2026

Employee Benefits Overview

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MEDICARE PART D NOTICE

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

Welcome to Your Benefits Guide

The benefits in this summary are effective
January 01, 2026 through **December 31, 2026**

Whether you're enrolling in benefits for the first time, nearing retirement, or somewhere in between, San Diego Metropolitan Transit System supports you with benefit programs and resources to help you thrive today and prepare for tomorrow.

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

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

! **IMPORTANT NOTE: This is a summary overview and does not provide a complete description of all benefit provisions.** While we've made every effort to make sure that this overview is comprehensive, it cannot provide a complete description of all benefits. Specific details and limitations are provided in the plan documents, such as the Summary of Benefits and Coverage (SBC), Evidence of Coverage (EOC), etc. Plan documents contain relevant provisions and determine how benefits are paid. If the information in this overview differs from the plan documents, the plan documents prevail.

Who Can You Cover?

Who is Eligible?

You are eligible if you are a regular full-time employee working 30 hours or more per week. The following dependents are eligible for benefits:

- Legally married spouse or registered domestic partner
- Children up to the age of 26 who are natural, adopted, stepchildren, or children of a domestic partner
- Children over age 26 who are disabled and depend on you for support
- Children named in a Qualified Medical Child Support Order (QMCSO)

*Proof of relationship, such as marriage or birth certificates, is necessary to enroll dependents.

Benefit Contributions

The San Diego Metropolitan Transit System will contribute toward your monthly medical, dental and vision premiums. Your contributions for medical, dental and vision coverages are deducted from your paycheck on a pre-tax basis, unless otherwise requested by you in writing.

When You Can Enroll

Benefits become effective on the first day of the month following 60 days from date of hire. You can enroll in benefits at any of the following times:

- Within the first 30 days of employment
- During the open enrollment period
- Within 30 days of a qualifying life event

If you do not enroll during the timeframes noted, you must wait for the next annual open enrollment period.

Making Changes During The Year

The choices you make during open enrollment will remain in effect for the entire year and cannot be changed unless you experience a qualifying life event. These include:

- Marriage, divorce or legal separation
- Birth or adoption of a child, or placement for adoption
- Death of a covered dependent
- Change in your spouse's employment that affects your benefits
- Dependent's loss of eligibility due to age
- Gain/loss of group insurance coverage
- Medicare or State Assistance
- Family Medical Leave

To make changes during the plan year, log into the MyADP website my.adp.com and complete changes within 30 days of the qualifying event. Otherwise, you must wait until the next Open Enrolment Period. It is your responsibility to process all desired changes within 30 days of any qualifying event. If you require assistance, you must contact Human Resources within this window.

How Do I Enroll?

To make your elections, log on to the MyADP website my.adp.com from any computer. If you have not yet registered on the MyADP website, you will need to register. Go to the MyADP website at my.adp.com and select the 'Get Started' button. The Registration code is SDMTS1-register. Once entered, click the 'Continue' button, and follow the instructions on screen to finish setting up your account.

If you have any questions with regard to enrollment, please contact Human Resources.

Medical

Our medical plans offer comprehensive coverage. Preventive care is fully covered under all plans if obtained in-network. Your costs for other services will depend on which plan you choose.

Medical Plan Overview

This guide serves as a summary of the medical plans. Please review the plan documents before selecting a plan.

	What you need to know
Blue Shield HMO *Full Network*	• In-network only • Requires PCP to see specialist • No deductible • Predictable costs
Blue Shield HMO *Trio Network*	• In-network only • Requires PCP to see specialist • No deductible • Predictable costs
Blue Shield PPO	• Must meet deductible for some services before the plan begins to pay a % of the cost • Out-of-network coverage; higher costs
Kaiser HMO *Kaiser Network*	• In-network only • Requires PCP to see specialist • No deductible • Predictable costs

Medical

This table shows member cost share.

	Blue Shield HMO Full Network	Blue Shield HMO Trio Network	Kaiser HMO
	In-Network Only	**In-Network Only**	**In-Network Only**
Annual Deductible Individual / Family	None / None	None / None	None / None
Out-of-Pocket Maximum Individual / Family	$1,500 / $3,000	$2,500 / $5,000	$1,500 / $3,000
Preventive Services	No copay	No copay	No copay
Office Visit Primary /Specialist	$20 copay	$20 copay	$20 copay
Teladoc Consultation (Blue Shield Plans Only)	$5 copay	$5 copay	Contact Kaiser for telemedicine service options/costs
Lab & X-Ray **CT/MRI/PET**	No copay No copay	No copay No copay	No copay No copay
Inpatient Hospital	$250 copay per admit	$500 copay per admit	$250 copay per admit
Outpatient surgery	$125 copay per procedure	$250 copay per procedure	$125 copay per procedure
Emergency Room (waived if admitted)	$100 copay	$150 copay	$100 copay
Urgent Care	$20 copay*	$20 copay*	$20 copay
Chiropractic **Acupuncture Care**	$15 copay $15 copay (Combined 30 visits per year)	$15 copay $15 copay (Combined 30 visits per year)	$15 copay $15 copay (Combined 30 visits per year)
PRESCRIPTION DRUGS			
Out-of-Pocket Maximum Individual / Family	$2,500 / $5,000	$2,500 / $5,000	Combined with Medical
Retail- Generic Brand Non-Preferred Brand Specialty	(30-day supply) $10 copay $20 copay $55 copay $50 copay	(30-day supply) $10 copay $20 copay $55 copay $50 copay	(30-day supply) $10 copay $20 copay $20 copay $20 copay
Mail Order- Generic Brand Non-Preferred Brand Specialty	(90-day supply) $20 copay $40 copay $100 copay $100 copay	(90-day supply) $20 copay $40 copay $100 copay $100 copay	(100-day supply) $20 copay $40 copay $40 copay Not covered

*For Urgent care services performed at a Freestanding Urgent Care center please refer to the Physician In-Office Visit/Consultation benefits. For Urgent Care services performed at a center affiliated with a licensed hospital please refer to the Emergency Room Hospital benefits.
**Blue Shield HMO Rx copays are the same when using an in-network and out-of-network retail pharmacy

Medical

This table shows member cost share.

	Blue Shield PPO	
	In-Network	**Out-of-Network**
Annual Deductible Individual / Family	$500 / $1,500	$1,000 / $3,000
Out-of-Pocket Maximum Individual / Family	$2,000 / $4,000	$4,000 / $8,000
Preventive Care	No copay	30% coinsurance after deductible
Office Visit Primary / Specialist	$20 copay	30% coinsurance after deductible
Teladoc Consultation	$20 copay	Not covered
Lab/Radiology/Scans	No copay[1]	30% coinsurance after deductible[2]
CT/MRI/PET	No copay[1]	30% coinsurance after deductible (up to $800 / day)[2]
Inpatient Hospital	20% coinsurance after deductible	30% coinsurance after deductible (up to $600 / day)
Outpatient Surgery	20% coinsurance after deductible	30% coinsurance after deductible (up to $350 / day)
Emergency Room (waived if admitted)	$100 copay	$100 copay
Urgent Care	$20 copay*	30% coinsurance after deductible*
Chiropractic	$20 copay	30% coinsurance after deductible
Acupuncture Care	$20 copay	30% coinsurance after deductible
	(Combined 30 visits per year)	
PRESCRIPTION DRUGS		
Out-of-Pocket Maximum Individual / Family	$5,850 / $10,700	
Retail-	(30-day supply)	(30-day supply)
Generic	$10 copay	$10 copay
Brand	$20 copay	$20 copay
Non-Preferred Brand	$35 copay	$35 copay
Specialty	$35 copay	$35 copay
Mail Order-	(90-day supply)	
Generic	$20 copay	
Brand	$40 copay	Not covered
Non-Preferred Brand	$70 copay	
Specialty	$70 copay	

*For Urgent care services performed at a Freestanding Urgent Care center please refer to the Physician In-Office Visit/Consultation benefits. For Urgent Care services performed at a center affiliated with a licensed hospital please refer to the Emergency Room Hospital benefits.

[1] 20% coinsurance applies if performed in an Outpatient Hospital setting

[2] Up to $350 per day if performed in an Outpatient Hospital setting

Medical Provider Information

When to use the ER

The emergency room shouldn't be your first choice unless there's a true emergency—a serious or life threatening condition that requires immediate attention or treatment that is only available at a hospital.

When to use Urgent Care

Urgent care is for serious symptoms, pain, or conditions that require immediate medical attention but are not severe or life-threatening and do not require use of a hospital or ER. Urgent care conditions include, but are not limited to: earache, sore throat, rashes, sprains, flu, and fever up to 104°.

Preventive or Diagnostic?

Preventive care is intended to prevent or detect illness before you notice any symptoms. Diagnostic care treats or diagnoses a problem after you have had symptoms.

Be sure to ask your doctor why a test or service is ordered. Many preventive services are covered at no out-of-pocket cost to you. The same test or service can be preventive, diagnostic, or routine care for a chronic health condition. Depending on why it's done, your share of the cost may change.

Whatever the reason, it's important to keep up with recommended health screenings to avoid more serious and costly health problems down the road.

HMO VS PPO Medical Plans

Deciding whether to enroll in an HMO or PPO plan can be overwhelming. For a quick overview about HMO plans, please visit the following link - vimeo.com/567586889/c1d054d32d. For a quick overview about PPO plans, please visit the following link - vimeo.com/567587527/4ec0a67b80.

Find a Doctor

Look up a doctor or facility in a particular zip code by following the steps below.

Kaiser HMO Plan

1. Visit kp.org
2. Click on Doctors and Locations
3. Click on California - Southern
4. Enter city or zip code
5. Under Health Plan, Select HMO
6. Choose the Provider Type
7. Narrow your results with the filters

Blue Shield PPO Plan

1. Visit blueshieldca.com/networkppo
2. Click on Doctors or Primary Care Physician
3. Enter city or zip code
4. Search by doctor type or name

Blue Shield HMO Plans

1. Trio HMO: Visit blueshieldca.com/networktriohmo

   Access+ HMO: Visit blueshieldca.com/networkhmo
2. Click on Doctors or Primary Care Physician
3. Enter city or zip code
4. Search by doctor type or name
5. Under Primary Care Physician ID, Click on View Details
6. NOTE: All Blue Shield HMO participants must provide the *Primary Care Physician's Name and PCP ID# with their enrollment for the employee* and any enrolled dependents

Health Reimbursement Account (HRA)

With the PPO medical plan, you will be automatically enrolled and have access to a Health Reimbursement Account (HRA) that MTS will fund. Employees may not contribute to their HRAs.

Your HRA can be used to pay eligible expenses such as office visits, surgery, dental and vision expenses, prescriptions, even eligible drugstore items. These HRA dollars will help offset your share of the deductible. Any unused balance at the end of the plan year will rollover as long as you remain enrolled in the associated PPO plan.

Summary of HRA Benefits

- Navia is the HRA Administrator. If enrolling for the first time, you will receive a packet with information about the HRA, how to file a claim, how to access your account information online, and your HRA debit card in the mail.
- HRA funds are available on your first day of coverage, which means you won't have to wait to use your HRA dollars.

Your HRA provides "first dollar coverage" for expenses – this means your HRA will reimburse you for medical and prescription drug expenses up to the accumulated balance in your HRA. The employer contributions are shown below. Employer contributions will be prorated if employee enrolls in the plan after January 1, 2026.

Coverage Level	HRA Contribution
Employee	**$1,000.00**
Employee & Spouse	**$2,000.00**
Employee & Child(ren)	**$2,000.00**
Employee & Family	**$3,000.00**

Blue Shield Prescription Drugs

Blue Shield members have access to prescription drug coverage through our pharmacy benefit manager (PBM), Navitus. The goal of your PBM is to help minimize your out-of-pocket costs, so you have access to the prescriptions you need.

Understanding Your Pharmacy Benefits

Network Pharmacy - If you prefer to pick up your prescriptions at your local pharmacy, most independent and all major chain pharmacies are part of the benefit network. All of your in-network pharmacies are listed in the Navitus portal.

Home Delivery – A 90-day supply of your medication may be eligible for home delivery at no cost to you. Navitus mail-order prescriptions are covered under Costco Home Delivery Pharmacy. Register online at pharmacy.costco.com or call 1-800-607-6861.

Rx 'n Go is an additional home delivery provider and can be accessed via Rxngo.com/medications or by calling 1-888-697-9646. Rx 'n Go is a separate program from Navitus which means they have their own list of approved prescriptions.

Get the most from your coverage

Check the Navitus member portal for a list of prescription drugs covered by your plan, referred to as the Formulary List. The list includes both brand-name and generic medications and is organized by tiers that affect your copay. Refer to the Prescription Drugs table listed in the Medical Plan section of this booklet for copay pricing.

Navitus App

You can also use the Navitus app to search for providers. Download from the App Store or Google Play®.

Navitus Customer Care

Provide your Carrier ID for the highest level of service.

- **Carrier ID: NVPSM**
- **855-847-1035**
- **benefitplans.navitus.com/nvpsm**

Blue Shield Member Benefits

Your Digbi Health Journey

The Digbi Health program is a personalized 52-week journey designed to transform your health and wellness. Whether you're managing your weight, Type 2 Diabetes, digestive health, or taking GLP-1s for weight management, Digbi is here to support you with care tailored to your biology. Digbi Health is available at no cost for eligible members covered by Blue Shield through your employer.

This program includes:

- Gut & Gene Testing Kits
- Glucose Monitoring Device
- Tailored Meals
- Health Coach
- GLP-1s for weight management

Contact Digbi at prism@digbihealth.com or at (866) 344-2189 if you have any questions.

Check your eligibility and sign up for the program at digbihealth.com/prism.

Wellvolution

Wellvolution is a digital platform for health and well-being. Wellvolution customizes your path to better health, matching you with clinically proven programs and apps that are right for you both in mind and body.

Wellvolution offers programs to help you achieve your health goals – at no extra cost. Areas of focus include disease prevention and reversal, nutrition, sleep, stress, smoking and more. Learn more at blueshieldca.com/wellvolution.

Available Wellvolution Programs

Emotional well-being	Headspace® and Headspace Care™ are now available as 12-month programs to help manage sleep, stress, anxiety, and depression, and boost resilience.[1]
Diabetes prevention	Coaching and digital tools like a Fitbit®[2] to track your success across a 12-month program for losing weight, feeling healthier, and reducing your risk of chronic disease.
Diabetes care and hypertension	Programs up to 18 months for treating common conditions, such as diabetes, hypertension, and heart disease. Receive digital tools to help manage and monitor risk as appropriate for each condition.
Weight management	Get a personalized plan, clinically proven to help you create better eating and fitness habits and lose weight through access to a 12-month program.
Tobacco and vaping cessation	Programs include nicotine replacement therapy in the form of a patch, lozenge, or gum. A two-month supply can be delivered to your home.
Physical therapy and fitness	Personalized digital therapy and health programs to reduce pain and increase strength. No matter your pain level or where it hurts, we have a program for you.
Healthy living	Discover ways to enhance your longevity with the Blue Zones Challenge™ app. Adopt the sustainable living practices of the world's longest-living populations by eating wisely, moving naturally, and connecting more with others and one's life purpose.

Dental

We offer dental coverage through MetLife. Dental insurance makes it easier and less expensive to get the care you need to maintain good oral health.

Dental Plan Overview

This guide serves as a summary of the dental plan. Please review the plan documents before enrolling in coverage.

	What you need to know
MetLife Low Dental PPO *PDP Plus Network*	• Must meet deductible for some services before the plan begins to pay a % of the cost • Out-of-network coverage; higher costs
MetLife High Dental PPO *PDP Plus Network*	• Must meet deductible for some services before the plan begins to pay a % of the cost • Out-of-network coverage; higher costs • Orthodontia included

Dental insurance covers multiple types of treatment:

1. **Preventive** care includes exams, cleanings and x-rays
2. **Basic** care focuses on repair and restoration with services such as fillings, root canals, and gum disease treatment
3. **Major** care goes further than basic and includes bridges, crowns and dentures
4. **Orthodontia** treatment to properly align teeth within the mouth.

Dental

This table shows member cost share.

	Low Dental PPO Plan		High Dental PPO Plan	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**
Deductible Individual / Family	None / None	$25 / $75	$50 / $150	
Calendar Year Benefit Maximum	$1,000		$2,500	
Preventive – Class I Exams Cleanings X-rays	0%	0%; deductible waived	0%; deductible waived	0%; deductible waived
Basic – Class II Fillings Endodontics Periodontics	20%	20% after deductible	10% after deductible	20% after deductible
Major – Class III Crowns Bridges Dentures	50%	50% after deductible	25% after deductible	30% after deductible
Orthodontia Services	Not covered		40%; deductible waived	50%; deductible waived
Orthodontia Lifetime Maximum	Not covered		$2,500	

Note: Out-of-network services are subject to Reasonable & Customary (R&C) limits for similar services in your geographic area. There are no R&C limits for in-network care.

Pretreatment Estimate You can ask for a pretreatment estimate. Your general dentist or specialist usually sends MetLife a plan for your care and requests an estimate of benefits. The estimate helps you prepare for the cost of dental services. We recommend that you request a pre-treatment estimate for services in excess of $300. Simply have your dentist submit a request online at dentalprovider.metlife.com or call 1-877-MET-DDS9. You and your dentist will receive a benefit estimate for most procedures while you are still in the office. Actual payments may vary depending up on plan maximums, deductibles, frequency limits and other conditions at time of payment.

Out-of-Network Balance Billing Providers may issue a bill to the patient using the difference between what the patient's dental insurance will cover and what the provider is charging. The patient is responsible to pay the remaining balance to the provider.

Find a Dental Provider:

1. Go to metlife.com/dental or register at metlife.com/mybenefits
2. Select Find a participating dentist
3. For Your Network, select PDP Plus
4. Enter city or zip code
5. Click Find
6. Narrow your results with the filters

Vision

We offer vision coverage through MetLife. Vision coverage helps with the cost of routine eye care, including eye exams, standard prescription eyeglass lenses, frames, and contacts.

Vision Plan Overview

This guide serves as a summary of the vision plan. Please review the plan documents before enrolling in coverage.

	What you need to know
Vision PPO Plan	• The plan will reimburse up to a specific dollar amount for most materials

Vision

This table shows member cost share.

	Vision PPO Plan	
	In-Network Member Allowance	**Out-of-Network Member Reimbursement**
Exams *Once every 12 months*	No copay	Up to $45
Eyeglass Lenses Single Vision Lens Bifocal Lens Trifocal Lens Lenticular Lens *Once every 24 months*	 No copay No copay No copay No copay	 Up to $30 Up to $50 Up to $65 Up to $100
Frames *Once every 24 months* *Frame at Costco, Walmart & Sam's Club*	Up to $200; then 20% off any remaining balance Up to $110 allowance	Up to $70
Contacts Lenses[1] Necessary Elective *Once every 24 months*	 No copay Up to $200	 Up to $210 Up to $105

[1]In lieu of lenses

MetLife Vision

Find a Vision Provider:

1. Go to metlife.com/vision
2. Select Find Vision Provider
3. Choose from a large network of ophthalmologists, optometrists and opticians, from private practices to retailers like Costco Optical, Walmart and Sam's Club.

Employee Assistance Program (EAP)

Help for you and your household members

There are times when everyone needs a little help or advice, or assistance with a serious concern. The EAP through Aetna Resources For Living can help you handle a wide variety of personal issues such as emotional health and substance abuse; parenting and childcare needs; financial coaching; legal consultation; and eldercare resources.

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

No cost EAP resources

The EAP is available around the clock to ensure you get access to the resources you need:

- Consultation and resource services including up to eight face-to-face assessment and brief counseling sessions per occurrence
- Referrals for community services, local and elder care services and resources provided through Aetna online
- 30-minute free legal/financial consultation per issue per year, including a 25% discount if legal counsel is retained

Available Resources

Counseling Benefits

- Difficulty with relationships
- Emotional distress
- Job stress
- Communication/ conflict issues
- Alcohol or drug problems
- Loss and death

Parenting & Childcare

- Referrals to quality providers
- Family day care homes
- Infant centers and preschools
- Before/after school care
- 24-hour care

Financial Coaching

- Money management
- Debt management
- Identity theft resolution
- Tax issues

Legal Consultation

- Referral to a local attorney
- Family issues (marital, child custody, adoption)
- Estate planning
- Landlord/tenant
- Immigration
- Personal Injury
- Consumer protection
- Real estate
- Bankruptcy

Eldercare Resources

- Help with finding appropriate resources to care for an elderly or disabled relative

Online Resources

- Self-help tools to enhance resilience and well-being
- Useful information and links to various services and topics

Contact the EAP

Phone: 800-342-8111

Website: resourcesforliving.com

Company Code: **SDMTS**

Password: **EAP**

Legal Notices

Medicare Part D Notice – Creditable Coverage Notice

Important Notice from About Your Prescription Drug Coverage and Medicare

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

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

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

When Can You Join A Medicare Drug Plan?

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

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

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current coverage will not be affected. See below for more information about what happens to your current coverage if you join a Medicare drug plan.

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

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

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

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

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

For More Information About This Notice Or Your Current Prescription Drug Coverage...

Contact the Human Resources Department listed below for further information. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage...

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

For more information about Medicare prescription drug coverage:

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

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

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

Date:	January 1, 2026
Name of Entity/Sender:	San Diego Metropolitan Transit System
Contact:	Brendan Shannon, Director of Human Resources
Address:	1255 Imperial Ave., Suite 1000 San Diego, California 92101
Phone Number:	619-557-4598

Women's Health and Cancer Rights Act

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

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. You can contact your health plan's Member Services for more information.

Newborns' and Mothers' Health Protection Act

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). If you would like more information on maternity benefits, call your plan's Member Services department.

HIPAA Notice of Special Enrollment Rights for Medical

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

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

If you request a change due to a special enrollment event within the 30 day timeframe, coverage will be effective the date of birth, adoption or placement for adoption. For all other events, coverage will be effective the first of the month following your request for enrollment. In addition, you may enroll in your employer's medical plan(s) if you become eligible for a state premium assistance program under Medicaid or CHIP.

You must request enrollment within 60 days after you gain eligibility for medical plan coverage. If you request this change, coverage will be effective the first of the month following your request for enrollment. Specific restrictions may apply, depending on federal and state law. Note: If your dependent becomes eligible for a special enrollment rights, you may add the dependent to your current coverage or change to another medical plan.

Health Insurance Portability & Accountability Act (HIPAA)

Your employer in accordance with HIPAA, protects your Protected Health Information (PHI). Your employer will only discuss your PHI with medical providers and third party administrators when necessary to administer the plan that provides you medical, dental, and vision benefits or as mandated by law. A copy of the Notice of Privacy Practices is available upon request from Human Resources.

Notice of Choice of Providers

Your employer's medical plans generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in the network of your employer's medical carrier and who is available to accept you or your family members. If the plan designates a primary care provider automatically, until you make this designation, your medical plan may designate one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact Member Services of your HMO health plan. For children, you may designate a pediatrician as the primary care provider. You do not need prior authorization from your employer's medical plan(s) or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a healthcare professional in the network of your employer's medical carrier who specializes in obstetrics or gynecology. The healthcare professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating healthcare professionals who specialize in obstetrics or gynecology, contact the plan administrator.

USERRA

Under the Uniformed Services Employment Reemployment Rights Act of 1994 (USERRA), employees are provided with broad protection in terms of their reemployment upon completion of military service. An employee who returns to work after active military duty must, with limited exceptions, be reemployed in the position that the employee held or would have attained had the military service not interrupted the employee's employment.

The Act provides specific time frames in which the employee must return to work upon completion of service. If the length of service was less than 31 days, the employee must return to work on the next regularly scheduled work period. If the leave was greater than 31 days and less than 180 days, the employee has 14 days upon completion to return to work. If greater than 180 days, the employee has up to 90 days to return to work. The Agency will comply with all aspects of USERRA.

Coordination of Benefits (COB)

Like other employer plans, group benefits programs include a Coordination of Benefits (COB) policy to help manage healthcare cost for employees and the Agency. This COB policy applies whenever an employee or covered family members (usually spouse) are covered under more than one healthcare plan.

COB helps to ensure that payments made by the healthcare provider chosen through the San Diego Metropolitan Transit System and the carrier for a spouse's plan never exceed 100% of the total medical costs incurred. It can also help employees save on out-of-pocket healthcare costs if an employee's secondary plan covers additional benefits not otherwise covered by the San Diego Metropolitan Transit System medical plan. Please keep in mind, if your spouse has coverage through his/her own employer's plan, that plan is considered their primary coverage, and the San Diego Metropolitan Transit System's plan is considered his/her secondary coverage.

Appeals

You have a right to two levels of appeal with our carriers and a right to a response within a reasonable amount of time. You should know that if a claim is not submitted within a reasonable amount of time, the carriers have a right to deny that claim. Please review each contract for specific procedures on how to submit an appeal.

Summary of Benefits and Coverage

As required by law, across the US, insurance companies and group health plans like ours are providing plan participants with a consumer-friendly SBC as a way to help understand and compare medical benefits. Each SBC contains concise medical plan information, in plain language, about benefits and coverage, including, what is covered, what you need to pay for various benefits, what is not covered and where to go for more information or to get answers to questions. SBC documents are updated when there is a change to the benefits information displayed on an SBC.

Government regulations are very specific about the information that can and cannot be included in each SBC. Plans are not allowed to customize very much of the SBC documents. There are detailed instructions the Plan had to follow about how the SBCs look, how many pages the SBC should be (maximum 4-pages), the font size, the colors used when printing the SBC and even which words were to be bold.

To get a copy of the most current Summary of Benefits and Coverage (SBC) documents for our medical plans, contact Human Resources.

Initial COBRA Notice

Introduction

You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it. When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

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

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

What is COBRA continuation coverage?

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

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

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

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

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

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

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

When is COBRA continuation coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

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

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify Human Resources within 30 days after the qualifying event occurs. You must provide this notice to selected insurance carrier.

How is COBRA continuation coverage provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

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

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage

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

Second qualifying event extension of 18-month period of continuation coverage

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

Are there other coverage options besides COBRA Continuation Coverage?

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

If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit healthcare.gov.

Keep your Plan informed of address changes

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

ACA Disclaimer

This offer of coverage may disqualify you from receiving government subsidies for an Exchange plan even if you choose not to enroll. To be subsidy eligible you would have to establish that this offer is unaffordable for you, meaning that the required contribution for employee only coverage under our base plan exceeds 9.96% in 2026 of your modified adjusted household income.

The 'No Surprises' Rules

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

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

View a sample notice and consent form (PDF).

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

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

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

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

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of **July 31, 2025**. Contact your State for more information on eligibility—

ALABAMA – Medicaid
Website: http://myalhipp.com/ | Phone: 1-855-692-5447
ALASKA – Medicaid
The AK Health Insurance Premium Payment Program | Website: http://myakhipp.com/ | Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com | Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid
Website: http://myarhipp.com/ | Phone: 1-855-MyARHIPP (855-692-7447)
CALIFORNIA – Medicaid
Health Insurance Premium Payment (HIPP) Program website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 | Fax: 916-440-5676 | Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943 | State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991 | State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ | HIBI Customer Service: 1-855-692-6442
FLORIDA – Medicaid
Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268
GEORGIA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra | Phone: 678-564-1162, press 2
INDIANA – Medicaid
Health Insurance Premium Payment Program All other Medicaid Website: https://www.in.gov/medicaid/ | http://www.in.gov/fssa/dfr/ | Family and Social Services Administration Phone: (800) 403-0864 | Member Services Phone: (800) 457-4584
IOWA – Medicaid and CHIP (Hawki)
Medicaid Website: Iowa Medicaid | Health & Human Services | Medicaid Phone: 1-800-338-8366 Hawki Website: Hawki - Healthy and Well Kids in Iowa | Health & Human Services | Hawki Phone: 1-800-257-8563 HIPP Website: Health Insurance Premium Payment (HIPP) | Health & Human Services (iowa.gov) HIPP Phone: 1-888-346-9562
KANSAS – Medicaid
Website: https://www.kancare.ks.gov/ | Phone: 1-800-792-4884 | HIPP Phone: 1-800-967-4660
KENTUCKY – Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx | Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kynect.ky.gov | Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms

LOUISIANA – Medicaid
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 | TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 800-977-6740 | TTY: Maine relay 711
MASSACHUSETTS – Medicaid and CHIP
Website: https://www.mass.gov/masshealth/pa | Phone: 1-800-862-4840 | TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid
Website: https://mn.gov/dhs/health-care-coverage/ | Phone: 1-800-657-3672
MISSOURI – Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm | Phone: 573-751-2005
MONTANA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 | email: HHSHIPPProgram@mt.gov
NEBRASKA – Medicaid
Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 | Lincoln: 402-473-7000 | Omaha: 402-595-1178
NEVADA – Medicaid
Medicaid Website: http://dhcfp.nv.gov | Medicaid Phone: 1-800-992-0900
NEW HAMPSHIRE – Medicaid
Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 | Toll-free number for the HIPP program: 1-800-852-3345, ext. 15218 Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov
NEW JERSEY – Medicaid and CHIP
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ | Phone: 800-356-1561 CHIP Premium Assistance Phone: 609-631-2392 | CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710 (TTY: 711)
NEW YORK – Medicaid
Website: https://www.health.ny.gov/health_care/medicaid/ | Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid
Website: https://medicaid.ncdhhs.gov/ | Phone: 919-855-4100
NORTH DAKOTA – Medicaid
Website: https://www.hhs.nd.gov/healthcare | Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP
Website: http://www.insureoklahoma.org | Phone: 1-888-365-3742
OREGON – Medicaid and CHIP
Website: http://healthcare.oregon.gov/Pages/index.aspx | Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP
Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html | Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) | CHIP Phone: 1-800-986-KIDS (5437)
RHODE ISLAND – Medicaid and CHIP
Website: http://www.eohhs.ri.gov/ | Phone: 1-855-697-4347 or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid
Website: https://www.scdhhs.gov | Phone: 1-888-549-0820
SOUTH DAKOTA – Medicaid
Website: http://dss.sd.gov | Phone: 1-888-828-0059
TEXAS – Medicaid
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493
UTAH – Medicaid and CHIP
Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/ Email: upp@utah.gov | Phone: 1-888-222-2542 | Adult Expansion Website: https://medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/ CHIP Website: https://chip.utah.gov/
VERMONT – Medicaid
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427
VIRGINIA – Medicaid and CHIP
Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select or https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid
Website: https://www.hca.wa.gov/ | Phone: 1-800-562-3022
WEST VIRGINIA – Medicaid and CHIP
Website: https://dhhr.wv.gov/bms/ or http://mywvhipp.com/ Medicaid Phone: 304-558-1700 | CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm | Phone: 1-800-362-3002
WYOMING – Medicaid
Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ | Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2025, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Plan Contacts

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

Plan Type	Phone Number	Website/Email
Medical Blue Shield	Trio HMO 855-599-2657 Access+ HMO 855-256-9404 PPO 855-256-9404	blueshieldca.com
Blue Shield Prescriptions Navitus	Rx 855-847-1035	navitus.com
Medical Kaiser Permanente	800-464-4000	kp.org
Dental MetLife	800-275-4638	metlife.com/dental
Vision MetLife	855-638-3931	metlife.com/vision
Retirement MissionSquare	800-669-7400 202-759-7060	missionsq.org
Employee Assistance Program Aetna	800-342-8111	resourcesforliving.com
Human Resources	619-557-4598	my.adp.com