EMPLOYEE BENEFITS *Guide*

2025
2026

Marin Community College District

Employee Benefits Guide 2025-2026

General Information

Core Benefits

Other Benefits

Miscellaneous

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 95 for more details.

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

General

College of Marin understands the importance of offering a comprehensive benefit program that meets the needs of our diverse workforce. We are pleased to continue to provide a suite of quality benefit plans to all benefit eligible employees for the 2025-2026 plan year.

2025 – 2026 Core Health Plan Offerings

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

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

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

Who Can You Cover

Who is Eligible?

The District provides Medical, Dental, Vision and Life Insurance benefits to all benefit eligible employees. Open Enrollment Coverage is effective October 1, 2025.

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, 2025, for an effective date of October 1, 2025.

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-2026, SISC will require tax documents from tax year 2025. Please redact financial information and the first five digits of SSN. If taxes were filed separately, a copy of both returns is required.

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

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

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

Coordination of Benefits (COB)

What is COB?

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

How COB Works

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

Primary vs. Secondary Carrier

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

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

Dependent Coverage When Parents Are Divorced

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

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

Other COB Issues

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

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

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

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

Qualifying Events

GUIDELINES AND PROCEDURES

QUALIFYING EVENTS OR STATUS CHANGES OUTSIDE OF OPEN ENROLLMENT

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

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

(Continued on next page.)

Qualifying Events (continued)

GUIDELINES AND PROCEDURES

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.)	• Enroll self, spouse/domestic partner, and any eligible dependent children, if applicable • Drop spouse/domestic partner and/or any other dependent children • Change health plans when options are available	• Proof of employment change; and • Other enrollment forms/documents as applicable
Changes to coverage as a result of Open Enrollment under other employer plan/different plan year including enrollment in a Qualified Health Plan (QHP) through a Public Marketplace such as Covered CA	• Enroll self, spouse/domestic partner, and any eligible dependent children, if applicable • Drop spouse/domestic partner and/or any other dependent children • Change health plans when options are available	• Proof of coverage change; and • Other enrollment forms/documents as applicable
Significant increase or decrease in the cost of coverage or an unpaid leave where the district will no longer be making a contribution	• Enroll self, spouse/domestic partner, and any eligible dependent children, if applicable • Drop spouse/domestic partner and/or any other dependent children • Change health plans when options are available	• Proof of increase in cost of coverage (e.g. district submitted plan change); or • Proof of decrease in cost of coverage (e.g. district submitted plan change); and • Other enrollment forms/documents as applicable
Gain or Loss of Coverage Elsewhere, including but not limited to: • Change of home address causing loss of eligibility • Change in employment status of spouse/domestic partner or dependent child (including commencement or termination of employment) • Significant curtailment in employee's spouse's/domestic partner's group coverage **NOTE:** HIPAA special enrollment rights may apply	• Enroll self, spouse/domestic partner, and any eligible dependent children, if applicable • Drop spouse/domestic partner and/or any other dependent children • Change health plans when options are available	• Proof of significant curtailment in spouse's/domestic partner's group coverage; or • Proof of enrollment in other coverage; or • Proof of loss of coverage; and • Other enrollment forms/documents as applicable

BenefitBridge

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: https://BenefitsEnrollment.as.me/MarinCommunityCollegeDistrict

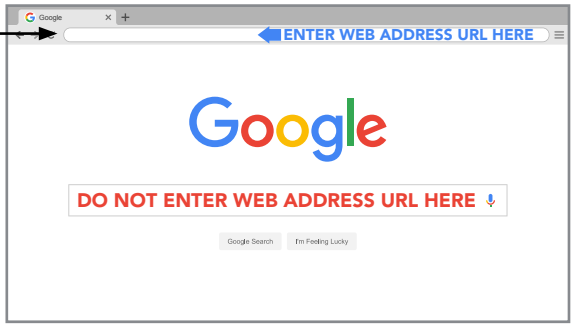
For BenefitBridge technical assistance ***only***, please contact BenefitBridge Customer Care at 800-814-1862; Mon – Fri, 8:00 a.m. – 5:00 p.m., PST or email benefitbridge@keenan.com.

Here's what you can do on BenefitBridge:

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

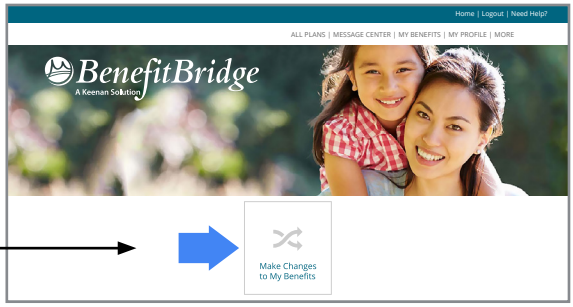
Login

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

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

Rates

Full-time Classified and Unrepresented Employees

Effective October 1, 2025, for benefit eligible CSEA, SEIU, Management, Supervisors and Confidential, the District contributes between $1,700 - $2,900 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 10/1/2025 (Monthly Rates)		
	Total Premium	District Contribution	Employee Contribution
Kaiser Permanente Traditional Plan			
• Employee Only	$1,297.00	$1,297.00	$0.00
• Employee + 1	$2,538.00	$2,400.00	$138.00
• Family	$3,572.00	$2,900.00	$672.00
Kaiser Permanente Deductible Plan			
• Employee Only	$1,156.00	$1,156.00	$0.00
• Employee + 1	$2,262.00	$2,262.00	$0.00
• Family	$3,183.00	$2,900.00	$283.00
Kaiser High deductible/Health Saving $1,700 90% Plan			
• Employee Only	$1,024.00	$1,024.00	$0.00
• Employee + 1	$2,002.00	$2,002.00	$0.00
• Family	$2,817.00	$2,817.00	$0.00
Blue Shield - 100% Plan A			
• Employee Only	$1,684.00	$1,700.00	$0.00
• Employee + 1	$3,316.00	$2,400.00	$916.00
• Family	$4,679.00	$2,900.00	$1,779.00
Blue Shield - 80% Plan K			
• Employee Only	$1,265.00	$1,265.00	$0.00
• Employee + 1	$2,486.00	$2,400.00	$86.00
• Family	$3,504.00	$2,900.00	$604.00
Blue Shield-High Deductible/Health Saving $1,700 90% Plan			
• Employee Only	$1,145.00	$1,145.00	$0.00
• Employee + 1	$2,247.00	$2,247.00	$0.00
• Family	$3,164.00	$2,900.00	$264.00
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 $998.40 - $3,485.86 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 10/1/2025 (Monthly Rates)		
	Total Premium	District Contribution	Employee Contribution
Kaiser Permanente Traditional Plan			
• Employee Only	$1,297.00	$1,212.70	$84.31
• Employee + 1	$2,538.00	$2,347.65	$190.35
• Family	$3,572.00	$3,125.50	$446.50
Kaiser Permanente Deductible Plan			
• Employee Only	$1,156.00	$1,121.32	$34.68
• Employee + 1	$2,262.00	$2,160.21	$101.79
• Family	$3,183.00	$2,912.45	$270.56
Kaiser High deductible/Health Saving $1,700 90% Plan			
• Employee Only	$1,024.00	$998.40	$25.60
• Employee + 1	$2,002.00	$1,931.93	$70.07
• Family	$2,817.00	$2,662.07	$154.94
Blue Shield - 100% Plan A			
• Employee Only	$1,684.00	$1,574.54	$109.46
• Employee + 1	$3,316.00	$2,802.02	$513.98
• Family	$4,679.00	$3,485.86	$1,193.15
Blue Shield - 80% Plan K			
• Employee Only	$1,265.00	$1,208.08	$56.93
• Employee + 1	$2,486.00	$2,299.55	$186.45
• Family	$3,504.00	$3,066.00	$438.00
Blue Shield-High Deductible/Health Saving $1,700 90% Plan			
• Employee Only	$1,145.00	$1,116.38	$28.63
• Employee + 1	$2,247.00	$2,190.83	$56.18
• Family	$3,164.00	$2,989.98	$174.02
Delta Dental			
• Composite Rate - UPM	$145.00	$145.00	$0.00
VSP			
• Composite Rate	$10.40	$10.40	$0.00

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Rates (continued)

Part-time Faculty

The District Contributes between $1,121.32 - $3,485.86 per month towards your Medical premium for eligible part-time faculty.

	Effective 10/1/2025 (Monthly Rates)		
	Monthly Premium	District Contribution	Employee Contribution
Kaiser Permanente Traditional Plan			
• Member only	$1,297.00	$1,212.70	$84.31
• Member plus one	$2,538.00	$2,347.65	$190.35
• Family	$3,572.00	$3,125.50	$446.50
Kaiser Permanente Deductible Plan			
• Member only	$1,156.00	$1,121.32	$34.68
• Member plus one	$2,262.00	$2,160.21	$101.79
• Family	$3,183.00	$2,912.45	$270.56
Blue Shield - 100% Plan A			
• Employee Only	$1,684.00	$1,574.54	$109.46
• Employee + 1	$3,316.00	$2,802.02	$513.98
• Family	$4,679.00	$3,485.86	$1,193.15
Blue Shield - 80% Plan K			
• Employee Only	$1,265.00	$1,208.08	$56.93
• Employee + 1	$2,486.00	$2,299.55	$186.45
• Family	$3,504.00	$3,066.00	$438.00

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Making the Most of Your Benefits Program

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

Stay Well!

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

Ask Questions and Stay Informed

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

Get a Primary Care Provider

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

Going to the Doctor?

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

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

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

An Apple a Day

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

Using the Emergency Room

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

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

Be Med Wise!

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

SISC Health Smarts

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

Medical – Kaiser

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

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

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Medical – Kaiser (continued)

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

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

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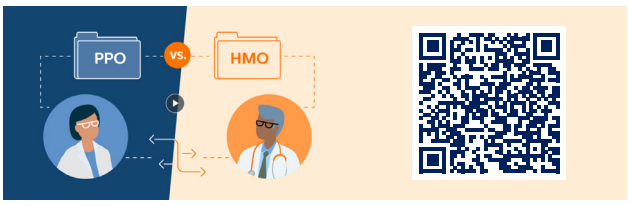
Medical – Kaiser (continued)

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



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

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

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

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

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

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Medical – Blue Shield (continued)

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

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Medical – Blue Shield (continued)

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

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Medical – Blue Shield (continued)

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

Prior Authorization

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

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

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

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Medical – Blue Shield (continued)

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

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

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

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SISC Added Value Programs

Program	Service	PPO	Kaiser	WABE	All Employees
Carrum Health	COE for Inpatient Hip & Knee Replacements and Certain Spine Procedures	✓			
Centivo Care	Virtual Primary Care	✓			
Costco	Flu Shot Clinics	✓	✓	✓	✓
EAP-Employee Assistance Program	EAP Life Assistance and Support	✓	✓	✓	✓
Hinge Health	Virtual Physical Therapy	✓			
Lantern Cancer Care	Cancer Support	✓			
Maven	Maternity and Postpartum Support	✓			
MDLive	Virtual Urgent Care and Mental Health	✓		✓	
Quest Population Health	Biometric Screenings	✓	✓	✓	
Quest Population Health	Colorectal Cancer Screenings	✓			
Teladoc Medical Expert	Expert Medical Opinion Program	✓	✓	✓	
Vida Health	Health Coaching, Chronic Condition Management, and Mental Health	✓		✓	

carrumhealth

This benefit is provided by

SISC
Self-Insured Schools of California
Schools Helping Schools

Your Carrum Health surgical benefit has expanded!

With Carrum, you know you're in good hands. Our vetted and trusted network is made up of the nation's top 10% of surgeons, meeting strict quality and patient care criteria.

Your Carrum Health network has grown to now include:

- Scripps
- Stanford Health
- Community Hospital of the Monterey Peninsula (**new!**)
- Adventist Lodi (**new!**)

What's Carrum?

Carrum Health is an employee benefit that makes it easier and less expensive for you to get the best possible surgical care while saving you money.

With Carrum, you're paired with a dedicated patient care specialist, who takes care of medical paperwork and next steps, while answering your questions and providing support at every step throughout your surgical journey.

From finding a surgeon and gathering paperwork to knowing costs up front and more, Carrum Health focuses on what matters most — **you**.

Better care
The surgeons in our program achieve better outcomes and have exceptional bedside manner.

No surprise bills
When you receive care through Carrum, your costs are covered on all PPO plans except HSAs*.

Total support
Our team helps with all the planning and paperwork, so you can focus on your health.

What's covered?

Musculoskeletal
Hip and knee joint replacements

Spine
Surgical repair of your spine including spinal fusions and spinal decompressions

How to get started:

Scan below, visit carrum.me/SISC, or call us at 888-855-7806

Who is eligible?

Those eligible for Carrum Health include SISC members enrolled in an Anthem Blue Cross or Blue Shield PPO plan.

*Carrum Health is a special surgery benefit for eligible SISC members enrolled in an Anthem Blue Cross or Blue Shield PPO plan. With the exception of second opinions, due to IRS regulations, members on an HSA plan must pay their deductible, but coinsurance is waived. Second opinions are provided at no cost to the member and do not require payment of any deductible. Per IRS rules, a portion of any covered travel expenses will be reported as taxable income.

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Schools Helping Schools

Need a primary care doctor?

Just ask Centivo Care.

As part of your PPO medical benefits from SISC, you and your enrolled adult dependents (18+) have access to free primary care through Centivo Care. We can address health concerns, assist with prescriptions, diagnose and manage chronic conditions and so much more – all from the palm of your hand.

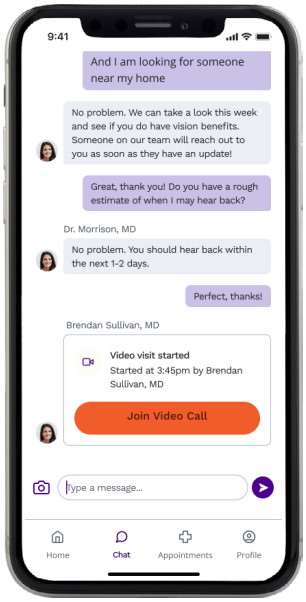
The answer to most of your health questions is now simple: "Just ask Centivo Care."

CARE FROM ANYWHERE

Chat with your doctor live or schedule a video visit

Diagnoses and treatments

Prescription refills



Answers to follow-up care questions

In-network specialist referrals

It's never been easier to stay on top of your health:

96% patient satisfaction	In-app appointment booking	Quick in-app responses from a team of clinicians

CENTIVO Care.

Scan the QR code to register and start accessing great care today

Costco Pharmacy

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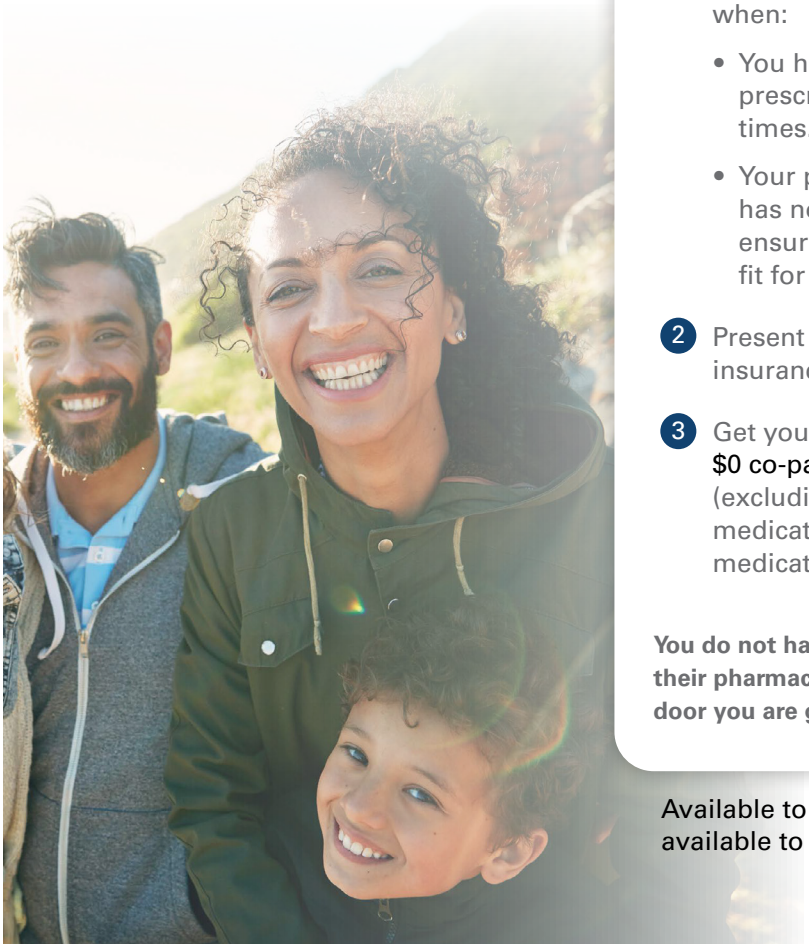
Schools Helping Schools

Get Free Generic Medications at Costco and Through Mail Order

This program is available to SISC members on participating drug plans.

To locate a Costco near you, call Costco at 1 (800) 774-2678 and press 1.



1. Take your prescription for a generic medication to a Costco Pharmacy. This includes 90-day prescriptions and supplies.

   You can also use your 90-day prescription to start Mail Order service.

   You are eligible for Costco Mail Order when:

   - You have filled your 30-day prescription a minimum of three times.
   - Your prescription, including dosage, has not changed in 90 days. This ensures the drug and dosage is a good fit for a longer-day supply.

2. Present the pharmacist with your insurance card.

3. Get your generic medication with a $0 co-payment. (excluding some narcotic pain medications and some cough medications).

You do not have to be a Costco member to use their pharmacy. Just tell the associate at the front door you are going to their pharmacy.

Available to SISC PPO and HMO Members. Not available to Kaiser Members.

Costco Pharmacy (continued)

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Self-Insured Schools of California
Schools Helping Schools

Start saving today!

With your SISC pharmacy coverage, many generic medications have a $0 copay for a 90-day supply, when you fill them at a Costco Pharmacy.[1]

Getting started is easy!

Simply call your local Costco location and let the pharmacy staff know that you would like to transfer your prescription. In most cases, they can contact your current pharmacy and complete the transfer.

New! Have your prescription delivered from your local Costco for free with Instacart. When you get a text from Costco that your prescription is ready, simply choose the delivery option.[2]

Note: You don't need to be a Costco member to take advantage of the Costco Pharmacy savings.

Plus, a 90-day supply of most medications is available exclusively at your local Costco Pharmacy or with Costco's Mail Order Pharmacy. To sign up for mail order, go to costco.com. Click Pharmacy > Mail Order > Get Started and follow the instructions. You can also call **800-607-6861** to speak with a pharmacy agent.

Questions?

If you have other questions about your pharmacy benefits, call Navitus Customer Care toll-free at **866-333-2757**.

[1]Restrictions apply to narcotic pain and cough medications and are not included in the free generics at Costco program. Other restrictions and limitations may apply. Refer to your formulary for the list of drugs covered under your plan. You can access the formulary on the member portal at Navitus.com/members.

[2]To qualify for free Instacart delivery, use the link in the Costco Rx confirmation text. Instacart home delivery distance restrictions may apply.

COSTCO WHOLESALE | NAVITUS
Our business is personal

Employee Assistance Program (EAP)

Anthem | SISC Self-Insured Schools of California

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: ◦ Depression ◦ Stress ◦ Anxiety ◦ Chronic pain ◦ Drug and alcohol use ◦ Emotional health issues	When you need help managing: ◦ Anxiety ◦ Depression ◦ Sleep issues ◦ Panic ◦ Social anxiety ◦ Stress ◦ Drug and alcohol use ◦ Worry	When you need help managing: ◦ Anxiety ◦ Depression ◦ Grief ◦ Relationships ◦ Sleep ◦ Stress ◦ Drug and alcohol use ◦ Trauma	When you need help managing: ◦ Anxiety ◦ Stress ◦ Depression ◦ Grief ◦ Relationships/ family issues ◦ Panic attacks ◦ Coping with illness	When you or someone you know are: ◦ 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.

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**.

Anthem | SISC School Employee Benefit Trust of California Schools Helping Schools

1 Centers for Disease Control and Prevention: *About Mental Health* (April 25, 2023): 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.

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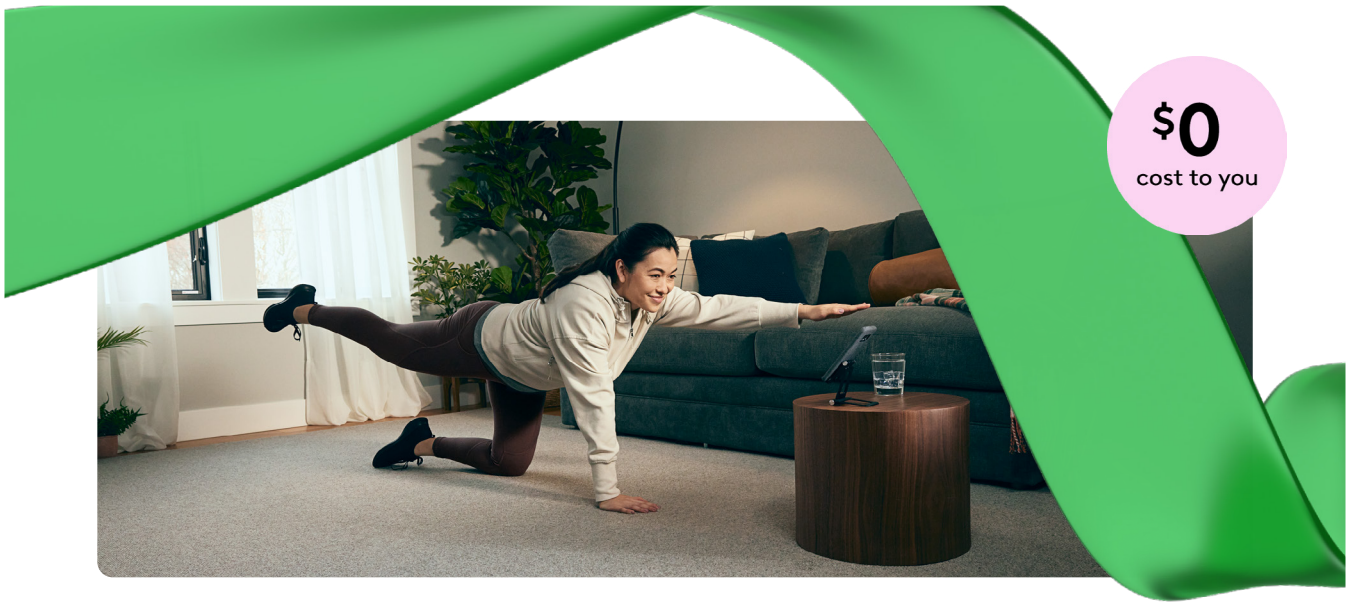
Hinge Health



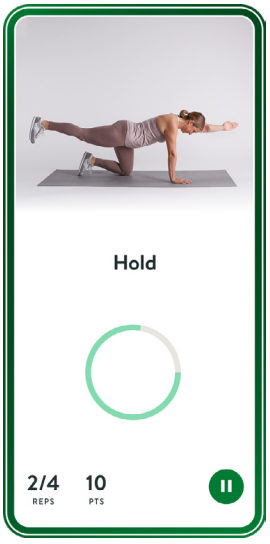
SISC | Hinge Health

Personalized pain care that gets you moving

Relieve joint and muscle pain with personalized exercise therapy **at no cost to you**. On average, participants reduce their pain by 68%.[1]

- **Virtual sessions anytime, anywhere**
- **Unlimited 1-on-1 health coaching**
- **Motion-tracking technology for instant form correction**
- **Pelvic floor care for pregnancy and postpartum, bladder control, and pelvic muscle strengthening**

Your family may be eligible, too!



To learn more and apply, scan the QR code or visit
hinge.health/sisc

Questions? Call (855) 902-2777

Hinge Health está disponible en español
Alivia los dolores articulares y musculares y previene las lesiones con tus beneficios de salud gratuitos. Únete ahora.

Available for free to employees, dependents 18+, and pre-65 retirees enrolled in an Anthem PPO or Blue Shield PPO medical plan with SISC as their primary insurance. Members enrolled in a high-deductible health plan (HDHP)/HSA-compatible plan are not eligible.

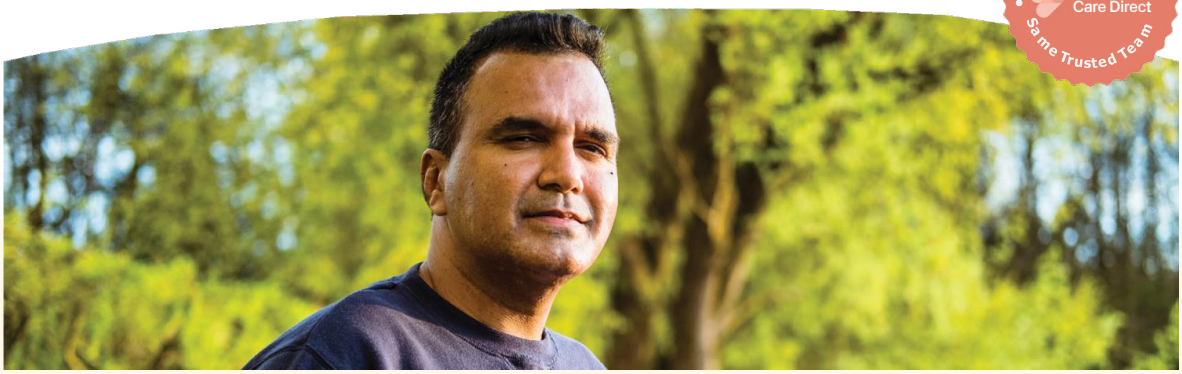
[1]After 12 weeks, in a study of chronic knee and back program participants. Bailey JF, et al. Digital Care for Chronic Musculoskeletal Pain: 10,000 Participant Longitudinal Cohort Study. J Med Internet Res 2020;22(5):e18250.

Lantern Cancer Care

LANTERN

SISC
Self-Insured Schools of California
Schools Helping Schools

Formerly Known As Cancer Care Direct Same Trusted Team



If You Ever Need Cancer Care, We're Here to Light Your Path

Lantern provides personalized guidance and support throughout the cancer journey. Our expert support team will help you or a loved one navigate the path ahead, connecting you with the best providers while coordinating care along the way.

An Experience with You at the Center

We're here to answer your questions and ensure that you understand the path ahead and that you have confidence in your team and treatment plan. We put the patient and their loved ones at the center of care, as we believe that a better more compassionate experience leads to better outcomes.

Call Us to Learn More at (855) 961-4533

Email: guide@lanterncare.com

Visit Lantern Today.
You can chat with nurses, track appointments and symptoms, and more.

The Lantern Difference

1. **Guided Support**
   Your personal Oncology Nurse Navigator-led team will be with you every step of the journey, coordinating appointments, explaining treatment information, and answering questions.
2. **Accessing Excellent Care**
   We connect you with the best in-network community oncology clinics, hospitals, and National Cancer Institutes for high-quality care as close to home as possible.
3. **Expert Review & Advice**
   Our team will assist in coordinating the expert review of your diagnoses and treatment plans, recommending second opinions and referrals as needed.

"Because my Oncology Nurse Navigator was able to get appointments within two weeks instead of waiting months and months, I was quickly enrolled into a treatment plan that has me on a path to recovery."

— Craig, Cancer Survivor and Lantern Member

LANTERN

SISC
Self-Insured Schools of California
Schools Helping Schools

Formerly Known As Cancer Care Direct Same Trusted Team

Frequently Asked Questions

Who can benefit from Lantern?

Lantern can help if you or a member of your family has been diagnosed with cancer. It's included as part of your PPO medical benefits through SISC at no extra cost to you.

I was diagnosed with cancer. What should I do to get started with Lantern?

Reach out to us as soon as you can—our team is only a phone call away and ready to help. Call Lantern at (855) 204-3923. We have Oncology Nurse Navigators and Care Guides available to help Monday through Friday, between 8 a.m. and 5 p.m. CT. You can also email us at guide@lanterncare.com.

I'm already getting cancer treatment. Can Lantern still help?

Yes. We provide guidance and support to our members at any point in their cancer journey, from initial diagnosis to remission. Call our team to see how we can help you.

I've already completed treatment, and I'm in remission. Can you still help me?

Yes. We're here to help you through survivorship. Our team can help you with continued screenings, guidelines, managing treatment late effects and more. We're also here to help you transition back into your daily life after cancer.

What will it cost me to use Lantern?

Lantern doesn't cost you anything. It's included as part of your SISC PPO medical benefits. You won't be billed for using Lantern.

Can Lantern help get treatment approved for me?

Yes. As your advocates, we work with your doctors and insurance to help get approvals for your treatment.

What do the Lantern Oncology Nurse Navigators and Care Guides do?

Our Oncology Nurse Navigators are experts in the field. They provide timely clinical guidance, coordinate care, facilitate expert advisory support and offer social and emotional support when you need it. Our Care Guides work with our nurses to coordinate any travel and appointments, request medical records and get answers to your questions. They help you handle the details, so you can focus on your health.

Will Lantern help cover the cost of my treatment or surgery?

No. Lantern does not cover the cost of surgeries or treatments. That will still be provided through your medical insurance. Lantern may be able to help with travel costs to and from appointments for your cancer diagnosis. Your team can also connect you with resources in your community that can provide financial help.

I like my oncologist. Do I have to switch doctors to use Lantern?

No. You can stay with your current oncologist and still get help from Lantern. But if you need to find an oncologist or want a second opinion, we can assist with finding a doctor and scheduling your appointments.

What happens if my insurance changes?

If your new insurance doesn't include Lantern as a benefit, our team will work with you to find resources and support in your community as you transition onto your new insurance plan. Our goal is to help you have a seamless transition if it's needed.

If your new insurance includes Lantern as a benefit, you can continue working with your team. If your new insurance doesn't provide Lantern, talk to your human resources department about adding it to your coverage.

Call us to learn more at:

(855) 961-4533

Visit Lantern Today.

You can chat with nurses, track appointments and symptoms, and more.

In the event of a medical emergency, call 911 or visit your nearest emergency room.

Maven

Virtual care designed for you and your family

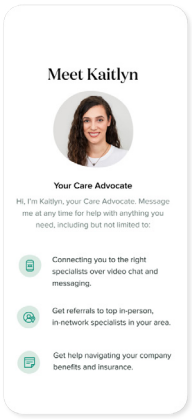
SISC is providing PPO members and their partners with free access to Maven for maternity and postpartum virtual care and support. Use Maven for 24/7 access to doctors, specialists and coaches and trustworthy content tailored to your experience.

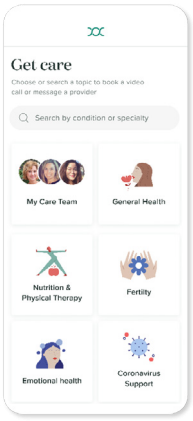
Personalized support for every step of your journey:

- Pregnancy
- Postpartum
- Pediatricians
- Infant sleep coaching
- Lactation support
- Return-to-work coaching
- Miscarriage & loss
- Birth planning
- Mental health
- Partner support

Your membership includes:

- A personal Care Advocate who serves as a trusted guide to help you navigate the Maven platform and connect you with providers throughout your journey
- Unlimited video chat and messaging with doctors, nurses, and coaches across 35+ specialties, including OB-GYNs, midwives, high-risk obstetricians, nutritionists, lactation consultants, and career coaches
- Provider-led virtual classes and vetted articles—tailored to your journey





Free diaper subscription from SISC if you enroll before the end of your second trimester and complete the Maven Maternity program!

Activate your free membership by scanning the QR code, downloading the Maven Clinic app, or visiting **mavenclinic.com/join/SISC**.

Enrollment in Maven is confidential.

MAVEN | SISC Self-Insured Schools of California *Schools Helping Schools*

SISC
Self-Insured Schools of California
Schools Helping Schools

MDLIVE

fast, hassle-free health care. anytime. anywhere.

Your benefits include reliable 24/7 health care by phone or video. Our national network of board-certified doctors provides personalized care for hundreds of medical and mental health needs. No surprise costs. No hassle. Just create an account to enroll.

URGENT CARE

On-demand care for illness and injuries.

- Talk to a board-certified doctor in just minutes when you need care fast, including prescriptions.
- Reliable and affordable alternative to urgent care clinics for more than 80 common, non-emergency conditions like flu, sinus infections, ear pain, and UTIs (Females, 18+).

MENTAL HEALTH

Talk therapy and psychiatry from the privacy of home.[1]

- Licensed therapists and board-certified psychiatrists.
- Schedule your appointment in as little as five days with after-hours and flexible sessions available.

USING MDLIVE IS AS EASY AS 1-2-3:

STEP 1: CREATE YOUR SECURE ACCOUNT.

STEP 2: REQUEST AN APPOINTMENT.

Have an urgent care appointment right away, or schedule a time that works for you.

STEP 3: FEEL BETTER FASTER.

Get a diagnosis, treatment plan, and prescriptions, when appropriate, sent right to your preferred pharmacy.[1]

Your copay is **$0** per appointment.

Get the app

Meet Sophie, your personal assistant
Text SISC to 635483
to create an account.

Create your account today.
mdlive.com/SISC | 800.657.6169

[1]Prescriptions are available at the physician's discretion when medically necessary.

Quest® | SISC Self-Insured Schools of California

Transform your health

Complete your Insure® ONE™ screening today

Colorectal cancer is the second leading cause of cancer deaths.[1] The Insure® ONE™ screening kit detects lower GI bleeding, a risk factor for colorectal cancer.[2]

Colorectal cancer that is caught in the early stages has a 5-year survival rate of over 90%.[3]

The Insure®ONE™ screening kit is a noninvasive test designed to be done in your own home. No doctor's visit required.

Your no-cost test provides you the knowledge you need to take charge of your health.

At-home screening kits are available at no cost to eligible SISC PPO Members.[4]
Visit **My.QuestForHealth.com** for more information or to request a kit.

1. Data is from the American Cancer Society website, www.cancer.org. The full text can be found at https://www.cancer.org/cancer/types/colon-rectal-cancer/about/key-statistics.html.

2. Data is from the Journal of Clinical and Translational Gastroenterology. The full text can be found at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4855159/

3. Data is from the American Cancer Society website, www.cancer.org. The full text can be found at https://www.cancer.org/cancer/types/colon-rectal-cancer/detection-diagnosis-staging/detection.html

4. SISC PPO Members age 45 and over enrolled on an active or <65 retiree plan are eligible for a free test kit.

Quest Diagnostics Incorporated and its subsidiaries (Quest) complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1.844.698.1022. ATENCIÓN: Si habla español (Spanish), tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1.844.698.1022. 注意：如果您使用繁體中文 (Chinese)：您可以免費獲得語言援助服務. 請致電 1.844.698.1022.

Quest® is the brand name used for services offered by Quest Diagnostics Incorporated and its affiliated companies. Quest Diagnostics Incorporated and certain affiliates are CLIA-certified laboratories that provide HIPAA-covered services. Other affiliates operated under the Quest® brand, such as Quest Consumer Inc., do not provide HIPAA-covered services.

Quest® SISC Self-Insured Schools of California *Schools Helping Schools*

Know your health better with in-home screening

The Insure® ONE™ colorectal screening kit is available at no cost to eligible SISC PPO Members age 45 and up.[1]
Adults between the ages of 45 to 75 should get screened regularly for colorectal cancer.[2]

Request

Create an account on My.QuestForHealth.com to request a no-cost Insure® ONE™ colorectal screening kit.

Receive

Your Insure® ONE™ cancer screening kit will arrive via mail within 2 weeks of your request.

Screen

Complete your noninvasive screening in the comfort of your own home using kit instructions.

Return

Return your kit through the included prepaid postage stamp by the program end date for lab processing.

Results

Receive your results report that you can use to discuss with your doctor.

1. SISC PPO Members over age 65 enrolled on an active or <65 group are eligible for the free kit.

2.Data received from the MyHealthFinder website at health.gov. Full text available at https://health.gov/myhealthfinder/doctor-visits/screening-tests/get-screened-colorectal-cancer.

Quest Diagnostics Incorporated and its subsidiaries (Quest) complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1.844.698.1022. ATENCIÓN: Si habla español (Spanish), tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1.844.698.1022注意：如果您使用繁體中文 (Chinese)：您可以免費獲得語言援助服務.

請致電

Quest Population Health (continued)

Quest Diagnostics®

SISC
Self-Insured Schools of California
Schools Helping Schools

Transform your health. Earn a $25 Amazon award and Schedule your screening today!

At a Patient Service Center (PSC)
Quest Diagnostics has 2,250 PSC locations nationwide.

Schedule an appointment at My.QuestForHealth.com*

- Use **Registration Key**: **SISC2025**
- In the **Wellness Screening** section, under **Patient Service Center**, select **Schedule a Screening**
- If you schedule as a walk-in, you may be required to make an appointment upon check-in
- You will receive an email when your results are ready to view online
- Please note: Member awards will be distributed to the email used at registration within 30 days of the completed appointment.

Take charge of your health.

*If you're unable to register online, please call 1.855.623.9355.

Teladoc Medical Expert

Teladoc HEALTH | SISC Self-Insured Schools of California *Schools Helping Schools*

No matter what you face, **we're here to help**

When it comes to your health, it's important you feel confident about the decisions you make.

Your benefits include access to Expert Medical Opinion **provided at no cost** to you and your eligible dependents.

Our leading medical experts:

- Answer medical questions and provide advice about any medical issue or concern
- Review conditions like heart disease, joint pain, cancer and more
- Recommend alternative treatments or modified diagnoses

When can I use Expert Medical Opinion?

- I see little improvement in my current treatment plan
- I have medical questions and need answers
- I'm looking for a local specialist
- My tests came back, now what?
- I'm considering a surgery

All services are provided at **no cost** to you and your eligible dependents

We're here to help. Contact us today.

Visit teladoc.com/SISC.

Call 855-380-7828 | Download the app

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Group ID: 353504

Vida Health

Vida Health – your free health benefit through SISC – will match you with a health coach or therapist who will help you manage diabetes, lose weight, feel less stressed, and make lifestyle changes that lead to a happier, healthier life.

Vida will help you get healthier. That's why SISC will cover the cost for you.

With Vida, you'll get a virtual coach or therapist to help you with things like:

- Losing weight
- Managing and preventing diabetes
- Lowering blood pressure or cholesterol
- Getting more exercise
- Reducing stress
- Feeling better and healthier overall

Explore your new benefit now

Visit vida.com/SISC to learn more about Vida. For help signing up, email support@vida.com.

Meet Karen

Because of Vida, I've lowered my blood sugar and my cholesterol. More importantly, I feel better. I have less pain, more energy, and a better relationship with food. I found exercise that I love and made changes that I know will last. Vida has changed my life for the better, perhaps even saved my life.

Anthem and Blue Shield PPO and HMO members over the age of 18 (Excluding 65+ Plans) are eligible for Vida Health. HSA members are not eligible for this program.

SISC Mental Health Support

SISC
Self-Insured Schools of California
Schools Helping Schools

Need Someone to talk to?

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

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

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

All Employees and Household Members

SISC Employee Assistance Program

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

Anthem and Blue Shield PPO and HMO Members

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

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

Anthem PPO and HMO Members

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

Blue Shield PPO and HMO Members

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

Kaiser Permanente Members

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

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

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

Dental

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

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

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

Plan Benefits	Delta Dental PPO	
	In-Network	Out-of-Network[1]
	Member Responsibility	
Annual Deductible	$0	$0
Annual Maximum Benefit	Plan Pays up to $2,500	Plan Pays up to $2,400
Diagnostic and Preventive Services **NOW Includes D&P Max Waiver**		
• Exams, *(3)* cleanings, x-rays and sealants. *(Doesn't apply towards Annual Max Benefit)*	Plan pays 100%	Plan pays 100%
Basic Services		
• Anesthesia	Plan pays 70% – 100%	
• Simple and Surgical Extractions	Plan pays 70% – 100%	
• Endodontics *(root canals)*	Plan pays 70% – 100%	
• Periodontics *(gum treatment)*	Plan pays 70% – 100%	
Major Services		
• Crowns, Inlays, Onlays, Veneers	Plan pays 70% – 100%	
• Prosthodontics *(Dentures, Bridges)*	Plan pays 70% – 100%	
• Implant Rider Benefit	$3,500 Per Calendar Year	
Orthodontics		
• Child *(to age 19)*	Plan pays 75%	
• Adult	Plan pays 75%	
• Lifetime Maximum	$3,000	

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

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.

DELTA DENTAL

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

DELTA DENTAL

SmileWay® Your smile. Your health. Your way.

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 Benefits[1]

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

DELTA DENTAL®

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

Dental (continued)

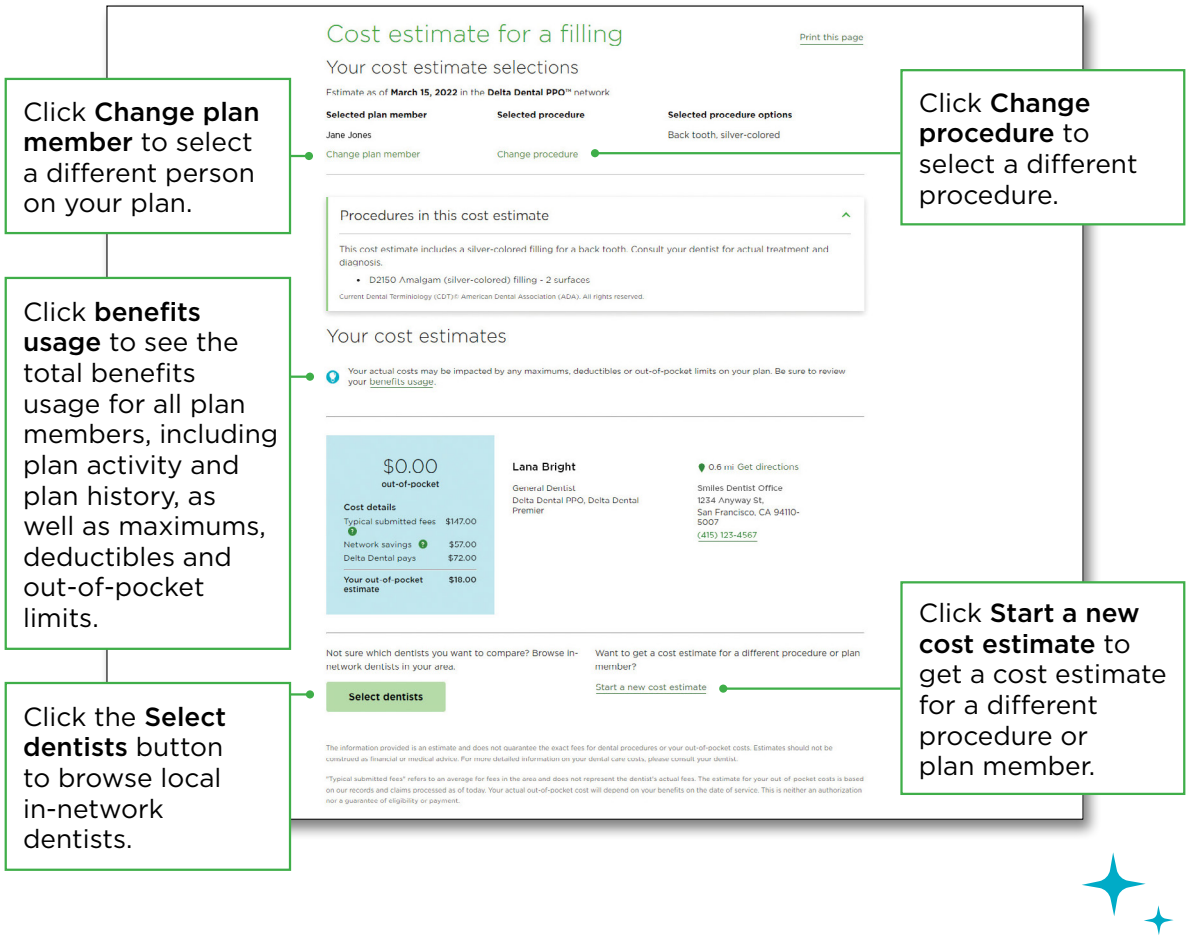
Try it out

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**.



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**.

DELTA DENTAL

Resources at your fingertips

Go online to manage your plan

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

Create an account

What you can do:

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

Dental (continued)

Understand your plan

What you can do:

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

Try it out: Visit **deltadentalins.com/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.

DELTA DENTAL

SmileWay® Your smile. Your health. Your way.

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 Benefits[1]

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

EF89A #133959A (rev. 11/22)

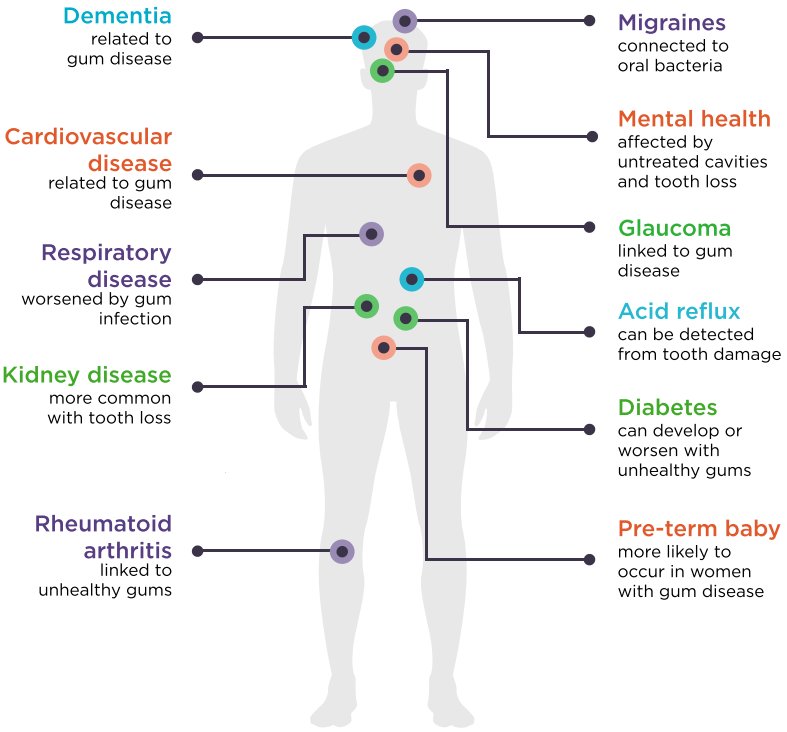
DELTA DENTAL®

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.

QualSight LASIK

Set your sights on even more value

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

Continued on back

QualSight LASIK (continued)

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

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

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

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

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

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

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

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

[4] QualSight provider file, February 2019

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

EF74 #120020B (rev. 3/19)

Amplifon Hearing Health Care

DELTA DENTAL® | amplifon Hearing Health Care

An offer to keep you smiling — from ear to ear

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

Continued on back

Amplifon Hearing Health Care (continued)

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

The new program gives you:

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

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

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

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

Ready to get started? It's simple.

1

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

2

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

3

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

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

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

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

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

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

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

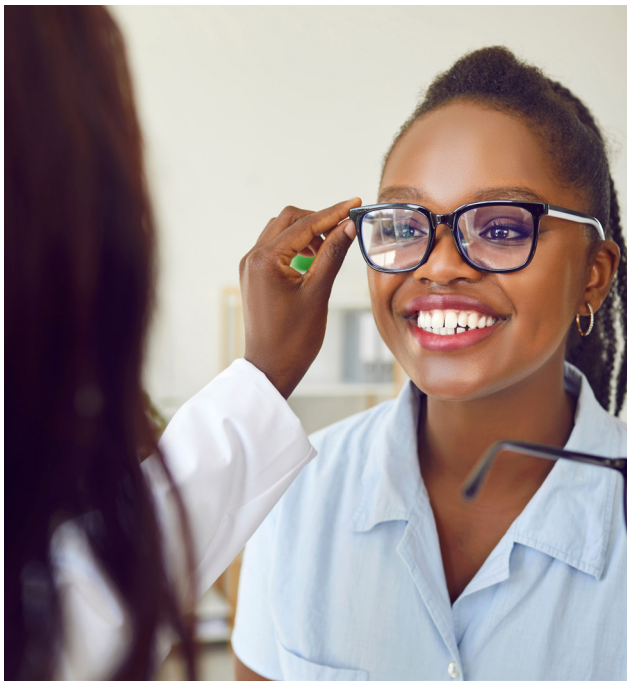
[6] Amplifon Hearing Health Care provider file, February 2019

Vision

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

You'll like what you see with VSP.

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



Plan Benefits	VSP	
	In-Network	Out-of-Network
Frequency		
• Eye Exam	Once every 12 months	
• Lenses / Contacts	Once every 12 months	
• Frames	Once every 12 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

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.

Savings never looked so good.

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

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

VSP PREMIER PROGRAM

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

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

LENSES AND FRAMES

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

CONTACTS

BAUSCH+LOMB See better. Live better. · CooperVision

LASIK

The LASIK Vision INSTITUTE · TLC Laser Eye Centers

HEARING AIDS AND FINANCING

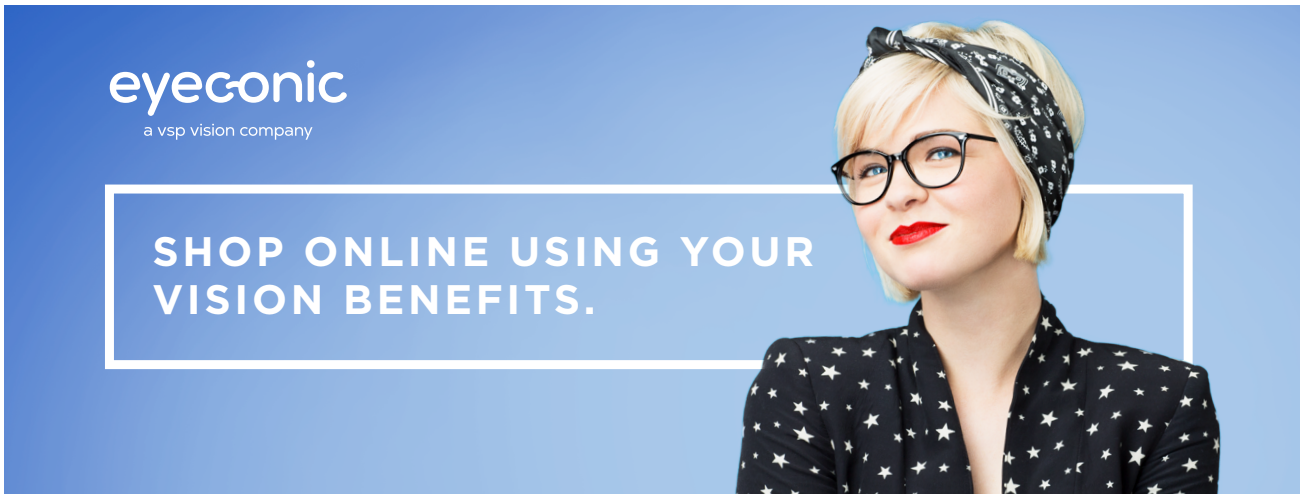
TruHearing · CareCredit

HEALTH AND ENTERTAINMENT

VSP SIMPLE VALUES

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

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



HAPPY EYES, HAPPY LIVES.

THAT'S OUR MOTTO.

From delivering your eyewear or contacts to your door to helping you find the perfect eye doctor, we're with you all the way. And the best part? You'll **save up to $220** when you connect your vision benefits.

You heard it here first: shopping online for contacts, glasses, and sunglasses just got more awesome.

SHOPPING WITH BENEFITS? HECK YES!

With vision benefits, you'll get VIP status at Eyeconic®. When you connect your benefits to buy contacts, glasses, or sunglasses, you'll immediately see your savings. No out-of-network claims necessary.

MORE REASONS TO LOVE EYECONIC:

- Free shipping and returns
- A free frame adjustment or contact consultation—on us
- Save up to $120 on contacts with an annual supply discount
- See yourself in any pair with our Virtual Try-On tool
- Choose from 50+ popular brands

Get an additional 20% off your glasses or sunglasses purchase, just for being a VSP® member.

eyeconic
a vsp vision company

EYEWEAR + EYE CARE.

Since we care about your eyes, we want to make sure you have the best eye care around. Use our handy Find a Doctor tool to search for a friendly eye doctor who can provide:

- A comprehensive eye exam;
- An updated Rx; and
- A frame adjustment or contact lens consultation—on us.

Our Find a Doctor tool can easily connect you with one of 41,000 doctors in our network.

TAKE YOUR PICK.

We're all about helping you find the perfect-for-you contacts, glasses, or sunglasses. If you're living the frame life, choose from brands like CALVIN KLEIN, Cole Haan, Dragon®, Flexon®, Nike, and more. Prefer to go frameless? We've got you covered with popular contact lens brands like ACUVUE, Biofinity, DAILIES, and more.

START SAVING NOW.
CHECK OUT EYECONIC.COM® TODAY.

GET STARTED IN JUST 3 EASY STEPS!

1. Find your product.
More than 50 brands you know and love. All at the best possible price when you apply your benefits.

2. Customize your order.
Choose your lenses, upload your prescription, and see your savings in real time.

3. We do the rest.
Eyeconic is the only site where you can buy eyewear with your VSP insurance—in-network.

Vision (continued)

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

VSP SIMPLE VALUES

Health and Wellness:

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

Family Fun:

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

Everyday Savings:

- Retail Rewards – **cash back**

FIND THE SAVINGS AVAILABLE TO YOU.

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

EXCLUSIVE MEMBER EXTRAS

Hearing

Save Up to 60% on Brand-name Hearing Aids

TruHearing™

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

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

In addition to great pricing, TruHearing provides you with:

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

Plus, with TruHearing you'll get:

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

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

Here's how it works:

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

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

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

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

Hearing (continued)

Basic Life & AD&D – The Hartford

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

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

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Basic Life & AD&D – The Hartford (continued)

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

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.

BENEFITS IN ACTION

IS THIS COVERAGE FOR ME? >

Watch a short video to help you decide.
TheHartford.com/bia/lifeandloss

Visit **TheHartford.com/employeebenefits** for more information.

THE HARTFORD
INSURANCE

Voluntary Life – The Hartford

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

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

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Voluntary AD&D – The Hartford

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

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

Short Term Disability – The Hartford

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

Note: Pre-existing condition limitations may apply.

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

Short Term Disability – The Hartford (continued)

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.

Watch a short video to help you decide.
TheHartford.com/bia/short-term-disability

Visit **TheHartford.com/employeebenefits** for more information.

THE HARTFORD
INSURANCE

Long Term Disability – The Hartford

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

Note: Pre-existing condition limitations may apply.

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

Long Term Disability – The Hartford (continued)

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.

Watch a short video to help you decide.
TheHartford.com/bia/long-term-disability

Visit **TheHartford.com/employeebenefits** for more information.

THE HARTFORD
INSURANCE

The Hartford Services

HealthChampion™

Health Care Support Service

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

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

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

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

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

Timely Answers From Trusted Professionals

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

Best of all, you can access the GuidanceConsultants 24 hours a day, seven days a week via a toll-free line: 1-800-96-HELPS (1-800-964-3577) so you'll have assistance when you need it.[3]

Administrative Support

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

Clinical Support

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

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

Better Care Without The Legwork And Guesswork

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

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

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

The Hartford Services (continued)

EstateGuidance® Will Services

Create a Simple Will From the Convenience of Your Desktop

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

An Easy and Empowering Solution.

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

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

Quick Answers to Key Questions.

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

"Isn't will preparation complicated?"

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

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

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

"What about my privacy?"

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

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

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

Good Intentions Aren't Enough

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

Visit www.estateguidance.com/wills today.

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

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

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

Services may not be available in all states.

The Hartford Services (continued)

Travel Assistance and ID Theft Protection Services

Even the Best Planned Trips Can be Full of Surprises

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

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

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

Good To Go: Multilingual Assistance 24/7

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

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

Services From Here to There

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

Identity Theft Assistance, Too

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

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

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

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The Hartford Services (continued)

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

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

Have a serious medical emergency? Please obtain emergency medical services first (contact the local "**911**"), and then contact Europ Assistance USA to alert them to your situation. Call: 1-800-243-6108 Collect from other locations: **202-828-5885** Fax: **202-331-1528**

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

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

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Colonial Life Benefit Enrollment

Colonial Life
The benefits of good hard work.

Marin Community College District

BENEFIT ENROLLMENT GUIDE

- **Schedule your Appointment:** Click or scan the QR Code using the camera app on a smartphone to schedule your Benefits Counseling session.
- **Prepare for your Appointment** Be sure to bring social security numbers and dates of birth for any dependents that will be covered.
- **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.
- **Breathe easier** The goal of this appointment is to ensure you feel knowledgeable and comfortable about the benefits you select.

SCAN ME!

A Benefit Specialist will discuss the following plan options offered :

Accident Insurance
Accident helps cover emergency room fees, deductibles and co-payments that can result from a covered accidental injury.

Disability Insurance
Disability replaces a portion of your income if you become disabled from a covered accident or covered sickness.

Life insurance
Life Insurance enables you to tailor coverage and helps provide financial security for your family members.

Cancer insurance
Cancer helps offset the out-of-pocket medical and indirect, non-medical expenses related to cancer that most plans do not cover.

Hospital Confinement Insurance
Hospital indemnity insurance provides a lump-sum benefit for a covered hospital confinement.

Critical Illness Insurance
Critical Illness provides a lump-sum benefit that you can use to pay for costs related to a covered critical illness.

www.ColonialLife.com / individuals

Flexible Benefits Plans by STERLING

STERLING ADMINISTRATION

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 2025 is $3,300. 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 $660. 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 2025 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.

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**

www.SterlingAdministration.com | 800-617-4729
1000 Broadway, #250 | Oakland, CA 94607

STERLING ADMINISTRATION

HEALTH SAVINGS ACCOUNTS: HOW THEY WORK

WHAT IS AN HSA?

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

WHAT ARE THE REQUIREMENTS FOR HAVING AN HSA?

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

HOW MUCH CAN BE CONTRIBUTED TO AN HSA?

For 2025, the IRS maximums are $4,300 for an individual and $8,550 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 2025. A separate HSA account is required for a spouse over age 55 to make a catch-up contribution.

HOW DO I FUND THE HSA?

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

HOW CAN HSA FUNDS BE USED?

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

Flexible Benefits Plans by STERLING (continued)

WHAT HAPPENS WHEN I TURN 65?

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

AS AN OWNER, CAN I CONTRIBUTE TO AN HSA?

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

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

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

HOW DO I PAY FOR THINGS?

As a Sterling accountholder, you will have a Sterling debit card (smart card) that you can use to purchase items that are qualified expenses. For example, after seeing an in-network doctor you will wait to receive an Explanation of Benefits (EOB) from your insurance carrier. Once you receive a bill from your doctor that matches your insurance carrier EOB, place your debit card numbers in the card options spot on the bill when you receive it. At the pharmacy, for dental, vision and out-of network doctors, you will also have the option of using your debit card at the time of service. If the doctor or provider does not take debit cards, then you can pay out of pocket and request a check by calling Sterling at 800-617-4729. 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.

1000 Broadway #250, Oakland, CA 94607
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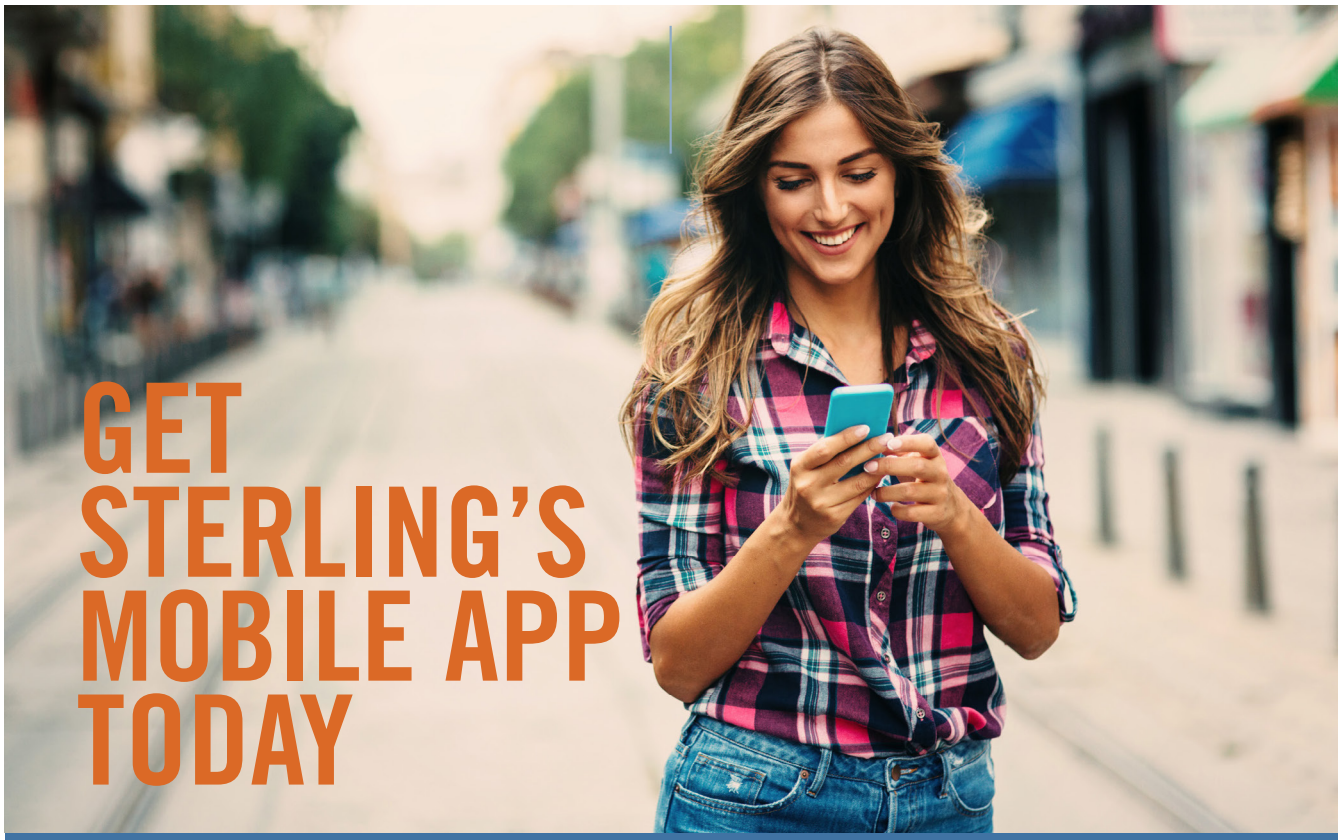
2

Flexible Benefits Plans by STERLING (continued)



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

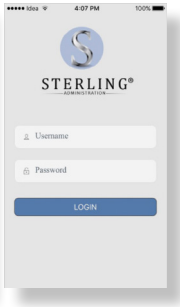
WHAT CAN YOU DO ON THE APP?

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

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

Look for the Sterling "S"

Mobile App Login Screen



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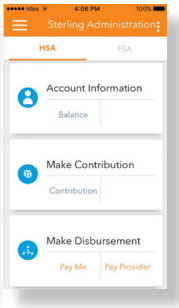

DOWNLOAD IT TODAY!

STERLING ADMINISTRATION

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www.sterlingadministration.com

LIMITED PURPOSE FLEXIBLE SPENDING ACCOUNT

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			
	2026	2025	Change
HSA contribution limit (employer + employee)	Self-only: $4,400 Family: $8,750	Self-only: $4,300 Family: $8,550	Self-only: +$100 Family: +$200
HSA catch-up contributions (age 55 or older)	$1000	$1000	No change
HDHP minimum deductibles	Self-only: $1,700 Family: $3,400	Self-only: $1,650 Family: $3,300	Self-only: +$50 Family: +$100
HDHP maximum out-of-pocket amounts (deductibles, co-payments and other amounts, but not premiums)	Self-only: $8,500 Family: $17,000	Self-only: $8,300 Family: $16,600	Self-only: +$200 Family: +$400
Source: IRS, Revenue Procedure 2025-26.			

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STERLING ADMINISTRATION

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 employers 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!

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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

STERLING ADMINISTRATION

1000 Broadway #250
Oakland CA 94607

1.800.617.4729
1.888.410.7361
www.sterlingadministration.com

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?

FSA store® HSA store®

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 2025

- **2025 annual elective deferral limits for 403(b) and 457(b):** $23,500
- **Age 50+ catch-up:** $7,500
- **Special catch-up provisions':** Please consult with a financial services professional

For Questions

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

Enrollment in the plan is optional.

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
  - 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

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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TOLL-FREE ENROLLMENT **1.855.653.3626** (1.855.6KEENAN) OR **KEENANDIRECT.COM**

KeenanDirect

Important Notices

No Surprises Act Notice

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

Discrimination is Against the Law

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

Newborns' and Mothers' Health Protection Act (NMHPA)

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

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

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

Networks/Claims/Appeals

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

Notice of Extended Coverage to Children Covered as Students

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

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

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

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

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

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

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

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

COBRA Continuation Coverage

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

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

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

WHAT IS COBRA CONTINUATION COVERAGE?

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

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

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

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

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

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

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

WHEN IS COBRA CONTINUATION COVERAGE AVAILABLE?

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

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

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

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

NOTICE AND ELECTION PROCEDURES

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

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

ELECTION AND ELECTION PERIOD

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

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

HOW IS COBRA CONTINUATION COVERAGE PROVIDED?

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

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

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

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

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

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

OTHER OPTIONS BESIDES COBRA CONTINUATION COVERAGE

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

ENROLLMENT IN MEDICARE INSTEAD OF COBRA

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

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

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

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

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

IF YOU HAVE QUESTIONS

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

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

KEEP YOUR PLAN INFORMED OF ADDRESS CHANGES

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

EFFECTIVE DATE OF COVERAGE

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

COST OF CONTINUATION COVERAGE

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

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

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

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

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

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

Uniformed Services Employment and Reemployment Rights Act (USERRA)

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

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

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

Special Enrollment Rights Notice

CHANGES TO YOUR HEALTH PLAN ELECTIONS

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

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

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

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

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

For information about Special Enrollment Rights, please contact:

Angela Lingo, HR Operations Manager, Academic Personnel
Shawna Callahan, HR Operations Manager, Classified Personnel
Marin Community College District
1800 Ignacio Blvd., Navato, CA 94949
Phone: 415.884.3159

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

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

Angela Lingo, HR Operations Manager, Academic Personnel
Shawna Callahan, HR Operations Manager, Classified Personnel
Marin Community College District
1800 Ignacio Blvd., Navato, CA 94949
Phone: 415.884.3159

Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: GENERAL INFORMATION

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

WHAT IS THE HEALTH INSURANCE MARKETPLACE?

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

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

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

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

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

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

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

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

STATES WITH INDIVIDUAL MANDATE

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

PART B: INFORMATION ABOUT HEALTH COVERAGE OFFERED BY YOUR EMPLOYER

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

3. Employer name 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? **Angela Lingo, HR Operations Manager, Academic Personnel,** **Shawna Callahan, HR Operations Manager, Classified Personnel**		
11. Phone number (if different from above)	**12. Email address** alingo@marin.edu sjcallahan@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.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Important Notices (continued)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Important Notices (continued)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Important Notice from Blue Shield and Kaiser Permanente About Your Prescription Drug Coverage and Medicare

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

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

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

WHEN CAN YOU JOIN A MEDICARE DRUG PLAN?

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

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

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

If you decide to join a Medicare drug plan, your current **Marin Community College District** coverage will not be affected. If you keep this coverage and elect Medicare, the **Marin Community College District** coverage will coordinate with Part D coverage.

If you do decide to join a Medicare drug plan and drop your current **Blue Shield and Kaiser Permanente** 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 **Blue Shield and Kaiser Permanente** and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

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

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

Contact the person listed below for further information.

NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through **Blue Shield and Kaiser Permanente** changes. You also may request a copy of this notice at any time.

Date: 2025

Name of Entity / Sender: **Marin Community College District**

Contact:
Angela Lingo, HR Operations Manager, Academic Personnel
Shawna Callahan, HR Operations Manager, Classified Personnel
Address: 1800 Ignacio Blvd., Navato, CA 94949
Phone: 415.884.3159

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

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

For more information about Medicare prescription drug coverage:

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

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

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

Contact Information

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

Plan	Plan Number	Phone Number	Web Site
Medical			
• Kaiser	60115	800-464-4000	www.kp.org
• Blue Shield	• SC13580 *(100% Plan A)* • SC13590 *(80% Plan K)* • SCB0380 *(2-Tier Anchor Bronze)*	855-256-9404	www.blueshieldca.com
Dental			
• Delta Dental	• 5438 0006 *(CSEA & Unrepresented)*	866-499-3001	www.deltadentalins.com
Vision			
• Vision Service Provider (VSP)	2606622A	800-877-7195	www.vsp.com
Employee Assistance Program (EAP)			
• Anthem EAP	SISC	800-999-7222	www.anthemeap.com
Basic Life / AD&D, Optional Life, Long Term Disability (LTD)			
• The Hartford	0GL875740 Employee Benefits	800-523-2233	www.thehartford.com
Beneficiary Assistance			
• Estate Guidance / Will Services	WILLHLF	800-411-7239	www.estateguidance.com
• Funeral Planning	HFEVLC	866-854-5429	www.everestfuneral.com
Advance Medical	SISC		
Identity Theft			
Personal Choices			

Glossary

Affordable Care Act and Patient Protection (ACA)

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

Allowed Amount

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

Balance Billing

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

Brand Name Drug

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

COBRA (Consolidated Omnibus Budget Reconciliation Act)

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

Children's Health Insurance Program (CHIP)

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

Claim

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

Coinsurance

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

Copayment (Copay)

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

Comprehensive Coverage

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

Deductible

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

Formulary

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

Generic Drug

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

High-Deductible Health Plan (HDHP)

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

Glossary (continued)

Health Savings Account (HSA)

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

Health Reimbursement Arrangements (HRAs)

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

In-Network

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

Non-Preferred Provider

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

Out-of-Pocket Maximum

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

Out-Of-Network

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

Out-Of-Pocket Limit

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

Plan Year

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

Preferred Provider

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

Premium

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

Preventive Care

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

Qualifying Life Event

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

Skilled Nursing Care

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

Urgent Care

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