Employee Benefits Guide

2023-24

Marin Community College District

Employee Benefits Guide 2023-2024

General Information

Core Benefits

Other Benefits

Miscellaneous

Click this icon in your benefits guide to watch a video explaining the associated topic.
See page 78 for a glossary of terms.

If you (and/or your dependents) have Medicare or you will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage.

Please see page 72 for more details.

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

General

College of Marin understands the importance of offering a comprehensive benefit program that meets the needs of our diverse workforce. We are pleased to continue to provide a suite of quality benefit plans to all benefit eligible employees for the 2023-2024 plan year.

2023 – 2024 Core Health Plan Offerings

- Medical Plan
- Dental Plan
- Vision Plan
- Life Insurance
- Long-Term Disability
- Short-Term Disability

In Addition to the Core Health Plans, You Can Purchase Any of the Following Voluntary Products

- Flexible spending accounts (health care and dependent care)
- Accident
- Cancer
- Disability
- Critical Illness
- Hospital Confinement
- Term Life
- Whole Life

Who Can You Cover

Who is Eligible?

The District provides Medical, Dental, Vision and Life Insurance benefits to all benefit eligible employees. Open Enrollment Coverage is effective October 1, 2023.

You can enroll the following family members in our medical, dental and vision plans.

- Your spouse (the person who you are legally married to under state law, including a same-sex spouse.)
- Your domestic partner is eligible for coverage if you have completed a Domestic Partner Affidavit. Please review the affidavit carefully because it includes important information about the guidelines for adding, ending or changing your domestic partner. Any premiums for your domestic partner paid for by College of Marin are taxable income and will be included on your W-2. Any premiums you pay for your domestic partner will be deducted on an after-tax basis.
- **Your children (including your domestic partner's children):**
  - Under the age of 26 are eligible to enroll in medical coverage. They do not have to live with you or be enrolled in school. They can be married and/or living and working on their own.
  - Over age 26 ONLY if they are incapacitated due to a disability and primarily dependent on you for support.
  - Named in a Qualified Medical Child Support Order (QMCSO) as defined by federal law.

Please refer to the Summary Plan Description for complete details on how benefits eligibility is determined.

It is employee's responsibility to notify the District within 31 calendar days of their Mid-Year Qualifying Event (i.e. marriage, divorce, birth of child, etc.) in order to be eligible for the Special Enrollment.

Contact the Benefits office for any questions related to Mid-Year Qualifying Events.

Who is not Eligible?

Family members who are not eligible for coverage include (but are not limited to):

- Parents, grandparents, grandchildren, siblings, and children of dependents.
- Variable hour, temporary, part-time or seasonal employees **working less than 130 hours a month**, or employees residing outside the United States.

When Can I Enroll?

You may enroll or make changes during open enrollment from August 1 to August 25, 2023, for an effective date of October 1, 2023.

Required Documentation

If you are adding an eligible dependent, the following documents are required:

Spouse, Domestic Partner (AB205), or Domestic Partner (Non-AB205):

In addition to the documentation listed below, a copy of last year's tax return(s) will be required. Starting in mid-2024, SISC will require tax documents from tax year 2023. Please redact financial information and the first five digits of SSN. If taxes were filed separately, a copy of both returns is required.

- **Spouse** – Photocopy of the legal Certificate of Marriage or officiate-issued certificate
- **Domestic Partner (AB205) –** Photocopy of a certified copy of the Declaration of Domestic Partnership that was filed with California Secretary of State (once filed, the form is stamped by the state)
- **Domestic Partner (Non-AB205)** – Photocopy of a notarized copy of the Declaration of Domestic Partnership form
- **Dependent Child –** Photocopy of the legal birth certificate, hospital certificate, adoption paperwork, or guardianship paperwork issued by a court (documentation must include both child and parents' names and the dependent relationship to the employee). Grandchildren are only eligible if they are the employee/retiree's dependent through adoption or legal guardianship.

As a large public entity purchasing pool of educational agencies, SISC requires dependent eligibility documentation to validate each dependent's legal relationship to the employee. If you do not have copies of the required documents, you may contact the county recorder's office in which the marriage or birth occurred.

Enrollment information submitted with incomplete forms or missing documents will cause a delay in access to benefits.

Coordination of Benefits (COB)

What is COB?

Coordination of Benefits (COB) applies to District members who are covered by more than one health care plan. COB helps ensure that you receive the benefits you are entitled to with more than one plan while avoiding overpayment by either plan. This avoids delay in processing your claim payments.

How COB Works

When you are covered by more than one health plan (for example, when you are covered under the District's plan as well as your spouse's health plan), one plan is considered to be the primary carrier and the other is considered to be the secondary carrier. The primary carrier covers the major portion of the bill according to plan allowances, and the secondary carrier covers any remaining allowable expenses.
The COB provisions of your plan determine which plan is primary. That plan's benefits are applied to the claim first. The unpaid balance is usually paid by the secondary plan to the limit of its responsibility. Benefits are thus "coordinated" among all of the health plans, and payments do not exceed 100% of charges for the covered services.

Primary vs. Secondary Carrier

The following rules apply when determining which plan will be the primary payer:

- Any plan without a COB provision always pays first.
- If the person receiving benefits is the participant under the contract, that plan will be primary. The spouse's plan will become secondary.
- If a dependent child is covered under two or more plans, the plan of the member covering the child whose birthday occurs earlier in the calendar year will be primary (known as the birthday rule). If both have the same birthday, the policy that has been in effect longer will be primary. The birthday rule is superseded when a court order or custody rule applies.

Dependent Coverage When Parents Are Divorced

If the dependent is a child of divorced or separated parents, primary payer status is determined according to the following:

- If the divorce decree places responsibility on one parent, that parent's plan is primary.
- Otherwise, the custodial parent's plan is primary and the other parent's plan becomes secondary.
- If there is joint custody, the birthday rule applies and the plan of the parent whose birthday occurs earlier in the calendar year is primary.

Other COB Issues

Often, some or all of the costs of medical care are the responsibility of your health plan carrier except for:

- Members who are injured or become ill as a result of work-related accidents or environment are eligible for benefits under the Workers' Compensation Law.
- Injuries as a result of car accidents. Auto insurance companies will pay for medical expenses.
- In certain situations, Medicare may be a participant's primary or secondary coverage. Your plan carrier will coordinate benefits with Medicare according to the Medicare Secondary Payer rules.

It is your responsibility to inform your plan carriers if you have another medical, dental or vision group plan coverage.

Make sure to respond promptly to requests for Coordination of Benefits/Other Health Information that you receive in the mail from your carriers to ensure timely claim payments.

Qualifying Events

GUIDELINES AND PROCEDURES

QUALIFYING EVENTS OR STATUS CHANGES OUTSIDE OF OPEN ENROLLMENT

Effective date will be determined by the qualifying event date that allows for no lapse in coverage.
This does not apply to Retiree Group Medicare Plans (RGMPs such as EGWP, CompanionCare, KPSA or Blue Shield 65 Plus).
This table is not all inclusive and is subject to SISC approval, retro, and participation guidelines.

Employee/Retiree experiences the following qualifying event	Employee/Retiree MAY make the following change within 31 days of the qualifying event	REQUIRED Documentation: SISC Membership Change Form and applicable documents below
Birth, Adoption, or Legal Guardianship **NOTE:** HIPAA special enrollment rights may apply	• Enroll self, if applicable • Enroll newly eligible child and any other eligible dependents • Change health plans when options are available	• Birth certificate indicating parents' full names; or • Adoption/Guardianship documents issued by a U.S. court
Marriage or Commencement of Domestic Partnership **NOTE:** HIPAA special enrollment rights may apply	• Enroll self, if applicable • Enroll spouse/domestic partner and any newly eligible dependent children • Change health plans when options are available	• Marriage Certificate; or • Declaration of Domestic Partnership filed with the California Secretary of State • Other enrollment forms/documents as applicable
Divorce or Termination of Domestic Partnership **NOTE:** HIPAA special enrollment rights may apply	• Drop spouse/domestic partner • Drop stepchildren gained from marriage or domestic partnership • Enroll self and any newly eligible dependent children who lost eligibility under spouse/domestic partner's plan • Change health plans when options are available	• Final Divorce Decree; or • Dissolution of Domestic Partnership filed with the California Secretary of State • Other enrollment forms/documents as applicable
Death of Dependent (spouse/ domestic partner or child) **NOTE:** HIPAA special enrollment rights may apply	• Remove the dependent from coverage • Change health plans when options are available	• Membership Change Form
Qualified Medical Child Support Order (QMCSO) requiring enrollment of dependent child	• Enroll self, if not already enrolled in coverage • Enroll dependent child named on the QMCSO to employee's health coverage • Change health plans when options are available	• Membership Change Form • Birth certificate indicating parents' full names; and • Qualified Medical Child Support Order (QMCSO) court document
Gain or Loss of Entitlement to Medicare/Medicaid coverage by covered person **NOTE:** HIPAA special enrollment rights may apply	• Enroll self, spouse/domestic partner, and any eligible dependent children, if applicable • Drop coverage for person who became entitled and enrolled in Medicare/Medicaid • Change health plans when options are available	• Proof of enrollment in or loss of coverage in Medicare/Medicaid (whichever applicable) • Other enrollment forms/documents as applicable

(Continued on next page.)

Qualifying Events (continued)

GUIDELINES AND PROCEDURES

Employee/Retiree experiences the following qualifying event	Employee/Retiree MAY make the following change within 31 days of the qualifying event	REQUIRED Documentation: SISC Membership Change Form and applicable documents below
Change in Employment Status (e.g., Part-time to Full-time, Full-time to Part-time, Hourly to Salaried, Unpaid Leave of Absence, Change in Bargaining Unit, etc.)	• Enroll self, spouse/domestic partner, and any eligible dependent children, if applicable • Drop spouse/domestic partner and/or any other dependent children • Change health plans when options are available	• Proof of employment change; and • Other enrollment forms/documents as applicable
Changes to coverage as a result of Open Enrollment under other employer plan/different plan year including enrollment in a Qualified Health Plan (QHP) through a Public Marketplace such as Covered CA	• Enroll self, spouse/domestic partner, and any eligible dependent children, if applicable • Drop spouse/domestic partner and/or any other dependent children • Change health plans when options are available	• Proof of coverage change; and • Other enrollment forms/documents as applicable
Significant increase or decrease in the cost of coverage or an unpaid leave where the district will no longer be making a contribution	• Enroll self, spouse/domestic partner, and any eligible dependent children, if applicable • Drop spouse/domestic partner and/or any other dependent children • Change health plans when options are available	• Proof of increase in cost of coverage (e.g. district submitted plan change); or • Proof of decrease in cost of coverage (e.g. district submitted plan change); and • Other enrollment forms/documents as applicable
Gain or Loss of Coverage Elsewhere, including but not limited to: • Change of home address causing loss of eligibility • Change in employment status of spouse/domestic partner or dependent child (including commencement or termination of employment) • Significant curtailment in employee's spouse's/domestic partner's group coverage **NOTE:** HIPAA special enrollment rights may apply	• Enroll self, spouse/domestic partner, and any eligible dependent children, if applicable • Drop spouse/domestic partner and/or any other dependent children • Change health plans when options are available	• Proof of significant curtailment in spouse's/domestic partner's group coverage; or • Proof of enrollment in other coverage; or • Proof of loss of coverage; and • Other enrollment forms/documents as applicable

CLICK HERE to watch a video on Qualifying Life Events

New! BenefitBridge

Marin College Community District Online Benefits Enrollment is easy with BenefitBridge!

Need Help?

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

Here's what you can do on BenefitBridge:

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

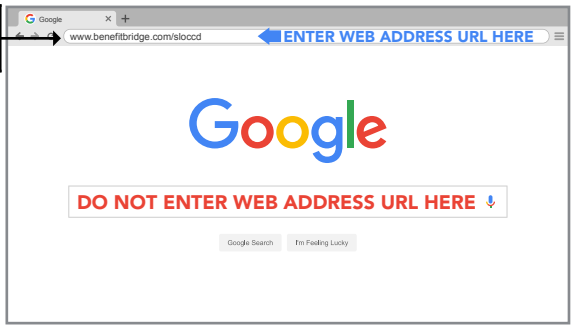
Registration and Login

Already have login credentials?

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

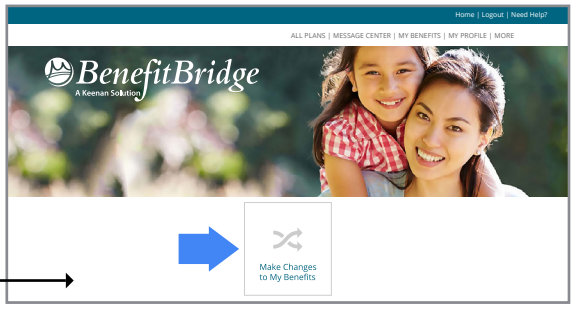
Need to create login credentials?

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



Enrolling in Benefits

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



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

800.814.1862

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

Rates

Full-time Classified and Unrepresented Employees

Effective October 1, 2023, for benefit eligible CSEA, SEIU, Management, Supervisors and Confidential, the District contributes between $1,500.00-$2,700.00 per month towards your Medical premium. The District offers the following plans: Kaiser Traditional, Kaiser Deductible, Kaiser High Deductible, Blue Shield 100%, Blue Shield 80% and Blue Shield High Deductible through SISC our Benefits Administrator.

	Renewal Effective 10/1/2023 (Monthly Rates)		
	Total Premium	District Contribution	Employee Contribution
Kaiser Permanente Traditional Plan			
• Employee Only	$1,103.00	$1,500.00	$0.00
• Employee + 1	$2,156.00	$2,200.00	$0.00
• Family	$3,034.00	$2,700.00	$334.00
Kaiser Permanente Deductible Plan			
• Employee Only	$982.00	$1,500.00	$0.00
• Employee + 1	$1,921.00	$2,200.00	$0.00
• Family	$2,703.00	$2,700.00	$3.00
Kaiser High deductible/Health Saving $1,500 90% Plan			
• Employee Only	$870.00	$1,500.00	$0.00
• Employee + 1	$1,701.00	$2,200.00	$0.00
• Family	$2,393.00	$2,700.00	$0.00
Blue Shield - 100% Plan A			
• Employee Only	$1,480.00	$1,500.00	$0.00
• Employee + 1	$2,913.00	$2,200.00	$713.00
• Family	$4,109.00	$2,700.00	$1,409.00
Blue Shield - 80% Plan K			
• Employee Only	$1,109.00	$1,500.00	$0.00
• Employee + 1	$2,179.00	$2,200.00	$0.00
• Family	$3,071.00	$2,700.00	$371.00
Blue Shield-High Deductible/Health Saving $1,500 90% Plan			
• Employee Only	$997.00	$1,500.00	$0.00
• Employee + 1	$1,954.00	$2,200.00	$0.00
• Family	$2,751.00	$2,700.00	$51.00
Delta Dental			
• Composite Rate - CSEA and Unrep.	$145.00	$145.00	$0.00
VSP			
• Composite Rate	$10.40	$10.40	$0.00

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Rates (continued)

Full-time Faculty

The District Contributes up to $2,100.00 per month towards your Medical premium. The District offers the following plans: Kaiser Traditional, Kaiser Deductible, Kaiser High Deductible, Blue Shield 100%, Blue Shield 80% and Blue Shield High Deductible through SISC our Benefits Administrator.

	Renewal Effective 10/1/2023 (Monthly Rates)		
	Total Premium	District Contribution	Employee Contribution
Kaiser Permanente Traditional Plan			
• Employee Only	$1,103.00	$1,103.00	$0.00
• Employee + 1	$2,156.00	$2,100.00	$56.00
• Family	$3,034.00	$2,100.00	$934.00
Kaiser Permanente Deductible Plan			
• Employee Only	$982.00	$982.00	$0.00
• Employee + 1	$1,921.00	$1,921.00	$0.00
• Family	$2,703.00	$2,100.00	$603.00
Kaiser High deductible/Health Saving $1,500 90% Plan			
• Employee Only	$870.00	$870.00	$0.00
• Employee + 1	$1,701.00	$1,701.00	$0.00
• Family	$2,393.00	$2,100.00	$293.00
Blue Shield - 100% Plan A			
• Employee Only	$1,480.00	$1,480.00	$0.00
• Employee + 1	$2,913.00	$2,100.00	$813.00
• Family	$4,109.00	$2,100.00	$2,009.00
Blue Shield - 80% Plan K			
• Employee Only	$1,109.00	$1,109.00	$0.00
• Employee + 1	$2,179.00	$2,100.00	$79.00
• Family	$3,071.00	$2,100.00	$971.00
Blue Shield-High Deductible/Health Saving $1,500 90% Plan			
• Employee Only	$997.00	$997.00	$0.00
• Employee + 1	$1,954.00	$1,954.00	$0.00
• Family	$2,751.00	$2,100.00	$651.00
Delta Dental			
• Composite Rate - UPM	$145.00	$145.00	$0.00
VSP			
• Composite Rate	$10.40	$10.40	$0.00

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Rates (continued)

Part-time Faculty

The District Contributes up to $2,050.00 per month towards your Medical premium for eligible part-time faculty.

	Effective 10/1/2023 (Monthly Rates)		
	Monthly Premium	District Contribution	Employee Contribution
Kaiser Permanente Traditional Plan			
• Member only	$1,103.00	$1,103.00	$0.00
• Member plus one	$2,156.00	$2,050.00	$106.00
• Family	$3,034.00	$2,050.00	$984.00
Kaiser Permanente Deductible Plan			
• Member only	$982.00	$982.00	$0.00
• Member plus one	$1,921.00	$1,921.00	$0.00
• Family	$2,703.00	$2,050.00	$653.00
Kaiser High deductible/Health Saving $1,500 90% Plan			
• Employee Only	$870.00	$870.00	$0.00
• Employee + 1	$1,701.00	$1,701.00	$0.00
• Family	$2,393.00	$2,050.00	$343.00

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Making the Most of Your Benefits Program

Helping you and your family members stay healthy and making sure you use your benefits program to its best advantage is our goal in offering this program. Here are a few things to keep in mind.

Stay Well!

Harder than it sounds, of course, but many health problems are avoidable. Take action—from eating well, to getting enough exercise and sleep. Taking care of yourself takes care of a lot of potential problems.

Ask Questions and Stay Informed

Know and understand your options before you decide on a course of treatment. Informed patients get better care. Ask for a second opinion if you're at all concerned.

Get a Primary Care Provider

Having a relationship with a PCP gives you a trusted person who knows your unique situation when you're having a health issue. Visit your PCP or clinic for non-emergency healthcare.

Going to the Doctor?

To get the most out of your doctor visit, being organized and having a plan helps. Bring the following with you:

- Your plan ID card
- A list of your current medications
- A list of what you want to talk about with your doctor

If you need a medication, you could save money by asking your doctor if there are generics or generic alternatives for your specific medication.

An Apple a Day

Eating moderately and well really does help keep the doctor away. Stay away from fat-heavy, processed foods and instead focus on whole grains, vegetables, and lean meats to be the healthiest you can be.

Using the Emergency Room

Did you know most ER visits are unnecessary? Use them only in a true emergency – like any situation where life, limb, and vision are threatened.

Otherwise, call your doctor, your nurse line, or go to an Urgent Care clinic. You'll save a lot of money and time.

Be Med Wise!

Always follow your doctor's and pharmacist's instructions when taking medications. You can worsen your condition(s) by not taking your medication or by skipping doses. If your medication is making you feel worse, contact your doctor.

SISC Health Smarts

SISC offers free, voluntary, and confidential onsite health screenings to member districts during Spring. These onsite health screenings only take about 15 minutes and require a small finger stick which include total cholesterol and HDL, blood pressure and pulse, blood glucose, BMI and other key biometrics. Watch out for announcements from the Benefit Offices for schedules.

Medical – Kaiser

Plan Benefits	Kaiser Traditional HMO	Kaiser Deductible HMO
	Member Responsibility	
Plan Year Deductible		
• Individual	$0	$1,000
• Family	$0	$2,000
Annual Out-of-Pocket Maximum		
• Individual	$1,500	$3,000
• Family	$3,000	$6,000
Inpatient Services		
• Hospital Room & Board, Ancillary Hospital Charges	$0	20% after deductible
Outpatient Services		
• Surgery	$20 copay/procedure	20% after deductible
Physician Services		
• Office Visit *(Primary Care)*	$20 copay	$20 copay
• Office Visit *(Specialist)*	$20 copay	$20 copay
Emergency Care		
• Urgent Care	$20 copay	$20 copay
• Emergency Room Services *(waived if admitted)*	$100 copay	20% after deductible
• Ambulance	$50 copay	$150 copay
Preventive Care / Wellness Services		
• Chiropractic Care *(limited to 30 visits/year)*	$10 copay	$10 copay
• Acupuncture *(limited to 30 visits/year)*	$10 copay	$10 copay
General Medical Services		
• X-Ray and Lab	$0	$0
• MRI, CT Scan, PET Scan, Nuclear Cardiac Scan	$0	$50 copay/procedure
Prescription Drugs		
• Plan Year Deductible	N/A	N/A
• Retail	100 day supply	30 day supply
– Generic*	$10 copay	$10 copay
– Formulary Brand	$20 copay	$30 copay
• Mail Order	100 day supply	100 day supply
– Generic**	$10 copay	$20 copay
– Formulary Brand	$20 copay	$60 copay

** **Preferred Generic Program:** If a brand drug is requested when a generic version exists, member pays the generic copay plus the cost difference between the maximum allowed charge for generic and brand, unless physician has specified "dispense as written" (DAW) or when medically necessary; OR
If a brand drug is dispensed and a generic is available, member is responsible for brand copay plus cost difference between generic and brand.

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Medical – Kaiser (continued)

Plan Benefits	Kaiser HSA-Qualified High Deductible Health Plan (HDHP) HMO
	Member Responsibility
Plan Year Deductible	
• Individual	$1,500
• Family	$2,800 Individual / $3,000 Family
Annual Out-of-Pocket Maximum	
• Individual	$3,000
• Family *(Each Member in a Family of two or more Members)*	$3,000
• Family *(Entire Family of two or more Members)*	$6,000
Professional Services *(Plan Provider office visits)*	
• Most Primary Care Visits and most Non-Physician Specialist Visits	10% coinsurance after deductible
• Most Physician Specialist Visits	10% coinsurance after deductible
• Routine physical maintenance exams, including well-woman exams	No charge
• Well-child preventive exams *(through age 23 months)*	No charge
• Family planning counseling and consultations	No charge
• Scheduled prenatal care exams	No charge
• Routine eye exams with a Plan Optometrist	10% coinsurance
• Urgent care consultations, evaluations, and treatment	10% coinsurance
• Most physical, occupational, and speech therapy	10% coinsurance
Outpatient Services	
• Outpatient surgery and certain other outpatient procedures	10% coinsurance after deductible
• Allergy injections *(including allergy serum)*	10% coinsurance after deductible
• Most immunizations *(including the vaccine)*	No charge
• Most X-rays and laboratory tests	10% coinsurance after deductible
• Preventive X-rays, screenings, and laboratory tests as described in the EOC	No charge
Hospitalization Services	
• Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs	10% coinsurance after deductible
Emergency Health Coverage	
• Emergency Department visits**	10% coinsurance after deductible
Ambulance Services	10% coinsurance after deductible

** **Note:** This Cost Share does not apply if you are admitted directly to the hospital as an inpatient for covered Services (see "Hospitalization Services" for inpatient Cost Share).

CLICK HERE to watch a video on Health Maintenance Organizations (HMO)

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Medical – Kaiser (continued)

Plan Benefits	Kaiser HSA-Qualified High Deductible Health Plan (HDHP) HMO
	Member Responsibility
Prescription Drugs	
• Plan Year Deductible	N/A
• Retail	30 day supply
– Generic	$10 copay
– Brand Name	$30 copay
• Mail Order	100 day supply
– Generic	$20 copay
– Brand Name	$60 copay
• Specialty Items	$30 for up to a 30-day supply after Deductible
Durable Medical Equipment (DME)	
• Base DME items as described in the EOC	10% coinsurance after deductible
Mental Health Services	
• Inpatient psychiatric hospitalization	10% coinsurance after deductible
• Individual outpatient mental health evaluation and treatment	10% coinsurance after deductible
• Group outpatient mental health treatment	10% coinsurance after deductible
Substance Use Disorder Treatment	
• Inpatient detoxification	10% coinsurance after deductible
• Individual outpatient substance use disorder evaluation and treatment	10% coinsurance after deductible
• Group outpatient substance use disorder treatment	10% coinsurance after deductible
Home Health Services	
• Home health care *(up to 100 visits per Accumulation Period)*	No charge
Other	
• Skilled nursing facility care *(up to 100 days per benefit period)*	10% coinsurance after deductible
• Prosthetic and orthotic devices as described in the EOC	No charge after deductible
• Services to diagnose or treat infertility and artificial insemination	No charge after deductible
• Assisted reproductive technology (ART) Services	Not covered
• Hospice care	No charge after deductible

CLICK HERE to watch a video on PPO vs HMO

CLICK HERE to watch a video on Preferred Provider Organizations (PPO)

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Medical – Blue Shield

Plan Benefits	Blue Shield PPO 100% Plan A ($20 Copay)	
	In-Network	Out-of-Network*
	Member Responsibility	
Plan Year Deductible		
• Individual	$0	
• Family	$0	
Annual Out-of-Pocket Maximum		
• Individual	$1,000	
• Family	$3,000	
Inpatient Services		
• Hospital Room & Board, Ancillary Hospital Charges	$0	Plan pays up to $600/day
Outpatient Services		
• Surgery	$0	Plan pays up to $350/day
Physician Services		
• Office Visit *(Primary Care)*	$20 copay	50%
• Office Visit *(Specialist)*	$20 copay	50%
Emergency Care		
• Urgent Care	$20 copay	50%
• Emergency Room Services *(waived if admitted)*	$100 copay	
• Ambulance	$100 copay	
Preventive Care / Wellness Services		
• Chiropractic Care *(20 visits/per calendar year)*	$0	Not Covered
• Acupuncture *(12 visits/per calendar year)*	$0	50%
General Medical Services		
• X-Ray and Lab	$0	Not Covered
Prescription Drugs		
• Plan Year Deductible	N/A	
• Retail *(30-day supply)*		
– Generic*	$5 copay ($0 at Costco)	
– Formulary Brand	$20 copay	
• Mail Order		
– Generic**	$0 copay	
– Formulary Brand	$50 copay	
– Speciality *(Must Use Navitus Specialty Rx)*	$20 copay	

* When utilizing Out-of-Network benefits, the Plan payment will be based on the Maximum Allowable Charges for the services. You will be responsible to pay the provider / facility any difference between the Plan's payment and the provider's / facility's full charge for the services.

** **Preferred Generic Program:** If a brand drug is requested when a generic version exists, member pays the generic copay plus the cost difference between the maximum allowed charge for generic and brand, unless physician has specified "dispense as written" (DAW) or when medically necessary; OR

If a brand drug is dispensed and a generic is available, member is responsible for brand copay plus cost difference between generic and brand.

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

Medical – Blue Shield (continued)

Plan Benefits	Blue Shield PPO 80% Plan K ($30 Copay)	
	In-Network	Out-of-Network*
	Member Responsibility	
Plan Year Deductible		
• Individual	$1,000	
• Family	$2,000	
Annual Out-of-Pocket Maximum		
• Individual	$3,000	
• Family	$6,000	
Inpatient Services		
• Hospital Room & Board, Ancillary Hospital Charges	20% after deductible	Plan pays up to $600/day
Outpatient Services		
• Surgery	20% after deductible	Plan pays up to $350/day
Physician Services		
• Office Visit *(Primary Care)*	$30 copay	50% after deductible
• Office Visit *(Specialist)*	$30 copay	50% after deductible
Emergency Care		
• Urgent Care	$30 copay	50%
• Emergency Room Services *(waived if admitted)*	$100 copay, then plan pays 20%	
• Ambulance	$100 copay, then plan pays 20%	
Preventive Care / Wellness Services		
• Chiropractic Care *(20 visits/per calendar year)*	20% after deductible	Not Covered
• Acupuncture *(12 visits/per calendar year)*	20% after deductible	50%
General Medical Services		
• X-Ray and Lab	20% after deductible	Not Covered
Prescription Drugs		
• Plan Year Deductible	N/A	
• Retail *(30-day supply)*		
– Generic*	$9 copay ($0 at Costco)	
– Formulary Brand	$35 copay	
• Mail Order		
– Generic**	$0 copay	
– Formulary Brand	$90 copay	
– Speciality *(Must Use Navitus Specialty Rx)*	$35 copay	

* When utilizing Out-of-Network benefits, the Plan payment will be based on the Maximum Allowable Charges for the services. You will be responsible to pay the provider / facility any difference between the Plan's payment and the provider's / facility's full charge for the services.

** **Preferred Generic Program:** If a brand drug is requested when a generic version exists, member pays the generic copay plus the cost difference between the maximum allowed charge for generic and brand, unless physician has specified "dispense as written" (DAW) or when medically necessary; OR

If a brand drug is dispensed and a generic is available, member is responsible for brand copay plus cost difference between generic and brand.

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

Medical – Blue Shield (continued)

Plan Benefits[6]	Blue Shield PPO 3-Tier HSA 1500 Plan A	
	In-Network[3]	Out-of-Network[4]
	Member Responsibility	
Plan Year Deductible[2]		
• Individual	$1,500	
• Family	$2,800 Individual / $3,000 Family	
Annual Out-of-Pocket Maximum[5]		
• Individual	$3,000	$6,000
• Family	$6,000 Individual / $6,000 Family	$6,000 Individual / $12,000 Family
Preventive Health Services[7]	$0	Not covered
Physician Services		
• Primary Care Office Visit	10%	50%
• Specialist Care Office Visit	10%	50%
• Physician Home Visit	10%	50%
• Physician or Surgeon Services in an Outpatient Facility	10%	50%
• Physician or Surgeon Services in an Inpatient Facility	10%	50%
Other Professional Services		
• Other Practitioner Office Visit *(Includes nurse practitioners, physician assistants, and therapists)*	10%	50%
• Acupuncture Services *(12 visits/per calendar year)*	10%	50%
• Chiropractic Services *(20 visits/per calendar year)*	10%	Not covered
• Family Planning		
– Counseling, Consulting, and Education	$0	Not covered
– Injectable Contraceptive	$0	Not covered
– Diaphragm Fitting	$0	Not covered
– Intrauterine Device (IUD)	$0	Not covered
– Insertion and/or Removal of Intrauterine Device (IUD)	$0	Not covered
– Implantable Contraceptive	$0	Not covered
– Tubal Ligation	$0	Not covered
– Vasectomy	10%	Not covered
– Diagnosis and Treatment of the Cause of Infertility	Not covered	Not covered
• Podiatric services	10%	50%
Pregnancy and maternity care[7]		
• Physician Office Visits: Prenatal and Postnatal	10%	50%
• Physician Services for Pregnancy Termination	10%	Not covered
• Certified Nurse Midwives	10%	10%
Emergency Services		
• Emergency Room Services *(If admitted to the Hospital, this payment for emergency room services does not apply. Instead, you pay the Participating Provider payment under Inpatient facility services/ Hospital services and stay.)*	$100/visit plus 10%	$100/visit plus 10%
• Emergency Room Physician Services	10%	10%

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Medical – Blue Shield (continued)

Plan Benefits[6]	Blue Shield PPO 3-Tier HSA 1500 Plan A	
	In-Network[3]	Out-of-Network[4]
	Member Responsibility	
Urgent Care Center Services	10%	50%
Ambulance Services	$100/transport plus 10%	$100/transport plus 10%
Outpatient Facility Services		
• Ambulatory Surgery Center	10%	All charges above $350
• Outpatient Department of a Hospital: surgery	10%	All charges above $350
• Arthroscopy[8]	10% of up to $4,500/procedure plus 100% of additional charges	Not covered
• Cataract Surgery[8]	10% of up to $2,000/procedure plus 100% of additional charges	Not covered
• Outpatient Department of a Hospital *(treatment of illness or injury, radiation therapy, chemotherapy, and necessary supplies)*	10%	50%
Inpatient Facility Services		
• Hospital Services and Stay	10%	
• Transplant Services *(This payment is for all covered transplants except tissue and kidney. For tissue and kidney transplant services, the payment for Inpatient facility services/ Hospital services and stay applies.)*		
– Special Transplant Facility Inpatient Services	10%	Not covered
– Physician Inpatient Services	10%	Not covered
• Transplant Travel Benefit: Maximum payment will not exceed $10,000 per transplant, *(not per lifetime) Ground transportation to and from the Center of Excellence (COE)* when the designated COE is 75 miles or more from the recipient's or donor's place of residence. Coach air-fare to and from the COE when the designated COE is 300 miles or more from the recipient's or donor's residence.	All charges above $10,000/ transplant	Not covered
Bariatric Surgery Services, Designated California Counties *(This payment is for bariatric surgery services for residents of designated California counties. For bariatric surgery services for residents of non-designated California counties, the payments for Inpatient facility services/ Hospital services and stay and Physician inpatient and surgery services apply for inpatient services; or, if provided on an outpatient basis, the outpatient facility services and Outpatient Physician services payments apply.)*		
• Inpatient Facility Services	10%	Not covered
• Outpatient Facility Services	10%	Not covered
• Physician Services	10%	Not covered
Diagnostic X-ray, Imaging, Pathology, and Laboratory Services *(This payment is for Covered Services that are diagnostic, non-Preventive Health Services, and diagnostic radiological procedures, such as CT scans, MRIs, MRAs, and PET scans. For the payments for Covered Services that are considered Preventive Health Services, see Preventive Health Services.)*		
• Laboratory Services *(Includes diagnostic Papanicolaou (Pap) test)*		
– Laboratory Center	10%	Not covered
– Outpatient Department of a Hospital	10%	Not covered
• X-ray and Imaging Services *(Includes diagnostic mammography.)*		
– Outpatient Radiology Center	10%	Not covered
– Outpatient Department of a Hospital	10%	Not covered
• Other Outpatient Diagnostic Testing *(Testing to diagnose illness or injury such as vestibular function tests, EKG, ECG, cardiac monitoring, non-invasive vascular studies, sleep medicine testing, muscle and range of motion tests, EEG, and EMG.)*		

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Medical – Blue Shield (continued)

Plan Benefits[6]	Blue Shield PPO 3-Tier HSA 1500 Plan A	
	In-Network[3]	Out-of-Network[4]
	Member Responsibility	
– Office Location	10%	Not covered
– Outpatient Department of a Hospital	10%	Not covered
• Radiological and nuclear imaging services		
– Outpatient Radiology Center	10%	50%
– Outpatient Department of a Hospital	10%	50% of up to $350/day plus 100% of additional charges
• Colonoscopy[8]	10% of up to $1,500/procedure plus 100% of additional charges	Not covered
• Upper GI Endoscopy[8]	10% of up to $1,000/procedure plus 100% of additional charges	Not covered
• Upper GI Endoscopy with Biopsy[8]	10% of up to $1,250/procedure plus 100% of additional charges	Not covered
Rehabilitative and Habilitative Services *(Includes Physical Therapy, Occupational Therapy, and Respiratory Therapy)*		
• Office Location	10%	Not covered
• Outpatient Department of a Hospital	10%	Not covered
Speech Therapy Services		
• Office Location	10%	50%
• Outpatient Department of a Hospital	10%	50% of up to $350/day plus 100% of additional charges
Durable Medical Equipment (DME)		
• DME	10%	Not covered
• Breast Pump	$0	Not covered
• Orthotic Equipment and Devices *(Up to 2 pairs of shoes and 2 inserts for therapeutic shoes per Calendar Year.)*	10%	Not covered
• Prosthetic Equipment and Devices	10%	50%
Home Health Care Services *(Up to 100 visits per Member, per Calendar Year, by a home health care agency. All visits count towards the limit, including visits during any applicable Deductible period. Includes home visits by a nurse, Home Health Aide, medical social worker, physical therapist, speech therapist, or occupational therapist, and medical supplies.)*	10%	Not covered
Home Infusion and Home Injectable Therapy Services		
• Home Infusion Agency Services *(Includes home infusion drugs and medical supplies.)*	10%	Not covered
• Home Visits by an Infusion Nurse	10%	Not covered
• Hemophilia Home Infusion Services *(Includes blood factor products.)*	10%	Not covered
Skilled Nursing Facility *(SNF) services (Up to 100 days per Member, per Benefit Period, except when provided as part of a Hospice program. All days count towards the limit, including days during any applicable Deductible period and days in different SNFs during the Calendar Year. 150 day limit per benefit period and will be combined with inpatient rehabilitation services.)*		
• Freestanding SNF	10%	10%
• Hospital-based SNF	10%	All charges above $600

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Medical – Blue Shield (continued)

Plan Benefits[6]	Blue Shield PPO 3-Tier HSA 1500 Plan A	
	In-Network[3]	Out-of-Network[4]
	Member Responsibility	
Hospice Program Services		
• Pre-Hospice Consultation	$0	Not covered
• Routine Home Care	$0	Not covered
• 24-hour Continuous Home Care	$0	Not covered
• Short-term Inpatient Care for Pain and Symptom Management	$0	Not covered
• Inpatient Respite Care	$0	Not covered
Other Services and Supplies		
• Diabetes Care Services		
– Devices, Equipment, and Supplies	10%	50%
– Self-management Training	10%	50%
• Dialysis Services	10%	50% of up to $350/day plus 100% of additional charges
• PKU Product Formulas and Special Food Products	10%	Not covered
• Allergy Serum Billed Separately from an Office Visit	10%	50%
• Hearing Services		
– Hearing Aids and Equipment *(Up to $700 combined maximum per member, per 24 months.)*	10%	10%
– Audiological Evaluations	10%	50%
Mental Health and Substance Use Disorder Benefits		
• Outpatient Services		
– Office Visit, including Physician Office Visit	10%	50%
– Intensive Outpatient Care	10%	50%
– Behavioral Health Treatment in an Office Setting	10%	50%
– Behavioral Health Treatment in Home or Other Non-institutional Setting	10%	50%
– Office-based Opioid Treatment	10%	50%
– Partial Hospitalization Program	10%	50% of up to $350/day plus 100% of additional charges
– Psychological Testing	10%	50%
• Inpatient Services		
– Physician Inpatient Services	10%	50%
– Hospital Services	10%	All charges above $600
– Residential Care	10%	All charges above $600

Prior Authorization

The following are some frequently-utilized Benefits that require prior authorization:

- Radiological and nuclear imaging services
- Hospice program services
- Outpatient mental health services, except office visits
- Inpatient facility services

Please review the Benefit Booklet for more about Benefits that require prior authorization.

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Medical – Blue Shield (continued)

Plan Benefits	Blue Shield PPO Two Tiered Anchor Bronze	
	In-Network	Out-of-Network*
	Member Responsibility	
Plan Year Deductible		
• Individual	$5,000	
• Family	$10,000	
Annual Out-of-Pocket Maximum		
• Individual	$6,350	
• Family	$12,700	
Inpatient Services		
• Hospital Room & Board, Ancillary Hospital Charges	30% after deductible	Plan pays up to $600/day
Outpatient Services		
• Surgery	30% after deductible	Plan pays up to $350/day
Physician Services		
• Office Visit *(Primary Care)*	$60/visit for first 3 visits, thereafter plan pays 70% after deductible	50% after deductible
• Office Visit *(Specialist)*		
Emergency Care		
• Urgent Care	30% after deductible	50% after deductible
• Emergency Room Services *(waived if admitted)*	$100 copay, then plan pays 30% after deductible	
• Ambulance	$100 copay, then plan pays 30% after deductible	
Preventive Care / Wellness Services		
• Chiropractic Care *(20 visits/per calendar year)*	30% after deductible	Not Covered
• Acupuncture *(12 visits/per calendar year)*	30% after deductible	Not Covered
General Medical Services		
• X-Ray and Lab	30% after deductible	Not Covered
Prescription Drugs		
• Plan Year Deductible	Subject to deductible	
• Retail *(30-day supply)*		
– Generic*	$9 copay	$9 copay
– Formulary Brand	$35 copay	$35 copay
– Non-Formulary Brand	$35 copay	$35 copay
• Mail Order		
– Generic**	$18 copay	Not Covered
– Formulary Brand	$90 copay	Not Covered
– Non-Formulary Brand	$90 copay	Not Covered

* When utilizing Out-of-Network benefits, the Plan payment will be based on the Maximum Allowable Charges for the services. You will be responsible to pay the provider / facility any difference between the Plan's payment and the provider's / facility's full charge for the services.

** **Preferred Generic Program:** If a brand drug is requested when a generic version exists, member pays the generic copay plus the cost difference between the maximum allowed charge for generic and brand, unless physician has specified "dispense as written" (DAW) or when medically necessary; OR
If a brand drug is dispensed and a generic is available, member is responsible for brand copay plus cost difference between generic and brand.

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SISC Value Added Services

SISC
Self-Insured Schools of California
Schools Helping Schools

Take advantage of no cost benefits to help you get and stay healthy

BENEFIT HIGHLIGHTS	AVAILABILITY AND HOW TO GET STARTED
24/7 Help with Personal Concerns *SISC Employee Assistance Program* Access free, confidential resources for help with emotional, marital, financial, addiction, legal, or stress issues.	All employees at member districts **Call** 800-999-7222 **Visit** anthemEAP.com and enter SISC
Expert Medical Opinions *Teladoc Medical Experts* Get answers to health care questions and second opinions from world-leading experts.	All members enrolled in a SISC medical plan **Call** 800-835-2362 **Visit** teladoc.com/SISC
24/7 Physician Access—Anytime, Anywhere *MDLive* Consult with doctors and pediatricians over the phone or using online video for common medical conditions and behavioral health issues. Physicians can prescribe medication when appropriate.	Anthem and Blue Shield members **Call** 888-632-2738 **Visit** mdlive.com/sisc
Free Generic Medications *Costco* Access most generic medications at no cost through Costco retail and mail oder pharmacies. You don't need to be a Costco member.	Anthem and Blue Shield members **Call** 800-774-2678 (press 1) **Visit** costco.com
Enhanced Cancer Benefit *Contigo Health* Consult experts on initial diagnosis and development of a care plan. Benefit includes care coordination services with at home provider, transportation, and more.	Anthem and Blue Shield PPO members **Call** 877-220-3556 **Visit** sisc.contigohealth.com

Per IRS guidelines, HSA members may need to satisfy a deductible when using these programs.

Continued → 1

SISC Value Added Services (continued)

BENEFIT HIGHLIGHTS	AVAILABILITY AND HOW TO GET STARTED
Hip, Knee, and Spine Surgical Benefit *Carrum Health* Consult top-quality surgeons on hip and knee replacements and certain spine surgeries. Benefit covers all related travel and medical bills.	Anthem and Blue Shield PPO members **Call** 888-855-7806 **Visit** carrumhealth.com/sisc
Personal Health Coaching *Vida Health* Get one-on-one health coaching, therapy, chronic condition management, health trackers and other tools and resources online or via phone.	Anthem and Blue Shield members **Call** 855-442-5885 **Visit** vida.com/sisc
Physical Therapy for Back or Joint Pain *Hinge Health* Get access to free wearable sensors and monitoring devices, unlimited one-on-one coaching and personalized exercise therapy.	Anthem and Blue Shield PPO members **Call** 855-902-2777 **Visit** hingehealth.com/sisc

Per IRS guidelines, HSA members may need to satisfy a deductible when using these programs. 2

SISC Value Added Services (continued)

SISC
Self-Insured Schools of California
Schools Helping Schools

Benefit Extras

Available through your SISC health plan

Get Started	Program Details	Who Is Eligible
Active & Fit Direct **Anthem PPO/HMO members** log into anthem.com/ca/sisc, click "Discounts" and visit "Special Offers". **Kaiser HMO members** must visit kp.org/choosehealthy, select region, click "Choose Healthy," then click "Learn More" next to the ASH Active & Fit logo.	**Discounted Gym Memberships** ***Active & Fit Direct*** Choose from over 9,000 participating fitness centers and YMCAs nationwide for a much lower cost than you would pay on your own. Use the online fitness tracking feature, which uses a variety of wearable devices and apps. You pay only $25 a month (plus $25 enrollment fee and taxes).	Anthem PPO/HMO and Kaiser HMO members **Low Cost**
Fitness Your Way **Go to** fitnessyourway.tivityhealth.com/bsc Click "Enroll". OR **Call** 833-283-8387	**Fitness Your Way** ***Tivity*** This program gives you the flexibility to work out at any participating fitness location. Cost is only $25 a month per person.	Blue Shield PPO and HMO members **Low Cost**
TruHearing **Call** 866-754-1607 OR **Go to** truhearing.com	**Discounted Hearing Aids** ***TruHearing*** Go to a TruHearing provider to be fitted and adjusted for a wide variety of the latest digital hearing aids. You will save about $980 per hearing aid compared to national average prices. PPO members may even be able to use their plan benefits in coordination with TruHearing discounts.	VSP members **Low Cost**
Amplifon **Go to** amplifonusa.com/deltadentalins OR **Call** 888-779-1429	**Discounted Hearing Aids** ***Amplifon*** Get an average savings of 62% off the latest retail hearing aid price. See an Amplifon network provider to be fitted. PPO members may even be able to use their plan benefits in coordination with Amplifon discounts.	Delta Dental members **Low Cost**
QualSight **Go to** qualsight.com/-delta-dental OR **Call** 855-248-2020	**Discounted LASIK Eye Surgery** ***QualSight*** Receive 40-50% off the national average price of traditional LASIK eye surgery when you use an experienced QualSight LASIK surgeon.	Delta Dental members **Low Cost**
EPIC Hearing **Go to** epichearing.com OR **Call** 866-956-5400	**Discounted Hearing Aids** ***EPIC Hearing*** Go to an EPIC Hearing network provider to be fitted to receive 30% – 60% off the retail hearing aid price. PPO members may even be able to use their plan benefits in coordination with EPIC Hearing discounts.	MES members **Low Cost**

These programs are not available to retired Medicare members enrolled on Retiree Group Medicare Plans.
Per IRS guidelines, HSA members may need to satisfy a deductible on these programs. 1

SISC Value Added Services (continued)

SISC
Self-Insured Schools of California
Schools Helping Schools

Need Someone to talk to?

We're here if you or someone in your family needs help.

Life can be stressful, be it work, family, or even just day-to-day tasks and responsibilities. It's okay to admit when things feel hard.

Now is a good time to tune in to your mental and emotional health. You have various low and no cost options available, and you can access many of them from the comfort of your home.

All Employees and Household Members

SISC Employee Assistance Program

To access free in-person and virtual therapy, call **800-999-7222**.

Anthem and Blue Shield PPO and HMO Members

MDLive — To access virtual therapy and psychiatry, visit mdlive.com/sisc or call **800-657-6169**.

VIDA —To access virtual therapy, visit www.vida.com/sisc or call **855-442-5885**.

Anthem PPO and HMO Members

To find participating therapists and psychiatrists, use the **Anthem Provider Finder** or call the phone number listed on your ID card.

Blue Shield PPO and HMO Members

To find participating therapists and psychiatrists, use the **Blue Shield PPO Provider Finder** or **Blue Shield HMO Provider Finder** website or call Shield Concierge at **855-599-2657**.

Kaiser Permanente Members

Northern California — To find participating therapists and psychiatrists, use the **NorCal Kaiser Permanente Location Finder** or call Member Services at **866-454-8855**.

Southern California — To find participating therapists and psychiatrists, use the **SoCal Kaiser Permanente Location Finder** or call Member Services at **833-574-2273**.

All support is confidential.
Our providers will never share your information with your employer.

Teladoc

TELADOC Medical Experts | SISC Self-Insured Schools of California Schools Helping Schools

World-renowned medical advice **for you and your family.**

If you or a dependent is facing a serious medical issue, make sure you get the right advice.

With Teladoc, you can:

- Have a world-renowned physician review a diagnosis and treatment plan
- Get expert medical guidance if you have been admitted into the hospital
- Get personalized answers to medical questions, big or small
- Find a leading local physician for you and your family

MDLIVE

Avoid the wait.

Your life is 24/7. Now your doctor is too.

Welcome to MDLIVE!

You're eligible, so activate your account today.

- **Consult with a board-certified doctor by phone, secure video, or MDLIVE App –** anytime, from anywhere. Licensed behavioral health professionals also available by appointment via secure video
- Average wait time is less than 10 minutes to see a state-licensed, board-certified physician averaging 15 years of practice experience
- Your covered family members are also eligible, and we have pediatricians available 24/7.

Non-emergency conditions we treat:

General Conditions - $5 co-pay Behavioral Health - $5 co-pay

- Acne
- Allergies
- Cold/Flu
- Constipation
- Cough
- Diarrhea
- Ear problems
- Fever*
- Headache
- Insect bites
- Nausea/ Vomiting
- Pink eye
- Rash
- Respiratory problems
- Sore throats
- Urinary problems/ UTI*
- Vaginitis
- Addictions
- Bipolar disorders
- Child and adolescent issues
- Depression
- Eating disorders
- Gay/Lesbian/Bisexual/ Transgender issues
- Grief and loss
- Life changes
- Men's issues
- Panic disorders
- Parenting issues
- Postpartum depression
- Relationship and marriage issues
- Stress
- Trauma and PTSD
- Women's issues
- And more

Activate your account online or by phone.

E-prescriptions can be sent to your local pharmacy (if required) for medical conditions. Anthem and Blue Shield PPO and HMO members are eligible for MDLIVE services. Anthem and Blue Shield HSA members will pay the entire cost of the visit until their plan deductible has been satisfied.

* MDLIVE physicians may not treat any children with urinary symptoms. Parents/guardian will be required to complete a different medical history disclosure form for children under the age of 36-months prior to making an appointment with an MDLIVE physician. Children under 36 months who present with fever must be referred to their pediatrician (medical home), child-friendly urgent care center or emergency department for clinical evaluation and care.

MDLIVE does not provide any healthcare services and is not an insurance product or a prescription fulfillment warehouse. MDLIVE does not replace the primary care physician. MDLIVE operates subject to state regulation and may not be available in certain states. MDLIVE does not guarantee that a prescription will be written. MDLIVE does not prescribe DEA controlled substances, non-therapeutic drugs and certain other drugs which may be harmful because of their potential for abuse. Contents in this material are not a substitute for professional healthcare advice, diagnosis or treatment. MDLIVE healthcare professionals reserve the right to deny care for potential misuse of services. MDLIVE interactive audio consultations with store and forward technology are available 24/7/365 for medical services only, while video consultations are available during the hours of 7:00 AM to 9:00 PM 7 days a week or by scheduled availability for medical and behavioral services. MDLIVE and the MDLIVE logo are registered trademarks of MDLIVE, Inc. and may not be used without written permission. For complete terms of use visit www.mdlive.com/pages/terms.html

MDLIVE.com/SISC 1.800.657.6169
Download the MDLIVE App

SISC Enhanced Cancer Benefit

SISC
Self-Insured Schools of California
Schools Helping Schools

City of Hope.

HEALTH DESIGN +

SISC Enhanced Cancer Benefit

A cancer diagnosis is scary.

If you or a covered family member is facing cancer diagnosis, ***you are not alone***.

The SISC Oncology Center of Excellence benefit is here to help you navigate the cancer journey.

The benefit offers free access* for SISC members on the Anthem and Blue Shield PPO plan to the City of Hope.

- An in-person or virtual evaluation – (travel costs covered for patient and a companion)
- A recommended care plan from a cancer expert who will discuss it with you and your treating oncologist.
- Continued access to cancer care experts for 12 months following the evaluation.

**Per IRS guidelines, this benefit is subject to the deductible for members enrolled on HSA plans. Excluding 65+ PPO Plans.*

Learn more about the program and initiate care by calling Health Design Plus at ***877-220-3556, Monday through Friday, 6 a.m. to 6 p.m. PT***

SISC Enhanced Cancer Benefit (continued)

SISC Enhanced Cancer Benefit
Oncology Center of Excellence FAQs

What is the Oncology Center of Excellence?
Self-Insured Schools of California (SISC) has partnered with Health Design Plus (HDP) to offer their Oncology Center of Excellence Program to help covered members navigate their cancer diagnosis and treatment journey.

The Oncology Center of Excellence Program is a specialized health care program that enables members to obtain expert care and support from a National Cancer Institute (NCI) designated Centers of Excellence. Founded in 1913, City of Hope is an NCI designated facility and is currently the facility available to SISC members through the Center of Excellence program. The National Cancer Institute has designated City of Hope as a comprehensive cancer center, an honor reserved for only 50 institutions nationwide. To retain this designation, City of Hope has to hold itself to the highest possible standards which translate into the best possible care for SISC members facing a cancer diagnosis.

Who can participate with the Oncology Center of Excellence?
Members enrolled in an Anthem or Blue Shield PPO medical plan excluding those enrolled in a SISC 65+ PPO plan. Per IRS guidelines, this benefit is subject to deductible for HSA members.

What's covered under the Oncology Center of Excellence?
Program elements include;

- An expert in-person or virtual evaluation at a recognized Center of Excellence, by a multidisciplinary cancer-focused clinical team led by an oncology expert specializing in the patient's particular type of cancer.
- Treatment options that may not be available in the member's local community.
- Navigation and advocacy support provided by the HDP nurse team every step of the way.
- 12 month follow up, to assist the patient with decision support or other resources available in the member's local community.

How much will the program cost?
If you are enrolled in a SISC PPO Plan, program services are paid at 100% and your deductible does not apply. If you are enrolled in an HSA plan, your program services are covered at 100% after meeting your deductible per IRS guidelines.

If I travel to an Oncology Center of Excellence, will my travel expenses be covered?
Transportation, lodging, and a daily stipend for meals/expenses for you and a companion will be covered and coordinated through HDP. Per IRS guidelines, a portion of the travel expenses covered may be treated as taxable income. Please check with your tax accountant about this topic.

SISC Enhanced Cancer Benefit (continued)

Will I have access to clinical trials?
Yes. All patients will be evaluated for clinical trials for which they may be suitable candidates.

City of Hope aggressively pursues ways to help their patients right now – not years from now. That focus puts City of Hope among the worldwide leaders in administering clinical trials. City of Hope is currently conducting more than 500 clinical trials, enrolling more than 6,200 patients.

Does everyone with a cancer diagnosis need to use the Oncology Care Program?
No, this program is optional and is not required. The Oncology Center of Excellence program was created to help with navigating a diagnosis and treatment, but you are not required to use the program. This program is available for eligible members who are looking for a program that provides assistance with navigating the process.

When is this program available?

April 1, 2020

How do eligible members access this benefit?

Members may call HDP at this toll-free number: (877) 220-3556. The Cancer Patient Advocate Nurses are available from 6am-6pm Pacific Time, M-F. You can also submit an online intake form by visiting SISC.hdplus.com.

Do eligible members need a prior authorization form Blue Shield or Anthem to access this benefit?

No, carrier authorizations are not needed for the Oncology Centers of Excellence Program. HDP may require you to complete an authorization for treatment form.

Vida Health

vida | SISC Self-Insured Schools of California

A personal health coach, to help you get healthier

Available at no cost to you, Vida Health matches you to a health coach with proven success in helping people improve nutrition, lose weight, manage stress and make the kind of lifestyle changes that lead to happier, healthier lives.

Whether you want to focus on nutrition, weight loss, anxiety, depression or simply building healthy routines one day at a time, your coach will develop a personal plan and guide you every step of the way.

You can sync devices – like fitness trackers, scales, and blood sugar meters – to monitor your progress in the app. And simple lessons and practices will help you create new healthy habits to last a lifetime.

- Download the app
- Choose your coach, therapist or nutritionist
- Set your goal
- Have weekly video calls and message anytime
- Develop new healthy habits

"I got farther in 1 year than I have in 2 decades of trying on my own." - Jenny

"In less than a year, I have lost 75 pounds and I'm no longer on blood pressure medication." - Natalie

"My energy is high every day, I am far less irritable, I've lost more than 25 pounds, and every aspect of my life has improved!" - Brad

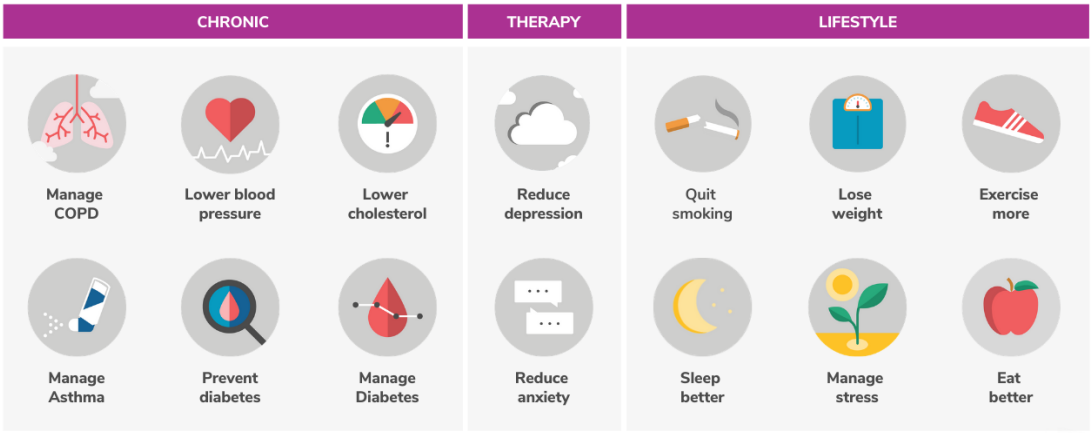
Download the Vida Health app from your phone's app store or visit vida.com/sisc to learn more (Available at no cost to you)

GET IT ON Google Play | Download on the App Store

Anthem and Blue Shield PPO and HMO members over the age of 18 (Excluding 65+ Plans) are eligible for Vida Health. Per IRS guidelines, this is subject to deductible for HSA members.

Vida Health (continued)

Programs to fit your needs



Become your healthiest self with Vida

Elaine has lost 28 pounds and 9+ inches from her waist. She tracked her weekly progress:

Week 1: "Heartburn gone."

Week 3: "Used a Fitbit to start 6,000 steps per day."

Week 5: "Vida coach taught me to use food as medicine. Kept up with my son at the trampoline park!"

Week 7: "A lot of people have noticed the 15-pound loss."

Week 9: "My body is functioning as it did 10 years ago."

Week 16: "Put on the size 5 ring my daughter bought me!!!"

Download the Vida Health app from your phone's app store (Available at no cost to you)

GET IT ON Google Play | Download on the App Store

Anthem and Blue Shield PPO and HMO members over the age of 18 (Excluding 65+ Plans) are eligible for Vida Health. Per IRS guidelines, this is subject to deductible for HSA members.

Hinge Health

SISC Hinge Health

Conquer back or joint pain without drugs or surgery

Members on the SISC Anthem PPO or Blue Shield PPO medical plans get *free access to Hinge Health's innovative digital programs for **back, knee, hip, neck, or shoulder pain.** Sign up for:

- Free wearable sensors & monitoring device
- Unlimited 1-on-1 health coaching
- Personalized exercise therapy

Over 30,000 members have participated in our programs so far, and cut their pain by over 60%!

*Participation is free for members who are not on a HDHP/HSA plan. Program fee for members on an HDHP/ HSA plan is subject to the deductible.

To learn more call (855) 902-2777, or apply at:
HINGEHEALTH.COM/SISC

Carrum Health Surgery Benefit

THE **SMARTER** SURGERY BENEFIT

Considering surgery? Carrum Health is your premium surgery benefit, offered through Self Insured Schools of California (SISC), that allows employees and dependents to access top surgeons and hospitals across the country at **no additional cost** to you, including travel*.

EXPLORE YOUR OPTIONS

A wide range of **covered procedures** at hospitals across California that specialize in the care you need.

CHOOSE THE BEST

Pick from among our highly-qualified surgeons who have performed **hundreds of medical procedures** on average.

WE'LL TAKE IT FROM HERE

Your **travel will be fully-covered** with a dedicated patient care specialist to help guide you through every step of the process.

PROCEDURES FULLY COVERED FOR YOU:

HIP **SPINE** **KNEE**

LEARN MORE:

CALL: 1-888-855-7806

TEXT: "SISC" to 555888

ANDROID APP ON Google play

Available on the App Store

VISIT: CARRUM.ME/SISC

Most SISC members on Anthem Blue Cross or Blue Shield of California PPO plans are eligible to use this optional benefit. It must be accessed through Carrum Health.

*Per IRS rules, a portion of the covered travel expenses will be reported as taxable income to the employee. Due to IRS regulations, on HSA plans the deductible applies but coinsurance is waived.

Carrum Health Surgery Benefit (continued)

MORE PROVIDERS, MORE COVERAGE

Carrum Health allows you to explore the best surgery options available so that you and your family can receive the highest quality care, with the least amount of stress, regardless of where you live.

YOUR CARRUM HEALTH HOSPITAL SPOTLIGHT:

THE BEST SURGEONS

To provide the highest-quality care for our patients, we use rigorous analysis to select top-quality surgeons, by procedure, at the best hospitals and surgical centers.

80%

Less complications compared to average California facilities

50%

Fewer readmissions compared to average California facilities

4x

Our surgeons perform up to 4x as many of your surgeries

VISIT: CARRUM.ME/SISC

Most SISC members on Anthem Blue Cross or Blue Shield of California PPO plans are eligible to use this optional benefit. It must be accessed through Carrum Health.

*Per IRS rules, a portion of the covered travel expenses will be reported as taxable income to the employee. Due to IRS regulations, on HSA plans the deductible applies but coinsurance is waived.

LEARN MORE:

CALL: 1-888-855-7806

TEXT: "SISC" to 555888

ANDROID APP ON Google play

Available on the App Store

Dental

Delta Dental of California offers you what no other dental plan can – The Delta Dental Difference℠. Here's what makes us a leading provider of dental benefits:

- **Exceptional Cost Savings:** Our networks protect enrollees from balance billing and prevent dentists from charging more by "unbundling" services that should be billed as one service. Your costs are usually lowest when you visit Delta Dental dentists.
- **Guaranteed Coinsurance / Copay:** Delta Dental dentists agree to accept our determination of fees. They won't balance bill over Delta Dental's approved amount for covered services.
- **Professional Treatment Standards:** Delta Dental reviews utilization patterns and office practices to ensure that Delta Dental dentists meet professional standards for safety and quality of care.

Although the PPO program allows you the freedom to visit any licensed dentist, there are advantages to visiting a Delta Dental dentist.

Plan Benefits	Delta Dental PPO	
	In-Network	Out-of-Network[1]
	Member Responsibility	
Annual Deductible	$0	$0
Annual Maximum Benefit	Plan Pays up to $2,500	Plan Pays up to $2,400
Diagnostic and Preventive Services		
• Oral Exams, Routine Cleanings, X-Rays, Fluoride Treatment	Plan pays 100%	Plan pays 100%
Basic Services		
• Anesthesia	Plan pays 70% – 100%	
• Simple and Surgical Extractions	Plan pays 70% – 100%	
• Endodontics *(root canals)*	Plan pays 70% – 100%	
• Periodontics *(gum treatment)*	Plan pays 70% – 100%	
Major Services		
• Crowns, Inlays, Onlays, Veneers	Plan pays 70% – 100%	
• Prosthodontics *(Dentures, Bridges)*	Plan pays 70% – 100%	
Orthodontics		
• Child *(to age 19)*	Plan pays 75%	
• Adult	Plan pays 75%	
• Lifetime Maximum	$3,000	

1. When utilizing Non-Participating Dentists, the Plan payment will be based on the Maximum Allowable Charges for the services. You will be responsible to pay the dentist any difference between the Plan's payment and the dentist's full charge for the services.

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QualSight LASIK

Set your sights on even more value

Think you'd never be able to afford LASIK eye surgery? Now it may be within reach. Why? Because Delta Dental[1] has selected QualSight[2] to offer you access to discounts on LASIK services. Through QualSight, you can save 40-50% off the national average price of Traditional LASIK[3] along with big savings on Custom and Custom Bladeless LASIK procedures!

Continued on back

QualSight LASIK (continued)

See it to believe it. QualSight can help you find the right vision solution.

Extra savings	Expert surgeons	Expansive choice
		
You get preferred pricing on LASIK through QualSight providers across the nation. Plus, pre- and postoperative visits are included, along with a one-year assurance plan.	There's no need to fear — QualSight's network is built with credentialed laser eye surgeons who have collectively performed more than 6.5 million procedures.[4]	With more than 1,000 LASIK locations[4], you can choose the physician with the experience, reputation and technology your vision correction requires.

Ready. Set. Save. It only takes three simple steps to take advantage of these savings.

1. Get ready.	2. Get set.	3. Save!
Give a QualSight care manager a call at 1-855-248-2020.	A care manager will explain the program and answer any questions.	Pick a physician and pay a discounted price for LASIK services.

To learn more about the LASIK discounts, visit www.qualsight.com/-delta-dental.

[1] Delta Dental of California, Delta Dental Insurance Company, Delta Dental of Pennsylvania, Delta Dental of New York, Inc. and our affiliated enterprise companies.

[2] The Vision Corrective Services are not an insured benefit. Delta Dental makes the Vision Corrective Services program available to enrollees to provide access to the preferred pricing for LASIK surgery.

[3] Refractive Quarterly Update, Market Scope LLC, November 2018. Discounts or savings may vary by provider.

[4] QualSight provider file, February 2019

Delta Dental is a registered trademark of Delta Dental Plans Association.

EF74 #120020B (rev. 3/19)

Amplifon Hearing Health Care

DELTA DENTAL® | amplifon Hearing Health Care

An offer to keep you smiling — from ear to ear

You now have access to discounts on hearing aids through Amplifon Hearing Health Care.[1] Delta Dental[2] selected Amplifon, a leader in hearing health care, to act as your personal concierge. They'll guide you through every step, from using your discounts to finding the right products and care to match your hearing needs.

Continued on back

Amplifon Hearing Health Care (continued)

Have you heard? 48 million Americans have significant hearing loss.[3] Let Amplifon help.

The new program gives you:

Access to the best hearing aid prices, guaranteed.
There's no sign-up fee for the program, and you'll enjoy 62% average savings off retail pricing.[4] If you find a lower price at another local provider, Amplifon will not only match it, they'll beat it by 5%.[5] Plus, no interest financing is available.

Choice of top hearing aid brands.
Amplifon offers access to the nation's leading hearing aid brands featuring the latest technology. And, all products are backed by a 60-day no-risk trial.

Thousands of hearing care providers.[6]
With a broad network of hearing clinics across the nation, it's likely Amplifon has a provider near you.

Industry-leading support for your purchase.
The advantages of Amplifon don't stop right after you buy. You get one year of free follow-up care, two years of free batteries and a three-year product warranty for all hearing aid purchases.

Ready to get started? It's simple.

1

Call Amplifon at 1-888-779-1429. A Patient Care Advocate will help you find a hearing care provider near you.

2

Your advocate will explain the discount process, ask you a few simple questions, then help you make an appointment.

3

Sit back. Amplifon will send you and your selected provider the necessary information to activate your hearing aid discounts.

Take advantage of your value-added feature!
Visit www.amplifonusa.com/deltadentalins or call 1-888-779-1429 to get started.

[1] Amplifon's hearing health care services are not insured benefits. Delta Dental makes the hearing health care services program available to enrollees to provide access to the preferred pricing for hearing aids and other hearing health services.

[2] Delta Dental of California, Delta Dental Insurance Company, Delta Dental of Pennsylvania, Delta Dental of New York, Inc. and our affiliated enterprise companies.

[3] Center for Hearing and Communication; http://chchearing.org/facts-about-hearing-loss/

[4] Amplifon Hearing Health Care utilization database, January-December 2018. Discounts or savings may vary by manufacturer and technology level of the hearing aid device.

[5] Amplifon offers a price match on most hearing devices; some exclusions apply. Not available where prohibited by law. Visit www.amplifonusa.com/deltadentalins or call 1-888-779-1429 for more details.

[6] Amplifon Hearing Health Care provider file, February 2019

Vision

At VSP, we invest in the things you value most—the best care at the lowest out-of-pocket costs. Because we're the only national not-for-profit vision care company, you can trust that we'll always put your wellness first.

You'll like what you see with VSP.

- **Value and Savings.** You'll enjoy more value and the lowest out-of-pocket costs.
- **High Quality Vision Care.** You'll get the best care from a VSP provider, including a WellVision Exam® - the most comprehensive exam designed to detect eye and health conditions. Plus, when you see a VSP provider, your satisfaction is guaranteed.
- **Choice of Providers.** The decision is yours to make - choose a VSP provider or any out-of-network provider.
- **Great Eyewear.** It's easy to find the perfect frame at a price that fits your budget.

Plan Benefits	VSP	
	In-Network	Out-of-Network
Frequency		
• Eye Exam	Once every 12 months	
• Lenses / Contacts	Once every 12 months	
• Frames	Once every 24 months	
Copay	**MEMBER RESPONSIBILITY**	**PLAN PAYS**
• Exam	$15 copay	Up to $45
Prescription Lenses	PLAN PAYS	PLAN PAYS
• Single	100%	Up to $45
• Lined Bifocal	100%	Up to $65
• Lined Trifocal	100%	Up to $85
	PLAN PAYS	**PLAN PAYS**
Frames	Up to $130/$150 featured frame brands ($70 at Costco)	Up to $47
Contacts *(in lieu of lenses and frames)*	**PLAN PAYS**	**PLAN PAYS**
• Medically Necessary	100%	Up to $105
• Elective	Up to $105	Up to $105
Lens Enhancements		
• Standard Progressive	$50 copay	Plan pays up to $85
• Premium Progressive	$80 – $90 copay	Plan pays up to $85
• Custom Progressive	$120 – $160 copay	Plan pays up to $85

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Vision (continued)

Savings never looked so good.

Receive access to more than $2,500 in savings with VSP® Exclusive Member Extras from industry leading brands like:

- Extra $20 on featured frame brands[1,3]
- Instant savings and satisfaction guarantees on popular lenses and enhancements[2,3]
- Savings on LASIK
- Mail-in rebates and free trials on popular contact lens brands
- Discounts on medical care, prescription drugs, lab work, as well as entertainment and theme park passes[4]
- Savings on digital hearing aids and replacement batteries[5]

VSP PREMIER PROGRAM

Maximize your savings with Bonus Offers, which are only available at Premier Program locations. View Bonus Offers at **vsp.com/bonusoffers**.

Check out offers from these brands at vsp.com/offers.

LENSES AND FRAMES

EXTRA $20 TO SPEND · eyeconic · Eyezen+ · sunsync · techshield · Transitions light intelligent lenses · unity · ZEISS

CONTACTS

BAUSCH+LOMB See better. Live better. · CooperVision

LASIK

The LASIK Vision INSTITUTE · TLC Laser Eye Centers

HEARING AIDS AND FINANCING

TruHearing · CareCredit

HEALTH AND ENTERTAINMENT

VSP SIMPLE VALUES

Offers subject to change without notice. Some members may not be eligible for all offers. Visit vsp.com/offers for terms and conditions on specific offers.

1. Brands and promotions are subject to change. **2.** Savings based on doctor's retail price and vary by plan and purchase selection; average savings determined after benefits are applied. **3.** Available to VSP members with applicable plan benefits. **4.** Some members may not be eligible for this program; visit vsp.com/simplevalues for terms and conditions. **5.** VSP is providing information to its members, but does not offer or provide any discount hearing program. The relationship between VSP and TruHearing is that of independent contractors. VSP makes no endorsement, representations or warranties regarding any products or services offered by TruHearing, a third-party vendor. The vendor is solely responsible for the products or services offered by them. If you have any questions regarding the services offered here, you should contact the vendor directly. TruHearing offers individuals the opportunity to purchase hearing aids at discounted prices, including individuals covered by self-funded health plans not subject to state insurance or health plan regulations. TruHearing is not insurance and not subject to state insurance regulations. TruHearing provides discounts to certain health care groups for hearing aid sales and services; TruHearing provides fitting, programming and three adjustment visits at no cost; the member is obligated to pay for testing, and all post-fitting hearing care services, but will receive a discount from those health care providers who have contracted with TruHearing. Not available directly from VSP in the states of Washington and California.

Vision (continued)

Enjoy VSP® Simple Values—an exclusive member extra that gives you and your family access to valuable discounts and everyday savings.

VSP® SIMPLE VALUES

Health and Wellness:

- Prescription Drugs – **save up to 85%**
  Accepted at CVS Pharmacy, COSTCO Wholesale, Walmart, Target, Walgreens, and others.
- Doctor Visits – **save up to 25%**
  Includes 24/7 doctor access via phone or video visit
- Dental – **save up to 50%**
- Lab Work, MRI, and Imaging – **save up to 60%**
- Hearing – **save up to 60%**
- Diabetic Care Services – **save up to 75%**

Family Fun:

- Live Entertainment, Movie Tickets, and Theme Park Passes – **save up to 40%**
- Travel and Hotels – **save up to 60%**

Everyday Savings:

- Retail Rewards – **cash back**

FIND THE SAVINGS AVAILABLE TO YOU.

Visit **vsp.com/simplevalues** and sign up to download your card today!

EXCLUSIVE MEMBER EXTRAS

Hearing

Save Up to 60% on Brand-name Hearing Aids

TruHearing™

Like vision loss, hearing loss can have a huge impact on your quality of life. However, the cost of a pair of quality hearing aids usually costs more than $5,000, and few people have hearing aid insurance coverage.

TruHearing® makes hearing aids affordable by providing exclusive savings to all VSP® Vision Care members. You can save up to 60% on a pair of hearing aids with TruHearing. What's more, your dependents and even extended family members are eligible, too.

In addition to great pricing, TruHearing provides you with:

- Three provider visits for fitting and adjustments
- 45-day trial
- Three-year manufacturer warranty for repairs and one-time loss and damage replacement
- 48 free batteries per hearing aid

Plus, with TruHearing you'll get:

- Access to a national network of more than 3,800 hearing healthcare providers
- Straightforward, nationally-fixed pricing on a wide selection of the latest brand-name hearing aids
- Deep discounts on batteries shipped directly to your door

Best of all, if you already have a hearing aid benefit from your health plan or employer, you can combine it with TruHearing prices to reduce your out-of-pocket expense even more!

Here's how it works:

Contact TruHearing.
Call **877.396.7194**. You and your family members must mention VSP.

Schedule exam.
TruHearing will answer your questions and schedule a hearing exam with a local provider.

Attend appointment.
The provider will perform a hearing exam, make a recommendation, order the hearing aids through TruHearing, and fit them for you.

Learn more about this VSP Exclusive Member Extra at truhearing.com/vsp or call 877.396.7194 with questions.

Hearing (continued)

Basic Life & AD&D – The Hartford

Plan Benefits	The Hartford
Eligible Class	• **Class 1:** Active F/T Permanent President working 7.5 hours/week • **Class 2:** Active F/T Permanent Employee, excluding President working 7.5 hours/week • **Class 3:** Active Board of Directors
Coverage Amount[1]	• **Class 1:** $250,000 • **Class 2 & 3:** $50,000
Maximum Benefit	• **Class 1:** $250,000 • **Class 2 & 3:** $50,000
Guaranteed Issue	• **Class 1:** $250,000 • **Class 2 & 3:** $50,000
Age Reduction	
• At age 65	Reduction to 65% of the initial benefit amount
• At age 70	Reduction to 50% of the initial benefit amount
Accelerated Benefit Option	Up to 80% of Benefit
Conversion	Yes
Portability	Yes

1. If the value of any pre-tax life insurance coverage is greater than $50,000, the amount over $50,000 is added to your taxable compensation as "imputed income."

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Voluntary Life – The Hartford

Plan Benefits	The Hartford
Eligible Class	Full-Time Active Permanent Employees
Coverage Amount	
• Employee	Increments of $10,000 / multiple of salary
• Spouse	Increments of $5,000
• Child(ren)	$10,000
Maximum Benefit	
• Employee	Lesser of 5x base annual salary or $500,000
• Spouse	Lesser of 100% of employee approved coverage or $100,000
• Child(ren)	$10,000
Guaranteed Issue[1]	
• Employee	$100,000
• Spouse	$50,000
• Child(ren)	$10,000
Waiver of Premium[2]	Included
Age Reduction	
• At age 65	Reduction to 65% of the initial benefit amount
• At age 70	Reduction to 50% of the initial benefit amount
Accelerated Benefit Option	Up to 80% of Benefit
Conversion	Yes
Portability	Yes

1. Guarantee Issue is the amount of insurance you are guaranteed without having to complete Evidence of Insurability (EOI). Any amounts above the Guaranteed Issue amount is subject to underwriting where you will be required to complete an EOI form.
2. If you become Totally Disabled while insured, the Waiver of Premium Provision may continue your Life Insurance without any further payment of premiums by you.

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Voluntary AD&D – The Hartford

Plan Benefits	The Hartford
Eligible Class	Full-Time Employees
Coverage Amount	
• Employee	Increments of $10,000 up to lesser of 10x covered annual earnings or $500,000
• Spouse	50% of employee amount if employee doesn't cover any children under AD&D policy. 40% of employee amount if employee covers any children.
• Child(ren)	15% of employee amount if employee does not cover a spouse under AD&D policy. 10% of employees amount if employee covers spouse.
Maximum Benefit	
• Employee	Lesser of $500,000 or 10x earnings
• Spouse	50%/40% of employee amount
• Child(ren)	15%/10% of employee amount
Age Reduction	
• At age 65	Reduction to 65% of the initial benefit amount
• At age 70	Reduction to 50% of the initial benefit amount
Conversion	No
Portability	No

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

Short Term Disability – The Hartford

Plan Benefits	The Hartford
Eligible Class	**District Paid** • All active full-time CSEA employees who work at least 15 hours per week. • All active full-time unrepresented employees who work at least 30 hours per week. **Employee Paid** • All active full-time SEIU employees who work at least 15 hours per week. • Active full-time UPM employees working at least 30 hours per week.
Weekly Benefit	60% of covered weekly earnings
Weekly Maximum	$1,500
Elimination Period	Accident 1 day, Sickness 8 days
Benefit Duration	13 weeks

Note: Pre-existing condition limitations may apply.

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

Long Term Disability – The Hartford

Plan Benefits	The Hartford
Eligible Class	• **Class 1:** Active F/T Permanent Employees w/ 5+ years of STRS working 20 hours/week • **Class 2:** Active F/T Permanent Employees earning less than $162,000 annually working 20 hours/week • **Class 3:** Active F/T Permanent CSEA/SEIU Employees working 15 hours/week • **Class 4:** Active F/T Permanent Employees earning $162,000 or more annually working 20 hours/week
New Hire Waiting Period	• 1st of the month following 90 days of employment
Monthly Benefit	• **Classes 1, 2 & 4:** 66.67% • **Class 3:** 60%
Monthly Maximum	• **Classes 1, 2 & 3:** $9,000 • **Class 4:** $12,000
Elimination Period *(All Classes)*	• **90 Day**
Tax Treatment	• **Classes 1, 2 & 4:** Benefit is taxable • **Class 3:** Benefit is not taxable
Benefit Duration	• **Class 1:** 2 years • **Classes 2, 3 & 4:** If disabled prior to 63, benefits may continue for as long as you remain disabled or until you reach your social security normal retirement age. If disability occurs at age 63 or above, the number of payments may reduce.

Note: Pre-existing condition limitations may apply.

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

The Hartford Services

HealthChampion™

Health Care Support Service

Get the Support You Need to Help Make Smarter Health Care Decisions

If you become disabled from an accident or are diagnosed with a critical illness, your first priority should be focusing on your treatment and recovery. What you don't need is more stress about your care options, medical benefits, co-pays and other expenses.

To help, there's ComPsych® HealthChampion[1] – a service provided to you as part of The Hartford's Ability Assist® EAP services.[2] HealthChampion helps take some of the burden off your shoulders. No matter what kind of health plan you have - whether a self-funded plan or a public or private health care exchange - the HealthChampion program can:

- Guide you through health care options
- Connect you with the right resources
- Advocate for timely and fair resolution of issues

How does it work? You have unlimited access to HealthChampion specialists who walk you through all aspects of your health care issue. Helping to ensure that you're fully supported with employee assistance programs and/or work-life services.

Timely Answers From Trusted Professionals

HealthChampion is staffed by both administrative and clinical experts who understand the nuances of any given health care concern. The GuidanceConsultants℠ intake staff are master's or doctoral degreed. They assess the issues and needs and then directly connect you to the appropriate HealthChampion specialist. HealthChampion can then help you through a variety of both administrative and clinically-related concerns. (See the table on the next page for a complete list.)

Best of all, you can access the GuidanceConsultants 24 hours a day, seven days a week via a toll-free line: 1.800.96.HELPS (1.800.964.3577) so you'll have assistance when you need it.[3]

Administrative Support

- An easy-to-understand explanation of your benefits - what's covered and what's not
- Cost estimation for covered and non-covered treatment options
- Step-by-step guidance on claims and billing issues
- Fee and payment plan negotiation
- Referral to financial resources for the under- and uninsured
- Explanation of the appeals process

Clinical Support

- One-on-one review of your health concerns
- Preparation for upcoming doctor's visits, lab work, tests and surgeries
- Straightforward answers regarding diagnosis and treatment options
- Coordination with appropriate health care plan provider(s)
- Referral to community resources and applicable support groups

Administrative and clinical specialists may also refer employees to EstateGuidance® EAP services and other work-life resources.[5]

Better Care Without The Legwork And Guesswork

Save yourself the time and burden of getting the answers for your health needs. Look into ComPsych® HealthChampion today.

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1. HealthChampion℠ services are provided through The Hartford by ComPsych®. ComPsych is not affiliated with The Hartford and is not a provider of insurance services. The Hartford does not provide basic hospital, basic medical, or major medical insurance.
2. Ability Assist® is offered through The Hartford by ComPsych®. ComPsych is not affiliated with The Hartford and is not a provider of insurance services. The Hartford is not responsible and assumes no liability for the goods and services goods and services provided by ComPsych.
3. HealthChampion specialists are only available during business hours. Inquiries outside of this timeframe can either request a call-back the next day or schedule an appointment.
4. This case study is fictional. It is intended for illustrative purposes only.
5. EstateGuidance® services are provided through The Hartford by ComPsych. ComPsych® is not affiliated with The Hartford and is not a provider of insurance services. The Hartford is not responsible and assumes no liability for the goods and services provided by ComPsych and reserves the right to discontinue any of these services at any time.

DISCLAIMER: Service Exclusions and Limitations: Europ Assistance USA (EA) services are eligible for payment or reimbursement by EA only if EA was contacted at the time of the services and arranged and/or preapproved the services. Certain terms, conditions and exclusions apply; for further information refer to the Web site listed or call EA at the number provided.

The Hartford Services (continued)

EstateGuidance® Will Services

Create a Simple Will From the Convenience of Your Desktop

Whether your assets are few or many, it's important to have a will. It's the only way to ensure that your intentions will be honored in the event of your death. A will states your wishes about who will inherit your property, who will be the guardian of your children, and who will manage your estate. Without a will, those decisions may be left to others.

An Easy and Empowering Solution.

As a covered employee under a Hartford Group Life insurance policy, you have access to EstateGuidance® Will Services provided by ComPsych®.[1] It helps you create a simple, legally binding will quickly and conveniently online, saving you the time and expense of a private legal consultation. Other advantages include:

- Online assistance from licensed attorneys should you have questions.
- The ability to save drafts for up to six months. During this period, you can revise your will at no cost, as long as you haven't already printed or downloaded it.

Quick Answers to Key Questions.

Where there's a will, there are bound to be questions. Here are answers to four common ones.

"Isn't will preparation complicated?"

Not with EstateGuidance®. You'll be asked a series of questions online that are used to compose your will. In many states, you need only add your signature to make the will valid.

"What if I have questions as I'm creating my will?"

The online education center provides answers regarding family law. You can also access fully licensed attorneys who'll respond to you online.

"What about my privacy?"

All information is kept secure and confidential with the latest encryption technology.[2]

"So, what happens if I don't create a will?"

The state, not you, would decide how your property is distributed. In most states, all of your community and joint property would pass to your spouse if you have one. Separate property is passed according to a complex order of distribution, regardless of your loved ones' wishes. By drafting a will, you can spare them a potentially awkward and contentious situation.

Good Intentions Aren't Enough

You might have the best of intentions, but without a will, they aren't legally binding. Take this opportunity to put your intentions into action.

Visit www.estateguidance.com/wills today.

Use this code: WILLHLF. Then follow the easy steps below:

1. Access The Hartford's EstateGuidance® Will Services online.
2. Sign in to the secure site by entering the access code.
3. Follow the instructions and create your will.
4. Download the final will to your computer and print.
5. Obtain signatures and determine if your will should be notarized.

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1. EstateGuidance® is offered through The Hartford by ComPsych® Corporation. ComPsych is not affiliated with The Hartford and is not a provider of insurance services. The Hartford is not responsible and assumes no liability for the goods and services provided by ComPsych and reserves the right to discontinue any of these services at any time. A simple will does not cover credit shelter trust, printing or certain other features. These features are available at an additional cost to you.
2. The EstateGuidance® website is secured with a GoDaddy.com Web Server Certificate. Transactions on the site are protected with up to 256-bit Secure Sockets Layer encryption.
3. This case illustration is fictitious and for illustrative purposes only.

Services may not be available in all states.

The Hartford Services (continued)

Travel Assistance and ID Theft Protection Services

Even the Best Planned Trips Can be Full of Surprises

The best laid travel plans can go awry, leaving you vulnerable and, possibly, unable to communicate your needs. When the unexpected happens far from home, it's important to know whom to call for assistance.

If you are covered under a Hartford Group Policy, you and your family have access to Travel Assistance Services provided by Europ Assistance USA.[1]

With a local presence in 200 countries and territories around the world, and numerous 24/7 assistance centers, they are available to help you anytime, anywhere.

Good To Go: Multilingual Assistance 24/7

Whether you're traveling for business or pleasure, Travel Assistance services are available when you're more than 100 miles from home for 90 days or less.[2,3]

As long as you contact Europ Assistance USA at the time of need, you could be approved for up to $1 million in covered services.[4]

Services From Here to There

Travel Assistance begins even before you embark, with pre-trip information, and continues throughout your trip. See the list of services in the chart on the back of this page.

Identity Theft Assistance, Too

Identity theft, America's fast growing crime, victimizes almost 10 million American consumers each year.[5] Europ Assistance USA helps protect you and your family from its consequences 24/7,[2] at home and when you travel.

In addition to prevention education, this service provides advice and help with administrative tasks resulting from identity theft.

1. Travel Assistance and Identity Theft services are provided by Europ Assistance USA Europ Assistance USA is not affiliated with The Hartford and is not a provider of insurance services. Europ Assistance USA may modify or terminate all or any part of the service at any time without prior notice. None of the benefits provided to you by Europ Assistance USA as a part of the Travel Assistance and Identity Theft service are insurance. This brochure, the Travel Assistance and Identity Theft service Terms and Conditions of Use, and the Identity Theft Resolution Kit constitute your benefit materials and contain the terms, conditions, and limitations relating to your benefits. These services may not be used for business or commercial purposes or by any person other than the individual insured under The Hartford's group insurance policy . The Hartford is not responsible and assumes no liability for the goods and services described in these materials.
2. Coverage includes spouse (or domestic partner) and dependent children under age 26.
3. Services are available in every country of the world. Depending on the current political situation in the country to which you are traveling, EA may experience difficulties providing assistance, which may result in delays or even the inability to render certain services. It is your responsibility to inquire, prior to departure, whether assistance service is available in the countries where you are traveling.
4. The Combined Single Limit (CSL), or amount of money available to the insured under a Hartford Group policy the Travel Assistance Program, is $1 million. One service or a combination of the services may exceed the CSL. The insured is responsible for payment of any expenses that exceed the CSL. **Note:** Certain Accidental Death and Dismemberment programs may offer different CSLs. Please consult with your Human Resources Manager for more details.
5. www.transunion.com/personal-credit/identity-theft-and-fraud/identity-theft-facts.page, viewed on 6/25/15.

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The Hartford Services (continued)

Travel Assistance and ID Theft Protection Services			
Emergency Medical Assistance[6]	**Pre-Trip Information**	**Emergency Personal Services[7]**	**Identity Theft Assistance**
• Medical referrals • Medical monitoring • Medical evacuation • Repatriation • Traveling companion assistance • Dependent children assistance • Visit by a family member or friend • Emergency medical payments • Return of mortal remains	• Visa and passport requirements • Inoculation and immunization requirements • Foreign exchange rates • Embassy and consular referrals	• Medication and eyeglass prescription assistance • Emergency travel arrangements[9] • Emergency cash[9] • Locating lost items • Bail advancement	• Prevention Services – Education – Identity Theft Resolution Kit • Detection Services – Fraud alert to three credit bureaus • Resolution Guidance and Assistance – Credit information review – ID Theft Affidavit Assistance – Card replacement • Personal Services – Translation – Emergency cash advance*

What to have ready: Your employer's name, a phone number where you can be reached, nature of the problem, Travel Assistance Identification Number and your company policy number, which can be obtained through your Human Resources department.

Have a serious medical emergency? Please obtain emergency medical services first (contact the local "**911**"), and then contact Europ Assistance USA to alert them to your situation. Call: **1.800.243.6108** Collect from other locations: **202.828.5885** Fax: **202.331.1528**

Travel Assistance Identification Number: **GLD-09012**

6. In a medical emergency, Europ Assistance USA pays for assistance as described herein, but you are personally responsible for paying your medical/hospital expenses.
7. Europ Assistance USA provides the described personal services to you in an emergency, but you are personally responsible for the cost of air fare not approved as medically necessary by the attending physician; food, hotel and car expenses; and attorney fees. Emergency cash advances and bail advancement require your personal satisfactory guarantee of reimbursement provided through a valid credit card.
8. This case illustration is fictitious and for illustrative purposes only.
9. Emergency cash is charged as a cash advance, and emergency airline tickets are charged as a purchase to your credit card account and are all subject to that account's finance rates.

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Colonial Life Benefit Enrollment

4 easy steps for a successful Benefit Enrollment

Schedule with a Benefits Specialist today!

Colonial Life
The benefits of good hard work.™

Marin Community College District

1. Schedule your Appointment

Click or scan the QR Code using the camera app on a smartphone to schedule your Benefits Counseling session.

2. Prepare for your Appointment

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

3. Meet with a Benefits Specialist

The Benefits Specialist will educate you, provide cost savings tips and discuss options that best fit you and your family.

4. Breathe easier

The goal of this appointment is to ensure you feel knowledgeable and comfortable about the benefits you select.

You can watch a quick video of each of the benefit options by clicking the plan below.

☑ **Disability insurance** replaces a portion of your income to help make ends meet if you become disabled from a covered accident or covered sickness.
Ask about Maternity options

☐ **Accident insurance** helps offset the unexpected medical expenses, such as emergency room fees, deductibles and co-payments that can result from a covered accidental injury.

☐ **Cancer insurance** helps offset the out-of-pocket medical and indirect, non-medical expenses related to cancer that most plans do not cover. This coverage also provides a benefit for specified cancer-screening tests.

☐ **Life insurance** enables you to tailor coverage for your individual needs and helps provide financial security for your family members.

☐ **Critical illness insurance** supplements your major medical coverage by providing a lump-sum benefit that you can use to pay for costs related to a covered critical illness.

☐ **Hospital confinement indemnity insurance** provides a lump-sum benefit for a covered hospital confinement. Additional options may be available.
Ask about Maternity option

To file a claim, click HERE to access the Colonial Life Policy Holder Website. If you still have questions do not hesitate to reach out to your account representative, Brittany Lloyd. She can be reached at 925-759-6027 or via email at Brittany.Lloyd@coloniallifesales.com

Employee Information:

NAME: _____ PHONE: _____ EMAIL: _____

These coverages may not be available in all states; product benefits vary by state. Policies have exclusions and limitations that may affect benefits payable. For cost and complete details, please see your Colonial Life benefits counselor.

www.ColonialLife.com/individuals

STERLING ADMINISTRATION

P.O. Box 71107
Oakland, CA 94612

1.800.617.4729
www.sterlingadministration.com

FLEXIBLE BENEFITS PLANS

WE MAKE THE COMPLEX SIMPLE

WHAT ARE FLEXIBLE BENEFIT PLANS?

Flexible Benefit Plans from Sterling give you another great way to pay for healthcare costs and realize substantial tax savings. Through payroll redirection, employees purchase "qualified benefits" that may not be included in gross income. They use the tax-advantaged money to pay for qualified medical expenses.

Your Flexible Benefit Plan includes:

- Healthcare Flexible Spending Accounts (FSAs)

HEALTHCARE FSAS

With a Healthcare FSA, you can be reimbursed for medical expenses not covered or reimbursed by other insurance or plans like health savings accounts (HSAs) and health reimbursement arrangements (HRAs). All expenses must be qualified medical, vision, pharmacy or dental benefit expenses as defined by Section 213(d) of the IRS Code. Thanks to the Coronavirus Aid, Relief and Economic Security (CARES) Act, you can use your FSA funds to buy over-the-counter medications without a prescription, like Tylenol and other pain relievers, heartburn medications, allergy relief and more, for the first time since 2011.

All medical care expenses must be incurred during the plan year and the "use it or lose it" rule applies to any funds not spent before the end of the plan year unless your employer has elected an optional rollover of up to $610. Funds may also be forfeited if you leave your employer that sponsors the FSA.

A Healthcare FSA annual contribution maximum of $3,050 will be imposed. Healthcare FSAs with a plan start date or renewal date on or after January 1, 2023 will be limited to this annual maximum contributionamount.

CLICK HERE to watch a video on Flexible Spending Accounts (FSA)

Flexible Benefits Plans by STERLING (continued)

WHAT ARE THE ADVANTAGES OF FLEXIBLE BENEFIT PLANS?

- Employees can reduce taxable income and use the savings to pay for qualified expenses. Tax savings include federal income tax, and in most jurisdictions, state and local income taxes. In addition, employees do not pay Social Security and Medicare tax on the amount excluded from income.

STERLING SERVICES

Sterling Administration offers many services to employees who participate in their employer sponsored Healthcare FSA.

- Help with enrollment in the plans by attending employer enrollment meetings
- Issuance of debit cards, if elected as part of the plan by your employer
- Healthcare expense claim review and payment of bills to providers or as reimbursement to you
- Quarterly reporting of account information
- Scan and archive of FSA claims and reimbursement documents in the event of an audit
- Money back guarantee of up to one year of monthly fees paid, if our clients are dissatisfied with our service
- Personal customer service on the phone and via email Monday – Friday
- Online access to account information, educational information and forms available at **www.sterlingadministration.com**

MORE INFORMATION

For more information, go to **www.sterlingadministration.com**, call us at 800-617-4729, or email us at **benefits@sterlingadministration.com**.

P.O. Box 71107, Oakland, CA 94612
Toll Free: 1.800.617.4729 | www.sterlingadministration.com ©
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2

STERLING ADMINISTRATION

HEALTH SAVINGS ACCOUNTS: HOW THEY WORK

WHAT IS AN HSA?

Think of HSAs as "medical" IRAs. They are tax advantaged accounts that individuals with an HSA compatible high deductible health plan (HDHP) can fund and use to pay for qualified medical, dental and vision expenses. Because they are tax advantaged and balances can accumulate over time, HSAs can also be used to accumulate wealth. In addition, HSAs are owned by the individual accountholder and are therefore portable. Since inception in January 2004, HSAs have quickly gained in popularity among individuals and employers alike.

WHAT ARE THE REQUIREMENTS FOR HAVING AN HSA?

1. You must be enrolled in a high deductible HSA qualified health plan with any carrier
2. You cannot be claimed as a dependent on another persons' tax return
3. You cannot be enrolled in Medicare
4. You cannot have dual health insurance coverage (be covered by another non-HSA qualified health plan).
5. You cannot have access to a general purpose healthcare FSA or HRA

HOW MUCH CAN BE CONTRIBUTED TO AN HSA?

For 2023, the IRS maximums are $3,850 for an individual and $7,750 for a family, as long as the HDHP and HSA are both effective on or before December 1st. The catch-up contribution for individuals age 55 and over is $1,000 for 2023. A separate HSA account is required for a spouse over age 55 to make a catch-up contribution.

HOW DO I FUND THE HSA?

You fund the HSA using federally tax-free dollars. If your employer has a Section 125/POP plan and allows it, you can elect to have pre-tax contributions made to your HSA via payroll deduction. You can also transfer funds online at www.sterlingadministration.com or send an "after tax" check and take the deduction as an above the line deduction on your federal income tax 1049 return when you file your taxes. Another option is to roll money over from an existing IRA (this is a once in a lifetime option). Please note that HSA contributions are tax-free in 47 states. HSA contributions in AL, CA and NJ are subject to state taxes.

HOW CAN HSA FUNDS BE USED?

The funds can be used for qualified healthcare expenses, including medical, dental and vision. Please see www.IRS.gov Publication 502 section 213(d) for a full listing of qualified expenses. HSA funds can also be used to pay for COBRA premiums, long-term care premiums and Medicare premiums (Part B, C and D). HSA funds can be spent on eligible expenses for an HSA accountholder's spouse and any IRS dependents, regardless of whether or not they are covered on the health plan. If funds are used for non-qualified expenses prior to age 65, a 20% IRS penalty applies.

Flexible Benefits Plans by STERLING (continued)

WHAT HAPPENS WHEN I TURN 65?

You can continue to use funds in an HSA for qualified medical, dental and vision expenses tax free, but another benefit for accountholders 65 and over is that the HSA funds can also be spent on non-qualified expenses without a 20% penalty. Distributions for non-qualified expenses are taxed as "ordinary income".

AS AN OWNER, CAN I CONTRIBUTE TO AN HSA?

Yes, HSAs are one of the only accounts that owners may participate in on a tax-free basis. Do keep in mind, 2% or greater shareholders and owners of any type of corporation, besides a C-corporation, must contribute to their account with personal funds and after tax dollars. They would then receive an above the line deduction when they file their income taxes. C-corporation shareholders and owners are exempt from this and are treated like employees.

DO I LOSE THE FUNDS IF THEY ARE NOT SPENT AT THE END OF EACH YEAR?

No. Unlike Flexible Spending Accounts (FSA) or Health Reimbursement Arrangements (HRA), there is no "use it or lose it" provision with HSAs. The funds in an HSA roll over from year to year, are interest bearing, and are even portable if the accountholder changes jobs or health insurance carriers. HSAs are often viewed as additional retirement savings accounts for these reasons.

HOW DO I PAY FOR THINGS?

As a Sterling accountholder, you will have a Sterling debit card (smart card) that you can use to purchase items that are qualified expenses. For example, after seeing an in-network doctor you will wait to receive an Explanation of Benefits (EOB) from your insurance carrier. Once you receive a bill from your doctor that matches your insurance carrier EOB, place your debit card numbers in the card options spot on the bill when you receive it. At the pharmacy, for dental, vision and out-of network doctors, you will also have the option of using your debit card at the time of service. If the doctor or provider does not take debit cards, then you can pay out of pocket and reimburse yourself from your Sterling account. You can reimburse yourself using the online banking feature, if you register your account online at www.sterlingadministration.com.

DO I HAVE INVESTMENT OPTIONS FOR BALANCES IN MY HSA?

Yes, you have full reign to self-direct the funds in your HSA account subject to some IRS limitations. However, it is recommended that you leave your annual deductible, or better yet your HDHP out-of-pocket maximum amount, liquid in your Sterling managed account in case of a medical emergency.

WHY WOULD I CHOOSE AN HSA?

HSAs are beneficial in many ways. Not only do account holders save money on health insurance premiums, they are also better able to take control over their healthcare choices and expenses. HSAsare the innovative financier of healthcare today and retirement tomorrow. Why spend more than you need to on healthcare premiums and taxes when you could be saving the money for yourself in your HSA?

WHY CHOOSE STERLING?

Sterling is the leader in HSA administration when it comes to in-depth knowledge of both the HSA and healthcare industries. We make the complex simple and offer a level of personal service that is unsurpassed in the industry. We are so committed to offering excellent service that we offer a money back guarantee. Some of the services we provide are: IRS audit protection by helping and advising you on what you can use HSA funds to buy under IRS guidelines; review of Explanation of Benefits to make sure you don't pay too much; preparation of required tax documentation; and payment plan assistance. Online and mobile access account management tools make it easy to request disbursement, make contributions, etc.

For more information on Sterling, visit our website at www.sterlingadministration.com.

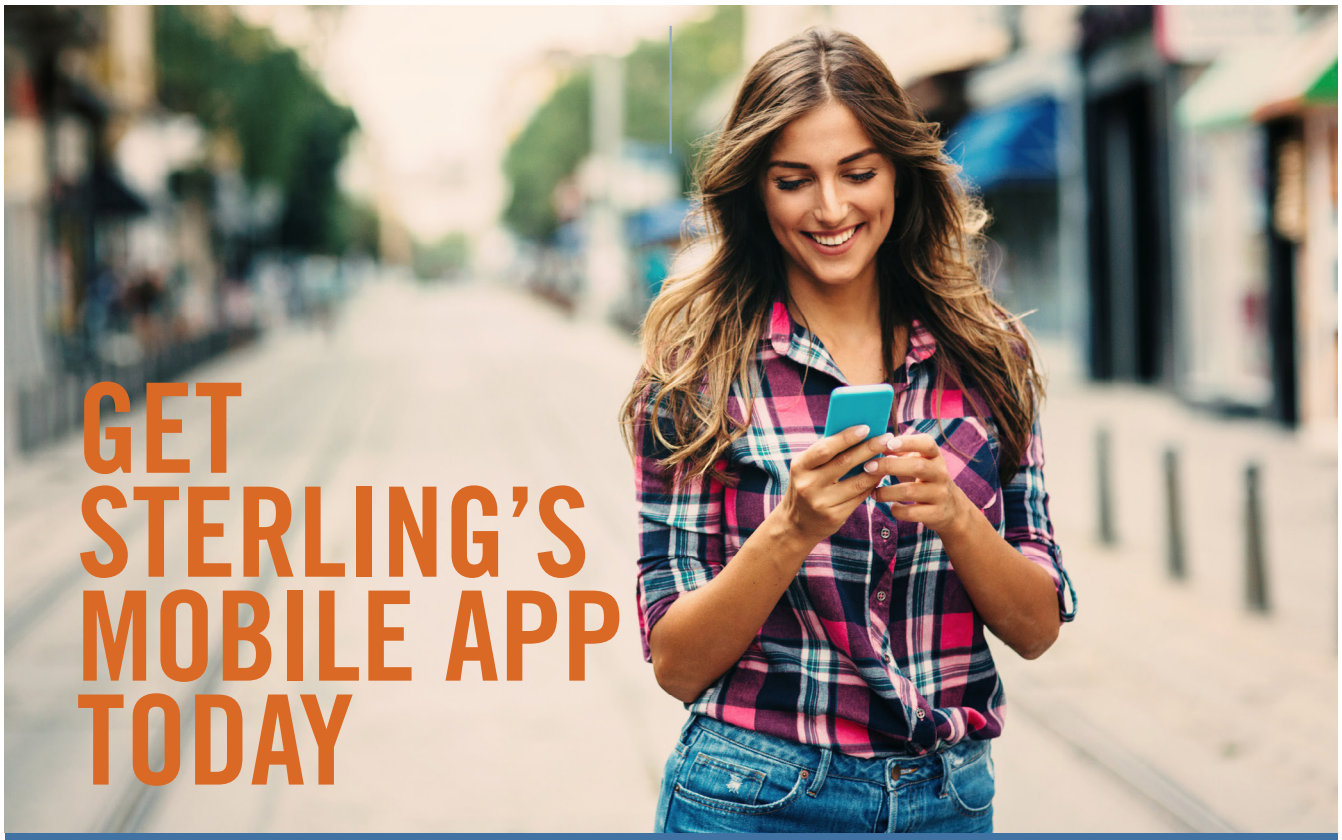
1000 Broadway #250, Oakland, CA 94607
Toll-Free: 1.800.617.4729 | www.sterlingadministration.com

FOLLOW US

2

CLICK HERE to watch a video on Health Savings Accounts (HSA)

Flexible Benefits Plans by STERLING (continued)



Available now for iOS and Android – get Sterling's free app, today! Just go to the Apple App Store or Google Play Store and search for "Sterling Administration."

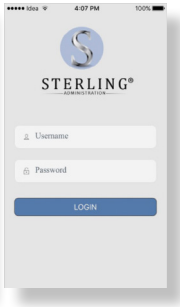
WHAT CAN YOU DO ON THE APP?

Just log on with the same credentials you use on Sterling's desktop site, and you're ready to go! All your Sterling products automatically will load onto your app.

- Check balances
- Schedule contributions for HSA accounts
- Schedule disbursements for HSA/HRA/FSA accounts
- Substantiate debit card claims for FSA and HRA
- Download tax statements (1099 and 5498)
- Download HSA activity statements
- Upload claim receipts
- COBRA qualified beneficiaries can view account info and payment history

Look for the Sterling "S"

Mobile App Login Screen



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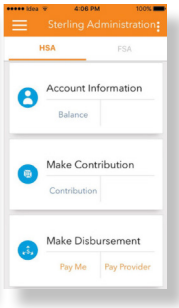

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LIMITED PURPOSE FLEXIBLE SPENDING ACCOUNT

WE MAKE THE COMPLEX SIMPLE

HELPS YOU SAVE MONEY FOR THE FUTURE

A Limited Purpose Flexible Spending Account (LPFSA) deals with how the FSA is treated in conjunction with health savings accounts (HSAs).

You can use a LPFSA to pay for eligible out-of-pocket dental and vision expenses such as:

- Dental and orthodontia care like fillings, X-rays and braces
- Vision care to include eyeglasses, contact lenses and LASIK surgery

You cannot use a LPFSA for medical expenses. You also cannot have a general purpose Healthcare FSA with an HSA and LPFSAs do not apply to expenses covered under Dependent Care FSAs.

How do you know if a LPFSA is right for you? To help you decide, consider the following:

- If you enroll in a LPFSA, you decide how much of your salary to contribute, up to the IRS limit.
- Your employer will deduct your LPFSA contributions from your paycheck on a pretax basis. This added advantage helps lower your taxable income.
- By using your LPFSA funds for eligible dental and vision expenses, you can save your HSA funds for future medical needs or retirement.
- To decide if you would benefit from a LPFSA and determine how much to set aside, review dental and vision expenses for you, your spouse and/or dependents from the last year and think about what you expect to spend this year. You can use the LPFSA funds for eligible expenses incurred by you, your spouse and your dependents.
- Plan carefully because the LPFSA has a "use-it-or-lose-it rule" unless your employer has elected an optional rollover of up to $550. Any contributions not used by the end of the plan year will be forfeited. If your employer sponsored plan has a grace period, you have an additional 2 months and 15 days (after the plan year) to use your funds. Also, if your employer plan allows for a "run-out" period, you will have additional days (after the end of your plan year) to submit claims for reimbursement. Your employer can provide details about the grace and run-out periods.

Tips on using your LPFSA funds:

- There are several options for paying for eligible expenses using funds in your LPFSA:
  - One option is with cash, check or personal credit card. Then submit an online claim for reimbursement or complete a paper claim form and email, fax or mail it to us. You must include the Explanation of Benefits (EOB) from your insurance carrier. If you have an expense that did not go through insurance, you'll have to include the detailed receipt. You can have your reimbursement deposited directly into your bank account by setting up that option online through Sterling or we can send you a check.
  - If your employer allows use of a Sterling issued debit card for your HSA and LPFSA, you must have a different debit card for each type of account. Once you use up your LPFSA funds, your eligible expenses will be deducted from your HSA balance.
- Managing your accounts online is easy! You can access your LPFSA and HSA online at www.sterlingadministration.com, including mobile access.

Need more information? Contact customer service at 800-617-4729 or benefits@sterlingadministration.com. Representatives are available Monday – Friday from 8 am – 5 pm Pacific time.

403(b) Retirement Plans

As an employee of Marin Community College District, you are eligible to participate in the District's 403(b) retirement plan. 403(b) plans allow you to contribute pre-tax dollars into an investment provider of your choice. Participation in these supplemental plans not only helps you prepare for a more financially secure future, it provides significant tax advantages today.

Importance of Supplemental Retirement Plans

Supplemental retirement plans can help you reduce or eliminate your retirement income gap? But, what is a retirement income gap?

When you retire, your pension will not be 100% of the income you're making now. The retirement income gap is the amount that is missing between what your pension pays (and other resources) and the amount you will need to live on.

STRS/PERS + Savings + Social Security (if applicable) – Expenses = Income Gap

You can start out contributing small; every bit helps towards securing the retirement you will be comfortable with in the future.

How To Start

You can start, stop or change elective deferrals at any time throughout the year.

For the 403(b)

1. Go to the OMNI Website and select a vendor. Or for assistance contact OMNI Customer Care Team Phone number (877) 544-6664.

   NOTE: OMNI cannot assist in choosing a provider or vendor. OMNI is not trained or licensed to give financial advice. As an independent third party administrator, OMNI is not directly affiliated with any provider or vendor or their representatives.

2. You may use a financial representative of your choice.
3. Contact the Investment Provider and open your account of choice with the vendor.
4. Complete and submit the online Salary Reduction Agreement (SRA) form.

For the 457(b)

1. For a 457(b) account you will need a financial advisor to assist you. Investment providers are limited to four (4) and are not the same as those offered through the 403(b) Plan.
2. Contact the Investment Provider and open your account of choice with the vendor.
3. Complete and submit the online Salary Reduction Agreement (SRA) form.

Make Changes Any Time

You can start, stop or change your elective deferrals at any time. To make a change to the amount, the frequency of your contributions or the investment provider, you must complete the following step:

1. Submit a new online Salary Reduction Agreement (SRA) form.

NOTE: The Salary Reduction Agreement (SRA) form can be found at OMNI Website or contact the OMNI Customer Care Team Phone number (877) 544-6664 for assistance.

403(b) Retirement Plans (continued)

Stop Contributions As Needed

We understand that participants may need to stop contributions from time to time. Your deferrals to the 403(b) or 457(b) Plan are completely voluntary. You are not under any obligation to continue making contributions to the Plan.

If a situation arises where you need to stop contributions you can do so at any time, just takes one step:

1. Fill out and submit a new Salary Reduction Agreement (SRA) form indicating your desire to stop your contribution.

PLEASE NOTE: For accurate records and to maintain compliance with State and Federal regulations and your Plan terms, you must use the Salary Reduction Agreement (SRA) form to start, make changes or stop deferrals from your payroll.

Elective Deferral Limits For 2023

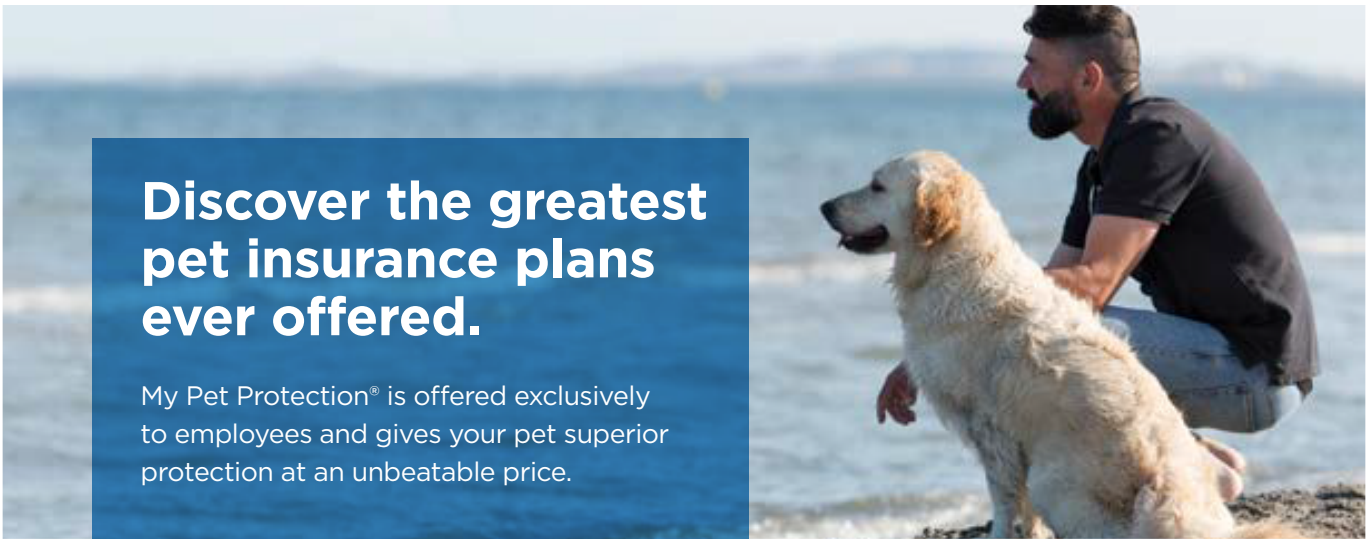
- **2023 annual elective deferral limits for 403(b) and 457(b):** $19,500
- **Age 50+ catch-up:** $6,500
- **Special catch-up provisions':** Please consult with a financial services professional

For Questions

Call (877) 544-6664 to speak with the OMNI Customer Care Team. For additional questions, you may also visit the OMNI website at OMNI Website or the COM website.

Enrollment in the plan is optional.

Pet Insurance



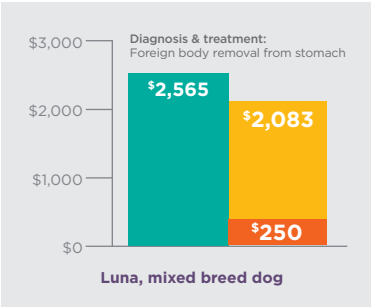
my pet protection® with wellness

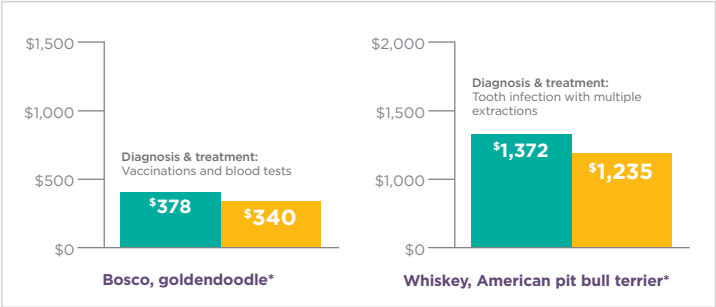
my pet protection®

- ✓ 90% back on vet bills[1]
- ✓ Exclusive to employees, not available to the general public
- ✓ Same price for pets of all ages
- ✓ Best deal: average savings of 30% over similar plans from other pet insurers[2]
- ✓ Wellness plan option that includes spay/neuter, vaccinations and more

Here's how My Pet Protection helped Nationwide® pet parents

Between big-ticket emergency vet bills and basic preventive care, My Pet Protection coverage helped keep these pet parents' bank accounts in the black.





*Annual deductible met on previous claim

Claim amount | Reimbursement by Nationwide | Annual deductible

Sample reimbursements are based on actual claims but have been edited for clarity. Coverage for wellness services only available on My Pet Protection with Wellness®.

Sign up multiple pets with individual plans and receive a discount[3] for even more savings.

Get a free, no-obligation quote today at
http://www.petinsurance.com/marin

Nationwide® is on your side

Pet Insurance (continued)

Choose a plan that's as unique as your pet.

Get back 90% of the vet bill for these items **and more**.[1]

Visit any vet, anywhere

	my pet protection® with wellness	my pet protection®
Accidents, including poisonings and allergic reactions	✓	✓
Injuries, including cuts, sprains and broken bones	✓	✓
Common illnesses, including ear infections, vomiting and diarrhea	✓	✓
Serious/chronic illnesses, including cancer and diabetes	✓	✓
Hereditary and congenital conditions	✓	✓
Surgeries and hospitalization	✓	✓
X-rays, MRIs and CT scans	✓	✓
Prescription medications and therapeutic diets	✓	✓
Wellness exams	✓	
Vaccinations	✓	
Spay/neuter	✓	
Flea and tick prevention	✓	
Heartworm testing and prevention	✓	
Routine blood tests	✓	

Just like all other pet insurers, we don't cover **pre-existing conditions.*** However, we go above and beyond with extra features such as **emergency boarding, lost pet advertising and more**. Plus, both plans have a low $250 annual deductible and a generous $7,500 maximum annual benefit.

*Any illness or injury that your pet had prior to the start of your policy will be considered a pre-existing condition.

Easy enrollment

1 Select the species (dog or cat)** → 2 Provide your zip code → 3 Pick your plan

**To enroll your bird, rabbit, reptile or other exotic pet, please call 888-899-4874.

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Available to all pet insurance members. Unlimited, 24/7 access to a veterinary professional ($150 value). Only from Nationwide®.

Get your pet insurance reimbursements deposited directly to your bank.

Submit claims right from your smartphone with the free VitusVet app.

Download from the App Store | Download from Google Play

Email, fax and snail mail claim submissions also available.

Learn more today. **http://www.petinsurance.com/marin**

[1]Some exclusions may apply. Certain coverages may be subject to pre-existing exclusion. See policy documents for a complete list of exclusions. [2]Average based on similar plans from top competitors' websites for a 4-year-old Labrador retriever in Calif., 90631. Data provided using information available as of December 2017. [3]Pet owners receive a 5% multiple-pet discount by insuring two to three pets or a 10% discount on each policy for four or more pets.

Insurance terms, definitions and explanations are intended for informational purposes only and do not in any way replace or modify the definitions and information contained in individual insurance contracts, policies or declaration pages, which are controlling. Such terms and availability may vary by state and exclusions may apply. Underwritten by Veterinary Pet Insurance Company (CA), Columbus, OH, an A.M. Best A+ rated company (2018); National Casualty Company (all other states), Columbus, OH, an A.M. Best A+ rated company (2018). Agency of Record: DVM Insurance Agency. Nationwide, the Nationwide N and Eagle, and Nationwide is on your side are service marks of Nationwide Mutual Insurance Company. ©2019 Nationwide. 19GRP5832 2-19 **19GRPMPP2CARDFLR**

Nationwide® is on your side

KeenanDirect

Helping you choose the right direction for your insurance needs

We are your advocate and offer enrollment assistance and expert guidance, FREE of charge.

- ✔ Full Suite of Individual & Family Plans
  - Health
  - Dental
  - Vision
  - Life
  - Accident
  - Cancer
  - Medicare Options
  - Short-term health
  - Small business health plans
- ✔ Access to major California carriers and health plans, including Covered California
- ✔ Subsidy eligibility and calculation – Find out if you qualify for tax credits

TOLL-FREE ENROLLMENT **1.855.653.3626**

Need Coverage?

Do you identify with one of these situations?

- Part time, seasonal or temporary employee
- Early retiree
- COBRA participant
- Have a family member or friend without access to employer-sponsored benefits
- Know an individual reaching age 26 who is no longer eligible under their parent's plan

Call Today! 1.855.653.3626

Monday through Friday 8am-6pm
Bi-lingual support

keenandirect.com

COVERED CALIFORNIA Certified *Insurance Agent*

KeenanDirect
License No. 0451271

Important Notices

Newborns' and Mothers' Health Protection Act (NMHPA)

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

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

Your plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema. For more information, you should review the Summary Plan Description or call your Plan Administrator at 415.884.3159 for more information.

Patient Protections

The medical plan requires the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. Until you make this designation, the plan will designate one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, go to www.KP.org.

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

You do not need prior authorization from the plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, www.BlueShield.com or www.KP.org.

Networks/Claims/Appeals

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

Notice of Extended Coverage to Children Covered as Students

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

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

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

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

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

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

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

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

COBRA Continuation Coverage

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

The right to COBRA continuation coverage was created by federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and 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 does not accept late enrollees.

WHAT IS COBRA CONTINUATION COVERAGE?

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

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

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

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

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

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

- The parent-employee dies;
- The parent-employee's employment ends for any reason other than 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; or,
- The child stops being eligible for coverage under the Plan as a "dependent child."

WHEN IS COBRA CONTINUATION COVERAGE AVAILABLE?

The Plan will offer COBRA continuation coverage to Qualified Beneficiaries only after the Plan Administrator has been notified 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; or,
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

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

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

NOTICE AND ELECTION PROCEDURES

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

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

ELECTION AND ELECTION PERIOD

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

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

HOW IS COBRA CONTINUATION COVERAGE PROVIDED?

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

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

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

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

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

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

Important Notices (continued)

OTHER OPTIONS BESIDES COBRA CONTINUATION COVERAGE

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

ENROLLMENT IN MEDICARE INSTEAD OF COBRA

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

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

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

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

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

[1] https://www.medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b/part-a-part-b-sign-up-periods

IF YOU HAVE QUESTIONS

[For ERISA Plans] 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 subject to ERISA, 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 www.dol.gov/ebsa. (Address and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

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

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

KEEP YOUR PLAN INFORMED OF ADDRESS CHANGES

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

EFFECTIVE DATE OF COVERAGE

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

COST OF CONTINUATION COVERAGE

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

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

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

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

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

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

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

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

Special Enrollment Rights Notice

CHANGES TO YOUR HEALTH PLAN ELECTIONS

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

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

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

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

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

For information about Special Enrollment Rights, please contact:

Ron Owen, Senior Benefits Analyst
Marin Community College District
1800 Ignacio Blvd., Novato, CA 94949
Phone: 415.884.3159

Medicare Part D – Important Notice 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 with Marin Community College and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

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

- **Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.**
- **SISC has determined that the prescription drug coverage offered by [Kaiser and Blue Shield] 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 Marin Community College coverage will not be affected. If you keep this coverage and elect Medicare, the Marin Community College coverage will coordinate with Part D coverage.

If you do decide to join a Medicare drug plan and drop your current Marin Community College coverage, be aware that you and your dependents will be able to get this coverage back.

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

You should also know that if you drop or lose your current coverage with Marin Community College 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 (i.e., a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

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

Contact the person listed below for further information. NOTE: You will get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Marin Community College 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 will get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

Important Notices (continued)

FOR MORE INFORMATION ABOUT MEDICARE PRESCRIPTION DRUG COVERAGE

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see 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 www.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:	2023
Name of Entity / Sender:	Marin Community College
Contact:	Ron Owen – Sr. Benefits Analyst
Address:	1800 Ignacio Blvd. Novato, CA 94949
Phone:	415.884.3159

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

Marin Community College Group Health Plan (Plan) maintains a Notice of Privacy Practices that provides information to individuals whose protected health information (PHI) will be used or maintained by the Plan. If you would like a copy of the Plan's Notice of Privacy Practices, please contact Marin Community College District, 1800 Ignacio Blvd., Novato, CA 94949. 415.884.3159.

Important Notices (continued)

Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: GENERAL INFORMATION

This notice provides you with information about Marin Community College District in the event you wish to apply for coverage on the Health Insurance Marketplace. All the information you need from Human Resources is listed in this notice. If you wish to have someone assist you in the application process or have questions about subsidies that you may be eligible to receive, (for California residents only) you can contact KeenanDirect at 855.653.3626 or at www.KeenanDirect.com, or (for everyone) contact the Health Insurance Marketplace directly at www.Healthcare.gov.

WHAT IS THE HEALTH INSURANCE MARKETPLACE?

The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a tax credit that lowers your monthly premium right away. Open Enrollment for health insurance coverage through Covered California will begin October 15, 2020 and end on the following January 31. Open Enrollment for most other states will begin on November 1 and close on December 15 of each year.

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

You may qualify to save money and lower your monthly premium, but only if your employer does not offer you coverage, offers medical coverage that is not "Affordable," or does not provide "Minimum Value." If the lowest cost plan from your employer that would cover you (and not any other members of your family) is more than 9.78% (for 2020) of your household income for the year, then that coverage is not Affordable. Moreover, if the medical coverage offered covers less than 60% of the benefits costs, then the plan does not provide Minimum Value.

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

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

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

PART B: EXCHANGE APPLICATION INFORMATION

In the event you wish to apply for coverage on the Exchange, all the information you need from Human Resources is listed below. If you are located in California and wish to have someone assist you in the application process or have questions about subsidies that you may be eligible to receive, you can contact KeenanDirect at 855.653.3626 or at www.KeenanDirect.com.

3. Employer name Marin Community College District	**4. Employer Identification Number (EIN)** 68-0194359	
5. Employer address 1800 Ignacio Blvd.	**6. Employer phone number** 415.883.3261	
7. City Novato	**8. State** CA	**9. ZIP code** 94949
10. Who can we contact about employee health coverage at this job? Ron Owen, Senior benefits Analyst		
11. Phone number (if different from above)	**12. Email address** rowen@marin.edu	

Important Notices (continued)

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

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

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

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

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call 866.444.EBSA (3272).

If you live in one of the following States, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2020. Contact your State for more information on eligibility.

ALABAMA – Medicaid
Website: http://myalhipp.com/
Phone: 855.692.5447

ALASKA – Medicaid
The AK Health Insurance Premium Payment Program
Website: http://myakhipp.com/
Phone: 866.251.4861
Email: CustomerService@MyAKHIPP.com
Medicaid Eligibility:
http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx

ARKANSAS – Medicaid
Website: http://myarhipp.com/
Phone: 855.MyARHIPP (855.692.7447)

CALIFORNIA – Medicaid
Website:
www.dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx
Phone: 800.541.5555

COLORADO – Health First Colorado
Colorado's Medicaid Program & Child Health Plan Plus (CHIP+)
Healthy First Colorado Website:
https://www.healthfirstcolorado.com/
Health First Colorado Member Contact Center: 800.221.3943
TTY: Colorado relay 711
CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus
CHP+ Customer Service: 800.359.1991
TTY: Colorado relay 711

FLORIDA – Medicaid
Website: http://flmedicaidtplrecovery.com/hipp/
Phone: 877.357.3268

GEORGIA – Medicaid
Website: http://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp/
Phone: 678.564.1162, ext. 2131

INDIANA – Medicaid
Healthy Indiana Plan for low-income adults 19-64
Website: http://www.in.gov/fssa/hip/
Phone: 877.438.4479
All other Medicaid
Website: http://www.indianamedicaid.com
Phone: 800.403.0864

IOWA – Medicaid and CHIP (Hawki)
Medicaid Website: https://dhs.iowa.gov/ime/members
Medicaid Phone: 800.338.8366
Hawki Website: http://dhs.iowa.gov/Hawki
Phone: 800.257.8563

KANSAS – Medicaid
Website: http://www.kdheks.gov/hcf/default.htm
Phone: 800.792.4884

KENTUCKY – Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website:
https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx
Phone: 855.459.6328
Email: KIHIPP.PROGRAM@ky.gov
KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx
Phone: 877.524.4718
Kentucky Medicaid Website: https://chfs.ky.gov

LOUISIANA – Medicaid
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp
Phone: 888.342.6207 (Medicaid hotline) or
855.618.5488 (LaHIPP)

MAINE – Medicaid
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html
Phone: 800.442.6003
TTY: Maine relay 711

Important Notices (continued)

MASSACHUSETTS – Medicaid and CHIP
Website:
http://www.mass.gov/eohhs/gov/departments/masshealth/
Phone: 800.862.4840

MINNESOTA – Medicaid
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/medical-assistance.jsp [Under Eligibility tab, see "what if I have other health insurance?"]
Phone: 800.657.3739

MISSOURI – Medicaid
Website:
https://www.dss.mo.gov/mhd/participants/pages/hipp.htm
Phone: 573.751.2005

MONTANA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: 800.694.3084

NEBRASKA – Medicaid
Website: http://www.ACCESSNebraska.ne.gov
Phone: 855.632.7633
Lincoln: 402.473.7000
Omaha: 402.595.1178

NEVADA – Medicaid
Medicaid Website: https://dhcfp.nv.gov/
Medicaid Phone: 800.992.0900

NEW HAMPSHIRE – Medicaid
Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf
Phone: 603.271.5218
Toll-Free for the HIPP program: 800.852.3345, ext. 5218

NEW JERSEY – Medicaid and CHIP
Medicaid Website:
http://www.state.nj.us/humanservices/dmahs/clients/medicaid/
Medicaid Phone: 609.631.2392
CHIP Website: http://www.njfamilycare.org/index.html
CHIP Phone: 800.701.0710

NEW YORK – Medicaid
Website: https://www.health.ny.gov/health_care/medicaid/
Phone: 800.541.2831

NORTH CAROLINA – Medicaid
Website: https://medicaid.ncdhhs.gov/
Phone: 919.855.4100

NORTH DAKOTA – Medicaid
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/
Phone: 844.854.4825

OKLAHOMA – Medicaid and CHIP
Website: http://www.insureoklahoma.org
Phone: 888.365.3742

OREGON – Medicaid
Websites: http://healthcare.oregon.gov/Pages/index.aspx
http://www.oregonhealthcare.gov/index-es.html
Phone: 800.699.9075

PENNSYLVANIA – Medicaid
Website:
https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx
Phone: 800.692.7462

RHODE ISLAND – Medicaid and CHIP
Website: http://www.eohhs.ri.gov/
Phone: 855.697.4347, or 401.462.0311 (Direct RIte Share Line)

SOUTH CAROLINA – Medicaid
Website: https://www.scdhhs.gov
Phone: 888.549.0820

SOUTH DAKOTA – Medicaid
Website: http://dss.sd.gov
Phone: 888.828.0059

TEXAS – Medicaid
Website: http://gethipptexas.com/
Phone: 800.440.0493

UTAH – Medicaid and CHIP
Medicaid Website: https://medicaid.utah.gov/
CHIP Website: http://health.utah.gov/chip
Phone: 877.543.7669

VERMONT – Medicaid
Website: http://www.greenmountaincare.org/
Phone: 800.250.8427

VIRGINIA – Medicaid and CHIP
Website: https://www.coverva.org/hipp/
Medicaid Phone: 800.432.5924
CHIP Phone: 855.242.8282

WASHINGTON – Medicaid
Website: https://www.hca.wa.gov/
Phone: 800.562.3022

WEST VIRGINIA – Medicaid
Website: http://mywvhipp.com/
Toll-free phone: 855.MyWVHIPP (855.699.8447)

WISCONSIN – Medicaid and CHIP
Website:
https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf
Phone: 800.362.3002

WYOMING – Medicaid
Website: https://wyequalitycare.acs-inc.com/
Phone: 307.777.7531

To see if any other states have added a premium assistance program since January 31, 2020, or for more information on special enrollment rights, contact either:

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

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
877.267.2323, Menu Option 4, Ext. 61565

Contact Information

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

Plan	Plan Number	Phone Number	Web Site
Medical			
• Kaiser	60115	800.464.4000	www.kp.org
• Blue Shield	• SC13580 *(100% Plan A)* • SC13590 *(80% Plan K)* • SCB0380 *(2-Tier Anchor Bronze)*	855.256.9404	www.blueshieldca.com
Dental			
• Delta Dental	• 5438 0006 *(CSEA & Unrepresented)*	866.499.3001	www.deltadentalins.com
Vision			
• Vision Service Provider (VSP)	2606622A	800.877.7195	www.vsp.com
Employee Assistance Program (EAP)			
• Anthem EAP	SISC	800.999.7222	www.anthemeap.com
Basic Life / AD&D, Optional Life, Long Term Disability (LTD)			
• The Hartford	0GL875740 Employee Benefits	800.523.2233	www.thehartford.com
Beneficiary Assistance			
• Estate Guidance / Will Services	WILLHLF	800.411.7239	www.estateguidance.com
• Funeral Planning	HFEVLC	866.854.5429	www.everestfuneral.com
Advance Medical	SISC		
Identity Theft			
Personal Choices			

Glossary

Affordable Care Act and Patient Protection (ACA)

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

Allowed Amount

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

Balance Billing

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

Brand Name Drug

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

COBRA (Consolidated Omnibus Budget Reconciliation Act)

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

Children's Health Insurance Program (CHIP)

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

Claim

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

Coinsurance

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

Copayment (Copay)

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

Comprehensive Coverage

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

Deductible

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

Formulary

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

Generic Drug

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

High-Deductible Health Plan (HDHP)

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

Glossary (continued)

Health Savings Account (HSA)

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

Health Reimbursement Arrangements (HRAs)

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

In-Network

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

Non-Preferred Provider

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

Out-of-Pocket Maximum

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

Out-Of-Network

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

Out-Of-Pocket Limit

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

Plan Year

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

Preferred Provider

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

Premium

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

Preventive Care

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

Qualifying Life Event

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

Skilled Nursing Care

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

Urgent Care

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

CLICK HERE to watch a video on Benefits Key Terms Explained