL SERVICES				
• **Semiprivate Room and Board (Precertification required)**	You pay $150 copay per admission; then you pay 20% after deductible	You pay $300 copay per admission; then you pay 40% after deductible	You pay 10% after deductible	You pay 10% after deductible
• **Emergency Room**	You pay $125 (waived if admitted); then 20% after deductible	You pay $125 (waived if admitted); then 20% after deductible	You pay 10% after deductible	You pay 10% after deductible
OTHER SERVICES				
• **Outpatient Surgery**	You pay 20% after deductible	You pay 40% after deductible	You pay 10% after deductible	You pay 10% after deductible
• **Durable Medical Equipment**	You pay 20% after deductible	You pay 40% after deductible	You pay 10% after deductible	You pay 10% after deductible; benefit limited to $2,500 per plan year
• **Outpatient CT, PET, MRI, MRA, and Nuclear Medicine**	You pay 20% after deductible	You pay 40% after deductible	You pay 10% after deductible	You pay 10% after deductible
• **Prosthetic Devices**	You pay 20% after deductible	You pay 40% after deductible	You pay 10% after deductible	No charge after deductible

[1] All references to "annual" and "per year" on this chart refer to policy year of January 1 through December 31, 2026.

[2] The individual deductible included in family coverage will not exceed $3,400 for 2026. If one member of the family reaches $3,400, co-insurance goes into effect for all family members.

Benefit Features	UHC/UMR Select Plus Plan PPO		UnitedHealthcare (UHC) Harmony HDHP with Health Savings Account (HSA) Option	Kaiser Permanente HDHP with Health Savings Account (HSA) Option
	PPO Network Self-referred (within UHC PPO network)	**Out-of-Network** Self-referred (outside PPO network)	**UHC Harmony HDHP Network** PCP Referred (within the UHC Harmony HDHP network)	**Kaiser Permanente Network** PCP Referred (within the Kaiser network)
OTHER SERVICES				
• **Skilled Nursing Facility (Maximum 100 days per year)**	You pay 20% after deductible; precertification required; maximum 100 days a year	You pay 50% after deductible; precertification required; maximum 100 days a year	You pay 10% after deductible	You pay 10% after deductible
• **Physical/ Occupational/ Speech Therapy**	You pay $20 copay	You pay 40% after deductible	You pay 10% after deductible	You pay 10% after deductible
• **Chiropractic Care/ Acupuncture**	You pay $20 copay for chiropractic care; you pay 20% after the deductible for acupuncture	You pay 40% after deductible	You pay 10% after deductible	Not covered; discounts available through **https://healthy.kaiserpermanente.org/health-wellness/fitness-offerings**
MENTAL HEALTH & SUBSTANCE ABUSE				
• **Outpatient Physician Visits**	You pay $20 per visit	You pay 40% after deductible	You pay 10% after deductible	You pay 10% after deductible
• **Inpatient Physician Visits**	You pay 20% after deductible	You pay 40% after deductible	You pay 10% after deductible	You pay 10% after deductible
PRESCRIPTION DRUG BENEFITS	**ALL PRESCRIPTION DRUG BENEFITS ARE SUBJECT TO THE PLAN DEDUCTIBLE.**			
RETAIL (UP TO 30-DAY SUPPLY)				
• **Generic (Tier 1)**	You pay $10 copay		You pay $10 copay	$10 copay after deductible
• **Brand (Tier 2)**	You pay $20 copay		You pay $20 copay	$30 copay after deductible
• **Non-Formulary (Tier 3)**	You pay $35 copay		You pay $35 copay	If prescribed by KP physician, covered at the brand copay
• **Specialty Rx (Tier 4)**	Above applicable copays apply		Above applicable copays apply	$30 copay
MAIL-ORDER[3]				
• **Generic (Tier 1)**	You pay $20 copay for up to 90-day supply		You pay $20 copay for up to 90-day supply	You pay $20 copay for a 31- to 100-day supply
• **Brand (Tier 2)**	You pay $40 copay for up to 90-day supply		You pay $40 copay for up to 90-day supply	You pay $60 copay for a 31- to 100-day supply
• **Non-Formulary (Tier 3)**	You pay $60 copay for up to 90-day supply		You pay $60 copay for up to 90-day supply	Not covered
• **Specialty Rx (Tier 4)**	Above applicable copays apply		Above applicable copays apply	Not covered
COST FOR COVERAGE (PER PAY PERIOD)[4]				
• **Employee Only**	$845.53		$280.74	$331.54
• **Employee +1 Dependent**	$1,691.07		$558.25	$663.08
• **Employee +2 or more Dependents**	$2,392.92		$787.26	$938.26
HEALTH SAVINGS ACCOUNT OPTION				
• **Individual Contribution Maximum for 2026**	N/A		$4,400	$4,400
• **Family Contribution Maximum for 2026 (Family includes employee plus one or more dependents)**	N/A		$8,750	$8,750

[3] UHC 90-day prescriptions for maintenance medications can be picked up at Rite Aid, Costco and Sharp Rees-Stealy at the same copay as using the ESI mail order service. 90-day prescriptions will not be allowed for pick up at any other pharmacy.

[4] Based on 24 pay periods in the year/twice a month deductions.

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Dental Plans

You have two dental plans to choose from, both administered by Delta Dental.

Delta Dental PPO/Premier Plan

Dentists/Other Dental Care Providers: You can choose any dentist you want for all services. You'll pay less when you use a provider or facility that participates in the Delta Dental PPO/Premier network, which includes the benefit of receiving the network-negotiated pricing.

Preventive Care: Preventive care is 100% covered when you use in-network providers.

Annual Deductible: You pay an annual deductible before the plan begins to pay for a portion of covered services.

Coinsurance: When receiving dental services, you pay a percentage of the cost, and the plan pays the remaining percentage.

Annual Maximum Benefit: This is the maximum amount the plan will pay for your dental services each year. Once reached, you will pay the full cost of any dental services for the remainder of the year.

Orthodontic Care: Orthodontia benefit will cover 50% of approved orthodontic services up to a lifetime maximum of $2,500 for adults and children. Members may visit any licensed dentist to access this benefit.

DeltaCare DHMO Plan

The DHMO plan allows you to receive comprehensive coverage at set prices in California through the DeltaCare USA DHMO network.

Dentists/Other Dental Care Specialists: You only use dentists to whom you are assigned in network. There is no coverage if you go to an unassigned dentist.

Annual Deductible: There is no annual deductible.

Copays: When you receive dental care, you pay a set dollar amount based on covered treatment codes found in the Dental Plan Summary.

Orthodontic Care: To receive orthodontic benefits, you **MUST** use a provider in the DeltaCare Orthodontic Network, and be referred by your Primary Care Dentist.

Designating a Primary Care Dentist (PCD) for DeltaCare DHMO Participants

Newly enrolled employees can designate a Primary Care Dentist or facility by: scheduling an appointment with an in-network Primary Care Dentist or facility, registering for an online account, or calling Delta at 844-697-0579.

To designate your PCD, go to www.deltadentalins.com and select the "DeltaCare USA" network to select a PCD from their Provider Directory.

You can also contact DeltaCare directly at 844-697-0579.

Want to Change Dentists?
You must notify Delta Dental by the 15th of the month for your change to be effective on the first day of the following month.

Dental Plans at a Glance

The following charts provide a comparison of costs and benefits for the County of San Diego dental plans.

Benefit Features	Delta Dental PPO/Premier Plan		DeltaCare DHMO
Choice of Dentist	Any licensed dentist. Coverage available outside of the US at the Non-Network level of benefits.		Your choice of Delta Dental DHMO dentist. (within California only)
Annual Deductible	$50 per individual $150 maximum per family (excludes preventive services)		None
Annual Maximum Benefit	$2,500 per individual[1]		None
Eligible Charges	**In-Network:** Negotiated fees.	**Non-Network:** Benefits based on usual, reasonable, and customary charges.	All benefits based on charges authorized by the Schedule of Benefits and performed by the assigned DHMO network dentist.
PREVENTIVE CARE	**In-Network**	**Non-Network**	
• **Cleaning**	No copay; 3x within a calendar year	You pay 20%	No copay; 1x per 6-month period
• **Fluoride Treatment**	No copay; 2x per calendar year for adults and children over age 16	You pay 20%	$10 copay for adults age 19 or older No copay for children to age 19; once per year
• **Sealants Treatment**	No copay; for children under age 16 for permanent molars every 5 years	You pay 20%	You pay $5 per tooth (to age 18 only)
• **Space Maintainer**	No copay	You pay 20%	You pay up to $10
• **X-rays (routine bite-wings)**	No copay 1x per calendar year	You pay 20%	No copay
BASIC SERVICES	**In-Network**	**Non-Network**	
• **Amalgam Filling**	You pay 20%	You pay 20%	You pay $0
• **Simple Extractions**	You pay 20%	You pay 20%	You pay $0
• **General Anesthesia**	You pay 20%	You pay 20%	You pay each 15 minutes – $60
• **Root Canal Therapy**	You pay 20%	You pay 20%	You pay between $35 – $105
• **Periodontal Maintenance**	You pay 20%	You pay 20%	You pay $0
• **Periodontal Scaling and Root Planning/ per Quadrant**	You pay 20%	You pay 20%	You pay $20 – $40 per Quadrant
• **Reline Denture**	You pay 20%[2]	You pay 20%[2]	You pay $0 (Chair side – you pay $25 if sent to lab)
• **Osseous Surgery**	You pay 20%	You pay 20%	You pay $100 – $200 per Quadrant
• **Resin-Composite Fillings**	You pay 20%	You pay 20%	You pay $10 – $117

[1] Diagnostic and Preventive Services will not count towards the annual benefit maximum of $2,500 per individual.

[2] Replacement bridges, crowns, dentures, and implants are not covered unless they are over five years old and cannot be made serviceable. A fixed bridge is not covered if the carrier determines a partial fixture is satisfactory. Must be preauthorized.

Benefit Features	Delta Dental PPO/Premier Plan		DeltaCare DHMO
MAJOR SERVICES	**In-Network**	**Out-of-Network**	
• **Crowns**	You pay 30%[2]	You pay 40%[2]	You pay $90 per crown (plus cost of precious/semi-precious metal)
• **Complete or Partial Denture**	You pay 30%[2]	You pay 40%[2]	You pay $70 per full denture; $50 – $70 per partial denture.
• **Fixed Bridge**	You pay 30%[2]	You pay 40%[2]	You pay $90 per unit
• **Implants**	You pay 30%[2]	You pay 40%[2]	Not covered
Orthodontia (24-month banding for children and adults)	Orthodontia benefit will cover 50% of approved orthodontic services up to a lifetime maximum of $2,500 for adults and children. Members may visit any licensed dentist to access this benefit.		You MUST use a provider in the DeltaCare Orthodontic Network. Confirm your orthodontist is in the Delta Care Orthodontics Network by calling DeltaCare at 844-697-0579 BEFORE you start treatment. You pay $1,695 plus all charges incurred before banding begins and after banding removal.
COST FOR COVERAGE (PER PAY PERIOD)[3]			
• **Employee Only**	$23.88		$9.07
• **Employee +1 Dependent**	$47.74		$16.39
• **Employee +2 or more Dependents**	$68.16		$21.00

[2] Replacement bridges, crowns, dentures, and implants are not covered unless they are over five years old and cannot be made serviceable. A fixed bridge is not covered if the carrier determines a partial fixture is satisfactory. Must be preauthorized.

[3] Based on 24 pay periods in the year/twice a month deductions.

THIS COMPARISON CHART IS NOT A CONTRACT

The Comparison Chart is a summary of general benefits available to County of San Diego eligible employees. Wherever conflicts occur between the contents of this Comparison Chart and the Plan terms, than the Evidence of Coverage (EOC) plan document shall prevail. Space does not permit listing all limitations and exclusions that apply to each plan. Before using your benefits, call the insurance carrier for more information.

Important Notes About Your Dental Plans

- Neither plan will cover crowns, inlays, onlays, posts and cores, dentures, or orthodontic services prescribed before your plan coverage becomes effective.
- Some major services require pre-authorization in order to be covered. Ask your dentist for a "pre-determination of benefits," which will let you know how much the plan will pay.
- If you are a DHMO member, you and your family members can elect different primary care dentists, as long as they are in-network and in California.

Vision Plan

The County of San Diego offers you vision coverage through Vision Service Plan (VSP). The plan features include:

- **Eye Doctors:** You can choose any vision provider you want.
- **Glasses vs. Contact Lenses:** You will be able to select frames and lenses or contact lenses annually.
- **VSP EasyOptions**[1], which allows for one of the following upgrades with an in-network provider:
  - Additional $100 frame allowance, or
  - Fully covered premium or custom progressive lenses, or
  - Fully covered light-reactive lenses, or
  - Fully covered anti-glare coating, or
  - Additional $50 contact lens allowance.

[1] *Members cannot use EasyOptions at Costco, Walmart, or Sam's Club. Use your base plan benefits at these locations, and EasyOptions at a VSP in-network provider's office.*

- **LightCare**, which allows you to use you to use your $150 prescription glasses or contacts allowance to purchase non-prescription sunglasses or ready-made non-prescription blue light filtering glasses.
- **Paying for Care:** When you receive vision care, the amount you pay depends on what type of eye doctor you use:
  - **In-network eye doctors:** You generally pay a set dollar amount called a copay. For frames and elective contact lenses, the plan will pay up to an allowance amount, and you pay any cost over this allowance.
  - **Out-of-network eye doctors: You pay for the full service and are reimbursed through VSP up to the allocated amounts.**

Vision Benefits at a Glance

Plan features and costs are highlighted below. You will save money when you use in-network providers.

Benefit Features	Vision Service Plan	
Choice of Doctor	Any provider. However, the plan pays higher benefits if you receive care from a VSP In-Network doctor	
	In-Network	**Out-of-Network**
Copay	$15 per individual	$15 per individual
Eye Exam (once every calendar year	Plan pays 100% per plan year	Plan pays up to $40 per exam per plan year
Lenses (one pair per calendar year) • Single vision, lined bifocal, polycarbonate, scratch coating, and lined trifocal lenses	Plan pays 100% after copay	Plan pays 100% after copay, up to the following amounts. You pay all charges over these amounts: • Single vision: Up to $40 • Bifocal: Up to $60 • Trifocal: Up to $80 • Progressives: Up to $80 • Lenticular: Up to $125
• Standard progressive lenses	Plan pays 100% after copay	
Frames (once every calendar year)	$170 featured frame brands allowance $150 frame allowance 20% savings on the amount over your allowance $80 Walmart®/Sam's Club®/Costco®[1] frame allowance	Plan pays up to $45; you pay retail price over $45

[1] *Costco products are covered, but not all Optometrists at Costco are VSP network providers.*

Benefit Features	Vision Service Plan	
	In-Network	**Out-of-Network**
Contact Lenses (once a year in lieu of lenses and frames) • Cosmetic	• Up to $150 for contacts; copay does not apply • Up to $60 for contact lens exam (fitting, evaluation)	• Up to $105 for contact lens fitting, evaluation & materials
• Medically necessary[2]	• Plan pays 100% per plan year	• Up to $210 for contact lens fitting, evaluation & materials
VSP LightCare (in lieu of prescription glasses or contacts)	• $250 frame and lens allowance for non-prescription sunglasses or non-prescription blue light filtering glasses	• $45 frame and lens allowance for non-prescription sunglasses or non-prescription blue light filtering glasses
VSP EasyOptions[3] Members can choose one of these upgrades	• Additional $100 frame allowance, or • Fully covered premium or custom progressive lenses, or • Fully covered light-reactive lenses, or • Fully covered anti-glare coating, or • Additional $50 contact lens allowance.	Not covered
Laser Eye Surgery	• $500 per eye per lifetime for Custom LASIK / PRK, Bladeless LASIK, LASIK, or PRK • Average 15% off regular price or 5% off promotions at contracted facilities	
COST FOR COVERAGE (PER PAY PERIOD)[4]		
• **Employee Only**	$4.07	
• **Employee +1 Dependent**	$9.41	
• **Employee +2 or more Dependents**	$12.76	

[2] There are certain eye conditions that can only be corrected by contact lenses. Non-elective contact lenses, also called medically necessary contact lenses, are prescribed by your optometrist to correct these types of eye problems. Your eye doctor will let you know if you need non-elective contact lenses.

[3] Members are unable to use EasyOptions at Costco, Walmart or Sam's Club. Members can use their base plan benefits at Costco, Walmart and Sam's Club, and EasyOptions at a VSP in-network provider's office.

[4] Based on 24 pay periods in the year/twice a month deductions.

Notes

(1) Call VSP Customer Service at (800) 877-7195 or visit the VSP website at www.vsp.com for a list of member doctors in your area. A participating doctor will call VSP to verify your eligibility.

(2) Additional glasses are available with a 30% discount from the same VSP doctor on the same day as your WellVision Exam.

Employee Assistance Program

Who is Eligible

The Employee Assistance Program (EAP) is a confidential service available to you and anyone in your household.

Available Resources

Anthem EAP's trained professionals can easily refer you to the following resources:

- **Face-to-Face Confidential Counseling:** See a licensed counselor up to eight times for each personal situation per calendar year. If more than eight sessions are needed, employees are referred to the health insurance company or to community resources for ongoing care.
- **Telephone and Online Counseling Sessions:** You may also speak to a licensed counselor remotely over the phone or via LiveHealth Online. Call 888-777-6665 for additional information.
- **Talkspace:** Anthem's EAP offers Talkspace as a confidential and secure online option for personal and professional individual and couples therapy. For added convenience, patients age 13 and above can send text, audio, and video messages to a dedicated licensed therapist anytime, anywhere. Live sessions via chat, audio, and video are also available.
- **Crisis Counseling:** If you have an emergency, call 888-777-6665. The service representative will put you in touch with a professional who can help.
- **Learn-to-Live:** The Learn-to-Live program is a no-cost online virtual program that supports your emotional health and wellness. Through Learn-to-Live, you can receive online help for:
  - Depression
  - Stress management
  - Social anxiety
  - Insomnia
  - Substance use
  - Comprehensive clinical assessments
  - Personalized, clinician coaching

  You can also take advantage of self-directed programs (English and Spanish).
- **Legal Assistance:** Access to legal consultations up to 30 minutes face-to-face or by telephone at no charge. For services beyond the initial 30 minutes, you will receive a preferred discount rate of 25% off an attorney's normal hourly fee. You have access to virtually all areas of law such as family/domestic matters, civil matters, criminal, real estate, etc. Matters involving disputes between employees and the County of San Diego are specifically excluded from eligibility for this program.
- **Tobacco Cessation Online Resources:** Free online resources are available through the EAP website to help you learn how to break the tobacco use habit.
- **Dependent Care and Daily Living Resources:** Provides information on child care, adoption, summer camps, college placement relocation, and resources on elder care and assisted living. In addition, you can receive assistance with daily living issues such as household maintenance, moving, pet care, etc. Referrals are available through the Assisted Search feature on the Anthem EAP website (**www.AnthemEAP.com**) or by calling toll-free at 888-777-6665.

Other Online Resources

Informational articles, self-assessment tools, and quizzes on behavioral health and health care topics are available through the interactive website at **www.AnthemEAP.com**. Legal information and financial calculators are also available.

Contact the EAP

- By phone: **888-777-6665**
- Online: **www.AnthemEAP.com**

Company code:
For Code access, go to **CoSD Anthem EAP Summary of Benefits (sharepoint.com)**

Spending Accounts (HCFSA, DCFSA and HRA)

Important!

If you want to participate in a Spending Account, you must enroll every year.

Plan Your FSA Contributions Carefully

The IRS has several rules about FSAs that require you to plan carefully:

- You must enroll annually.
- Expenses must be incurred between January 1 and December 31 of the year for which you are making contributions. If you leave County employment in the middle of the year, expenses incurred after your termination date will not be reimbursable. Please note that if you stop working for the County, you may still submit claims for reimbursement of eligible dependent care expenses incurred through December 31st of the year you terminate employment.
- A combination of HRA and Health Care FSA balances up to $660 will roll over for the following year. The rollover will take place as long as the account is active at the end of the year. Any HRA/HCFSA balances over $660 at the end of the year will be forfeited.
- If you enroll in an HSA for the following plan year, any Health Care FSA rollover funds will be directed into a Limited Purpose Health Care FSA (dental and vision purposes only).
- You can reimburse health care expenses only through the Health Care FSA; you can reimburse dependent day care expenses only through the Dependent Care FSA.

Flexible Spending Accounts (FSAs)

Flexible Spending Accounts (FSAs) provide you with a way to pay for eligible out-of- pocket health care and dependent day care expenses.

The County of San Diego offers FSAs through ASIFlex.

Health Care FSA (HCFSA)

You may generally contribute from $120 to $3,300 per year to the Health Care FSA to pay for out-of-pocket health care expenses for you and your dependents.

Eligible expenses include:

- Deductibles
- Copays
- Coinsurance
- Over-the-counter drugs

For a complete list of eligible expenses, visit **www.asiflex.com/sdcounty**.

Limited Purpose Health Care FSA (LPHCFSA)

The Limited Purpose Health Care FSA is available for employees who enroll in the HDHP with an HSA. You may contribute from $120 to $3,300 per year to a LPHCFSA for reimbursement of dental and vision care expenses only.

Dependent Care FSA (DCFSA)

With the Dependent Care FSA, you can pay for eligible out-of-pocket dependent care expenses you have so that you can work. Eligible dependents include children under age 13 and adult dependents who are identified as dependents on your income tax return and who live with you at least eight hours per day. Eligible expenses include:

- Daycare (provided by someone who is not your spouse or child under age 19)
- Babysitting
- Day camps
- Before and after school care programs

You may contribute from $120 to $7,500 per year to the Dependent Care FSA. If you are married and filing jointly, the combined maximum you can contribute to a Dependent Care FSA between both spouses is $7,500. If you are married and you and your spouse file separate federal income tax returns, the most each of you can contribute to a Dependent Care FSA is $3,750 (for a combined total of $7,500).

Your Participation in an FSA during a Leave of Absence

Your contributions will automatically continue as long as you continue to receive pay and/or your excess Flex Credits are directed to this account. **Although you will continue to contribute to your Dependent Care FSA during a leave of absence, dependent care expenses that you incur during the leave will not be eligible for reimbursement due to IRS rules**.

Your Dependent Care FSA After You Leave County Employment

If you stop working for the County, your contributions to your Dependent Care FSA will end. You may still submit claims for reimbursement of eligible expenses incurred through December 31st of the year you terminate employment, and you will have until March 31st of the following year to submit your claims.

Health Reimbursement Accounts (HRA)

A Health Reimbursement Account is an employer-funded plan that reimburses you for out-of-pocket eligible health care expenses with remaining Flex Credits over $120 a year, up to a $5,000 annual maximum contribution.

The HRAs work just like the Health Care FSA and is administered by ASIFlex.

You will not be eligible for HRA rollover if you elect an HSA for the next plan year.

Spending Account Comparison

Review the table below for a high-level comparison of all of the Spending Accounts available to you.

	Health Care FSA	Limited Purpose FSA	Dependent Care FSA	HSA	HRA
Eligibility	All; except those contributing to an HSA account	Must be covered under a qualified HDHP and have an HSA	All	Must be covered under a qualified HDHP	Those enrolled in a Group Medical Plan
Account Owner	County of San Diego	County of San Diego	County of San Diego	You	County of San Diego
Who Funds	You or County of San Diego	You	You or County of San Diego	You or County of San Diego	County of San Diego
Annual Contribution Maximums	You, up to $3,300, County of San Diego, up to $500 Max of $3,800 combined	You, up to $3,300	$7,500 per calendar year; $3,750 per calendar year if married and filing separate tax returns	$4,400 (individual); $8,750 (family)	Up to $5,000
Eligible Expenses	Code 213(d) medical, dental, and vision expenses of employee, spouse, and children under age 26 incurred during the coverage period	Dental and vision expenses not covered by insurance or under any other source	Child or adult care while working and for the protection and well-being of the dependent	Code 213(d) medical, dental, and vision expenses of employee, spouse, and children under age 26	Code 213(d) medical, dental, and vision expenses of employee, spouse, and children under age 26 incurred during the coverage period
Itemized Statement Required	Yes	Yes	Yes	Yes (HSA account holder must retain records)	Yes
Carries Over Year to Year*	You can carry over up to $660 into the following plan year, combined with an HRA	You can carry over up to $660 into the following plan year	You cannot carry over any remaining balance into the following plan year	Yes	Up to $660 combined with Health Care FSA rollover funds. However, you will not be eligible for HRA rollover if you elect an HSA for the next plan year
HDHP Election	Cannot contribute	Can continue to have the option to contribute to a Limited Purpose Health Care FSA	Can continue to have the option to contribute to a Dependent Care FSA	Can have employee contribution and excess Flex Credits contributed to an HSA account (subject to contribution maximums)	Cannot contribute
Enrollment Requirements	Annually	Annually	Annually	Automatic enrollment if excess Flex Credits are available.* However, you will need to select any out-of-pocket contributions annually	Automatic enrollment if excess flex credits are available*

** Your excess Flex Credits must total a minimum of $5 a pay period and $120 annually to be placed in a Spending Account.*

Life Insurance

Life Insurance is administered by MetLife and provides a financial benefit for your beneficiary(ies) in the case of your death.

Basic Life Insurance

The County provides Basic Life Insurance coverage for you at no cost and is determined by your job classification.

In addition, the County provides $2,000 of Life Insurance coverage for your spouse, domestic partner, and each dependent child, up to age 26.

Supplemental Life Insurance

You may choose to purchase additional Life Insurance coverage for yourself. Coverage is available up to six times your annual salary, up to a maximum of $2,000,000 of coverage.

Guaranteed Issue Amount

If you enroll in Supplemental Life Insurance when you are first eligible as a new hire, you can purchase up to three times your annual salary without submitting a Statement of Health.

Statement of Health for Supplemental Life Insurance

If you enroll or increase Supplemental Life Insurance outside the initial eligibility period, you will need to complete a Statement of Health. MetLife will email you a request to log in to MyBenefits to complete an electronic Statement of Health. Final approval comes from MetLife, and your coverage will become effective the 1st of the following month after approval.

Costs for Supplemental Life

Your cost depends on your age and coverage amount.

Rate per $1,000 of Coverage	AGE (as of September 9, 2025)										
	<35	35 - 39	40 - 44	45 - 49	50 - 54	55 - 59	60 - 64	65 - 69	70 - 74	75 - 79	80>
Per Pay Period*	$0.0128	$0.0187	$0.0266	$0.0325	$0.0517	$0.0970	$0.1137	$0.2507	$0.6383	$0.6383	$0.6383

** Based on 24 pay periods in the year/twice a month deductions.*

Supplemental Spouse Life Insurance

You can purchase Supplemental Spouse Life insurance to cover your spouse or qualified domestic partner in the amount of $10,000. A Statement of Health will not be required.

Costs for Supplemental Spouse Life Insurance

Your spouse's Supplemental Life Insurance rate is based on **your age**.

Rate per $1,000 of Coverage	AGE (As of January 1, 2026)											
	<25	25 - 29	30 - 34	35 - 39	40 - 44	45 - 49	50 - 54	55 - 59	60 - 64	65 - 69	70 - 74	75 - 79	80+
Per Pay Period*	$0.038	$0.045	$0.060	$0.068	$0.075	$0.113	$0.173	$0.323	$0.495	$0.953	$1.545	$1.545	$1.545

** Based on 24 pay periods in the year/twice a month deductions.*

For Couples Who Are Both County Employees

- If you and your spouse/domestic partner are both County employees, each of you will receive employee Basic Life Insurance and be eligible for Supplemental Life Insurance as an employee. However, neither of you can be covered as a dependent for Supplemental Spouse Life or Voluntary Accidental Death and Dismemberment Insurance.
- For your children, the County will provide $2,000 of Dependent Life coverage, and you have the option to enroll your children in family coverage for Voluntary Accidental Death and Dismemberment Insurance, but your children can only be covered by one of you, not both.

Designate a Life Insurance Beneficiary

All County of San Diego employees are required to designate their life insurance beneficiaries in the **MetLife MyBenefits** system.

Remember: The beneficiary(ies) that you choose will receive all eligible life and AD&D financial benefits if you pass away, plus your last paycheck and any leave balance pay off. It is important to keep your beneficiary designation up to date. You can change your beneficiary(ies) any time during the year.

Click **here** for instructions for MetLife's MyBenefits website.

Need help registering on MetLife's website for the first time or using the website? Call MetLife Online Support at 1-866-363-8669.

Unable to access the MetLife website? Call MetLife Record-Keeping at 866-492-6983 to designate your beneficiary over the phone.

Unable to designate your beneficiary online or by phone? Complete the **MetLife Beneficiary Designation Form** and follow the instructions on the form to submit it directly to MetLife.

Primary and Secondary Beneficiaries

You may designate one or more primary beneficiaries to receive a portion of your Life and AD&D insurance benefits; if you designate more than one beneficiary, the benefit percentage amounts designated to each beneficiary must total 100%.

You may also designate secondary beneficiaries. Secondary beneficiaries receive your Life and AD&D insurance benefits in the event your primary beneficiary(ies) are unable to receive the benefit designated to them (for example, if a primary beneficiary passes away first or cannot be contacted).

Accidental Death & Dismemberment (AD&D) Insurance

The County provides Basic AD&D insurance at no cost to you. The amount of coverage is equal to your Basic Life Insurance coverage, based on your job classification.

Regarding beneficiaries, please note:

- If an accident causes your death, your beneficiary will receive your Basic and any Supplemental Life and AD&D coverage amounts purchased.
- If an accident causes you to lose one or more limbs or senses, you may receive all or part of your coverage amount.
- You are the beneficiary for any dependents on this plan.

For coverage details, review MetLife's **AD&D certificate of insurance**.

Supplemental AD&D Coverage

You may purchase Supplemental AD&D coverage for yourself and for your eligible dependents:

Coverage	Coverage Amount
For You	1, 2, or 3 times your annual salary, up to $1,000,000
For Your Spouse/Domestic Partner Only	60% of your Supplemental AD&D coverage amount
For Your Dependent Children Only	25% of your Supplemental AD&D coverage amount per child, up to $50,000 per child
For Your Spouse/Domestic Partner and Dependent Children	Spouse/domestic partner: 50% of your Supplemental AD&D coverage amount Dependent children: 15% of your Supplemental AD&D coverage amount per child, up to $50,000 per child

Costs for Supplemental AD&D

Your cost depends on your coverage level and amount elected.

Coverage Level	Per Pay Period* (rate per thousand)
Employee Only	$0.0075
Employee + Family	$0.0125

** Based on 24 pay periods in the year/twice a month deductions.*

Voluntary Short-Term Disability Insurance (STD)

When a non-work related illness or injury makes it impossible for you to work for a short period of time, STD guards you against financial loss.

There are two voluntary Short-Term Disability plans offered through Lincoln Financial Group. The plans are designed separately for employees who currently pay into the State Disability Insurance (SDI) through their paycheck, and for those who do not.

There is a three-month look-back period for pre-existing conditions. Benefits are not payable for medical conditions for which you incurred expenses, took prescription drugs, or received medical treatment, care, or services (including diagnostic measures) during the 3 months just prior to the most recent effective date of insurance.

Benefits are not payable for any disability resulting from a pre-existing condition unless the disability occurs after you have been insured under this plan for at least 12 months after your most recent effective date of insurance.

If you become pregnant prior to the voluntary Short-Term Disability effective date, your pregnancy will be considered pre-existing and will not be eligible for STD benefits. However, you still will be eligible for Paid Family Leave under the Non-CA/SDI STD plan.

For more details, please refer to the table below:

SHORT-TERM DISABILITY INSURANCE		
	Employees who are CA/SDI Participants	**Employees who are NON-CA/SDI Participants**
Benefit Waiting Period	14 days	7 days
Weekly Maximum Benefit	25% to $1,000	60% to $1,750
Weekly Minimum Benefit	$100 per week	$100 per week
Maximum Benefit Duration	24 weeks	3, 7, or 12 weeks Be sure to review your County-paid LTD waiting period so that you choose the STD benefits that matches as closely as possible to your LTD waiting period.
Benefit Reductions due to other income	Social Security payments	Social Security payments, a retirement plan, workers' compensation and any income received from the employer

When you take a PFL, the Non-CA/SDI STD plan will pay 60% to 70% of your weekly salary each week, consistent with CA SDI. There's no waiting period or pre-existing condition exclusions for this benefit.

Employees covered by CA/SDI have similar PFL benefits under the California state plan.

Non-CA/STD Paid Family Leave Benefits

In addition to the Short-Term Disability benefits shown in the table at right, participants in the Non-CA/SDI Plan can receive up to eight weeks of Paid Family Leave (PFL) each year under the plan to:

1. Bond with a child
2. Care for a seriously ill family member
3. Participate in a qualifying event because of a family member's military deployment to a foreign country

Under this STD plan, you are not required to use up your vacation or sick days first before the plan pays benefits.

The per pay period* costs are shown below.

Rates for CA/SDI Participants:

Age	Cost per $10 of weekly covered benefit
<50	$0.310
50 - 54	$0.310
55 - 59	$0.345
60 - 64	$0.405
65 - 99	$0.440

Rates for **Non**-CA/SDI Participants:

Age	Rate per $10 of Weekly Covered Benefit 3 - week Duration (Option 1)	Rate per $10 of Weekly Covered Benefit 7 - week Duration (Option 2)	Rate per $10 of Weekly Covered Benefit 12 - week Duration (Option 3)
<50	$0.290	$0.475	$0.550
50 - 54	$0.290	$0.475	$0.550
55 - 59	$0.325	$0.530	$0.610
60 - 64	$0.375	$0.620	$0.715
65 - 99	$0.415	$0.675	$0.785

** Based on 24 pay periods in the year/twice a month deductions.*

Voluntary Long-Term Disability Insurance (LTD)

This plan, offered through Lincoln Financial Group, pays Long-Term Disability benefits monthly to replace a portion of your income until you are able to return to work, as shown below. **Refer to your Benefit Summary to determine if you are eligible for this plan**.

LONG-TERM DISABILITY INSURANCE	
Benefit Waiting Period	180 days
Monthly Benefit	60% to $5,000
Monthly Minimum Benefit	$100
Maximum Benefit Duration	Social Security normal retirement age
Benefit Reductions	Social Security payments, state disability, and any income received from the employer

Please see your **Summary Plan Description** for a complete description of plan provisions, exclusions and limitations for the plan.

The per pay period* costs are shown below.

Age	Rate per $100 of pay period covered payroll	Age	Rate per $100 of pay period covered payroll
<20	$0.035	**45 - 49**	$0.272
20 - 24	$0.035	**50 - 54**	$0.377
25 - 29	$0.045	**55 - 59**	$0.400
30 - 34	$0.087	**60 - 64**	$0.422
35 - 39	$0.135	**65 - 69**	$0.438
40 - 44	$0.202	**70+**	$0.449

** Based on 24 pay periods in the year/twice a month deductions.*

County-Paid Long-Term Disability (LTD)

Depending on your job classification, you may be eligible for long-term disability insurance paid by the County and administered through Lincoln Financial Group. **Refer to your Benefit Summary to determine if you are eligible for this plan.**

COUNTY-PAID LONG-TERM DISABILITY INSURANCE	
Benefit Waiting Period	30, 60, or 90 days, depending on job classification
Monthly Benefit	66-2/3% of earnings, up to $8,000 or $12,000, depending on job classification
Monthly Minimum Benefit	$100 or 10% of LTD benefit before income reduction (e.g., benefits reduced because of work earnings, Workers' Compensation benefits, state disability payments, etc.)
To Make a Claim	Contact Lincoln Financial at 888-480-8710

See the **Lincoln Financial Group LTD Summary of Benefits** for more details, including determination of eligibility and waiting period.

Accident Insurance

You have the option to elect and pay for Accident Insurance offered by Lincoln Financial Group. This plan pays a cash benefit if you or your covered dependent suffers a covered injury as the result of an accident.

Accident insurance does not replace medical insurance, but you can use the benefit to help with additional out-of-pocket expenses that come up when you seek medical treatment for injuries sustained in an accident. The benefit is paid directly to you, giving you the control to decide where your needs are. How you spend it is completely up to you – from everyday bills, groceries, transportation, child care, to other expenses. Benefits are paid regardless of other insurance benefits you may have.

You are eligible to cover yourself, your spouse/domestic partner, and your children under this plan.

Health Assessment Benefit

If you enroll in accident insurance, you can receive a $75 cash benefit each year you and any of your covered family members complete a single covered assessment test, such as a covered exam, screening, or immunizations.

Costs for Accident Insurance

Coverage	Per-Pay-Period Rate[1]
Employee Only	$4.21
Employee + Spouse/Domestic Partner	$7.05
Employee + Child(ren)	$7.75
Employee + Family	$10.53

[1] Based on 24 pay periods in the year/twice-a-month deductions.

Critical Illness Insurance

Critical Illness Insurance is being offered by Lincoln Financial Group. This plan pays a cash benefit to you for any of a comprehensive list of serious illnesses.

You are eligible to cover yourself, your spouse/domestic partner, and your children under this plan. Coverage for children is offered at no cost when you cover yourself. You can elect coverage in four different amounts.

Critical Illness		
Benefit Amounts	Employee: $10,000, $20,000, $30,000, or $40,000 Spouse/Domestic Partner & children: 50% of employee elected amount	
Benefit Triggers (100%)	Invasive cancer Coma Heart attack End stage renal failure Major organ transplant	Benign brain tumor Complete blindness Complete loss of hearing Paralysis Stroke
Benefit Triggers	25% enhancement: • Coronary artery bypass surgery • Multiple sclerosis	30% enhancement: • Carcinoma in situ (non-invasive cancer)
Pre-Existing Condition Clause	Waived	
Wellness Screening Benefit	$100 annually	
Second Event Benefit	100% with 6-month separation of diagnoses or treatment	
Skin Cancer Benefit	$750 – once per lifetime	

By enrolling in this plan, you are confirming you currently have comprehensive health benefits.

Health Assessment Benefit

If you enroll in Critical Illness Insurance, you are eligible for a $100 health assessment benefit each year. To receive your health assessment benefit, you must undergo a single covered exam, screening, or immunization, such as an EKG (electrocardiogram), mammogram, PSA (prostate specific antigen blood test), and more. For a complete list of eligible health assessment procedures, see the **Critical Illness Summary** or call Lincoln Financial at 888-480-8710.

You can submit a health assessment claim:

- **Online:** Through the secure **self-service portal**
- **Email:** **FileClaim@LFG.com**
- **Fax:** 888-735-7636
- **Mail:** The Lincoln National Life Insurance Company
  P.O. Box 2609
  Omaha, NE 68103
- **Phone:** 888-480-8710

Costs for Critical Illness Insurance

The per pay period[1] costs are shown below.

$10,000 Policy[2]		
Ages	EE, EE+CH	EE+SP, FAM
18 - 24	$1.81	$3.17
25 - 29	$2.26	$3.85
30 - 34	$2.91	$4.81
35 - 39	$3.56	$5.79
40 - 44	$4.83	$7.70
45 - 49	$6.54	$10.27
50 - 54	$8.49	$13.20
55 - 59	$11.72	$18.04
60 - 64	$18.03	$27.50
65 - 69	$26.94	$40.86
70 - 74	$32.18	$48.73
75 - 79	$32.18	$48.73
80+	$32.18	$48.73

$20,000 Policy[2]		
Ages	EE, EE+CH	EE+SP, FAM
18 - 24	$3.61	$6.33
25 - 29	$4.52	$7.70
30 - 34	$5.81	$9.62
35 - 39	$7.11	$11.58
40 - 44	$9.66	$15.40
45 - 49	$13.08	$20.53
50 - 54	$16.98	$26.39
55 - 59	$23.44	$36.08
60 - 64	$36.05	$54.99
65 - 69	$53.87	$81.72
70 - 74	$64.36	$97.46
75 - 79	$64.36	$97.46
80+	$64.36	$97.46

$30,000 Policy[2]		
Ages	EE, EE+CH	EE+SP, FAM
18 - 24	$5.41	$9.49
25 - 29	$6.78	$11.55
30 - 34	$8.71	$14.43
35 - 39	$10.66	$17.36
40 - 44	$14.48	$23.10
45 - 49	$19.61	$30.79
50 - 54	$25.47	$39.58
55 - 59	$35.16	$54.11
60 - 64	$54.07	$82.48
65 - 69	$80.80	$122.57
70 - 74	$96.53	$146.18
75 - 79	$96.53	$146.18
80+	$96.53	$146.18

$40,000 Policy[2]		
Ages	EE, EE+CH	EE+SP, FAM
18 - 24	$7.22	$12.66
25 - 29	$9.04	$15.40
30 - 34	$11.62	$19.24
35 - 39	$14.22	$23.15
40 - 44	$19.31	$30.80
45 - 49	$26.15	$41.06
50 - 54	$33.96	$52.78
55 - 59	$46.88	$72.15
60 - 64	$72.10	$109.98
65 - 69	$107.74	$163.43
70 - 74	$128.71	$194.91
75 - 79	$128.71	$194.91
80+	$128.71	$194.91

[1] Based on 24 pay periods in the year/twice a month deductions.

[2] Insured spouse & each insured dependent are covered at 50% of Employee Benefit Amount.

Hospital Indemnity Insurance

You may purchase additional protection for yourself and your eligible dependents if you have a short stay in the hospital for an accident or illness. Hospital indemnity insurance pays you and/or your covered dependents a lump-sum cash benefit if you have expenses related to emergency room treatment or hospital confinement. The benefit you receive varies based on the length and type of hospital care you receive.

Your hospital indemnity insurance benefit is paid directly to you, and how you spend it is completely up to you – from health insurance deductibles, transportation, child care, and anything else you and your family need while you receive treatment and recover.

You are eligible to cover yourself, your spouse/domestic partner, and your children under this plan.

Health Assessment Benefit

If you enroll in hospital indemnity insurance, you can receive a $50 cash benefit each year you and any of your covered family members complete a single covered assessment test, such as a covered exam, screening, or immunizations.

Costs for Hospital Indemnity Insurance

Coverage	Per-Pay-Period Rate[1]
Employee Only	$7.98
Employee + Spouse/Domestic Partner	$16.98
Employee + Child(ren)	$12.27
Employee + Family	$22.19

[1] Based on 24 pay periods in the year/twice-a-month deductions.

Using the Lincoln Financial Website for Accident, Critical Illness, and Hospital Indemnity Insurance

To register on Lincoln Financial's self-service portal, visit **LincolnFinancial.com**, then:

1. Click Register on the top right of the page.
2. Click the Product link under Employee Benefits.
3. Enter requested information.
4. Validate your identity, and create username and password. Click Log in Now.
5. Enter your username and password, and create your security question.

Accessing the Lincoln Financial Secure Self-service Portal

Once registered, log in to your account and select Accident, Critical Illness, or Hospital Indemnity to access the portal, where you can:

- View policy information
- Download a Beneficiary Form – Send the completed form to Lincoln Financial to designate a beneficiary for your accident, critical illness, and/or hospital indemnity benefits in the event of your death. You must designate your beneficiary with Lincoln Financial directly. Please note that if you do not designate a beneficiary, your benefit will be paid to your estate.
- File claims

Where to Get More Information

For Information About Eligibility and General Questions	
Address	County of San Diego | Department of Human Resources | Employee Benefits Division 5500 Overland Avenue, Suite 370 San Diego, CA 92123
Hours	Monday through Friday, 8:00 a.m. to 5:00 p.m. (except County holidays)
Telephone	888-550-2203
Fax	858-467-9708
Mail Stop	O-7
Email	DHRBenefits.FGG@sdcounty.ca.gov
Benefits Information	www.sandiegocounty.gov/content/sdc/hr/EmployeeBenefits.html

Plan and Benefits Information				
Carrier	**Group Number**		**Member Services**	**Website**
	Medical Group Number	**Rx Group Number**		
Medical and Prescription Drug Plans				
UHC CS VEBA Performance HMO (Sharp/Rady)	685700	MVISDD133	888-586-6365	https://www.whyuhc.com/cosd
UHC Alliance HMO (Scripps/UCSD/Rady)	685710	MVISDAH33		
UHC Harmony HDHP HMO (Sharp/UCSD)	685726	MVISDHDS33 (EE Only) MVISDHDF33 (EE+Dep)		
Select Plus PPO	76-414102	MVISDSPPO	800-826-9781	www.umr.com
VEBA Advocacy Center (for UHC, UHC/UMR, and SIMNSA members)	N/A		888-276-0250 Follow the prompts for "COSD Advocacy Department"	www.vebaonline.com/
SIMNSA Mexico HMO	560		800-424-4652	www.simnsa.com
Kaiser Permanente	104301		800-464-4000	https://my.kp.org/sdcounty/
Express Scripts pharmacy	See Rx Group Numbers above		800-918-8011	www.express-scripts.com
Health Savings Account (HSA) For HDHP Plans				
Optum Bank	HB2505A		866-234-8913	www.optumbank.com
Dental Plans				
Delta Dental PPO DHMO	17214 76990		877-688-3503 844-697-0579 Confirm Network Orthodontist: 844-697-0579 (DHMO)	https://www.deltadentalins.com/countyofsandiego/

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Plan and Benefits Information				
Carrier	**Group Number**		**Member Services**	**Website**
	Medical Group Number	**Rx Group Number**		
Vision Plan				
VSP Vision Service Plan	00107506		800-877-7195	http://countyofsd.vspforme.com/
Spending Accounts (FSA and HRA)				
ASIFlex	N/A		800-659-3035	http://www.asiflex.com/sdcounty/
Life and AD&D Insurance				
MetLife Basic Life and AD&D Insurance Supplemental Life and AD&D Insurance	158540 158540		Submit a claim or Statement of Health status: 800-638-6420 Beneficiary Designation: 866-492-6983	www.metlife.com/countyofsandiego To designate beneficiaries: www.metlife.com/mybenefits Benefits login: County of San Diego
Disability Insurance				
Lincoln Financial Group Paid Family Leave Short-Term Disability County-Paid Long-Term Disability Voluntary Long-Term Disability	N/A 010261914-00000 010261917-00000		Submit a claim: 888-480-8710	Questions or claims Claims@lfg.com https://www.sandiegocounty.gov/content/sdc/hr/EmployeeBenefits/Disability-Insurance.html
Accident, Critical Illness, and Hospital Indemnity Insurance				
Lincoln Financial Group	800020		888-480-8710	https://www.lincolnfinancial.com File a claim: https://www.sandiegocounty.gov/content/sdc/hr/EmployeeBenefits/open-enrollment/critical-illness.html
Employee Assistance Program				
Anthem EAP	N/A		888-777-6665	www.anthemeap.com Company Code: For Code access, go to CoSD Anthem EAP Summary of Benefits (sharepoint.com)