



EMPLOYEE
2024
2025 **BENEFITS**
GUIDE

**Marin Community
College District**

General Information

- General..... 1
- Who Can You Cover..... 2
- Required Documentation..... 3
- Coordination of Benefits (COB)..... 4
- Qualifying Events..... 5
- BenefitBridge..... 7
- Rates..... 8
- Making the Most of Your Benefits Program..... 11

Core Benefits

- Medical – Kaiser..... 12
- Medical – Blue Shield..... 15
- SISC Value Added Services..... 22
- Teladoc..... 28
- MDLIVE..... 29
- SISC Enhanced Cancer Benefit..... 30
- Vida Health..... 34
- Hinge Health..... 36
- Carrum Health Surgery Benefit..... 37
- Employee Assistance Program (EAP)..... 39
- Dental..... 41


- QualSight LASIK..... 49
- Amplifon Hearing Health Care..... 51
- Vision..... 53
- Hearing..... 56

Other Benefits

- Basic Life & AD&D – The Hartford..... 58
- Voluntary Life – The Hartford..... 60
- Voluntary AD&D – The Hartford..... 61
- Short Term Disability – The Hartford..... 62
- Long Term Disability – The Hartford..... 64
- The Hartford Services..... 66
- Colonial Life Benefit Enrollment..... 70
- Flexible Benefits Plans by STERLING..... 71
- 403(b) Retirement Plans..... 80
- Pet Insurance..... 82
- KeenanDirect..... 85

Miscellaneous

- Important Notices..... 86
- Contact Information..... 98
- Glossary..... 99



Click this icon in your benefits guide to watch a video explaining the associated topic.

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 91 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.



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 2024-2025 plan year.

2024 – 2025 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

Hospital Indemnity Insurance

IMPORTANT: This is a fixed indemnity policy, NOT health insurance.

This fixed indemnity policy may pay you a limited dollar amount if you're sick or hospitalized. You're still responsible for paying the cost of your care.

- The payment you get isn't based on the size of your medical bill.
- There might be a limit on how much this policy will pay each year.
- This policy isn't a substitute for comprehensive health insurance.
- Since this policy isn't health insurance, it doesn't have to include most Federal consumer protections that apply to health insurance.

Looking for comprehensive health insurance?

- Visit [HealthCare.gov](https://www.healthcare.gov) or call [1-800-318-2596](tel:1-800-318-2596) (TTY: [1-855-889-4325](tel:1-855-889-4325)) to find health coverage options.
- To find out if you can get health insurance through your job, or a family member's job, contact the employer.

Questions about this policy?

- For questions or complaints about this policy, contact your State Department of Insurance. Find their number on the National Association of Insurance Commissioners' website ([naic.org](https://www.naic.org)) under "Insurance Departments."
- If you have this policy through your job, or a family member's job, contact the employer.

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, 2024.

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, 2024, for an effective date of October 1, 2024.



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-2025, SISC will require tax documents from tax year 2024. 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.



GUIDELINES AND PROCEDURES

SISC Health Benefits Manual rev 3/1/2021

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, KPSSA 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	<ul style="list-style-type: none"> Enroll self, if applicable Enroll newly eligible child and any other eligible dependents Change health plans when options are available 	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> Enroll self, if applicable Enroll spouse/domestic partner and any newly eligible dependent children Change health plans when options are available 	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> 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 	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> Remove the dependent from coverage Change health plans when options are available 	<ul style="list-style-type: none"> Membership Change Form
Qualified Medical Child Support Order (QMCSO) requiring enrollment of dependent child	<ul style="list-style-type: none"> 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 	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> 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 	<ul style="list-style-type: none"> Proof of enrollment in or loss of coverage in Medicare/Medicaid (whichever applicable) Other enrollment forms/documents as applicable

(Continued on next page.)



GUIDELINES AND PROCEDURES

SISC Health Benefits Manual rev 3/1/2021

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.)	<ul style="list-style-type: none"> • 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 	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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 	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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 	<ul style="list-style-type: none"> • 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: <ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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 	<ul style="list-style-type: none"> • 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**



College of Marin Online Benefits Enrollment is easy with BenefitBridge!



Need Help?

For all questions related to your benefits, please contact your employer's benefits administrator. For questions about Colonial Life, schedule a one-on-one Benefits Counseling session with a Benefits Specialist who can assist with your questions. To schedule your appointment with a Benefits Specialist, click on the following [LINK](#).

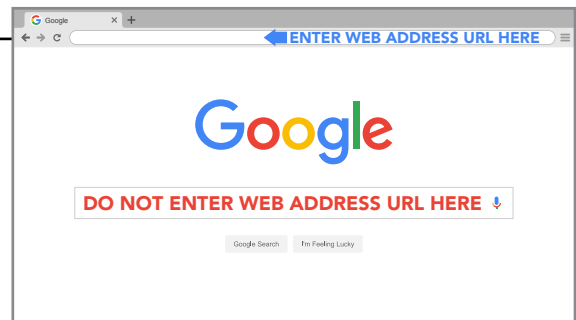
For BenefitBridge technical assistance **only**, please contact BenefitBridge Customer Care at [800-814-1862](tel:800-814-1862); Mon – Fri, 8:00 a.m. – 5:00 p.m., PST or email benefitbridge@keenan.com.

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

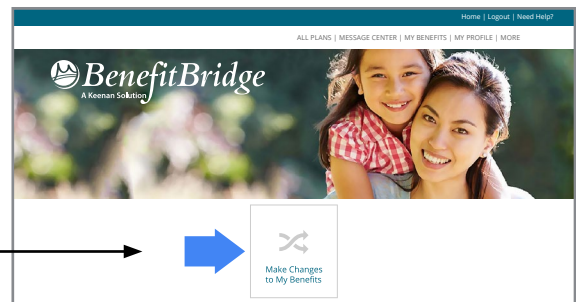
Login

Click on this link [BenefitBridge Login](#) or in the address bar (use browsers, Chrome, MS Edge or Firefox) type or copy and paste: <https://www.benefitbridge.com/SSO/SPLogin/collegeofmarin>



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](tel:800-814-1862)

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



Full-time Classified and Unrepresented Employees

Effective October 1, 2024, for benefit eligible CSEA, SEIU, Management, Supervisors and Confidential, the District contributes between \$1,600.00-\$2,800.00 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 10/1/2024 (Monthly Rates)		
	Total Premium	District Contribution	Employee Contribution
Kaiser Permanente Traditional Plan			
• Employee Only	\$1,199.00	\$1,199.00	\$0.00
• Employee + 1	\$2,346.00	\$2,300.00	\$46.00
• Family	\$3,301.00	\$2,800.00	\$501.00
Kaiser Permanente Deductible Plan			
• Employee Only	\$1,069.00	\$1,069.00	\$0.00
• Employee + 1	\$2,090.00	\$2,090.00	\$0.00
• Family	\$2,941.00	\$2,800.00	\$141.00
Kaiser High deductible/Health Saving \$1,700 90% Plan			
• Employee Only	\$946.00	\$946.00	\$0.00
• Employee + 1	\$1,849.00	\$1,849.00	\$0.00
• Family	\$2,602.00	\$2,602.00	\$0.00
Blue Shield - 100% Plan A			
• Employee Only	\$1,554.00	\$1,554.00	\$0.00
• Employee + 1	\$3,061.00	\$2,300.00	\$761.00
• Family	\$4,319.00	\$2,800.00	\$1,519.00
Blue Shield - 80% Plan K			
• Employee Only	\$1,164.00	\$1,164.00	\$0.00
• Employee + 1	\$2,290.00	\$2,290.00	\$0.00
• Family	\$3,227.00	\$2,800.00	\$427.00
Blue Shield-High Deductible/Health Saving \$1,700 90% Plan			
• Employee Only	\$1,046.00	\$1,046.00	\$0.00
• Employee + 1	\$2,053.00	\$2,053.00	\$0.00
• Family	\$2,891.00	\$2,800.00	\$91.00
Delta Dental			
• Composite Rate - CSEA and Unrep.	\$145.00	\$145.00	\$0.00
VSP			
• Composite Rate	\$10.40	\$10.40	\$0.00

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.

Rates (continued)



Full-time Faculty

The District contributes between \$927.08 - \$3,239.25 per month towards your Medical premium for eligible full-time faculty. 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 10/1/2024 (Monthly Rates)		
	Total Premium	District Contribution	Employee Contribution
Kaiser Permanente Traditional Plan			
• Employee Only	\$1,199.00	\$1,127.06	\$71.94
• Employee + 1	\$2,346.00	\$2,181.78	\$164.22
• Family	\$3,301.00	\$2,904.88	\$396.12
Kaiser Permanente Deductible Plan			
• Employee Only	\$1,069.00	\$1,042.28	\$26.72
• Employee + 1	\$2,090.00	\$2,006.40	\$83.60
• Family	\$2,941.00	\$2,705.72	\$235.28
Kaiser High deductible/Health Saving \$1,700 90% Plan			
• Employee Only	\$946.00	\$927.08	\$18.92
• Employee + 1	\$1,849.00	\$1,793.53	\$55.47
• Family	\$2,602.00	\$2,471.90	\$130.10
Blue Shield - 100% Plan A			
• Employee Only	\$1,554.00	\$1,460.76	\$93.24
• Employee + 1	\$3,061.00	\$2,601.85	\$459.15
• Family	\$4,319.00	\$3,239.25	\$1,079.75
Blue Shield - 80% Plan K			
• Employee Only	\$1,164.00	\$1,117.44	\$46.56
• Employee + 1	\$2,290.00	\$2,129.70	\$160.30
• Family	\$3,227.00	\$2,839.76	\$387.24
Blue Shield-High Deductible/Health Saving \$1,700 90% Plan			
• Employee Only	\$1,046.00	\$1,025.08	\$20.92
• Employee + 1	\$2,053.00	\$2,011.94	\$41.06
• Family	\$2,891.00	\$2,746.45	\$144.55
Delta Dental			
• Composite Rate - UPM	\$145.00	\$145.00	\$0.00
VSP			
• Composite Rate	\$10.40	\$10.40	\$0.00

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Part-time Faculty

The District Contributes between \$1,042.28 - \$3,239.25 per month towards your Medical premium for eligible part-time faculty.

	Effective 10/1/2024 (Monthly Rates)		
	Monthly Premium	District Contribution	Employee Contribution
Kaiser Permanente Traditional Plan			
• Member only	\$1,199.00	\$1,127.06	\$71.94
• Member plus one	\$2,346.00	\$2,181.78	\$164.22
• Family	\$3,301.00	\$2,904.88	\$396.12
Kaiser Permanente Deductible Plan			
• Member only	\$1,069.00	\$1,042.28	\$26.72
• Member plus one	\$2,090.00	\$2,006.40	\$83.60
• Family	\$2,941.00	\$2,705.72	\$235.28
Blue Shield - 100% Plan A			
• Employee Only	\$1,554.00	\$1,460.76	\$93.24
• Employee + 1	\$3,061.00	\$2,601.85	\$459.15
• Family	\$4,319.00	\$3,239.25	\$1,079.75
Blue Shield - 80% Plan K			
• Employee Only	\$1,164.00	\$1,117.44	\$46.56
• Employee + 1	\$2,290.00	\$2,129.70	\$160.30
• Family	\$3,227.00	\$2,839.76	\$387.24



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.

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 (<i>Primary Care</i>)	\$20 copay	\$20 copay
• Office Visit (<i>Specialist</i>)	\$20 copay	\$20 copay
Emergency Care		
• Urgent Care	\$20 copay	\$20 copay
• Emergency Room Services (<i>waived if admitted</i>)	\$100 copay	20% after deductible
• Ambulance	\$50 copay	\$150 copay
Preventive Care / Wellness Services		
• Chiropractic Care (<i>limited to 30 visits/year</i>)	\$10 copay	\$10 copay
• Acupuncture (<i>limited to 30 visits/year</i>)	\$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 Preferred Provider Organizations \(PPO\)](#)

[CLICK HERE to watch a video on PPO vs HMO](#)

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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.

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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 (<i>Primary Care</i>)	\$30 copay	50% after deductible
• Office Visit (<i>Specialist</i>)	\$30 copay	50% after deductible
Emergency Care		
• Urgent Care	\$30 copay	50%
• Emergency Room Services (<i>waived if admitted</i>)	\$100 copay, then plan pays 20%	
• Ambulance	\$100 copay, then plan pays 20%	
Preventive Care / Wellness Services		
• Chiropractic Care (<i>20 visits/per calendar year</i>)	20% after deductible	Not Covered
• Acupuncture (<i>12 visits/per calendar year</i>)	20% after deductible	50%
General Medical Services		
• X-Ray and Lab	20% after deductible	Not Covered
Prescription Drugs		
• Plan Year Deductible	N/A	
• Retail (<i>30-day supply</i>)		
– Generic*	\$9 copay (\$0 at Costco)	
– Formulary Brand	\$35 copay	
• Mail Order		
– Generic**	\$0 copay	
– Formulary Brand	\$90 copay	
– Speciality (<i>Must Use Navitus Specialty Rx</i>)	\$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.

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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	
Plan Year Deductible²		
• Individual	\$1,500	
• Family	\$2,800 Individual / \$3,000 Family	
Annual Out-of-Pocket Maximum⁵		
• Individual	\$3,000	\$6,000
• Family	\$6,000 Individual / \$6,000 Family	\$6,000 Individual / \$12,000 Family
Preventive Health Services⁷	\$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 (<i>Includes nurse practitioners, physician assistants, and therapists</i>)	10%	50%
• Acupuncture Services (<i>12 visits/per calendar year</i>)	10%	50%
• Chiropractic Services (<i>20 visits/per calendar year</i>)	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 care⁷		
• 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 (<i>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.</i>)	\$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 (<i>Up to \$700 combined maximum per member, per 24 months.</i>)	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
- Outpatient mental health services, except office visits
- Hospice program services
- 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



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/SISC



24/7 Virtual Primary Care Doctor

Eden Health

Virtually connect with a primary care physician to manage all your physical and mental healthcare needs. Eden providers diagnose conditions, manage prescriptions, refer to specialists, and answer follow up questions using video visits or live chat.

Anthem and Blue Shield PPO members

Scan the QR code to download the Eden Health app, and register for your Eden Health membership.



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



24/7 Physician Access—Anytime, Anywhere

MDLive

Access to virtual visits with psychiatrists and therapists for members age 10 and up. Virtual urgent care services are available to all members. Physicians can prescribe medication when appropriate. *copays may apply

Anthem and Blue Shield members

Call 800-657-6169

Visit mdlive.com/sisc



Free Generic Medications

Costco

Access most generic medications at no cost through Costco retail and mail order pharmacies. You don't need to be a Costco member.

Anthem and Blue Shield members

Call 800-774-2678 (press 1)

Visit costco.com



Per IRS guidelines, SISC HSA & MEC \$9000 Members may not be eligible for these programs.

Continued → 1

SISC Value Added Services (continued)



BENEFIT HIGHLIGHTS



AVAILABILITY AND HOW TO GET STARTED

Expert Medical Opinions

Teladoc Medical Experts

Get answers to health care questions and second opinions from world-leading experts.

Anthem, Blue Shield, and Kaiser Permanente members

Call 855-380-7828

Visit teladoc.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



24/7 Access to Virtual Maternity and Postpartum Support

Maven

Consult with a care advocate who connects you with trustworthy content delivered by doctors, specialists coaches and other maternity providers to help deal with pregnancy and postpartum concerns.

Anthem and Blue Shield PPO members

Visit mavenclinic.com/join/SISC



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 info.carrumhealth.com/sisc



Enhanced Cancer Benefit

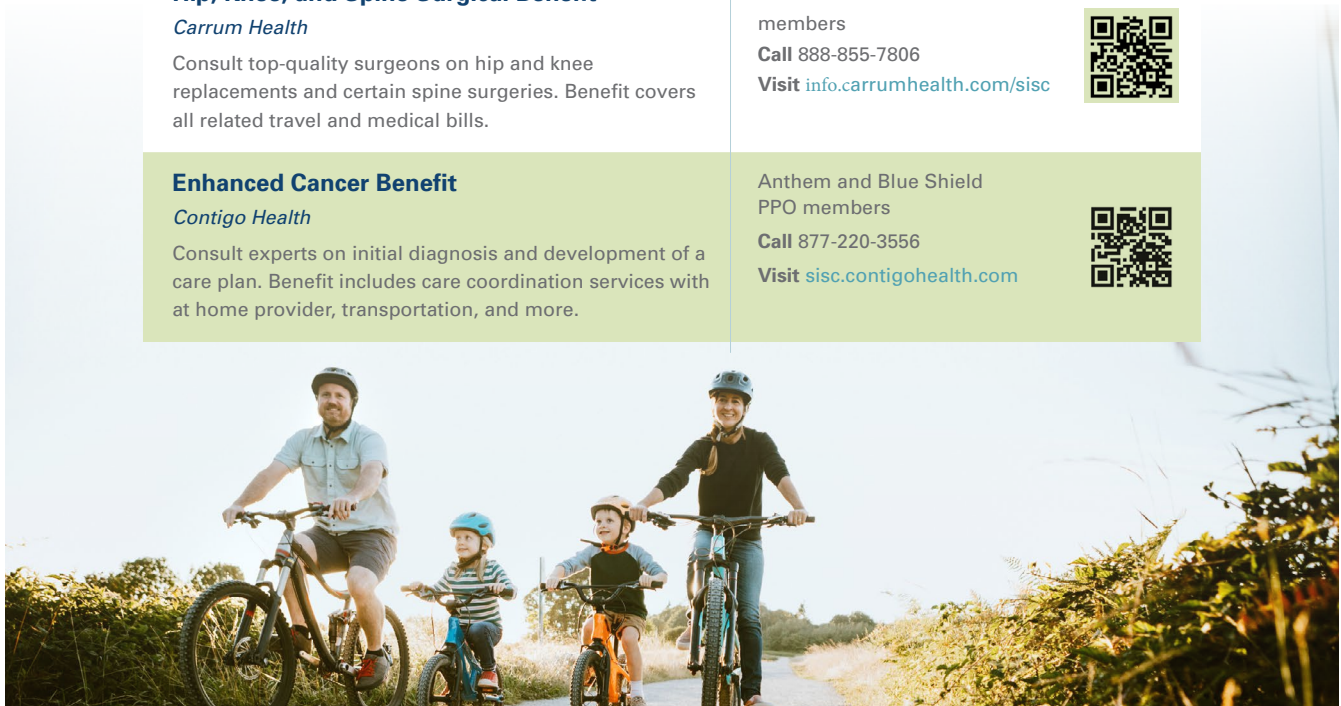
Contigo Health

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, SISC HSA & MEC \$9000 Members may not be eligible for these programs.

2

SISC Value Added Services (continued)



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 & enter SISC



Telehealth

Skip the trip to the doctor's office

Next time you have a minor health issue, you have many convenient ways to get care when and where it works for you.

Kaiser Permanente Members

Call 866-454-8855

Visit kp.org/telehealth



Manage your health 24/7

Stay connected wherever you go

With our Kaiser Permanente app, keeping up with your care is quick, easy, and secure.

Kaiser Permanente Members

Call 800-464-4000

Visit kp.org/register



Away from Home Travel

More care options while you're away from home

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

Kaiser Permanente Members

Call 951-268-3900

Visit kp.org/travel



Wellness Coaching

Say hello to better health

Changing your habits can be hard but working with a wellness coach can help. You'll get one-on-one guidance and support from one dedicated coach.

Kaiser Permanente Members

Call 866-862-4295

Visit kp.org/coaching



Per IRS guidelines, SISC HSA Members may not be eligible for these programs.

Continued → 1

SISC Value Added Services (continued)



BENEFIT HIGHLIGHTS



AVAILABILITY AND HOW TO GET STARTED

Fitness Deals

Find more ways to stay healthy and save

Stay active & fit with a variety of reduced rates on studios, gyms, fitness gear, and online classes.

•Active&Fit •ClassPass •ChooseHealthy

Kaiser Permanente Members

Call 800-464-4000
Visit kp.org/exercise



Expert Medical Opinions

Teladoc Medical Experts

Get answers to health care questions and second opinions from world-leading experts.

Kaiser Permanente Members

Call 855-380-7828
Visit teladoc.com/SISC



Ginger

Support for emotional wellness

1-on-1 emotional support coaching and self-care activities to help with many common challenges.

•Coaches are available by text 24/7 with no cost and no referral needed

Kaiser Permanente Members

Call 800-464-4000
Visit kp.org/selfcareapps



Calm

Support for emotional wellness

The #1 app for meditation and sleep. You can choose from hundreds of programs and activities.

•Guided meditation, Sleep Stories, Mindful movement videos

Kaiser Permanente Members

Call 800-464-4000
Visit kp.org/selfcareapps



My Strength

Support for emotional wellness

Personalized programs designed to help you:

- Set mental health goals
- Track your progress
- Learn coping skills
- Make positive changes

Kaiser Permanente Members

Call 800-464-4000
Visit kp.org/selfcareapps



Per IRS guidelines, SISC HSA Members may not be eligible for these programs.

SISC Value Added Services (continued)



Benefit Extras

Available through your SISC health plan

Get Started	Program Details	Who Is Eligible
<p>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.</p>	<p>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).</p>	<p>Anthem PPO/HMO and Kaiser HMO members Low Cost</p>
<p>Fitness Your Way Go to fitnessyourway.tivityhealth.com/bsc Click "Enroll". OR Call 833-283-8387</p>	<p>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.</p>	<p>Blue Shield PPO and HMO members Low Cost</p>
<p>TruHearing Call 866-754-1607 OR Go to truhearing.com</p>	<p>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.</p>	<p>VSP members Low Cost</p>
<p>Amplifon Go to amplifonusa.com/deltadentalins OR Call 888-779-1429</p>	<p>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.</p>	<p>Delta Dental members Low Cost</p>
<p>QualSight Go to qualsight.com/-delta-dental OR Call 855-248-2020</p>	<p>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.</p>	<p>Delta Dental members Low Cost</p>
<p>EPIC Hearing Go to epichearing.com OR Call 866-956-5400</p>	<p>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.</p>	<p>MES members Low Cost</p>

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.

SISC Value Added Services (continued)



*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.

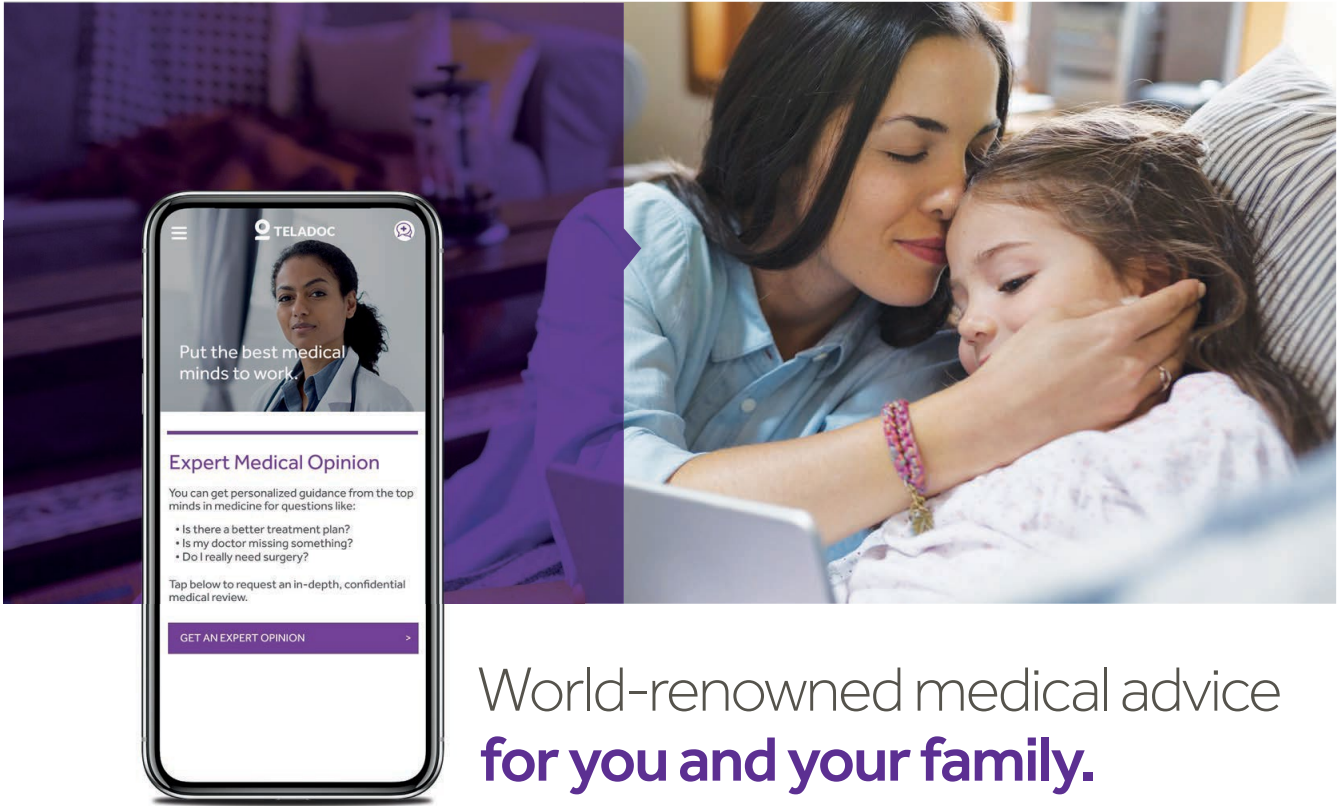
Kaiser Permanente Members

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.



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



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

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 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 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.



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.





SISC is providing PPO members with Cancer Care Direct

To support our members no matter what may come.

You may not need cancer treatment support today, but we want you to know what's available should the need ever arise.



Facing a cancer diagnosis can be overwhelming.

Cancer Care Direct is here to help with personalized guidance, support, and more.



Guided Support

Get help from a personal Oncology Nurse who can partner with you through every step of your cancer journey.



Accessing Excellent Care

Keep your oncology care local, while we add access to the top national cancer centers if needed.



Expert Review & Advice

We can coordinate expert reviews of your diagnosis and your treatment plan to be sure you're getting the right care, at the right place at the right time.

Want to know more?

We believe everyone deserves a confident and capable partner for every step of a cancer journey.

Learn more about this new SISC-provided benefit today.



Scan to learn more at
CancerCareDirect.com
or download our app



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.

“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 app



Choose your coach, therapist or nutritionist



Set your goal



Have weekly video calls and message anytime



Develop new healthy habits














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)



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.



Programs to fit your needs

CHRONIC			THERAPY	LIFESTYLE		
 Manage COPD	 Lower blood pressure	 Lower cholesterol	 Reduce depression	 Quit smoking	 Lose weight	 Exercise more
 Manage Asthma	 Prevent diabetes	 Manage Diabetes	 Reduce anxiety	 Sleep better	 Manage stress	 Eat better

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)



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.



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



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.



Less complications compared to average California facilities



Fewer readmissions compared to average California facilities



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

VISIT: [CARRUM.ME/SISC](https://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

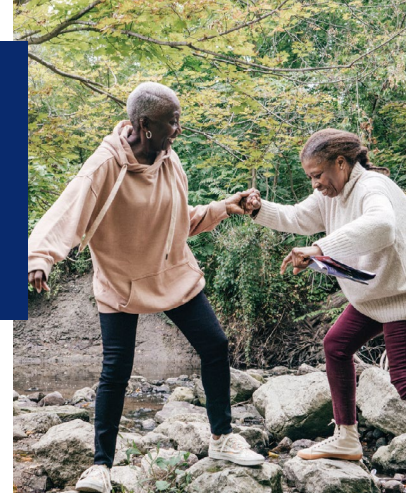


Employee Assistance Program (EAP)



Mental health support at no extra cost

Learn about the care options available with your EAP



If you or a loved one need support for coping with life, reducing stress, or living with a mental health issue, you are not alone. Your Employee Assistance Program (EAP) offers work and life support at no extra cost. Each member of your household can have six visits with an EAP counselor per issue, per year. Asking for help can be the hardest part. The information below details the resources available to you, including how to reach out when you're ready.

	Face to Face Counseling	Emotional Well-being Resources	Talkspace	LiveHealth Online	Suicide and Crisis Lifeline
What is it?	Confidential in-person sessions with a licensed professional counselor.	Resources and support to help you live your happiest, healthiest life, including self-help digital tools to help improve your emotional well-being.	Personalized match with a therapist. 24/7 access to confidential messaging with therapist via text, audio, or video and the ability to schedule a virtual visit in real time.	24/7 confidential counseling through scheduled visits over live text message, telephone, or video.	24/7 confidential mental health support, including prevention and crisis resources, for anyone in distress.
When do I use it?	When you need help managing: <ul style="list-style-type: none"> Depression Stress Anxiety Chronic pain Drug and alcohol use Emotional health issues 	When you need help managing: <ul style="list-style-type: none"> Anxiety Depression Sleep issues Panic Social anxiety Stress Drug and alcohol use Worry 	When you need help managing: <ul style="list-style-type: none"> Anxiety Depression Grief Relationships Sleep Stress Drug and alcohol use Trauma 	When you need help managing: <ul style="list-style-type: none"> Anxiety Stress Depression Grief Relationships/family issues Panic attacks Coping with illness 	When you or someone you know are: <ul style="list-style-type: none"> Experiencing suicidal thoughts or behavior. Experiencing emotional distress. Behaving in a way that could harm others.
What does it cost?	No extra cost.	No extra cost.	No extra cost. Includes six sessions per issue, per year, as part of your EAP counseling	No extra cost. Includes six sessions per issue, per year, as part of your EAP counseling visits.	No extra cost.
How do I connect?	Call your EAP 24/7 at 800-999-7222 .	Visit anthem.com/CA/EAP .	Visit talkspace.com/associatecare and select Get Started. Provide the requested information and enter SISC as your organization name.	Visit anthem.com/ca or anthem.com/CA/EAP to find virtual care options that are right for you.	Call or text 988 or chat with someone at 988lifeline.org , 24/7.

Take care of yourself

Your mental and emotional well-being matter just as much as anything else on your to-do list. Don't hesitate to reach out to any of the resources above when you need support. You can also call your EAP at **800-999-7222** or visit **anthem.com/CA/EAP** and enter company code: SISC.

LiveHealth Online is offered through an arrangement with Amwell, a separate company, providing telehealth services on behalf of your health plan. Online counseling is not appropriate for all kinds of problems. If you are in crisis or have suicidal thoughts, it's important that you seek help immediately. Please call 988 (National Suicide Prevention Lifeline) and ask for help. If your issue is an emergency, call 911 or go to your nearest emergency room. Talkspace does not offer emergency services. Anthem Blue Cross is the trade name of Blue Cross of California. Anthem Blue Cross and Anthem Blue Cross Life and Health Insurance Company are independent licensees of the Blue Cross Association. Anthem is a registered trademark of Anthem Insurance Companies, Inc. 1050058CAMENABC VPOD Rev. 05/23 66393657-149712255



Make time for your mental health



Our mental health is just as important as our physical health. It plays a big role in how we think, feel, and act. It can have an impact on how we handle stress, make choices, and relate to those around us.¹

Many people deal with mental health concerns at some point in their lives. Making time to care for your mental health is one of the best things you can do to improve your well-being and live a happier life. Your Employee Assistance Program (EAP) is here to help. With access to tools, resources, and support, you'll find ways to:

- Access virtual or in-person counseling.
- Learn about different mental health conditions.
- Understand common signs and symptoms that you or someone else might need help.
- Learn tips and strategies to improve your mental health.

If it's an emergency, call 988 to reach the National Suicide Prevention Hotline or go to your nearest emergency room.

Support you can count on

Lean on these EAP resources anytime you need a helping hand.



Counseling

Talk to a licensed counselor in person or online. You and your household members can each have up to six visits with a counselor per issue, per year at no extra cost.²



Self-paced learning materials

Explore short, educational articles, podcasts, and videos on dozens of emotional wellness topics.



Emotional Well-being Resources

Access one-on-one coaching and digital self-help tools to help you take charge of your emotional wellness.

Your EAP is here for you

Get the help you need anytime 24/7.

Call us at **800-999-7222**.

Go to **anthemEAP.com/SISC**



¹ Centers for Disease Control and Prevention: *About Mental Health* (April 25, 2023). [cdc.gov](https://www.cdc.gov).

² Appointments subject to the availability of a therapist. Online counseling is not appropriate for all kinds of problems. If you are in crisis or have suicidal thoughts, it's important that you seek help immediately. Please call 988 (National Suicide Prevention Lifeline) and ask for help. If your issue is an emergency, call 911 or go to your nearest emergency room.

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

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

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Dental



Delta Dental of California offers you what no other dental plan can – The Delta Dental DifferenceSM. 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.

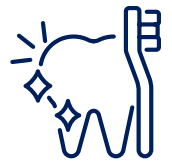
Although the PPO program allows you the freedom to visit any licensed dentist, there are advantages to visiting a Delta Dental dentist.



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 **NOW Includes D&P Max Waiver**		
<ul style="list-style-type: none"> • Exams, (3) cleanings, x-rays and sealants. (Doesn't apply towards Annual Max Benefit) 	Plan pays 100%	Plan pays 100%
Basic Services		
<ul style="list-style-type: none"> • Anesthesia 	Plan pays 70% – 100%	
<ul style="list-style-type: none"> • Simple and Surgical Extractions 	Plan pays 70% – 100%	
<ul style="list-style-type: none"> • Endodontics (root canals) 	Plan pays 70% – 100%	
<ul style="list-style-type: none"> • Periodontics (gum treatment) 	Plan pays 70% – 100%	
Major Services		
<ul style="list-style-type: none"> • Crowns, Inlays, Onlays, Veneers 	Plan pays 70% – 100%	
<ul style="list-style-type: none"> • Prosthodontics (Dentures, Bridges) 	Plan pays 70% – 100%	
Orthodontics		
<ul style="list-style-type: none"> • Child (to age 19) 	Plan pays 75%	
<ul style="list-style-type: none"> • Adult 	Plan pays 75%	
<ul style="list-style-type: none"> • 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.

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.



Protect your teeth and your wallet

Get preventive care without hitting your maximum



Thinking of skipping a cleaning? Think again. With Delta Dental's D&P Maximum Waiver®, you can get your diagnostic and preventive care without affecting your maximum. You'll keep your mouth healthy — and save benefit dollars for when you really need them.

What services are included?

Diagnostic and preventive dental services may include routine exams, cleanings, x-rays and related treatments as defined by your dental plan.

How does it help me save?

The cost of exams, cleanings and x-rays can add up. Without the D&P Maximum Waiver, these procedures would eat into your maximum. With the waiver, you'll have more of your maximum left over. That can help you cover expensive treatment down the road.

For more details about your coverage, check your plan booklet.

	Delta Dental pays	You pay	Your remaining maximum
Without D&P Maximum Waiver	\$350	\$0	\$650
With D&P Maximum Waiver	\$350	\$0	\$1,000

This example assumes an annual maximum of \$1,000, with 100% coverage for two routine exams, cleanings and x-rays at a Delta Dental dentist. Please review your plan booklet for specific details about your coverage.

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



deltadentalins.com/enrollees

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Estimate your costs



Looking to budget your dental costs? Try the Cost Estimator. This helpful tool gives you a personalized estimate of how much you'll pay for your next dentist visit.

Whether you're getting braces or need a cavity filled, you'll choose from the most common dental services, described in everyday language. The Cost Estimator organizes information logically, so you don't need to be concerned whether your treatment involves multiple procedure codes or visits.

Advantages

Easy to use. Questions guide you through the process, letting you add services to your visit, like getting x-rays or a cleaning alongside your dental exam.

- **Based on real data.** Your cost estimate is calculated from actual claims Delta Dental has processed, updated daily.
- **Personalized.** You'll get a customized cost based on your actual benefits.
- **Available on desktop and mobile.** Get an estimate on your computer, tablet or phone.

Features

- **Change your dentist.** Want to know if you'd save by switching to another dentist? Test it out by comparing up to five dentists.
- **Personalize your procedure.** Specify which tooth is being treated, the type of filling you need or whether you're going to a specialist. The price will be calculated accordingly.



deltadentalins.com/members



Try it out

Ready to get an estimate?

1. Log in to your account at **deltadentalins.com**. (If you don't have one yet, click **Create an account**.)
2. Click the **Plan ahead for a visit** icon, then click **Estimate costs**. (Or, click the **Cost Estimator** link by your name.)

How to navigate

Start by selecting the service you need. As you explore, you can answer additional questions (like “Which tooth?” or “Are you a new patient?”) to further customize your results. If you've been using your dental benefits, your current dentist will show up by default, but if you want to see other options, just click **Select dentists** to compare. Whenever you're ready, click **Get cost estimate**.

Cost estimate for a filling Print this page

Your cost estimate selections

Estimate as of **March 15, 2022** in the **Delta Dental PPO™** network

Selected plan member	Selected procedure	Selected procedure options
Jane Jones	Change procedure	Back tooth, silver-colored

Change plan member | Change procedure

Click **Change plan member to select a different person on your plan.**

Click **Change procedure to select a different procedure.**

Procedures in this cost estimate

This cost estimate includes a silver-colored filling for a back tooth. Consult your dentist for actual treatment and diagnosis.

- D2150 Amalgam (silver-colored) filling - 2 surfaces

Current Dental Terminology (CDT)® American Dental Association (ADA). All rights reserved.

Your cost estimates

Your actual costs may be impacted by any maximums, deductibles or out-of-pocket limits on your plan. Be sure to review your [benefits usage](#).

Cost details	Lana Bright	0.6 mi Get directions
\$0.00 out-of-pocket	General Dentist Delta Dental PPO, Delta Dental Premier	Smiles Dentist Office 1234 Anyway St. San Francisco, CA 94110-5007 (415) 123-4567
Typical submitted fees: \$147.00		
Network savings: \$57.00		
Delta Dental pays: \$72.00		
Your out-of-pocket estimate: \$18.00		

Click **benefits usage to see the total benefits usage for all plan members, including plan activity and plan history, as well as maximums, deductibles and out-of-pocket limits.**

Not sure which dentists you want to compare? Browse in-network dentists in your area. [Select dentists](#)

Want to get a cost estimate for a different procedure or plan member? [Start a new cost estimate](#)

Click **Select dentists button to browse local in-network dentists.**

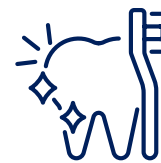
Click **Start a new cost estimate to get a cost estimate for a different procedure or plan member.**

The information provided is an estimate and does not guarantee the exact fees for dental procedures or your out-of-pocket costs. Estimates should not be construed as financial or medical advice. For more detailed information on your dental care costs, please consult your dentist.

*Typical submitted fees refers to an average for fees in the area and does not represent the dentist's actual fees. The estimate for your out-of-pocket costs is based on our records and claims processed as of today. Your actual out-of-pocket cost will depend on your benefits on the date of service. This is neither an authorization nor a guarantee of eligibility or payment.

Delta Dental PPO™ is underwritten by Delta Dental Insurance Company in AL, DC, FL, GA, LA, MS, MT, NV and UT and by not-for-profit dental service companies in these states: CA - Delta Dental of California; PA, MD - Delta Dental of Pennsylvania; NY - Delta Dental of New York, Inc.; DE - Delta Dental of Delaware, Inc.; WV - Delta Dental of West Virginia, Inc. In Texas, Delta Dental Insurance Company provides a dental provider organization (DPO) plan.

West Virginia: Learn about our commitment to providing access to a quality dentist network at www.deltadentalins.com/about/legal/index-enrollee.html.



Resources at your fingertips

Go online to manage your plan



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

Create an account

What you can do:

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



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

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

Find an in-network dentist

What you can do:

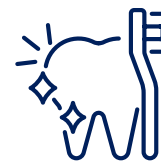
- Search by distance, specialty, language spoken, extended office hours, wheelchair accessibility and more.
- Browse Yelp ratings and reviews from real patients, and check out DentaQual scores for an objective quality metric based on actual claims data.



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



deltadentalins.com/enrollees



Understand your plan

What you can do:

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



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

Explore dental wellness

What you can do:

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



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

Download the app

What you can do:

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



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

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

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

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EF30 #1342981 (rev. 04/22)



Support for chronic conditions

Your plan offers additional dental coverage to support your overall health



Chronic conditions and the medications used to treat them can impact your oral health. If you or a covered family member has been diagnosed with a chronic medical condition like diabetes, cancer or rheumatoid arthritis, you may benefit from additional teeth and gum cleanings.

Take advantage of expanded coverage to help safeguard your oral health. To qualify, you or a covered family member must be diagnosed with any of the following:

- Amyotrophic lateral sclerosis (ALS)
- Cancer
- Chronic kidney disease
- Diabetes
- Heart disease
- HIV/AIDS
- Huntington’s disease
- Joint replacement
- Lupus
- Opioid misuse and addiction
- Parkinson’s disease
- Rheumatoid arthritis
- Sjögren’s syndrome
- Stroke

SmileWay® Wellness Benefits¹

100% coverage	One periodontal scaling and root planing procedure per quadrant (D4341 or D4342) per calendar or contract year ²
Four of the following (any combination) per calendar or contract year:²	
100% coverage	Prophylaxis (teeth cleaning) (D1110 or D1120)
	Periodontal maintenance procedure (D4910)
	Scaling in presence of moderate or severe gingival inflammation (D4346)

¹ Known as SmileWay Enhanced Benefits in Texas.

² This coverage is subject to any applicable maximums and deductibles under the terms and conditions outlined in your plan’s Evidence of Coverage. Please review your plan booklet for specific details about your coverage.

Delta Dental PPO™ is underwritten by Delta Dental Insurance Company in AL, DC, FL, GA, LA, MS, MT, NV and UT and by not-for-profit dental service companies in these states: CA — Delta Dental of California; PA, MD — Delta Dental of Pennsylvania; NY — Delta Dental of New York, Inc.; DE — Delta Dental of Delaware, Inc.; WV — Delta Dental of West Virginia, Inc. In Texas, Delta Dental Insurance Company provides a dental provider organization (DPO) plan.



Opt in by visiting
www1.deltadentalins.com/smileway
 or by calling Customer Service
 Monday through Friday.



deltadentalins.com/enrollees

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 EF89A #133959A (rev. 11/22)



The vital connection between oral health and overall health

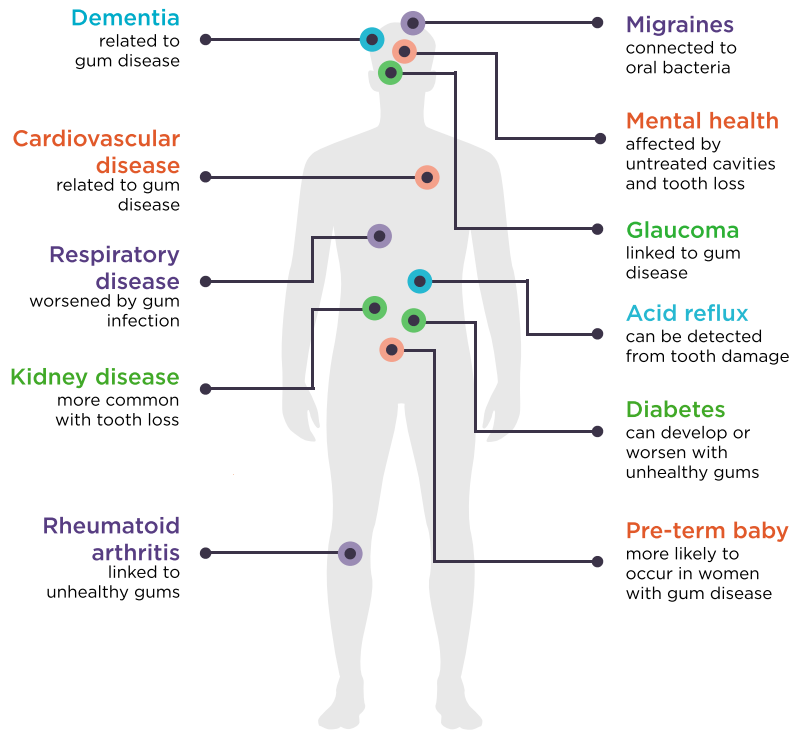


Did you know?

Nearly half of U.S. adults over the age of 30 have some form of gum disease.

Why it matters

Poor gum health and tooth loss can affect your overall health. Research has linked gum disease to cardiovascular disease, diabetes and strokes. Both can **increase your risk for a variety of chronic conditions and health issues, including:**



Good oral hygiene is essential. Be sure to brush and floss twice a day.

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

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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 Dental¹ has selected QualSight² to offer you access to discounts on LASIK services. Through QualSight, you can save 40-50% off the national average price of Traditional LASIK³ along with big savings on Custom and Custom Bladeless LASIK procedures!

Continued on back ►



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

<p>Extra savings</p>  <p>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.</p>	<p>Expert surgeons</p>  <p>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</p>	<p>Expansive choice</p>  <p>With more than 1,000 LASIK locations⁴, you can choose the physician with the experience, reputation and technology your vision correction requires.</p>
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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.

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 Dental² 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 ►



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://chcheating.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



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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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 passes⁴
- Savings on digital hearing aids and replacement batteries⁵



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		
CONTACTS		
LASIK		
HEARING AIDS AND FINANCING		
HEALTH AND ENTERTAINMENT		

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.

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



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!



THESE DISCOUNT OFFERINGS ARE NOT INSURANCE, and are not intended to replace insurance. These discount offerings, powered by Competitive Health, Inc., are made by third parties, and are not made by VSP. These offerings are not a Qualified Health Plan under the Affordable Care Act. THIS IS NOT A MEDICARE PRESCRIPTION DRUG PLAN. The third-party discount offers may provide discounts on certain services or products. The range of discounts and the range of services and products to which they may apply may vary. VSP shall have no liability whatsoever for the services or products or the discounts that may be offered by third parties. These third-party offers are void where prohibited. The discount medical plan organization is AccessOne Consumer Health, Inc., 84 Villa Rd., Greenville, SC 29615, <http://www.accessonedmpo.com>.

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Save Up to 60% on Brand-name Hearing Aids

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!

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

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.

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TruHearing™

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.



Special Offer!
Exp. 6/31/2019

120 Hearing Aid Batteries Only \$39!

VSP® members and their extended family members
get hearing aid batteries for less with TruHearing®

Call today: 1-844-300-1673
Batteries shipped straight to your door

Use promo code: **VSPB**



FREE
Battery Tester
with Purchase

Test your batteries!
It's also a flashlight!



vso Vision Care | **TruHearing**

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Basic Life & AD&D – The Hartford



Plan Benefits	The Hartford
Eligible Class	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • Class 1: \$250,000 • Class 2 & 3: \$50,000
Maximum Benefit	<ul style="list-style-type: none"> • Class 1: \$250,000 • Class 2 & 3: \$50,000
Guaranteed Issue	<ul style="list-style-type: none"> • 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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LIFE AND ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

PROTECTING YOUR LOVED ONES, ONE DECISION AT A TIME.



LIFE AND ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

Life insurance is protection for those you leave behind with a cash benefit that can help with final planning and a loss of future income.

Accidental Death and Dismemberment insurance, which we call Accidental Loss of Life and Severe Injury Benefits, covers you for an accidental loss of motion, sight, limb, or life.

How Could These Benefits Help Me?

A sudden death or accident can change everything for your loved ones, but they don't have to be unprepared. **Life insurance** combined with **Accidental Loss of Life and Severe Injury Benefits** offers a payment that those who depend on your salary can use to ease the financial stress that comes with a sudden loss or severe injury.

They can use the money in any way they choose. Examples could include:



Immediate costs

Burial
Funeral expenses



Ongoing bills

Rent/mortgage
Credit card debt



Future expenses

College tuitions
Retirement savings



BENEFITS IN ACTION

IS THIS COVERAGE FOR ME? >

Watch a short video to help you decide.
[TheHartford.com/bia/lifeandloss](https://www.TheHartford.com/bia/lifeandloss)

Life and Loss Benefits, which is what we call the combination of Life Insurance and Accidental Loss of Life and Severe Injury Benefits, helps provide for those who depend on you if you can no longer financially support them. You and your loved ones can use the benefits from both plans together after an accident strikes.

Visit [TheHartford.com/employeebenefits](https://www.TheHartford.com/employeebenefits) for more information.



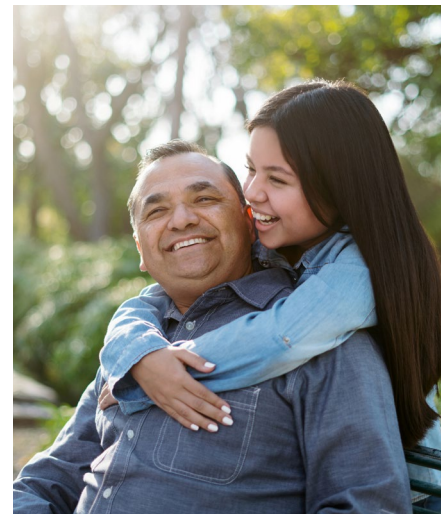
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Accident Form Series includes GBD-1000, GBD-1300, or state equivalent. Life Form Series includes GBD-1000, GBD-1100, or state equivalent.
2001051 08/23

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 Issue¹	
• Employee	\$100,000
• Spouse	\$50,000
• Child(ren)	\$10,000
Waiver of Premium²	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

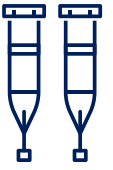


Plan Benefits	The Hartford
Eligible Class	Full-Time Employees
Coverage Amount	
• Employee	Increments of \$10,000 up to lesser of 10x covered annual earnings or \$500,000
• Spouse	50% of employee amount if employee doesn't cover any children under AD&D policy. 40% of employee amount if employee covers 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

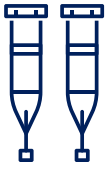


Plan Benefits	The Hartford
Eligible Class	District Paid <ul style="list-style-type: none"> • All active full-time CSEA employees who work at least 15 hours per week. • All active full-time unrepresented employees who work at least 30 hours per week. Employee Paid <ul style="list-style-type: none"> • 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.



SHORT-TERM DISABILITY INSURANCE

LIFE IS UNPREDICTABLE, YOUR INCOME DOESN'T HAVE TO BE.



SHORT-TERM INCOME PROTECTION BENEFITS

Short-term Disability insurance, which we call Short-term Income Protection Benefits, replaces part of your income if you're unable to work due to childbirth, illness or injury.

How Could These Benefits Help Me?

Life can be uncertain. Your paycheck doesn't have to be. These benefits can offer financial support during your recovery from an injury or serious illness.

While health insurance can help cover medical costs, these benefits can help with a part of your paycheck while you're out of work. You can use this benefit while you focus on recovery from an illness or medical event, like childbirth, a broken bone or surgery. The cash can be used for anything, like:

- 
Rent/Mortgage payments
- 
Childcare
- 
Medical deductibles
- 
Groceries

You can help protect your income with Short-term Income Protection Benefits when you're unable to work because of childbirth, an illness or an injury.



BENEFITS IN ACTION

IS THIS COVERAGE FOR ME? >

Watch a short video to help you decide. [TheHartford.com/bia/short-term-disability](https://www.TheHartford.com/bia/short-term-disability)

Visit [TheHartford.com/employeebenefits](https://www.TheHartford.com/employeebenefits) for more information.

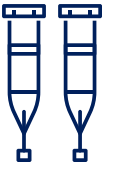


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THE DISABILITY POLICY PROVIDES LIMITED BENEFITS. This limited benefit plan (1) does not constitute major medical coverage, and (2) does not satisfy the individual mandate of the Affordable Care Act (ACA) because the coverage does not meet the requirements of minimum essential coverage. In New York: This Disability policy provides disability income insurance only. It does NOT provide basic hospital, basic medical or major medical insurance as defined by the New York State Department of Financial Services.

Disability Form Series includes GBD-1000, GBD-1200, or state equivalent.
1775301 07/23

Long Term Disability – The Hartford

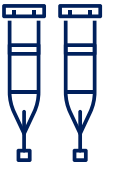


Plan Benefits	The Hartford
Eligible Class	<ul style="list-style-type: none"> • Class 1: Active F/T Permanent Employees w/ 5+ years of STRS working 20 hours/week • Class 2: Active F/T Permanent Employees earning less than \$162,000 annually working 20 hours/week • Class 3: Active F/T Permanent CSEA/SEIU 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	<ul style="list-style-type: none"> • 1st of the month following 90 days of employment
Monthly Benefit	<ul style="list-style-type: none"> • Classes 1, 2 & 4: 66.67% • Class 3: 60%
Monthly Maximum	<ul style="list-style-type: none"> • Classes 1, 2 & 3: \$9,000 • Class 4: \$12,000
Elimination Period (All Classes)	<ul style="list-style-type: none"> • 90 Day
Tax Treatment	<ul style="list-style-type: none"> • Classes 1, 2 & 4: Benefit is taxable • Class 3: Benefit is not taxable
Benefit Duration	<ul style="list-style-type: none"> • 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.



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LONG-TERM DISABILITY INSURANCE

THE PROTECTION YOU WANT WHEN YOU NEED IT MOST.



LONG-TERM INCOME PROTECTION BENEFITS

Long-term Disability insurance, which we call Long-term Income Protection Benefits, helps cover your day-to-day living expenses when you're not able to work for an extended time due to an illness or injury.

How Could These Benefits Help Me?

Life can be uncertain. Your paycheck doesn't have to be. These benefits can offer financial support during your recovery from an injury or serious illness.

While health insurance can help cover medical expenses, these benefits help replace a percentage of your paycheck while you're out of work for an extended period of time. You can use this benefit while you focus on recovery from an illness or medical event. Long-term Income Protection Benefits can be used for anything. Examples could include:



Bills



Therapy



Financial
services



Legal help

You can help protect your income when you're unable to work. Whether you face a serious illness or injury, Long-term Income Protection Benefits can help you avoid serious financial trouble during a long-term disability.



BENEFITS IN ACTION

IS THIS COVERAGE FOR ME? >

Watch a short video to help you decide.
[TheHartford.com/bia/long-term-disability](https://www.TheHartford.com/bia/long-term-disability)

Visit [TheHartford.com/employeebenefits](https://www.TheHartford.com/employeebenefits) for more information.



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Disability Form Series includes GBD-1000, GBD-1200, or state equivalent.
1774501.07/23



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® HealthChampion¹ – 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 GuidanceConsultantsSM 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 \(1-800-964-3577\)](tel:1-800-96-HELPS) 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.

1. HealthChampionSM 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 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.



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.

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.



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
<ul style="list-style-type: none"> • 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 	<ul style="list-style-type: none"> • Visa and passport requirements • Inoculation and immunization requirements • Foreign exchange rates • Embassy and consular referrals 	<ul style="list-style-type: none"> • Medication and eyeglass prescription assistance • Emergency travel arrangements⁹ • Emergency cash⁹ • Locating lost items • Bail advancement 	<ul style="list-style-type: none"> • Prevention Services <ul style="list-style-type: none"> – Education – Identity Theft Resolution Kit • Detection Services <ul style="list-style-type: none"> – Fraud alert to three credit bureaus • Resolution Guidance and Assistance <ul style="list-style-type: none"> – Credit information review – ID Theft Affidavit Assistance – Card replacement • Personal Services <ul style="list-style-type: none"> – 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](tel:1-800-243-6108) Collect from other locations: [202-828-5885](tel:202-828-5885) Fax: [202-331-1528](tel: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

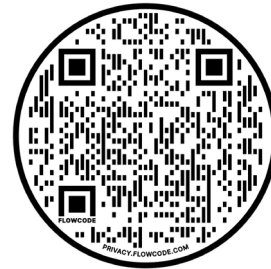
Be sure to bring social security numbers and dates of birth for any dependents that will be covered.

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](#)
- Life insurance** enables you to tailor coverage for your individual needs and helps provide financial security for your family members.
- 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.
- 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.
- 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.
- 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



WHAT ARE FLEXIBLE BENEFIT PLANS?



FLEXIBLE BENEFIT PLANS

Sterling Administration offers a great way to realize substantial tax savings with Flexible Benefit Plans. Through payroll redirection, employees may elect to pay for certain qualified expenses, and funds contributed are not included in gross income.

HEALTHCARE FSA

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, dental, vision, or pharmacy expenses as defined by Section 213(d) of the IRS Code.

The IRS annual contribution maximum for 2024 is \$3,200. 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 \$640. Funds may also be forfeited if you leave the company.

DEPENDENT CARE FSA

Dependent Care FSAs allow you to accumulate pre-tax funds to reimburse for qualified childcare expenses or day care expenses for a disabled or elderly/disabled dependent. If married, employees generally must have a working spouse to qualify for a Dependent Care FSA. Other IRS restrictions may apply.

The IRS annual contribution maximum for 2024 is \$5,000 (\$2,500 if married and filing separately). All dependent 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. Funds do not roll over to the next plan year and may be forfeited if you leave the company.

LIMITED PURPOSE

While you cannot have HSA with a general-purpose Healthcare FSA, you can pair an HSA with a Limited Purpose FSA. This account allows you to pay for eligible out-of-pocket dental and vision. All expenses must be qualified medical, dental, vision, or pharmacy expenses as defined by Section 213(d) of the IRS Code.

The IRS annual contribution maximum for 2024 is \$3,200. All dental and vision 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 \$640. Funds may also be forfeited if you leave the company.

COMMUTER (TRANSIT + PARKING)

With a Commuter account, you can set aside pre-tax compensation in two categories – Transit and Parking. Transit includes qualified commuter expenses such as the use of mass transportation (train, subway, bus, commuter highway vehicle, transit passes).

The IRS monthly contribution maximum for 2024 is \$315 for Transit and \$315 for Parking. There is no “use it or lose it” rule and unused funds roll over at the end of a plan year. Funds may be forfeited if you leave the company.



WHAT ARE FLEXIBLE BENEFIT PLANS?

WHAT ARE THE ADVANTAGES?

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.

ANNUAL TAX SAVINGS EXAMPLE	WITHOUT FSA	WITH FSA
IF YOUR TAXABLE INCOME IS:	\$50,000	\$50,000
AND YOU DEPOSIT THIS AMOUNT INTO AN FSA:	\$0	\$2,000
YOUR TAXABLE INCOME IS NOW:	\$50,000	\$48,000
SUBTRACT FEDERAL AND SOCIAL SECURITY TAXES:	\$14,383	\$13,807
IF YOU SPEND AFTER-TAX DOLLARS FOR EXPENSES:	\$2,000	\$0
YOUR REAL SPENDABLE INCOME IS:	\$33,617	\$34,193
YOUR TAX SAVINGS:	\$0	\$576

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





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 2024, the IRS maximums are \$4,150 for an individual and \$8,300 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 2024. 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.



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 request a check by calling Sterling at 800-617-4729, or by going online, faxing, mailing or emailing a request for reimbursement form. The bill will then be paid directly to the party requested within 5 business days. Another option is to 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, or by filling out and sending a request for reimbursement to Sterling.

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 accountholders save money on health insurance premiums, they are also better able to take control over their healthcare choices and expenses. HSAs are 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. For predominantly Spanish speaking customers, we offer Spanish speaking customer service representatives.

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2

CLICK HERE to watch a video on How to Optimize Your HSA

How to optimize your HSA

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

Health Savings Account (HSA)



GET STERLING'S MOBILE APP TODAY



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ADMINISTRATION

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1.888.410.7361
www.sterlingadministration.com

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?

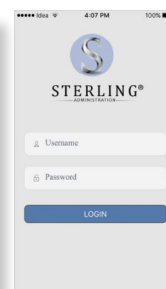
Just log on with the same credentials you use on Sterling's desktop site, and you're ready to go! All your Sterling products automatically will load onto your app.

- 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

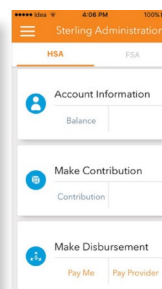
Look for the Sterling "S"



Mobile App Login Screen



Your Sterling products will automatically load on the app.





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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.

Flexible Benefits Plans by STERLING (continued)



CONTRIBUTIONS & OUT-OF-POCKET LIMITS FOR HEALTH SAVINGS ACCOUNTS & HIGH DEDUCTIBLE HEALTH PLANS			
	2024	2023	Change
HSA contribution limit (employer + employee)	Self-only: \$4,150 Family: \$8,300	Self-only: \$3,850 Family: \$7,750	Self-only: +\$300 Family: +\$550
HSA catch-up contributions (age 55 or older)	\$1000	\$1000	No change
HDHP minimum deductibles	Self-only: \$1,600 Family: \$3,200	Self-only: \$1,500 Family: \$3,000	Self-only: +\$100 Family: +\$200
HDHP maximum out-of-pocket amounts (deductibles, co-payments and other amounts, but not premiums)	Self-only: \$8,050 Family: \$16,100	Self-only: \$7,500 Family: \$15,000	Self-only: +\$550 Family: +\$1,100

Source: IRS, Revenue Procedure 2023-23.

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 800.617.4729
 877.517.4729
 www.SterlingAdministration.com
HSA@SterlingAdministration.com



7 REASONS MILLENNIALS LOVE HSAs

HSAs ARE THE PERFECT FIT FOR MILLENNIALS. WHETHER YOU'RE A MILLENNIAL LOOKING FOR A NEW SAVINGS TOOL OR AN EMPLOYER LOOKING FOR A NEW BENEFIT TO BOOST EMPLOYEE RETENTION, HSAs ARE A GREAT OPTION TO CONSIDER.



1 HSAs Put Millennials in Control.

With HSAs, users decide how much to contribute, up to the government-determined maximums. This is the perfect way to let millennials take charge of their savings.



2 Digital Tools Fit the Millennial Lifestyle.

Millennials do everything online. They shop online. They socialize online. And yes, they manage their HSAs online. Apps and online decision-making tools make it easy for millennials.



3 Triple Tax Advantages = Triple Appeal.

Millennials love hearing that HSAs come with not one, not two, but three tax advantages.

- HSA contributions are tax deductible. When made through payroll deductions, contributions are made pre-tax.
- Interest earned in an HSA is tax-free. Millennials can watch their investment grow without worrying about Uncle Sam.
- Withdrawals are tax-free when made for qualified medical expenses.



4 Portability Means Flexibility.

CareerBuilder found that 25 percent of employees have held at least five jobs by age 35, and 32 percent of employees now accept job-hopping as normal.¹ When employees change insurance plans or jobs, they keep their HSAs. This is exactly the type of flexibility that can attract millennial workers – and possibly convince them to stay.



5 They're Ready for Anything – or Nothing.

Millennials might not mind high deductible plans because they don't need much health care. One broken bone or burst appendix could change that. With an HSA, they're ready for unexpected medical expenses – and if they don't have any, they keep their money.



6 Expiration Dates, Eliminated.

With HSAs, any money that's not used one year is simply carried over to the next. Millennials never have to worry that a year of good health will result in money down the drain.



7 Pull Double Duty as Retirement Savings.

Don't let the "health" in health savings accounts fool you. HSAs are also a great tool for retirement savings. Two-thirds of millennials have saved nothing for retirement, according to the National Institute of Retirement Security.² HSAs can help.

Ready to Get Started?

Contact Sterling Administration to learn more!

- 📍 1000 Broadway #250
Oakland CA 94607
- ☎ 1.800.617.4729
- 📞 1.888.410.7361
- 🌐 www.sterlingadministration.com

Sources:

1. <http://www.careerbuilder.com/share/aboutus/pressreleasesdetail.aspx?sd=5%2F15%2F2014&id=pr824&ed=12%2F31%2F2014>
2. <https://www.nirsonline.org/2018/02/new-research-finds-95-percent-of-millennials-not-saving-adequately-for-retirement>



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WHAT ARE THE ELIGIBLE EXPENSES FOR FSA HSA & HRA PLANS?



Congratulations! You've made a smart consumer choice by enrolling in a Health Savings Account (HSA), Flexible Spending Account (FSA), or an Health Reimbursement Arrangement (HRA). There are thousands of eligible expenses for tax-free purchase, including prescriptions, doctor's office copays, health insurance deductibles, and coinsurance. Many over-the-counter (OTC) treatments are also eligible now, due to the CARES Act, enacted in March 2020. These items no longer require a prescription, letter of medical necessity (LMN), or doctor's directive. **NOTE: HRAs are unique to each employer. PLEASE check your plan document to see what is eligible for your specific HRA, it may be limited to certain categories.*

WHAT'S ELIGIBLE?



The quickest way to see what is eligible is to visit our partner the [FSA Store](#) and [HSA Store](#) online. There you can browse their online store and even make your purchase.

SAMPLE LIST OF ELIGIBLE EXPENSES

The list below is just a sample of eligible expenses. For the complete list, see IRS Publication 502 Section 213(d) (<http://www.irs.gov/publications/p502/>).

Abdominal supports	Braces	Gum treatment	Pediatrician
Abortion	Cardiographs	Gynecologist	Hearing aids & batteries
Acupuncture	Chiropractor	Hydrotherapy	Hospital bills
Air conditioner	Childbirth / delivery	Insulin treatment	Podiatrist
Alcoholism treatment	Christian Science Practitioner	Lab tests	Prenatal care
Ambulance	Dermatologist	Lead paint removal	Psychiatrist
Anesthetist	Diagnostic fees	Legal fees	Psychotherapy
Arch supports	Drug addiction therapy	Menstrual Products	Registered nurse
Artificial limbs	Drugs (prescription and OTC)	Oral surgery	Splints
Autoette	Elastic hosiery (prescription)	Organ transplant	Vaccines
Birth control pills	Eye glasses	Orthotic shoes	Vitamins (if prescribed)
Blood tests	Fluoridation unit	Oxygen & oxygen equipment	Wheel chair
Blood transfusions	Guide dog		

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 2024

- **2024 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](tel: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.





Nationwide® My Pet Protection® PLANS SUMMARY



Nationwide pet insurance helps you cover veterinary expenses so you can provide your pets with the best care possible—without worrying about the cost.

Nationwide offers two plans for you to choose from: My Pet Protection® and My Pet Protection® with Wellness500.¹

My Pet Protection is a medical plan that offers an annual benefit of \$7,500 for eligible veterinary bills related to accidents, injuries and illnesses, including emergency clinics and specialists.

My Pet Protection with Wellness500 offers the same protection as our medical plan, but includes coverage for preventive care. With this plan, up to \$500 of the annual \$7,500 benefit can be used for wellness, including checkups, flea and heartworm preventives, vaccinations, spay and neuter and more.

Both plans are guaranteed issuance,² have a \$250 annual deductible and include medical coverage with the choice of 50% or 70% reimbursement levels.³

	My Pet Protection®	My Pet Protection® with Wellness500
Accidents	✓	✓
Injuries	✓	✓
Illnesses	✓	✓
Hereditary and congenital conditions	✓	✓
Diagnostics and imaging	✓	✓
Procedures and surgeries	✓	✓
Wellness exams		✓
Vaccinations		✓
Flea prevention		✓
Spay or neuter		✓
And more	✓	✓



Get a quote at PetsNationwide.com • 877-738-7874



Pet Insurance (continued)



What makes My Pet Protection different?

My Pet Protection is available through workplace benefits programs and is guaranteed issuance.² It also includes additional benefits like lost pet advertising, emergency boarding and more.

It's no surprise that My Pet Protection is the most paw-pular coverage plan from America's #1 pet insurer.⁴



Did you know? Nationwide is the industry-first provider of coverage for birds and exotic pets.

Nationwide offers more than great coverage

VetHelpline[®]

- Unlimited access to veterinary care experts
- Download the app and schedule a video consultation anytime 24/7
- No additional cost to use for Nationwide pet insurance members

Nationwide[®] PetRxExpressSM

- Save time and money by filling pet prescriptions at participating in-store retail pharmacies across the U.S.
- Pharmacy submits claims directly to Nationwide
- More than 4,700 pharmacy locations

petco veterinary services

Members save 10% on every visit to a Vetco Total Care Hospital or Vetco Vaccination Clinic inside Petco

vetco total care

Vetco Total Care is a full-service animal hospital that offers everything from preventive care to diagnostics and surgery

vetco vaccination clinic

Vetco Vaccination Clinic offers express care for vaccinations, flea/tick and heartworm prescriptions and microchipping

How to use your pet insurance plan

- 1 Visit any vet, anywhere.
- 2 Submit claim.
- 3 Get reimbursed for eligible expenses.



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[1] Existing members can enroll in My Pet Protection[®] with Wellness500 during their respective renewal period only. Products and discounts not available to all persons in all states.

[2] Guaranteed issuance means any new pets enrolling into a My Pet Protection plan are eligible for enrollment regardless of health status. Guaranteed issuance does not mean guaranteed coverage since certain exclusions could apply.

[3] These are examples of general coverage; please review plan document for specific coverages. Some exclusions may apply. Certain coverages may be excluded due to pre-existing conditions. See policy documents for a complete list of exclusions and annual limits.

[4] State of the Industry Report 2022, North American Pet Health Insurance Association.

Products underwritten by Veterinary Pet Insurance Company (CA), Columbus, OH; National Casualty Company (all other states), Columbus, OH; Agency of Record: DVM Insurance Agency. All are subsidiaries of Nationwide Mutual Insurance Company. Subject to underwriting guidelines, review and approval. Products and discounts not available to all persons in all states. 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. Nationwide, the Nationwide N and Eagle, Nationwide is on your side, Vet-Helpline[®] and Nationwide PetRxExpressSM are service marks of Nationwide Mutual Insurance Company. Third party marks are the property of their respective owners. ©2024 Nationwide, Z3GRP9695F

24GRPLNSMRY





Save time and money when filling pet prescriptions at participating pharmacies with Nationwide® **PetRxExpress**™.

For no extra cost, members get discounts on pet prescriptions, while enjoying the effortless convenience of automatic claim submission.

Get prescription pet meds for less

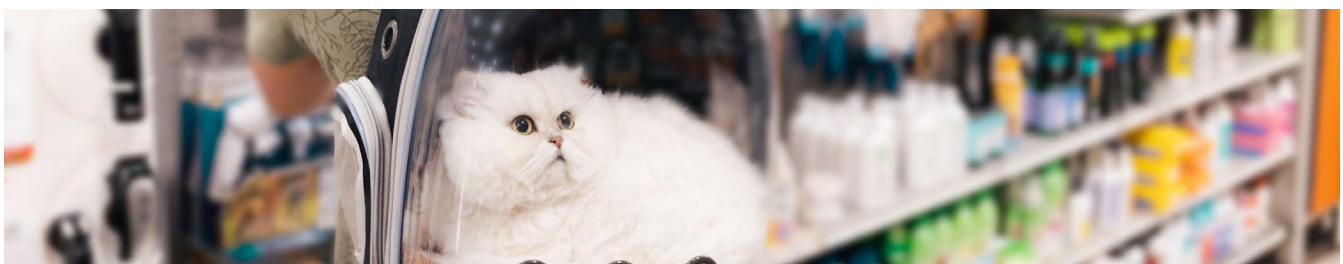


- Program available to all active Nationwide pet insurance members
- Receive discounted pricing on medications
- No additional cost to use

How it works

Using Nationwide® **PetRxExpress**™ is easy and convenient for Nationwide pet insurance members.

1. Download a digital pet insurance card at my.petinsurance.com.
2. Take a prescription to any participating pharmacy location, or have the veterinarian call it in.
3. Show your pet insurance card at checkout to have your discount applied.



Get a quote at PetsNationwide.com • 877-738-7874

Products underwritten by Veterinary Pet Insurance Company (CA), Columbus, OH; National Casualty Company (all other states), Columbus, OH, Agency of Record; DVM Insurance Agency, All are subsidiaries of Nationwide Mutual Insurance Company, Subject to underwriting guidelines, review and approval. Products and discounts not available to all persons in all states. 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. Nationwide, the Nationwide N and Eagle, Nationwide is on your side, VetHelpline® and Nationwide PetRxExpress™ are service marks of Nationwide Mutual Insurance Company, Third party marks are the property of their respective owners. ©2024 Nationwide, 23GRP9695H





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

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

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Bi-lingual support

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Discrimination is Against the Law

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

Newborns' and Mothers' Health Protection Act (NMHPA)

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

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

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

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, 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 any other person (including a primary care provider) to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, www.blueshield.com or www.kp.org

Networks/Claims/Appeals

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

Notice of Extended Coverage to Children Covered as Students

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

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

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

- *Dependent child means a child over age 26 who is a dependent of a plan participant and who is eligible under the terms of the Plan based on their student status and enrollment at a post-secondary educational institution immediately before the first day of a medically necessary leave of absence.*
- *Medically necessary leave of absence means a leave of absence or any other change in enrollment:*

Important Notices (continued)



- of a dependent child from a post-secondary educational institution that begins while the child is suffering from a serious illness or injury;
- Which is medically necessary; and,
- Which causes the dependent child to lose student status under the terms of the Plan.

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

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

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

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

COBRA Continuation Coverage

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

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

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

WHAT IS COBRA CONTINUATION COVERAGE?

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

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

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

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

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

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

- The parent-employee dies;
- The parent-employee's employment ends for any reason other than their gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);



- The parents become divorced or legally separated; or,
- The child stops being eligible for coverage under the Plan as a “dependent child.”

WHEN IS COBRA CONTINUATION COVERAGE AVAILABLE?

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

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

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

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

NOTICE AND ELECTION PROCEDURES

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

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

ELECTION AND ELECTION PERIOD

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

If, during the election period, a Qualified Beneficiary waives COBRA continuation coverage rights, the waiver can be revoked at any time before the end of the election period. Revocation of the waiver will be an election of COBRA continuation coverage. However, if a waiver is revoked, coverage need not be provided retroactively (that is, from the date of the loss of coverage until the waiver is revoked). Waivers and revocations of waivers are 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. (See Notice and Election Procedures.)



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

If your family experiences another Qualifying Event during the 18 months of COBRA continuation of coverage, the spouse and dependent children in your family can 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. (See Notice and Election Procedures.)

OTHER OPTIONS BESIDES COBRA CONTINUATION COVERAGE

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

ENROLLMENT IN MEDICARE INSTEAD OF COBRA

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period¹ to sign up for Medicare Part A or B, beginning on the earlier of:

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

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

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

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

IF YOU HAVE QUESTIONS

[For 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.

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

Important Notices (continued)



KEEP YOUR PLAN INFORMED OF ADDRESS CHANGES

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

EFFECTIVE DATE OF COVERAGE

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

COST OF CONTINUATION COVERAGE

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

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

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

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

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

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

Uniformed Services Employment and Reemployment Rights Act (USERRA)

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

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

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

Special Enrollment Rights Notice

CHANGES TO YOUR HEALTH PLAN ELECTIONS

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

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



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

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

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

For information about Special Enrollment Rights, please contact:

Ron Owen, Senior Benefits Analyst
Marin Community College District
1800 Ignacio Blvd., Navato, 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 Client Name 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 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.**
- **[Client/Carrier] has determined that the prescription drug coverage offered by [Insert Name of Client Medical Plan(s)] 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 [Client Name] coverage will not be affected. If you keep this coverage and elect Medicare, the [Client Name] coverage will coordinate with Part D coverage.

If you do decide to join a Medicare drug plan and drop your current [Client Name] 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 [Client Name] 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.

Important Notices (continued)



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 [Client Name] 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.

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: 2024

Name of Entity / Sender: Marin Community College District

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

[Client Name] 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 [insert name, address or telephone number of person to contact].

Wellness – Alternative Standards

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

Important Notices (continued)



Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: GENERAL INFORMATION

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

WHAT IS THE HEALTH INSURANCE MARKETPLACE?

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

Open Enrollment for health insurance coverage through Covered California will begin on November 1, 2023, and end on January 31, 2024. For more information on Open Enrollment and other opportunities to enroll, visit www.coveredca.com or KeenanDirect at 855-653-3626 or www.KeenanDirect.com.

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

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

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

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

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

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

STATES WITH INDIVIDUAL MANDATE

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

Important Notices (continued)



PART B: INFORMATION ABOUT HEALTH COVERAGE OFFERED BY YOUR EMPLOYER

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

3. Employer name Marin Community College District	4. Employer Identification Number (EIN) 68-01943459	
5. Employer address 1800 Ignacio Blvd.	6. Employer phone number 415.883.3261	
7. City Navato	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) Phone Number	12. Email address rowen@marin.edu	

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

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 July 31, 2023. Contact your State for more information on eligibility.

ALABAMA – Medicaid

Website: <http://myalhipp.com/>
Phone: 855-692-5447

ALASKA – Medicaid

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

ARKANSAS – Medicaid

Website: <http://myarhipp.com/>
Phone: 855-MyARHIPP (855-692-7447)

CALIFORNIA – Medicaid

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

COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHIP+)

Health First Colorado Website:
<https://www.healthfirstcolorado.com/>
Health First Colorado Member Contact Center:
800-221-3943 | TTY: Colorado relay 711
CHP+: <https://hcpf.colorado.gov/child-health-plan-plus>
CHP+ Customer Service:
800-359-1991 | TTY: Colorado relay 711
Health Insurance Buy-In Program (HIBI):
<https://www.mycোধibi.com/>
HIBI Customer Service: 855-692-6442

FLORIDA – Medicaid

Website:
<http://www.flmedicaidprecovery.com/flmedicaidprecovery.com/hipp/index.html>
Phone: 877-357-3268

GEORGIA – Medicaid

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

INDIANA – Medicaid

Healthy Indiana Plan for low-income adults 19-64
Website: <http://www.in.gov/fssa/hip/>
Phone: 877-438-4479
All other Medicaid
Website: <https://www.in.gov/medicaid/>

Phone: 800-457-4584 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>
Hawki Phone: 800-257-8563
HIPP Website:
<https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp>
HIPP Phone: 888-346-9562

Important Notices (continued)



KANSAS – Medicaid

Website: <https://www.kancare.ks.gov/>
Phone: 800-792-4884
HIPPA Phone: 800-967-4660

KENTUCKY – Medicaid

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

LOUISIANA – Medicaid

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

MAINE – Medicaid

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

MASSACHUSETTS – Medicaid and CHIP

Website: <https://www.mass.gov/masshealth/pa>
Phone: 800-862-4840 | TTY: Massachusetts relay 711
Email: masspremassistance@accenture.com

MINNESOTA – Medicaid

Website: <https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp>
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
Email: HSHIPPProgram@mt.gov

NEBRASKA – Medicaid

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

NEVADA – Medicaid

Medicaid Website: <http://dhcfnv.gov/>
Medicaid Phone: 800-992-0900

NEW HAMPSHIRE – Medicaid

Website: <https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program>
Phone: 603-271-5218
HIPP Program Toll-Free Phone: 800-852-3345, ext. 5218

NEW JERSEY – Medicaid and CHIP

Medicaid Website:
<http://www.state.nj.us/humanservices/dmahs/clients/medicaid/>
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: <https://www.hhs.nd.gov/healthcare>
Phone: 844-854-4825

OKLAHOMA – Medicaid and CHIP

Website: <http://www.insureoklahoma.org>
Phone: 888-365-3742

OREGON – Medicaid

Websites: <http://healthcare.oregon.gov/Pages/index.aspx>
Phone: 800-699-9075

PENNSYLVANIA – Medicaid and CHIP

Website:
<https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx>
Phone: 800-692-7462
CHIP Website: <https://www.dhs.pa.gov/CHIP/Pages/CHIP.aspx>
CHIP Phone: 800-986-KIDS (5437)

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

Important Notices (continued)



TEXAS – Medicaid

Website: <https://www.hhs.texas.gov/services/financial/health-insurance-premium-payment-hipp-program>
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: <https://dvha.vermont.gov/members/medicaid/hipp-program>
Phone: 800-250-8427

VIRGINIA – Medicaid and CHIP

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

WASHINGTON – Medicaid

Website: <https://www.hca.wa.gov/>
Phone: 800-562-3022

WEST VIRGINIA – Medicaid and CHIP

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

WISCONSIN – Medicaid and CHIP

Website:
<https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm>
Phone: 800-362-3002

WYOMING – Medicaid

Website: <https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/>
Phone: 800-251-1269

To see if any other states have added a premium assistance program since July 31, 2023, 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			
<ul style="list-style-type: none"> Kaiser 	60115	800-464-4000	www.kp.org
<ul style="list-style-type: none"> Blue Shield 	<ul style="list-style-type: none"> SC13580 (100% Plan A) SC13590 (80% Plan K) SCB0380 (2-Tier Anchor Bronze) 	855-256-9404	www.blueshieldca.com
Dental			
<ul style="list-style-type: none"> Delta Dental 	<ul style="list-style-type: none"> 5438 0006 (CSEA & Unrepresented) 	866-499-3001	www.deltadentalins.com
Vision			
<ul style="list-style-type: none"> Vision Service Provider (VSP) 	2606622A	800-877-7195	www.vsp.com
Employee Assistance Program (EAP)			
<ul style="list-style-type: none"> Anthem EAP 	SISC	800-999-7222	www.anthemeap.com
Basic Life / AD&D, Optional Life, Long Term Disability (LTD)			
<ul style="list-style-type: none"> The Hartford 	0GL875740 Employee Benefits	800-523-2233	www.thehartford.com
Beneficiary Assistance			
<ul style="list-style-type: none"> Estate Guidance / Will Services 	WILLHLF	800-411-7239	www.estateguidance.com
<ul style="list-style-type: none"> Funeral Planning 	HFEVLC	866-854-5429	www.everestfuneral.com
Advance Medical	SISC		
Identity Theft			
Personal Choices			



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).



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](#)

