Classified, Confidential & Management
Employee Benefits Overview

2022-2023

SANTA CLARITA COMMUNITY COLLEGE DISTRICT
COLLEGE OF THE CANYONS

WE'VE GOT YOU COVERED.

At Santa Clarita Community College District, we believe that you, our employees, are our most important asset. Helping you and your families achieve and maintain good health is the reason Santa Clarita Community College District offers you this benefits program. We are providing you with this overview to help you understand the benefits that are available to you and how to best use them. Please review it carefully and make sure to ask about any important issues that are not addressed here. A list of plan contacts is provided at the back of this summary.

While we've made every effort to make sure that this guide is comprehensive, it cannot provide a complete description of all benefit provisions. For more detailed information, please refer to your plan benefit booklets or summary plan descriptions (SPDs). The plan benefit booklets determine how all benefits are paid.

The benefits in this summary are effective:

October 1, 2022 - September 30, 2023

TABLE OF CONTENTS

Medicare Part D Notice: If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a federal law gives you more choices about your prescription drug coverage. Please see the Annual Notices at the back of this booklet for more details.

Who Can You Cover?

WHO IS ELIGIBLE?

In general, permanent and probationary employees working at least 20 hours or more hours per week are eligible to ***ONLY*** enroll themselves in benefits outlined in this overview.

Permanent and probationary employees working at least 30 hours or more per week are eligible to enroll themselves ***AND*** their eligible dependents in benefits outlined in this overview.

Eligible dependents include:

- Your spouse (the person who you are legally married to under state law, including a same-sex spouse).
- Your registered domestic partner (Registered domestic partners are defined as same or opposite sex partners who are both at least 18 years of age).
- Your children (including your Domestic Partner's children):
    - Under the age of 26 are eligible to enroll in benefits. 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.

REQUIRED DEPENDENT DOCUMENTATION

Certain documentation will be required to enroll a dependent in health benefit plans. The required documents vary on the type of dependents being enrolled. Please contact Human Resources to confirm what documentation needs to be provided.

WHEN CAN I ENROLL?

Coverage for new employees begins on the 1st of month following date of hire.

Open enrollment for current employees is generally held in August. Open enrollment is the one time each year that employees can make changes to their benefit elections without a qualifying life event.

WHAT IF I HAVE A QUALIFYING EVENT?

Make sure to notify Human Resources right away if you do have a qualifying life event and need to make a change (add or drop) to your coverage election. Life events include (but are not limited to):

- Birth or adoption of a baby or child
- Loss of other healthcare coverage
- Eligibility for new healthcare coverage
- Marriage
- Divorce

You have 30 days to make your change.

Click to Play

Getting Care When You Need It Now

WHEN TO USE THE ER

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

WHEN TO USE URGENT CARE

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

WHEN YOU NEED CARE NOW

What do you do when you need care right away, but it's not an emergency?

- ANTHEM MEMBERS: Call the Anthem 24/7 nurse line at (800) 700-9184
- KAISER MEMBERS: Call the nurse line number on the back of your ID card.

PREVENTIVE OR DIAGNOSTIC?

Preventive care is intended to prevent or detect illness before you notice any symptoms. Diagnostic care treats or diagnoses a problem after you have had symptoms. Many preventive services are covered at no out-of-pocket cost to you. The same test or service can be preventive, diagnostic, or routine care for a chronic health condition. Depending on why it's done, your share of the cost may change.

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

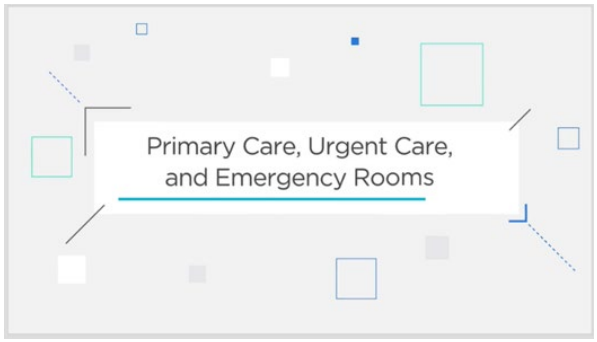
Important: Be sure to communicate with your doctor and ask why a test or service is ordered. When scheduling a preventative care visit, make sure to confirm with the provider that you are there for preventative care only. Request to be notified if any additional services will be added to your claim.

WHAT TO ASK IF YOU'RE DIAGNOSED WITH A HEALTH PROBLEM

If your doctor finds you have a health problem, you want to understand, in simple language, what the problem is. Because health issues can come up at any time, prepare yourself by bringing the following list of questions:

- What's the name of the condition? How do you spell it?
- What does it mean?
- Why do you think I have this problem?
- What may have caused it?
- How long will it last?
- How will this problem affect me? Will I need to change my activities?
- Are there long-term effects?
- Can it be cured? How can it be treated, managed or made better?
- How can I learn more about it?

Click to Play



SISC Value Added Services

EMPLOYEE ASSISTANCE PROGRAM

Available to all Anthem and Kaiser Members.

NEW! Learn to Live (4/1/2022)

Online Programs based on proven principals of Cognitive Behavioral Therapy (CBT). Learn effective ways to manage stress, depression, anxiety, substance use, and sleep issues.

The Employee Assistance Program (EAP) is designed to help you with everyday concerns and questions, both big and small, which impact you or anyone residing in your household. These 'normal problems in living" include things like stress, anxiety, depression, chemical dependency, relationship issues, legal issues, parenting questions, financial counseling, and dependent care resources.

If you need counseling, you get **up to 6 visits** with a licensed professional, and best of all, it's free!
The program is available to your family and household members.

CONDITION MANAGEMENT

Available to Anthem PPO members.

Condition management is a **confidential, voluntary**

Help is available 24/7, 365 days a year by telephone at **(800) 999-7222**.

Other resources are available online at www.anthemEAP.com

Program name: **SISC**

program designed to help people with specific conditions stay as healthy as possible for as long as possible. Health management nurses work over the telephone with **PPO plan participants** who are living with one of the following conditions:

- **Diabetes**
- **Coronary artery disease (CAD)**

Please visit the Health Smarts web page at www.sischealth.com for additional information.

EXPERT SECOND OPINIONS

Available to all Anthem and Kaiser Members.

SISC's Expert Medical Opinions is provided by Teladoc Medical Experts and provides second opinions from nationally recognized experts specializing in different areas of need with no required travel.

This program is sponsored by SISC and **available at no cost to eligible employees and covered dependents!**

This is a second opinion delivered online from a world-leading expert in the specific area of need. You and your covered dependents should use this service when:

- You have a documented diagnosis from a doctor, and would like an expert's second opinion regarding the diagnosis
- You find yourself confronting a complex medical condition
- You would like your medications or treatment plan reviewed

Getting started with Expert Second Opinion program is completely confidential and only takes a few minutes.

To begin using this benefit, members must register online at www.teladoc.com/sisc/ or call Teladoc at: (855) 380-7828.

CARRUM HEALTH

Available to Anthem PPO members.

Need surgery? Get the care you deserve with this new benefit.

- Personalized "Concierge" support for PPO plan members
- Access to top-quality surgeons at Scripps
- No medical bills! Co-insurance and deductibles are waived.
- Travel expenses are covered

Eligible procedures include knee replacements, hip replacement, and spinal fusion.
Visit Carrum's website at carrumhealth.com/sisc or call 1-888-855-7806

COSTCO GENERIC PRESCRIPTIONS

Available to Anthem PPO and HMO members.

$0 copay for generic prescriptions. Costco membership is NOT required.
30 or 90-day supplies of most generics. Some narcotic pain and cough medications are not included in the Costco Free Generic or 90-day supply programs.

NEW! Maven Maternity Care Benefit

Available to Anthem PPO members (4/1/2022)

One-on-one maternity and postpartum support.
Free 6-month diaper subscription available

SISC PPO Plans – Value Based Care Benefit Change

SISC continually evaluates ways to limit unnecessary spending in an effort to keep benefits affordable without impacting access to high quality and safe care. SISC PPO plans will limit the maximum benefit amount at an in-network outpatient hospital facility for the following **five** procedures:

	Arthroscopy	Cataract Surgery	Colonoscopy	Upper GI Endoscopy with Biopsy	Upper GI Endoscopy without Biopsy
Maximum benefit at an in-network outpatient hospital facility	$4,500	$2,000	$1,500	$1,250	$1,000
There is no limit at an in-network Ambulatory Service Center (ASC)	There is no benefit change at an ASC. The limits at an outpatient hospital facility do not apply at an ASC.				

NOTE: The value-based site of care benefit applies to facility fees only. The fees paid to physicians and any other practitioners who assist in the procedure, such as anesthesiologists or radiologists, are not affected by this change.

HOW THE VALUE-BASED SITE OF CARE BENEFIT WORKS

If you use an in-network outpatient hospital facility, you will be responsible for the regular deductible and coinsurance **PLUS** any amount by which the hospital charge exceeds the maximum benefit. This provision can be waived if your doctor receives advanced certification from Anthem that you need to be in an outpatient hospital setting. The benefit includes a simple process to exempt the member if the physician provides clinical justification for using a hospital.

It also allows exceptions when:

- A member lives more than 30 miles from an ASC and a hospital that offers the service for less than the maximum benefit; or
- If a procedure cannot be scheduled in a medically appropriate timely manner due to available ASCs not having capacity.

If you use an in-network ASC, then there is no benefit change! You will only be responsible for the regular deductible and coinsurance. ASCs deliver the same quality of care as in an outpatient hospital setting at a lower price point due to a more efficient operating structure. It's time to address the disparity in costs between hospitals and ASCs. Limiting spending at higher cost facilities is one of the things we can all do to make a difference.

IMPORTANT

Most physicians have privileges at both hospitals and ASCs. If you need one of the outpatient procedures on the list shown above, it will be up to you to either request treatment at the in-network ASC or have your doctor obtain an advance certification from Anthem. If you have questions call member services.

Anthem Programs and Services

NURSE HELP 24/7

Having a medical concern and not sure what to do? Just call Anthem's NurseHelp 24/7 at **(800) 700-9184** for immediate health advice. Registered nurses are available 24 hours a day at no cost to you and can answer questions regarding:

- Symptoms you are experiencing
- Minor Illnesses and injuries
- Chronic conditions
- Medical tests and medications
- Preventive Care

MOBILE APP

Helpful programs, services and resources are available to you over the phone and online to help you and your family stay healthy.

Using our mobile app can help make it easier than ever to manage your health care:

1. Go to the app store on your smartphone or mobile device.
2. Search for "Anthem Blue Cross."
3. Select the Anthem Blue Cross Anywhere app. Start the free download.

To use the mobile app, you must be registered on our secure member site and have a username and password. If you haven't registered yet, go to www.anthem.com/ca from your computer and select **Register Now**.

Use the mobile app to see your ID card any time. Log in and select **View Card**. This card will look the same as the card you get in the mail.

ANTHEM DISCOUNT PROGRAMS

Anthem offers a variety of member discounts on popular programs that can help you save money and get healthier. To find the discounts that are available to you, log in to www.anthem.com/ca and select **Discounts.**

DIABETES PREVENTION PROGRAM

SISC and Anthem are pleased to announce a new diabetes management program for qualified members called Lark.

Members who qualify receive a free fitness tracker and digital scale. You will have a personalized health coach that will provide compassionate support that will help you lose weight, adopt healthy habits and significantly reduce your risk of developing diabetes. And it's available at no cost to members that qualify.

CONTIGO HEALTH

Members facing a cancer diagnosis have the opportunity to have an in-person or virtual comprehensive consultation at City of Hope at no cost. Members also receive access to a personal nurse to coordinate care, clinical trial and genetic risk education, and transition of care and collaboration with home oncologist for one-year post-evaluation.

Anthem Programs and Services, continued

MD LIVE

With our 24/7 Physician Line, SISC Anthem members can visit with a doctor 24/7, 365 days a year from the comfort of their own home, office or while on the go. This confidential and secure service is offered to SISC Anthem PPO and HMO members and provides them with a large network of Board Certified doctors available by phone or secure video to assist members with non-emergency medical conditions. (The 24/7 MDLIVE Line is **NOT** available to Kaiser Members.)

24/7 access to Doctors on your computer or mobile device. Behavioral health therapy and psychiatrist visits now available!

HOW DOES IT WORK?

Register → Request Consult → Talk with a Physician

HOW MUCH DOES IT COST?

There is a $5 copay per doctor consultation fee for this service regardless of the plan's office visit copay. Behavioral Health Consultations match the office copay of your health plan.

HOW DO I ACCESS THIS BENEFIT?

Download MDLIVE app, visit www.mdlive.com/sisc or call (888) 632-2738

Anthem members will need to have their member ID number and the name, address and phone number of the covered member who needs medical assistance.

Spanish speaking physicians and representatives are available.

Doctors can help with many different health issues, some common conditions treated are:

- Allergies
- Asthma
- Bronchitis
- Cold & Flu
- Diarrhea
- Ear Infections
- Bronchitis
- Fever
- Headache
- Infections
- Insect bites
- Joint Aches
- Rashes
- Respiratory Infections
- Sinus Infections
- Skin infections
- Sore throat
- Urinary Tract Infection
- Therapy
- **And many more!**

Doctors can also provide prescriptions, if needed.

MDLIVE®
The Future of Healthcare

Kaiser Programs and Services

GET CONNECTED

Manage your health anytime, anywhere. Get connected and see how easy it is to stay on top of your health.
Sign on anytime to:

- View most lab test results
- Refill most prescriptions
- Email your doctor's office with non-urgent questions
- Schedule and cancel routine appointments
- Print vaccination records for school, sports, and camp
- Use tools to help you manage your coverage and costs
- Manage a family member's health care

Even if you don't need care right away, register today, and explore our tools so you can use them as soon as you need them.
Connect online when you register at www.kp.org

Your first step is registering on kp.org. Once that's done, you can connect to these great features anytime.

- Have your health/medical record number handy
- Go to kp.org/register from a computer and follow the sign-on instructions

Connect on the go with our mobile app.
The Kaiser Permanente mobile app gives you access to many of these great features from your smartphone. Once you're registered on kp.org, you can download the app anytime in 2 easy steps:

- Using your smartphone, search for the Kaiser Permanente app on App Store SM (iOS) or Google Play™ (Android™)
- Activate the app using your kp.org user ID and password. Learn more at www.kp.org

24/7 NURSE ADVICE

If you're not sure what kind of care you need, you can call our advice nurses anytime. They'll help you figure out what type of care is best for your symptom or condition, help you decide where to go for care, and even schedule a routine appointment for you, if appropriate. You can locate this number on the back of your ID card.

CHOOSE HOW YOU CONNECT TO CARE

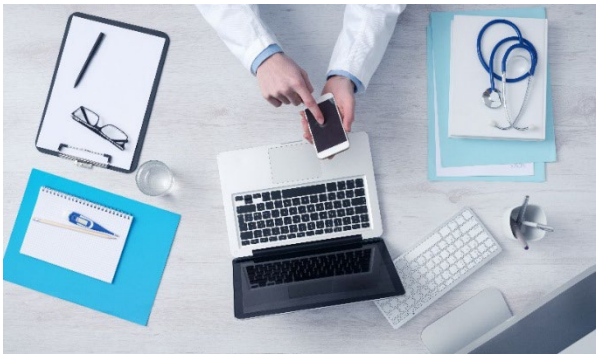
IN PERSON: Because most of our locations offer many services under one roof, you can see your doctor, get lab services and X-rays, and pick up your prescriptions — all in one trip.
TELEPHONE: Where telephone appointments are available, you can save yourself a trip to our medical offices and talk with your doctor by phone. And if you're not sure what kind of care you need, you can also call our advice nurses 24/7.
E-MAIL: For non-urgent questions, you can simply email your doctor's office. You'll get a reply usually within 2 business days, if not sooner. You can also email a pharmacist for questions about medications, or Member Services for questions about your benefits.
VIDEO: For some conditions and symptoms, you can connect with your doctor face-to-face by video — from your computer, smartphone, or tablet.

CHOOSE HOW YOU MANAGE YOUR CARE

AT HOME: Stay on top of your care from home or work 24/7, through My Health Manager at kp.org. View your medical record, refill most prescriptions, schedule and cancel routine appointments, get vaccination records, pay medical bills, and more.
ON THE GO: Wherever you are, you can access most of the features of My Health Manager on any mobile device through the KP app. You can also find a facility near you and get directions. Learn more at www.kp.org.

Calm Meditation & Mindfullness APP

NO COST. 10-minute daily calm guided meditations covering anxiety, stress, relaxation and more.
Get access to Calm at kp.org/selfcareapps.



Medical HMO Plans: Classified & Confidential

Medical coverage provides you with benefits that help keep you healthy, like preventive care screenings and access to urgent care. It also provides important financial protection if you have a serious medical condition. Santa Clarita Community College District provides you with comprehensive coverage through SISC.
Here is an overview of our Anthem Blue Cross and Kaiser HMO medical plans.

	Anthem Blue Cross HMO Plan	Kaiser HMO Plan
	In-Network	In-Network
Annual Deductible	$0	$0
Annual Out-of-Pocket Max	$2,000 Individual / $4,000 Family	$1,500 Individual / $3,000 Family
Office Visit		
Primary Provider	$20 copay	$20 copay
Specialist	$40 copay	$20 copay
Preventive Services	No charge	No charge
Chiropractic Care	$20 copay (up to 60 visits per year combined Physical, Occupational and Speech therapy)	$10 copay (up to 30 visits per year combined with Acu)
Acupuncture	$20 copay	$10 copay (up to 30 visits per year combined with Chiro)
Lab and X-ray (CT, MRI, PET) **Other lab and X-ray tests**	Complex imaging: $100 per test Diagnostic: No charge	No charge
Inpatient Hospitalization	$250 per Admission	No charge
Outpatient Surgery	$125 per Admission	$20 copay
Urgent Care	$20 copay	$20 copay
Emergency Room	$100 copay (copay waived if admitted)	$100 copay (copay waived if admitted)

This is a partial list of the most commonly used services. If you would like to review a full list of covered services, please contact Human Resources.

Click to Play

Anthem Blue Cross HMO
Customer Service Contact Information
Phone: (800) 825-5541
Website: www.anthem.com/ca/sisc

Kaiser HMO
Customer Service Contact Information
Phone: (800) 464-4000
Website: www.kp.org

Medical PPO Plan: Classified & Confidential

	Anthem Blue Cross PPO Plan	
	In-Network	Out-Of-Network
Annual Deductible	$100 Individual / $300 Family	
Annual Out-of-Pocket Max	$1,000 Individual / $3,000 Family	No Limit
Office Visit		
Primary Provider	$0 copay for visits 1-3 $20 copay (deductible waive)	Plan pays 100% of fee schedule after deductible exceeding the fee schedule (Member is responsible for all amounts exceeding the fee schedule)
Specialist	$20 copay (deductible waive)	Plan pays 100% of fee schedule after deductible exceeding the fee schedule (Member is responsible for all amounts exceeding the fee schedule)
Preventive Services	No charge	Not covered
Chiropractic Care	10% after deductible	Not covered
Acupuncture	10% after deductible (up to 12 visits per calendar year)	50% of maximum allowed amount (after deductible)
Lab and X-ray (CT, MRI, PET)	10% after deductible	0% (advanced imaging limited to $800/procedure)
Other lab and X-ray tests	10% after deductible	Not Covered
Inpatient Hospitalization	10% after deductible	All billed amounts exceeding $600 per day (after deductible)
Outpatient Surgery	10% after deductible	50% of maximum allowed amount (after deductible)
Urgent Care	$20 copay (deductible waive)	Plan pays 100% of fee schedule after deductible exceeding the fee schedule (Member is responsible for all amounts exceeding the fee schedule)
Emergency Room	$100 copay + 10% coinsurance after deductible (copay waived if admitted)	

This is a partial list of the most commonly used PPO medical services through Anthem Blue Cross. If you would like to review a full list of covered services, please contact Human Resources.

Click to Play

Anthem Blue Cross PPO
Customer Service Contact Information
Phone: See I.D. Card
Website: www.anthem.com/ca/sisc

Prescription Drugs: Classified & Confidential

Prescription drug coverage provides a benefit that is important to your overall health, whether you need a prescription for a short-term health issue like bronchitis or an ongoing condition like high blood pressure.

If you enroll in medical coverage, you will automatically receive coverage for prescription drugs. Here are the prescription drug plans that are offered with our SISC medical plans.

	Anthem Blue Cross HMO Plan		Kaiser HMO Plan	Anthem Blue Cross PPO Plan	
	In-Network		In-Network	In-Network	
Annual Out-of-Pocket Limit	$2,500 Individual $3,500 Family		$2,500 Individual $3,500 Family	$1,500 Individual $2,500 Family	
Pharmacy	**Walk In**	**Costco**		**Walk In**	**Costco**
Generic	$9 copay	No charge	$10 copay	$5 copay	No charge
Brand	$35 copay	$35 copay	$20 copay	$20 copay	$20 copay
Supply Limit	30 days	30 days	100 days	30 days	30 days
Mail Order	**Navitus**			**Navitus**	**Costco**
Generic	No charge	No charge	$10 copay	No charge	No charge
Brand	$90 copay	$90 copay	$20 copay	$50 copay	$50 copay
Supply Limit	90 days	90 days	100 days	90 days	90 days

Click to Play

Anthem Blue Cross HMO & PPO Rx
Navitus Customer Care Contact Information
Mail order services provided by Costco
Phone: (866) 333-2757
Website: www.navitus.com

Kaiser HMO Rx
Customer Service Contact Information
Phone: (800) 464-4000
Website: www.kp.org

Medical HMO Plans: Management

Medical coverage provides you with benefits that help keep you healthy like preventive care screenings and access to urgent care. It also provides important financial protection if you have a serious medical condition. Santa Clarita Community College District provides you with comprehensive coverage through SISC. Here is an overview of our Anthem Blue Cross and Kaiser HMO medical plans.

	Anthem Blue Cross HMO Plan	Kaiser HMO Plan
	In-Network	In-Network
Annual Deductible	None	None
Annual Out-of-Pocket Max	$2,000 Individual / $4,000 Family	$1,500 Individual / $3,000 Family
Office Visit		
Primary Provider	$20 copay	$30 copay
Specialist	$40 copay	$30 copay
Preventive Services	No charge	No charge
Chiropractic Care	$20 copay (up to 60 visits per year combined Physical, Occupational and Speech therapy)	$10 copay (up to 30 visits per year combined with Acu)
Acupuncture	$20 copay	$10 copay (up to 30 visits per year combined with Chiro)
Lab and X-ray (CT, MRI, PET)	Complex imaging: $100 per test	0% (advanced imaging limited to $800/procedure)
Other lab and X-ray tests	Diagnostic: No charge	
Inpatient Hospitalization	$250 per Admission	No charge
Outpatient Surgery	$125 per Admission	$30 copay
Urgent Care	$20 copay	$30 copay
Emergency Room	$100 copay (copay waived if admitted)	$100 copay (copay waived if admitted)

This is a partial list of the most commonly used services. If you would like to review a full list of covered services, please contact Human Resources.

Click to Play

Anthem Blue Cross HMO
Customer Service Contact Information
Phone: (800) 825-5541
Website: www.anthem.com/ca/sisc

Kaiser HMO
Customer Service Contact Information
Phone: (800) 464-4000
Website: www.kp.org

Medical PPO Plan: Management

Here is an overview of our SISC PPO medical plan offered through Anthem Blue Cross.

	Anthem Blue Cross PPO Plan	
	In-Network	**Out-Of-Network**
Annual Deductible	$200 Individual / $500 Family	
Annual Out-of-Pocket Max	$1,000 Individual / $3,000 Family	No Limit
Office Visit		
Primary Provider	$0 copay for visits 1-3; $20 copay (deductible waived)	Plan pays 100% of fee schedule after deductible exceeding the fee schedule (Member is responsible for all amounts exceeding the fee schedule)
Specialist	$20 copay (deductible waived)	Plan pays 100% of fee schedule after deductible exceeding the fee schedule (Member is responsible for all amounts exceeding the fee schedule)
Preventive Services	No charge	Not covered
Chiropractic Care	10% after deductible	Not covered
Acupuncture	10% after deductible (up to 12 visits per calendar year)	50% of maximum allowed amount (after deductible)
Lab and X-ray (CT, MRI, PET)	10% after deductible	0% (advanced imaging limited to $800/procedure)
Other lab and X-ray tests	10% after deductible	Not Covered
Inpatient Hospitalization	10% after deductible	All billed amounts exceeding $600 per day (after deductible)
Outpatient Surgery	10% after deductible	50% of maximum allowed amount (after deductible)
Urgent Care	$30 copay (deductible waived)	Plan pays 100% of fee schedule after deductible exceeding the fee schedule (Member is responsible for all amounts exceeding the fee schedule)
Emergency Room	$100 copay + 10% coinsurance after deductible (copay waived if admitted)	

This is a partial list of the most commonly used services. If you would like to review a full list of covered services, please contact Human Resources.

Click to Play

Anthem Blue Cross PPO
Customer Service Contact Information
Phone: See I.D. Card
Website: www.anthem.com/ca/sisc

Prescription Drugs: Management

Prescription drug coverage provides a benefit that is important to your overall health, whether you need a prescription for a short-term health issue like bronchitis or an ongoing condition like high blood pressure. If you enroll in medical coverage, you will automatically receive coverage for prescription drugs. Here are the prescription drug plans that are offered with our SISC medical plans.

	Anthem Blue Cross HMO Plan		Kaiser HMO Plan	Anthem Blue Cross PPO Plan	
	In-Network		In-Network	In-Network	
Annual Out-of-Pocket Limit	$2,500 Individual $3,500 Family		$1,500 Individual $3,000 Family (Combined with medical)	$2,500 Individual $3,500 Family	
Pharmacy	**Walk In**	**Costco**		**Walk In**	**Costco**
Generic	$9 copay	No charge	$10 copay	$9 copay	No charge
Brand	$35 copay	$35 copay	$30 copay	$35 copay	$35 copay
Supply Limit	30 days	30 days	100 days	30 days	30 days
Mail Order	**Navitus**			**Navitus**	**Costco**
Generic	No charge	No charge	$10 copay	No charge	No charge
Brand	$90 copay	$90 copay	$30 copay	$90 copay	$90 copay
Supply Limit	90 days	90 days	100 days	90 days	90 days

Click to Play

Anthem Blue Cross HMO & PPO Rx
Navitus Customer Care Contact Information
Mail order services provided by Costco
Phone: (866) 333-2757
Website: www.navitus.com

Kaiser HMO Rx
Customer Service Contact Information
Phone: (800) 464-4000
Website: www.kp.org

Dental PPO

Regular visits to your dentist can protect more than your smile; they can help protect your health. Recent studies have linked gum disease to damage elsewhere in the body and dentists are able to screen for oral symptoms of many other diseases including cancer, diabetes, and heart disease.

Santa Clarita Community College District provides you with comprehensive coverage through Delta Dental. Below are the plan highlights for the Dental PPO plan.

Delta Dental PPO Plan

	In-Network	Out-Of-Network
Calendar Year Deductible	None	None
Annual Plan Maximum	$2,500 per member	
Dental Services Waiting Period	None	None
Diagnostic & Preventive	Plan pays 70% - 100%	Plan pays 70% - 100%
Basic Services		
Fillings	Plan pays 70% - 100%	Plan pays 70% - 100%
Root Canals	Plan pays 70% - 100%	Plan pays 70% - 100%
Periodontics	Plan pays 70% - 100%	Plan pays 70% - 100%
Major Services	Prosthodontics: Plan pays 50% All Other: Plan pays 70% - 100	Prosthodontics: Plan pays 50% All Other: Plan pays 70% - 100
Dental Accident Benefits	Plan Pays 100% Separate $1,000 maximum per person each calendar year.	
Orthodontic Services		
Orthodontia	Plan pays 50%	Plan pays 50%
Lifetime Maximum	$2,000 per person	$2,000 per person
Adults	Covered	Covered
Dependent Children	Covered	Covered

In this incentive plan, Delta Dental pays 70% of the contract allowance for covered diagnostic, preventive and basic services and 70% of the contract allowance for major services during the first year of eligibility. The coinsurance percentage will increase by 10% each year (to a maximum of 100%) for each enrollee if that person visits the dentist at least once during the year. If an enrollee does not use the plan during the calendar year, the percentage remains at the level attained the previous year. If an enrollee becomes ineligible for benefits and later regains eligibility, the percentage will drop back to 70%.

Delta Dental PPO
Customer Service Contact Information
Phone: (866) 499-3001
Website: www.deltadentalins.com

Dental HMO

Santa Clarita Community College District also provides you with a comprehensive Dental coverage through United Concordia. Below are the plan highlights for the Dental HMO plan.

You must select a United Concordia Primary Dental Office (PDO) to receive covered services. Your PDO will perform the below procedures or refer you to a specialty care dentist for further care. Treatment by an Out-of-Network dentist is not covered.

	United Concordia Dental Plan
	In-Network
Calendar Year Deductible	None
Annual Plan Maximum	Unlimited
Diagnostic & Preventive	$0 - $10 copay (copays vary)
Basic Services	
Fillings	$0 - $140 copay (copays vary)
Root Canals	$0 - $70 copay (copays vary)
Periodontics	$0 - $120 copay (copays vary)
Major Services	$0 - $63 copay (copays vary)
Orthodontic Services	
Orthodontia	Adult: $2,000 Copay Child: $1,500 copay
Lifetime Maximum	Unlimited

This is a partial list of the most commonly used services. If you would like to review a full list of covered services, please contact Human Resources.

United Concordia Dental HMO
Customer Service Contact Information
Phone: (866) 357-3304
Website: www.unitedconcordia.com

Vision

Routine vision exams are important, not only for correcting vision but because they can detect other serious health conditions.

We offer you a vision plan through Vision Service Plan (VSP).

VSP Plan

	In-Network	Out-Of-Network
Examination		
Benefit	$5 copay	Up to $50
Frequency	1x every 12 months from last date of service	
Basic Eyeglass Lenses		
Single Vision Lens	$5 copay	Up to $50
Bifocal Lens	$5 copay	Up to $75
Trifocal Lens	$5 copay	Up to $100
Frequency	1x every 12 months from last date of service	
Frames		
Benefit	**VSP Providers**: $120 allowance, plus 20% discount from the remaining balance **Costco**: $65 allowance	Up to $70
Frequency	1x every 12 months from last date of service	
Contacts (Elective)		
Benefit	$105 allowance (instead of eyeglasses)	$105 allowance (instead of eyeglasses, in-network limitations apply; combined with in-network)
Frequency	1x every 12 months from last date of service	

EXTRA SAVINGS

GLASSES AND SUNGLASSES

- ✓ Extra $20 to spend on featured frame brands - visit www.vsp.com/specialoffers for details.
- ✓ 30% savings on additional glasses and sunglasses, including lens enhancements, from any VSP provider within 12 months of your last WellVision Exam. Or get 20% from any VSP provider within 12 months of your last WellVision Exam.

RETINAL SCREENING

- ✓ Max $39 copay on routine retinal screening as an enhancement to a WellVision Exam.

LASER VISION CORRECTION

- ✓ Average 15% off the regular price or 5% off promotional price; discounts only available from contracted facilities.
- ✓ After surgery, use your frame allowance (if eligible) for sunglasses from any VSP doctor.

VSP
Customer Service Contact Information
Phone: (800) 877-7195
Website: www.vsp.com

Basic Life and AD&D Insurance

Think about what your loved ones may face after you're gone. Term life insurance can help them in so many ways, like covering everyday expenses, paying off debt, and protecting savings. AD&D provides even more coverage if you die or suffer a covered loss in an accident.

BASIC LIFE AND AD&D

Basic Life Insurance pays your beneficiary a lump sum if you die. Accidental Death and Dismemberment (AD&D) provides another layer of benefits to either you or your beneficiary if you suffer from loss of a limb, speech, sight, or hearing, or if you die in an accident.

The cost of coverage is paid in full by the district. Coverage is provided by Lincoln Financial Group.

Basic Life Amount	$50,000
Basic AD&D Amount	$50,000

ADDITIONAL DETAILS

Conversion: You can convert your group term life coverage to an individual life insurance policy without providing evidence of insurability if you lose coverage due to leaving your job or for another reason outlined in the plan contract. AD&D benefits cannot be converted.

Benefit Reduction: Coverage amounts begin to reduce at age 65 and benefits terminate at retirement. See the plan certificate for details.

For questions or more information call **800-423-2765** and mention **Group ID: SANTACLARI.**

Beneficiary Reminder: Make sure that you have named a beneficiary for your life insurance benefit. It's important to know that the state of California requires that a spouse be named as the beneficiary, unless they sign a waiver.

Voluntary Life and Voluntary AD&D Insurance

If you have loved ones who depend on your income for support, having life and accidental death insurance can help protect your family's financial security.

VOLUNTARY LIFE

Voluntary Life Insurance allows you to purchase additional life insurance to protect your family's financial security. Coverage is provided by Lincoln Financial Group.

Employee Voluntary Life Amount	Increments of $5,000 up to $500,000 or 5 times your annual earnings
Spouse Voluntary Life Amount	Increments of $5,000 up to $250,000 (coverage cannot exceed 50% of employee amount)
Child(ren) Voluntary Life Amount	Amounts of $3,000 or $5,000

Voluntary Life Monthly Rates per $1,000	Employee	Spouse
Under 29	$0.070	$0.070
30-34	$0.080	$0.080
35-39	$0.090	$0.090
40-44	$0.160	$0.160
45-49	$0.250	$0.250
50-54	$0.410	$0.410
55-59	$0.730	$0.730
60-64	$1.090	$1.090
65-69	$1.670	$1.670
70-74	$3.320	$3.320
75+	$5.670	$5.670
Dependent Child(ren)	For $3,000: $0.15 For $5,000: $0.25	

VOLUNTARY AD&D

Voluntary AD&D Insurance allows you to purchase additional accidental death and dismemberment insurance to protect your family's financial security in case you suffer from loss of a limb, speech, sight or hearing or if you die in an accident. Coverage is provided by Lincoln Financial Group.

Employee Voluntary AD&D Amount	• Increments of $5,000 up to $500,000 or 5 times your annual earnings
Spouse Voluntary AD&D Amount	• 50% of employee amount, if you do **NOT** have children enrolled in this Voluntary AD&D benefit • 60% of employee amount if you do have children enrolled in this Voluntary AD&D benefit
Child(ren) Voluntary AD&D Amount	• 25% of employee amount, if you do **NOT** have a spouse enrolled in this Voluntary AD&D benefit • 10% of employee amount if you do have a spouse enrolled in this Voluntary AD&D benefit

Voluntary AD&D Tenthly Rates per $1,000	Employee	Family
All Ages	$0.032	$0.049

CALCULATING YOUR COST

Voluntary Life Formula (Employee and Spouse):
Life Benefit Amount x Rate based on age / $1,000 = Monthly Cost

Voluntary Life Formula (Children):

Life Benefit Amount x $0.15 for Child(ren) for $3,000 of coverage or x $0.25 cents for $5,000 of coverage

Voluntary AD&D Formula:

AD&D Employee Benefit Amount x $.032 / $1,000 = Tenthly Cost

AD&D Employee + Family Benefit Amount x $0.049 / $1,000 = Tenthly Cost

For questions or more information call **800-423-2765** and mention **Group ID: SANTACLARI.**

Disability Insurance

If you become disabled and cannot work, your financial security may be at risk. Protecting your income stream can provide you and your family with peace of mind.

LONG-TERM DISABILITY INSURANCE

This benefit is available to full-time and permanent part-time employees with at least 50% assignment.

Long-Term Disability coverage pays you a certain percentage of your income if you can't work because an injury or illness prevents you from performing any of your job functions over a long time. It's important to know that benefits are reduced by income from other benefits you might receive while disabled, like workers' compensation and Social Security. Coverage is provided by Lincoln Financial Group.

Monthly Benefit Amount	Plan pays 66.67% covered monthly earnings
Maximum Monthly Benefit	$6,000
Benefits Begin After:	
Accident	120 days of disability
Sickness	120 days of disability
Maximum Payment Period*	Social Security Normal Retirement age

*The age at which the disability begins may affect the duration of the benefits.

For questions or more information call **800-423-2765** and mention **Group ID: SANTACLARI.**

Additional Programs and Services

EMPLOYEE ASSISTANCE PROGRAM

All employees are enrolled in the Employee Assistance Program through Lincoln and EmployeeConnect. This valuable resource is provided at no cost to you.

Life presents opportunities and challenges. Lincoln and EmployeeConnect's program, offered by ComPsych, helps you and your family cope with life, from the everyday to the unexpected. Whether managing everyday issues such as job pressures, relationships, retirement planning, finding child care, impact of grief, loss, or the impact of a disability, EmployeeConnect is your resource for professional support. You and your family, including spouse and dependents, have access to EmployeeConnect at no additional cost to you.

- Three (3) Face-to-Face Visits
- Child & Elder Care Resources
- Online Financial Calculators & Tools
- Family Law, Civil Lawsuits, Bankruptcy
- Depression, Marital and Family Conflicts
- Help Handling Life Events or the Loss of a Loved One
- Identify Theft Victim Recovery Services
- Landlord and Tenant Issues
- Alcohol and Drug Abuse
- Retirement Planning, Tax Questions

GETTING IN TOUCH IS EASY.

ON THE PHONE: Just one simple call. For access over the phone, simply call toll-free 1-888-628-4824.

ONLINE: The point is simplicity. You'll also have 24/7 access to EmployeeConnect Online (offered by ComPsych).

Visit WWW.GUIDANCERESOURCES.COM and login using the username: LFGsupport and password: LFGsupport1.

Click to Play

Click to Play

For Assistance

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

Plan Type	Provider	Phone Number	Website
Medical HMO	Kaiser	(800) 464-4000	www.kp.org
Medical HMO	Anthem	(800) 825-5541	www.anthem.com/ca/sisc
Medical PPO	Anthem	See I.D. Card	www.anthem.com/ca/sisc
24/7 Physician Line (Anthem Members Only)	MD Live	(888) 632-2738	www.mdlive.com/sisc
Pharmacy (Anthem Members Only)	Navitus Costco Mail Order	(866) 333-2757 (800) 607-6869	www.navitus.com www.pharmacy.costco.com
Expert Second Opinion Program	Teladoc	(855) 380-7828	www.teladoc.com/sisc
Dental PPO	Delta Dental	(866) 499-3001	www.deltadentalins.com
Dental HMO	United Concordia	(866) 357-3304	www.unitedconcordia.com
Vision	VSP	(800) 877-7195	www.vsp.com
Life and AD&D	Lincoln	(800) 423-2765	www.lfg.com
Voluntary Life and AD&D	Lincoln	(800) 423-2765	www.lfg.com
Disability	Lincoln	(866) 783-2255	www.lfg.com
Employee Assistance Program (SISC Members)	Anthem EAP	(800) 999-7222	www.anthemeap.com
Employee Assistance Program (All Employees)	ComPsych	(888) 628-4824	www.guidanceresources.com Username: LFGsupport Password: LFGsupport1

Human Resources
Phone: (661) 362-5112

Key Terms

MEDICAL/GENERAL TERMS

Allowable Charge - The most that an in-network provider can charge you for an office visit or service.

Balance Billing - Non-network providers are allowed to charge you more than the plan's allowable charge. This is called Balance Billing.

Coinsurance - The cost share between you and the insurance company. Coinsurance is always a percentage totaling 100%. For example, if the plan pays 70%, you are responsible for paying the remaining 30% of the cost.

Copay - The fee you pay to a provider at the time of service.

Deductible - The amount you have to pay out-of-pocket for expenses before the insurance company will cover any benefit costs for the year (except for preventive care and other services where the deductible is waived).

Explanation of Benefits (EOB) - The statement you receive from the insurance carrier that explains how much the provider billed, how much the plan paid (if any) and how much you owe (if any). In general, you should not pay a bill from your provider until you have received and reviewed your EOB (except for copays).

Family Deductible - The maximum dollar amount any one family will pay out in individual deductibles in a year.

Individual Deductible - The dollar amount a member must pay each year before the plan will pay benefits for covered services.

In-Network - Services received from providers (doctors, hospitals, etc.) who are a part of your health plan's network. In-network services generally cost you less than out-of-network services.

Out-of-Network - Services received from providers (doctors, hospitals, etc.) who are not a part of your health plan's network. Out-of-network services generally cost you more than in-network services. With some plans, such as HMOs and EPOs, out-of-network services are not covered.

Out-of-Pocket - Healthcare costs you pay using your own money, whether from your bank account, credit card, Health Reimbursement Account (HRA), Health Savings Account (HSA) or Flexible Spending Account (FSA).

Out-of-Pocket Maximum – The most you would pay out-of-pocket for covered services in a year. Once you reach your out-of-pocket maximum, the plan covers 100% of eligible expenses.

Preventive Care – A routine exam, usually yearly, that may include a physical exam, immunizations and tests for certain health conditions.

PRESCRIPTION DRUG TERMS

Brand Name Drug - A drug sold under its trademarked name. A generic version of the drug may be available.

Generic Drug – A drug that has the same active ingredients as a brand name drug, but is sold under a different name. Generics only become available after the patent expires on a brand name drug. For example, Tylenol is a brand name pain reliever commonly sold under its generic name, Acetaminophen.

Dispense as Written (DAW) - A prescription that does not allow for substitution of an equivalent generic or similar brand drug.

Maintenance Medications - Medications taken on a regular basis for an ongoing condition such as high cholesterol, high blood pressure, asthma, etc. Oral contraceptives are also considered a maintenance medication.

Non-Preferred Brand Drug - A brand name drug for which alternatives are available from either the plan's preferred brand drug or generic drug list. There is generally a higher copayment for a non-preferred brand drug.

Preferred Brand Drug - A brand name drug that the plan has selected for its preferred drug list. Preferred drugs are generally chosen based on a combination of clinical effectiveness and cost.

Specialty Pharmacy - Provides special drugs for complex conditions such as multiple sclerosis, cancer and HIV/AIDS.

Step Therapy - The practice of starting to treat a medical condition with the most cost effective and safest drug therapy and progressing to other more costly or risky therapy, only if necessary.

DENTAL TERMS

Basic Services - Generally include coverage for fillings and oral surgery.

Diagnostic and Preventive Services - Generally include routine cleanings, oral exams, x-rays, sealants and fluoride treatments. Most plans limit preventive exams and cleanings to two times a year.

Endodontics - Commonly known as root canal therapy.

Implants - An artificial tooth root that is surgically placed into your jaw to hold a replacement tooth or bridge. Many dental plans do not cover implants.

Major Services - Generally include restorative dental work such as crowns, bridges, dentures, inlays and onlays.

Orthodontia - Some dental plans offer Orthodontia services for children (and sometimes adults too) to treat alignment of the teeth. Orthodontia services are typically limited to a lifetime maximum.

Periodontics - Diagnosis and treatment of gum disease.

Pre-Treatment Estimate - An estimate of how much the plan will pay for treatment. A pre-treatment estimate is not a guarantee of payment.

Important Plan Notices and Documents

CURRENT HEALTH PLAN NOTICES

Notices must be provided to plan participants on an annual basis and are available in this benefits brochure and include:

- Medicare Part D Notice
  Describes options to access prescription drug coverage for Medicare eligible individuals.
- Women's Health and Cancer Rights Act
  Describes benefits available to those that will or have undergone a mastectomy.
- Newborns' and Mothers' Health Protection Act
  Describes the rights of mother and newborn to stay in the hospital 48-96 hours after delivery.
- HIPAA Notice of Special Enrollment Rights
  Describes when you can enroll yourself and/or dependents in health coverage outside of open enrollment.
- Notice of Choice of Providers
  Notifies you about the plan's requirement that you name a Primary Care Physician (PCP).

CURRENT PLAN DOCUMENTS

Important documents for our health plans are available on our benefits website.

Summary of Benefits and Coverage (SBCs)

A Summary of Benefits and Coverage (SBC) is a document required by the Affordable Care Act (ACA) that presents benefit plan features in a standardized format. The following SBCs are available (please contact Human Resources):

- Kaiser HMO
- Anthem HMO
- Anthem PPO

Statement of Material Modifications

This enrollment guide constitutes a Summary of Material Modifications (SMM) to Santa Clarita Community College's Group Health Plan. It is meant to supplement and/or replace certain information in the SPD, so retain it for future reference along with your SPD. Please share these materials with your covered family members.

Medicare Part D Notice

Important Notice from Santa Clarita Community College District
About Your Prescription Drug Coverage and Medicare

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

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

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. Santa Clarita Community College District has determined that the prescription drug coverage offered by the Anthem Blue Cross and Kaiser plans are, 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 Santa Clarita Community College District coverage will not be affected. See below for more information about what happens to your current coverage if you join a Medicare drug plan.

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

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

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

You should also know that if you drop or lose your current coverage with Santa Clarita Community College District 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 Santa Clarita Community College District changes. You also may request a copy of this notice at any time.

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

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

For more information about Medicare prescription drug coverage:

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

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

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

Date:	October 1, 2022
Name of Entity/Sender:	Santa Clarita Community College District
Contact-Position/Office:	Human Resources
Address:	26455 Rockwell Canyon Road, Santa Clarita, CA 91355
Phone Number:	(661) 362-5112

Women's Health and Cancer Rights Act

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

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. If you would like more information on WHCRA benefits, call Human Resources.

Newborns' and Mothers' Health Protection Act

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

HIPAA Notice of Special Enrollment Rights

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

- Lose other health insurance or group health plan coverage. You must request enrollment within 30 days after the loss of other coverage.
- Gain a new dependent as a result of marriage, birth, adoption, or placement for adoption. You must request health plan enrollment within 31days after the marriage, birth, adoption, or placement for adoption.
- Lose Medicaid or Children's Health Insurance Program (CHIP) coverage because you are no longer eligible. You must request medical plan enrollment within 60 days after the loss of such coverage.

If you request a change due to a special enrollment event within the 30 day timeframe, coverage will be effective the date of birth, adoption or placement for adoption. For all other events, coverage will be effective the first of the month following your request for enrollment. In addition, you may enroll in Santa Clarita Community College District's health plan if you become eligible for a state premium assistance program under Medicaid or CHIP. You must request enrollment within 60 days after you gain eligibility for medical plan coverage. If you request this change, coverage will be effective the first of the month following your request for enrollment. Specific restrictions may apply, depending on federal and state law.

Note: If your dependent becomes eligible for a special enrollment rights, you may add the dependent to your current coverage or change to another health plan.

Notice of Choice of Providers

The Anthem Blue Cross HMO generally 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, Anthem Blue Cross designates one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact Anthem Blue Cross directly.

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

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

Michelle's Law

The CalPers plan may extend medical coverage for dependent children if they lose eligibility for coverage because of a medically necessary leave of absence from school. Coverage may continue for up to a year, unless your child's eligibility would end earlier for another reason.

Extended coverage is available if a child's leave of absence from school — or change in school enrollment status (for example, switching from full-time to part-time status) — starts while the child has a serious illness or injury, is medically necessary and otherwise causes eligibility for student coverage under the plan to end. Written certification from the child's physician stating that the child suffers from a serious illness or injury and the leave of absence is medically necessary may be required.if your child will lose eligibility for coverage because of a medically necessary leave of absence from school and you want his or her coverage to be extended, notify CalPers in writing as soon as the need for the leave is recognized. In addition, contact your child's health plan to see if any state laws requiring extended coverage may apply to his or her benefits.

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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2021. Contact your State for more information on eligibility –

ALABAMA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447
ALASKA – Medicaid
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx
ARKANSAS – Medicaid
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)
CALIFORNIA – Medicaid
Website: Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp Phone: 916-445-8322 Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711
FLORIDA – Medicaid
Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268
GEORGIA – Medicaid
Website: Medicaid https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162 ext. 2131
INDIANA – Medicaid
Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid

Website: https://www.in.gov/medicaid/ Phone 1-800-457-4584

IOWA – Medicaid and CHIP (Hawki)

Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366
Hawki Website: http://dhs.iowa.gov/hawki Hawki Phone: 1-800-257-8563
HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562

KANSAS – Medicaid

Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884

KENTUCKY – Medicaid

Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website:
https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328
Email: KIHIPP.PROGRAM@ky.gov
KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718
Kentucky Medicaid Website: https://chfs.ky.gov/

LOUISIANA – Medicaid

Website: http://www.medicaid.la.gov or http://www.ldh.la.gov/lahipp
Phone: 1-888-342-6027 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)

MAINE – Medicaid

Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms
Phone: 1-800-442-6003 TTY: Maine relay 711
Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms
Phone: 1-800-977-6740 TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP

Website: https://www.mass.gov/info-details/masshealth-premium-assistance-pa
Phone: 1-800-862-4840

MINNESOTA – Medicaid

Website: **Error! Hyperlink reference not valid.**https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp
Phone: 1-800-657-3739

MISSOURI – Medicaid

Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm
Phone: 573-751-2005

MONTANA – Medicaid

Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: 1-800-694-3084

NEBRASKA – Medicaid

Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633
Lincoln: 402-473-7000 Omaha: 402-595-1178

NEVADA – Medicaid

Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900

NEW HAMPSHIRE – Medicaid

Website: https://www.dhhs.nh.gov/oii/hipp.htm Phone: 603-271-5218
Toll free number for the HIPP program: 1-800-852-3345, ext 5218

NEW JERSEY – Medicaid and CHIP

Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/
Medicaid Phone: 609-631-2392
CHIP Website: http://www.njfamilycare.org/index.html
CHIP Phone: 1-800-701-0710

NEW YORK – Medicaid

Website: https://www.health.ny.gov/health_care/medicaid/
Phone: 1-800-541-2831

NORTH CAROLINA – Medicaid

Website: https://dma.ncdhhs.gov/ Phone: 919-855-4100

NORTH DAKOTA – Medicaid

Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/
Phone: 1-844-854-4825

OKLAHOMA – Medicaid and CHIP

Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
OREGON – Medicaid and CHIP
Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid
Website: https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx Phone: 1-800-692-7462
RHODE ISLAND – Medicaid and CHIP
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347 or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid
Website: https://www.scdhhs.gov Phone: 1-888-549-0820
SOUTH DAKOTA - Medicaid
Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS – Medicaid
Website: http://gethipptexas.com/ Phone: 1-800-440-0493
UTAH – Medicaid and CHIP
Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
VERMONT– Medicaid
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
VIRGINIA – Medicaid and CHIP
Medicaid Website: https://www.coverva.org/hipp/ Phone: 1-800-432-5924 CHIP Phone: 1-855-242-8282
WEST VIRGINIA – Medicaid
Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WASHINGTON – Medicaid
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
WISCONSIN – Medicaid and CHIP
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
WYOMING – Medicaid
Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since January 31, 2021, or for more information on special enrollment rights, contact either:

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

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

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of

information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 1/31/2023)

Notes:

Rev. 7/29/2022