2024-2025 CLASSIFIED, CONFIDENTIAL & MANAGEMENT BENEFITS

Fresh Look at Benefits!

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 Important Plan Information section for more details.

GETTING STARTED

2024-2025 BENEFITS

October 1, 2024
through
September 30, 2025

IMPORTANT NOTE:
This guide is a summary overview and does not provide a complete description of all benefit provisions. For more detailed information, please refer to your plan documents including your benefit summaries, summary of benefits and coverage (SBCs) and summary plan descriptions (SPDs). The plan documents determine how all benefits are paid.

Whether you're enrolling in benefits for the first time, nearing retirement, or somewhere in between, Santa Clarita Community College District supports you with benefit programs and resources to help you thrive today and prepare for tomorrow.

This guide provides an overview of your healthcare coverage, life, disability, retirement benefits, and more.

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

WHO'S ELIGIBLE FOR BENEFITS?

Employees

In general, permanent and probationary employees working at least 20 hours or more per week are eligible to 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

- Legally married spouse, including same-sex partners.
- Registered Domestic Partner, (RDPs are defined as same or opposite sex partners who are both at least 18 years of age).
- Natural, adopted or stepchildren, or children of a domestic partner up to age 26.
- Children over age 26 who are disabled and depend on you for support.
- Children named in a Qualified Medical Child Support Order (QMCSO).

For additional information, please refer to the plan documents for each benefit.

Who is not eligible

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

- Parents, grandparents, and siblings.

When you can enroll

You can enroll in benefits as a new hire or during the annual open enrollment period. New hire coverage begins on the first of the month following date of hire.

If you miss the enrollment deadline, you'll need to wait until the next open enrollment, the one time each year that you can make changes to your benefits for any reason. Open enrollment is generally held in August every year.

CHANGING YOUR BENEFITS

Click to play video

LIFE HAPPENS

A change in your life may allow you to update your benefit choices. Watch the video for a quick take on your options.

THREE RULES APPLY TO MAKING CHANGES TO YOUR BENEFITS DURING THE YEAR:

1. Any change you make must be consistent with the change in status.
2. You must make the change within 30 days of the date the event occurs.
3. All proper documentation is required to cover dependents (marriage certificates, birth certificates, etc.).

Outside of open enrollment, you may be able to enroll or make changes to your benefit elections if you have a big change in your life, including:

- Change in legal marital status
- Change in number of dependents or dependent eligibility status
- Change in employment status that affects eligibility for you, your spouse, or dependent child(ren)
- Change in residence that affects access to network providers
- Change in your health coverage or your spouse's coverage due to your spouse's employment
- Change in an individual's eligibility for Medicare or Medicaid
- Court order requiring coverage for your child
- "Special enrollment event" under the Health Insurance Portability and Accountability Act (HIPAA), including a new dependent by marriage, birth or adoption, or loss of coverage under another health insurance plan
- Event allowed under the Children's Health Insurance Program (CHIP) Reauthorization Act (you have 60 days to request enrollment due to events allowed under CHIP)

You must submit your change within 30 days after the event.

Dependent Verification

Making changes to dependents is subject to eligibility verification to ensure only eligible individuals are participating in our plans. You will be required to provide proof of one or more of the following within 30 days of their eligibility:

- Marriage Certification or License
- Certificate of Domestic Partnership
- Birth Certificate
- Final decree of divorce
- Court documents showing legal responsibility for adopted children, foster children or children under legal guardianship
- Physician's written certification of disabling condition (for dependent children over age 26 incapable of self-support)

If you do not supply the proper documentation to make changes to dependents within the 30-day period, you will not be able to add the dependent(s) until the next open enrollment period.

MEDICAL

WORDS TO KNOW

Can you beat the Health Lingo game? Learn the words that will help you understand how your plan works.

Click to play video

- **DEDUCTIBLE:** The amount of healthcare costs you have to pay for with your own money before your plan will start to pay anything.
- **OUT-OF-POCKET MAXIMUM:** Protects you from big medical bills. Once costs "out of your own pocket" reach this amount, the plan pays 100% of most eligible expenses for the rest of the plan year.
- **COINSURANCE:** After the deductible (if applicable), you and the plan share the cost. For example, if the plan pays 80%, your coinsurance share of the cost is 20%. You are billed for your coinsurance after your visit.
- **COPAY:** A set fee you pay instead of coinsurance for some healthcare services, for example, a doctor's office visit. You pay the copay at the time you receive care.
- **IN-NETWORK / OUT-OF-NETWORK:** In-network services will always be the lowest cost option. Out-of-network services will cost more, or may not be covered. Check your plan's website to find doctors, hospitals, labs, and pharmacies that belong to the network.

WHICH PLAN IS RIGHT FOR YOU?

Consider an HMO (Health Maintenance Organization) if:

- You want lower, predictable out-of-pocket costs
- You like having one doctor to manage your care
- You are happy with the selection of network providers
- You don't see any doctors that are out-of-network
- You have convenient access to Kaiser facilities (for Kaiser members)

Plans To Consider for Classified & Confidential

- Kaiser HMO Plan
- Anthem Blue Cross HMO Plan

Plans To Consider for Management

- Kaiser HMO Plan
- Anthem Blue Cross HMO Plan

Consider a PPO (Preferred Provider Organization) if:

- You want to be able to see any provider, even a specialist, without a referral
- You are willing to pay more to see out-of-network providers

Plans To Consider for Classified & Confidential

- Anthem Blue Cross PPO Plan

Plans To Consider for Management

- Anthem Blue Cross PPO Plan

SISC Medical – Classified & Confidential HMO Plans

You always pay the copayment ($). The coinsurance (%) shows what you pay after the deductible.

	Anthem Blue Cross HMO Plan		Kaiser HMO Plan
	In-Network		In-Network
Calendar Year Deductible	None		None
Calendar Year Out-of-Pocket Maximum[1] Individual Family Embedded/Aggregate[2]	 $2,000 $4,000 Embedded		 $1,500 $3,000 Embedded
Office Visit Primary Care Specialist	 $20 copay $40 copay		 $20 copay $20 copay
Preventive Services	No charge		No charge
Chiropractic Medical Network ASH Network	 $20 copay (20 visits/year) $10 copay (30 visits/year, combined with Acu)		 N/A $10 copay (30 visits/year, combined with Acu)
Acupuncture Medical Network ASH Network	 $20 copay (20 visits/year) $10 copay (30 visits/year, combined with Chiro)		 N/A $10 copay (30 visits/year, combined with Chiro)
Lab, X-ray & Diagnostic	No charge		No charge
Advanced Imaging (CT, MRI, PET)	$100 copay per test		No charge
Urgent Care	$20 copay		$20 copay
Emergency Room	$100 copay (waived if admitted)		$100 copay (waived if admitted)
Inpatient Hospitalization	$250 copay per admission		No charge
Outpatient Surgery	$125 copay per visit		$20 copay
PRESCRIPTION DRUGS	**Navitus**		**Kaiser**
Calendar Year Deductible	N/A		None
Calendar Year Out-of-Pocket Maximum (individual/family)	$2,500/$3,500		Combined w/ medical
Retail Generic Brand Specialty Supply Limit	**Walk in** $9 copay $35 copay N/A 30 days	**Costco** No charge/ No charge $35 copay/$90 copay N/A 30 days / 90 days	 $10 copay $20 copay $20 copay (30-day supply only) 100 days
Mail Order Generic Brand Specialty Supply Limit	**Navitus** N/A N/A $35 copay 30 days	**Costco** No charge $90 copay N/A 90 days	 $10 copay $20 copay N/A 100 days

[1]Out-of-pocket maximums accumulate on a calendar year from January 1 through December 31.
[2]An embedded family maximum means the plan will cover 100% for an individual member as soon as they reach their individual maximum.

SISC Medical – Classified & Confidential PPO Plan

You always pay the deductible and copayment ($). The coinsurance (%) shows what you pay after the deductible.

	Anthem Blue Cross PPO Plan		
	In-Network		**Out-of-Network**
Calendar Year Deductible[1] Individual Family Embedded/Aggregate[2]	$100 $300 Embedded		
Calendar Year Out-of-Pocket Maximum[1,4] Individual Family Embedded/Aggregate[3]	$1,000 $3,000 Embedded		No limit No limit Embedded
Office Visit Primary Care Specialist	$0 copay for visits 1-3, $20 copay for visits 4+ $20 copay		After deductible, the plan pays 100% up to Anthem's fee schedule. Member is responsible for billed amounts above the fee schedule.
Preventive Services	No charge		Not covered
Chiropractic[6]	10%[5]		Not covered
Acupuncture (up to 12 visits/year)	10%[5]		50%[5] of maximum allowed amount
Lab, X-ray & Diagnostic	10%[5]		Not Covered
Advanced Imaging (CT, MRI, PET)	10%[5]		All billed amounts exceeding the lessor or $800/procedure or maximum allowed amount
Urgent Care	$20 copay		All billed amounts exceeding the maximum allowed amount
Emergency Room	$100 copay + 10%[5] (waived if admitted)		$100 copay + 10%[5] (waived if admitted)
Inpatient Hospitalization	10%[5]		All billed amounts exceeding $600 per day (after deductible)
Outpatient Surgery Hospital Ambulatory Surgical Center (ASC)	 10%[5] 10%[5]		All billed amounts exceeding the maximum allowed amount All billed amounts exceeding $350/day or maximum allowed amount
PRESCRIPTION DRUGS - NAVITUS			
Calendar Year Deductible	N/A		N/A
Calendar Year Out-of-Pocket Maximum (individual/family)	$1,500/$2,500		N/A
Retail Generic Brand Supply Limit	**Walk in** $5 copay $20 copay 30 days	**Costco** No charge $20 copay 30 days	Not Covered
Mail Order Generic Brand Specialty Supply Limit	**Navitus** N/A N/A $20 copay 30 days	**Costco** No charge $50 copay N/A 90 days	Not Covered

[1]Deductibles and out-of-pocket maximums accumulate on a calendar year from January 1 through December 31.
[2]An embedded family deductible means the plan begins to make payments for a member when they reach their individual deductible.
[3]An embedded family maximum means the plan will cover 100% for an individual member as soon as they reach their individual maximum.
[4]All covered expenses including your medical deductibles accumulate towards the medical out-of-pocket maximum.
[5]After deductible.
[6]Pre-authorization review by American Specialty Health (ASH) is required after the 5th visit

SISC Medical – Management HMO Plans

You always pay the copayment ($). The coinsurance (%) shows what you pay after the deductible.

	Anthem Blue Cross HMO Plan		Kaiser HMO Plan
	In-Network		In-Network
Calendar Year Deductible	None		None
Calendar Year Out-of-Pocket Maximum[1] Individual Family Embedded/Aggregate[2]	 $2,000 $4,000 Embedded		 $1,500 $3,000 Embedded
Office Visit Primary Care Specialist	 $20 copay $40 copay		 $30 copay $30 copay
Preventive Services	No charge		No charge
Chiropractic Medical Network ASH Network	 $20 copay (20 visits/year) $10 copay (30 visits/year, combined with Acu)		 N/A $10 copay (30 visits/year, combined with Acu)
Acupuncture Medical Network ASH Network	 $20 copay (20 visits/year) $10 copay (30 visits/year, combined with Chiro)		 N/A $10 copay (30 visits/year, combined with Chiro)
Lab, X-ray & Diagnostic	No charge		No charge
Advanced Imaging (CT, MRI, PET)	$100 copay per test		No charge
Urgent Care	$20 copay		$30 copay
Emergency Room	$100 copay (waived if admitted)		$100 copay (waived if admitted)
Inpatient Hospitalization	$250 copay per admission		No charge
Outpatient Surgery	$125 copay per visit		$30 copay
PRESCRIPTION DRUGS	**Navitus**		**Kaiser**
Calendar Year Deductible	N/A		None
Calendar Year Out-of-Pocket Maximum (individual/family)	$2,500/$3,500		Combined w/ medical
Retail Generic Brand Specialty Supply Limit	**Walk in** $9 copay $35 copay N/A 30 days	**Costco** No charge/ No charge $35 copay/$90 copay N/A 30 days / 90 days	 $10 copay $30 copay $30 copay (30-day supply only) 100 days
Mail Order Generic Brand Specialty Supply Limit	**Navitus** N/A N/A $35 copay 30 days	**Costco** No charge $90 copay N/A 90 days	 $10 copay $30 copay N/A 100 days

[1]Out-of-pocket maximums accumulate on a calendar year from January 1 through December 31.
[2]An embedded family maximum means the plan will cover 100% for an individual member as soon as they reach their individual maximum.

SISC Medical – Management PPO Plan

You always pay the deductible and copayment ($). The coinsurance (%) shows what you pay after the deductible.

	Anthem Blue Cross PPO Plan		
	In-Network		**Out-of-Network**
Calendar Year Deductible[1] Individual Family Embedded/Aggregate[2]	$200 $500 Embedded		$200 $500 Embedded
Calendar Year Out-of-Pocket Maximum[1,4] Individual Family Embedded/Aggregate[3]	$1,000 $3,000 Embedded		No limit No limit Embedded
Office Visit Primary Care Specialist	$0 copay for visits 1-3, $20 copay for visits 4+ $20 copay		After deductible, the plan pays 100% up to Anthem's fee schedule. Member is responsible for billed amounts above the fee schedule.
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Urgent Care	$20 copay		All billed amounts exceeding the maximum allowed amount
Emergency Room	$100 copay + 10%[5] (waived if admitted)		$100 copay + 10%[5] (waived if admitted)
Inpatient Hospitalization	10%[5]		All billed amounts exceeding $600 per day (after deductible)
Outpatient Surgery Hospital Ambulatory Surgical Center (ASC)	 10%[5] 10%[5]		All billed amounts exceeding the maximum allowed amount All billed amounts exceeding the lesser of $350/day or maximum allowed amount[5]
PRESCRIPTION DRUGS – NAVITUS			
Calendar Year Deductible	N/A		N/A
Calendar Year Out-of-Pocket Maximum (individual/family)	$2,500/$3,500		N/A
Retail Generic Brand Supply Limit	**Walk in** $9 copay $35 copay 30 days	**Costco** No charge $35 copay 30 days	Not Covered
Mail Order Generic Brand Specialty Supply Limit	**Navitus** N/A N/A $35 copay 30 days	**Costco** No charge $90 copay N/A 90 days	Not Covered

[1]Deductibles and out-of-pocket maximums accumulate on a calendar year from January 1 through December 31.
[2]An embedded family deductible means the plan begins to make payments for a member when they reach their individual deductible.
[3]An embedded family maximum means the plan will cover 100% for an individual member as soon as they reach their individual maximum.
[4]All covered expenses including your medical deductibles accumulate towards the medical out-of-pocket maximum.
[5]After deductible.
[6]Pre-authorization review by American Specialty Health (ASH) is required after the 5th visit

SISC Added Value Programs

Take advantage of these benefits to help you get and stay healthy.

BENEFIT HIGHLIGHTS	AVAILABILITY & HOW TO GET STARTED
24/7 Help with Personal Concerns **SISC Employee Assistance Program** Access free, confidential resources for help with emotional, marital, financial, addiction, legal, or stress issues.	*All employees* **Call** 800-999-7222 **Visit** anthemEAP.com and enter SISC
Online Counseling and Therapy **Talkspace** Digital platform that supports behavioral health and emotional wellness needs from a secure, HIPAA-compliant app. Up to 6 counseling sessions per situation.	*All employees* **Call** 800-999-7222 **Visit** talkspace.com/associatecare and enter SISC as your organization name
Expert Medical Opinions **Teladoc Medical Experts** Get answers to health care questions and second opinions from world-leading experts.	*Anthem and Kaiser members* **Call** 800-835-2362 **Visit** teladoc.com/SISC
Personal Health Coaching **Vida Health** Get one-on-one health coaching, therapy, chronic condition management, health trackers and other tools and resources online or via phone.	*Anthem members* **Call** 855-442-5885 **Visit** vida.com/sisc
24/7 Physician Access—Anytime, Anywhere **MDLive**[1] Access to virtual visits with psychiatrists and therapists for members age 10 and up. Virtual urgent care services are available to all members. Physicians can prescribe medication when appropriate.	*Anthem members* **Call** 888-632-2738 **Visit** mdlive.com/sisc
Free Generic Medications **Costco** Access most generic medications at no cost through Costco retail and mail order pharmacies. You don't need to be a Costco member.	*Anthem members* **Call** 800-774-2678 (press 1) **Visit** costco.com

[1] Effective October 1, 2023, MDLive visits will have a $10 co-pay.

SISC Added Value Programs

BENEFIT HIGHLIGHTS	AVAILABILITY & HOW TO GET STARTED
Physical Therapy for Back or Joint Pain **Hinge Health** Get access to free wearable sensors and monitoring devices, unlimited one-on-one coaching and personalized exercise therapy.	*Anthem PPO members* **Call** 855-902-2777 **Visit** hingehealth.com/sisc
24/7 Virtual Primary Care Doctor **Eden Health** Virtually connect with a primary care physician to manage all your physical and mental healthcare needs. Eden providers diagnose conditions, manage prescriptions, refer to specialists, and answer follow up questions using video visits or live chat.	*Anthem PPO members* **Visit** edenhealth.com/members or download the app
24/7 Access to Virtual Maternity and Postpartum Support **Maven** Consult with a care advocate who connects you with trustworthy content delivered by doctors, specialists' coaches and other maternity providers to help deal with pregnancy and postpartum concerns.	*Anthem PPO members* **Call** 855-442-5885 **Visit** mavenclinic.com/join/SISC
Hip, Knee, and Spine Surgical Benefit **Carrum Health** Consult top-quality surgeons on hip and knee replacements and certain spine surgeries. Benefit covers all related travel and medical bills.	*Anthem PPO members* **Call** 888-855-7806 **Visit** carrumhealth.com/sisc
Enhanced Cancer Benefit **Contigo Health** Consult experts on initial diagnosis and development of a care plan. Benefit includes care coordination services with at home provider, transportation, and more.	*Anthem PPO members* **Call** 877-220-3556 **Visit** sisc.contigohealth.com

[1] Effective October 1, 2023, MDLive visits will have a $10 co-pay.

MEDICAL PLAN RESOURCES - FOR ANTHEM MEMBERS

FINDING AN ANTHEM PROVIDER

To find a provider in the Anthem PPO network, please visit www.anthem.com/ca/sisc.

SYDNEY MOBILE APP

Use Sydney™ Health to keep track of your health and benefits- all in one place. Access your plan details, Member Services, virtual care, and wellness resources. You can also set up an account at anthem.com/ca/register to access most of the same features from your computer.

Building Healthy Families

Building Healthy Families offers personalized, digital support through the Sydney℠ Health mobile app or on anthem.com/ca. This all-in-one program, at no extra cost to you, can help your family grow strong whether you're trying to conceive, expecting a child, or in the thick of raising young children.

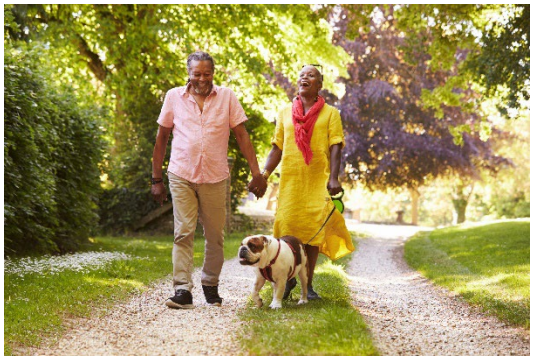
24/7 Nurse Line

24/7 NurseLine serves as your first line of defense for unexpected health issues. You can call a trained, registered nurse to decide what to do about a fever, give you allergy relief tips, or advise you where to go for care. For help, call 24/7 NurseLine at 800-700-9184.

Hip, Knee, and Spine Surgeries: Blue Distinction+ Requirement

In order to be covered by the Preferred Provider Organization (PPO) plan, hip and knee replacements and certain inpatient spine surgeries must be performed at an Anthem Blue Cross Blue Distinction+ center. BD+ Centers meet affordability criteria and deliver better results — including fewer complications and readmissions — than other hospitals. For a specific list of hip, knee and spine procedures that are part of the program, please call the Customer Service number on the back of your ID card. To find BD+ hospital, go to anthem.com/ca/sisc/find-care/ and scroll down to "Blue Distinction Centers and Centers of Medical Excellence".

MEDICAL PLAN RESOURCES – KAISER PERMANENTE MEMBERS



Kaiser Members

24/7 care advice

Get medical advice and care guidance in the moment from a Kaiser Permanente provider at (833) 574-2273.

Calm App

The Calm app uses meditation and mindfulness to help lower stress, reduce, anxiety, and improve sleep quality. Adult members can get Calm at kp.org/selfcareapps .

My Health Manager

Stay engaged with your health and simplify your busy life by using the Kaiser Website or download the Kaiser Permanente app from the App Store℠ or Google Play®.

Finding a Kaiser Provider

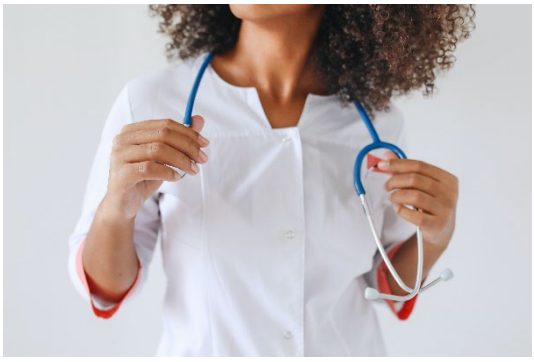
To find a Kaiser Permanente provider near you, please visit www.kp.org or call (800) 464-4000.

KNOW WHERE TO GO

Where you get medical care can have a significant impact on the cost. Here's a quick guide to help you know where to go, based on your condition, budget, and time.

Type	Appropriate for	Examples	Access	Cost
Nurseline 	Quick answers from a trained nurse	▪ Identifying symptoms ▪ Decide if immediate care is needed ▪ Home treatment options and advice	24/7	**$0**
Online visit 	Many non-emergency health conditions	▪ Cold, flu, allergies ▪ Headache, migraine ▪ Skin conditions, rashes ▪ Minor injuries ▪ Mental health concerns	24/7	**$**
Office visit 	Routine medical care and overall health management	▪ Preventive care ▪ Illnesses, injuries ▪ Managing existing conditions	Office Hours	**$$**
Urgent care, walk-in clinic 	Non-life-threatening conditions requiring prompt attention	▪ Stitches ▪ Sprains ▪ Animal bites ▪ Ear-nose-throat infections	Office Hours, or up to 24/7	**$$$**
Emergency room 	Life-threatening conditions requiring immediate medical expertise	▪ Suspected heart attack or stroke ▪ Major bone breaks ▪ Excessive bleeding ▪ Severe pain ▪ Difficulty breathing	24/7	**$$$$$**

PREVENTIVE CARE SCREENING BENEFITS



TYPICAL SCREENINGS FOR ADULTS

- Blood pressure
- Cholesterol
- Diabetes
- Colorectal cancer screening
- Depression
- Mammograms
- OB/GYN screenings
- Prostate cancer screening
- Testicular exam

You take your car in for maintenance. Why not do the same for yourself?

Annual preventive checkups can help you and your doctor identify your baseline level of health and detect issues before they become serious.

What is Preventive Care?

The Affordable Care Act (ACA) requires health insurers to cover a set of preventive services at no cost to you, even if you haven't met your yearly deductible. The preventive care services you'll need to stay healthy vary by age, sex, and medical history.

Visit **cdc.gov/prevention** for recommended guidelines.

Preventive care is covered in full only when obtained from an IN-NETWORK provider.

Not all exams and tests are considered preventive

Exams performed by specialists are generally not considered preventive and may not be covered at 100 percent.

Additionally, certain screenings may be considered diagnostic, not preventive, based on your current medical condition. You may be responsible for paying all or a share of the cost for those services.

If you have a question about whether a service will be covered as preventive care, contact your medical plan.

TURNING 65? UNDERSTAND YOUR MEDICARE OPTIONS

Alliant
MEDICARE SOLUTIONS
A Non-Government Entity

Alliant Medicare Solutions is a no-cost service available to you, your family members, and friends nearing age 65.

alliantmedicaresolutions.com

Alliant Medicare Solutions is provided by Insuractive LLC, a Nebraska resident insurance agency. Insuractive LLC is wholly owned by Alliant Insurance Services, Inc.

Whether you retire or continue to work, choosing the right healthcare option is an important decision when you reach age 65

Most people become eligible for Medicare at age 65. When that happens, you'll probably have some time-sensitive decisions to make, based on your individual situation.

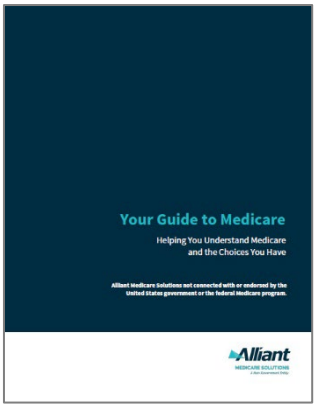
Introducing Alliant Medicare Solutions

Medicare can be complicated. Figuring out the rules—not to mention how Medicare works with or compares to your employer-provided medical coverage—can be a headache. That's why we are offering Alliant Medicare Solutions. The licensed insurance agents at AMS can help you understand Medicare, what is and isn't covered, and how to choose the best coverage for your situation.

How does it work?

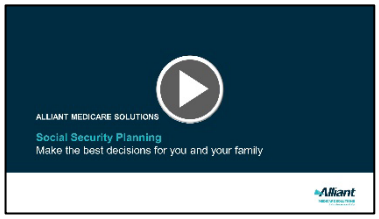
1. Call Alliant Medicare Solutions at **(877) 888-0165** to speak to a licensed insurance agent. Have your current medical coverage information available when you call.
2. Discuss with Alliant Medicare Solutions your existing insurance coverage, your Medicare options, and which of those plans might work the best for you.
3. If Medicare is the best option, Alliant Medicare Solutions helps you enroll immediately or emails policy materials for you to review and enroll at a later date.

Find Out More



Your Guide to Medicare

Medicare 101 Video



Social Security Planning Video

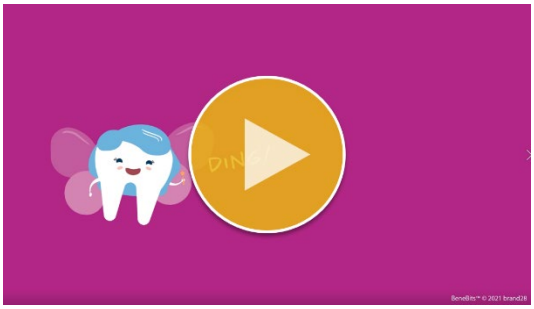
DENTAL

OUR PLANS

Delta Dental PPO (ACSIG) Plan

United Concordia Dental HMO Plan

Click to play video



We offer 2 dental plans through Delta Dental and United Concordia Dental.

Why Sign Up For Dental Coverage?

It's important to go to the dentist regularly. Brushing and flossing are great, but regular exams catch dental issues early before they become more expensive and difficult to treat.

That's where dental insurance comes in. Dental insurance makes it easier and less expensive to get the care you need to maintain good oral health.

Dental insurance covers four types of treatments:

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

Dental – Delta Dental PPO Plan

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%.

The coinsurance (%) shows what the plan pays after the deductible.

	Delta Dental PPO (ACSIG) Plan*	
	In-Network	**Out-of-Network**
Calendar Year Deductible	None	None
Calendar Year Plan Maximum	$3,000/member	$2,500/member
Waiting Period	None	None
Diagnostic & Preventive ***NEW** 4 cleanings and 3 exams*	70%-100%	70%-100%
Basic Services Fillings, Root Canals, Periodontics	70%-100%	70%-100%
Major Services Prosthodontics Crowns, inalys, onlays and cast restorations, *NEW implants[1] *	50% 70%-100%	50% 70%-100%
Dental Accident Benefits Dental Accident Benefits Maximum	100% Separate $1,000/person each calendar year	100% Separate $1,000/person each calendar year
Orthodontia Adults and Dependent Children	50%	50%
Ortho Lifetime Max	$2,000/person	$2,000/person

*Limitations or waiting periods may apply for some benefits; some services may be excluded from your plan. Reimbursement is based on Delta Dental contract allowances and not necessarily each dentist's actual fees.

[1] implant services are covered under annual max

What you need to know about this plan

Features:	See any provider, but you'll pay more out of network
Am I restricted to in-network providers?	No
Do I have to select a primary dentist?	No
Where can I get more details?	Call (866) 499-3001 or visit www.deltadentalins.com

Dental – United Concordia Dental HMO Plan

You always pay the copayment ($).

	United Concordia HMO Plan*
	In-Network
Annual Deductible	None
Annual Plan Maximum	None
Waiting Period	None
Diagnostic & Preventive	$0-$15 copay
Basic Services Fillings Root Canals Periodontics	 $0-$140 copay $0-$45 copay $0-$120 copay
Major Services	$0-$245 copay
Orthodontia Adults Dependent Children	 $2,000 copay $1,500 copay
Ortho Lifetime Max	None

*The copays listed on this page are illustrative. Please refer to United Concordia's Dental HMO benefit summary for the applicable copay for the specific procedure you are interested in having.

What you need to know about this plan

Features:	In-Network providers only
Am I restricted to in-network providers?	Yes
Do I have to select a primary dentist?	Yes
Where can I get more details?	Call (866) 357-3304 or visit www.unitedconcordia.com

VISION

OUR PLAN

VSP Signature Vision (ACSIG)

Click to play video

Why Sign Up For Vision Coverage?

Vision coverage helps with the cost of eyeglasses or contacts. But even if you don't need vision correction, an annual eye exam checks the health of your eyes and can even detect more serious health issues such as diabetes, high blood pressure, high cholesterol, and thyroid disease.

You'll even find discounts on glasses, sunglasses, services like LASIK, and savings on retinal screenings and featured frames. Visit the plan's website to check out these extra savings.

Vision – VSP Signature Vision (ACSIG)

Your vision checkup is fully covered after your Exam copay. After any Materials copay, the plan covers frames, lenses, and contacts as described below.

	VSP Signature Vision (ACSIG)	
	In-Network	**Out-of-Network**
Exams		
Benefit	$5 copay	Up to $50
Frequency	Once every 12 months	Once every 12 months
Eyeglass Lenses		
Single Vision Lens	$5 copay	Up to $50
Bifocal Lens	$5 copay	Up to $75
Trifocal Lens	$5 copay	Up to $100
Polycarbonate Lens	Covered	Not Covered
Frequency	Once every 12 months	Once every 12 months
Frames		
Benefit	$200 allowance + 20% off remaining balance $110 allowance at Costco	Up to $70
Frequency	Once every 12 months	Once every 12 months
Contacts (Elective)*		
Conventional	$200 allowance	$105 allowance (combined w/ in-network)
Frequency	Once every 12 months	Once every 12 months

*In lieu of frames

What you need to know about this plan

Features:	See any provider, but you'll pay more out of network
What other services are covered?	The plan can also help you save money on LASIK procedures, sunglasses, computer glasses, and retinal screenings.
Eyeglasses are expensive. Will I still be able to afford them, even with insurance?	Look for moderately priced frames and remember that your benefit is higher in-network.
Where can I get more details?	Call (800) 877-7195 or visit www.vsp.com

LIFE & DISABILITY

YOUR BENEFICIARY = WHO GETS PAID

If the worst happens, your beneficiary—the person (or people) on record with the life insurance carrier—receives the benefit. Make sure that you name at least one beneficiary for your life insurance benefit, and change your beneficiary as needed if your situation changes.

Is your family protected?

Life, AD&D, and disability insurance can fill a number of financial gaps due to a temporary or permanent reduction of income. Consider what your family would need to cover day-to-day living expenses and medical bills during a pregnancy or illness-related disability leave, or how you would manage large expenses (rent or mortgage, children's education, student loans, consumer debt, etc.) after the death of a spouse or partner.

We provide long-term disability benefits and a base amount of life and AD&D insurance to help you recover from financial loss.

If you need additional coverage

We offer voluntary coverage that you can purchase for yourself, your spouse, and your children.

COMPANY-PROVIDED LIFE AND AD&D INSURANCE

MORE INFORMATION

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

Basic Life and AD&D

Basic Life Insurance pays your beneficiary a lump sum if you die. AD&D (Accidental Death & Dismemberment) coverage provides a benefit to you if you suffer from loss of a limb, speech, sight, or hearing, or to your beneficiary if you have a fatal accident. Coverage is provided by Lincoln Financial Group and premiums are paid in full by Santa Clarita Community College District.

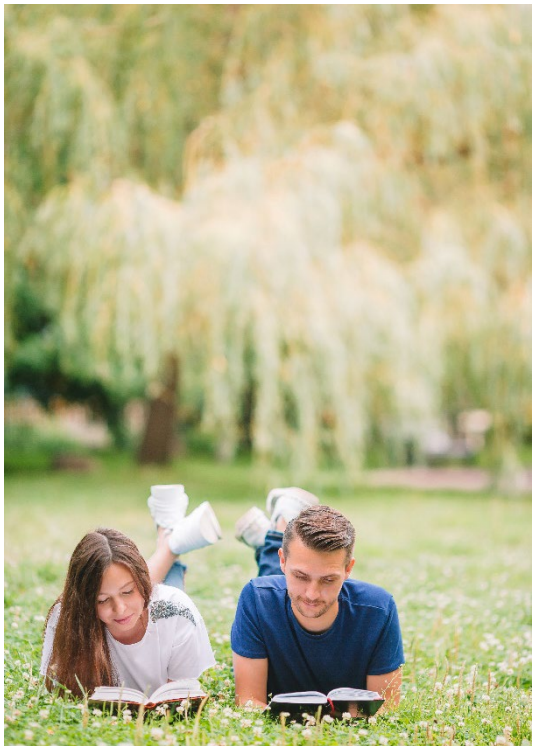
These benefits are available for all full-time and permanent part-time employees with at least 50% assignment.

Lincoln Financial Group Basic Life and AD&D

Basic Life and AD&D Amount: $50,000*

*Benefit amounts reduces at age 65. Please see Certificate of Coverage for more details.

VOLUNTARY LIFE AND AD&D INSURANCE



EVIDENCE OF INSURABILITY (EOI)

If you elect Voluntary Life coverage above guaranteed issue (noted on this page), or if you are a late entrant (enrolling more than 31 days after the date you become eligible), you must complete and submit EOI. This can be completed online through Lincoln Financial Group. You can find the form at lfg.com.

Protecting those you leave behind

Voluntary Life Insurance allows you to purchase additional life insurance to protect your family's financial security. Coverage is provided by Lincoln Financial Group and available for your spouse and/or child(ren).

Lincoln Financial Group Voluntary Life

Employee	Increments of $5,000 up to $500,000 (or 5x your annual earnings)* Guaranteed Issue: Lessor of $300,000 or 3x salary
Spouse	Increments of $5,000 up to $250,000 (not to exceed 50% of employee amount)* Guaranteed Issue: $50,000
Child(ren)	Option of $3,000 or $5,000 benefit (age 1 day to 6 months: $250 Benefit) Guaranteed Issue: $5,000

*Benefit amount reduces to at age 65.

In the event of a serious or fatal accident

Voluntary AD&D Insurance allows you to purchase accidental death and dismemberment coverage that pays your beneficiary if you have a fatal accident. If you experience a serious injury such as a loss of a limb, speech, sight or hearing, the plan pays a benefit to you.

Coverage is provided by Lincoln Financial Group and is available for your spouse and/or child(ren).

Lincoln Financial Group Voluntary AD&D

Employee	Increments of $5,000 up to $500,000 (or 5x your annual earnings)*
Spouse	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)	20% 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

*Benefit amount reduces to at age 65.

VOLUNTARY LIFE & AD&D INSURANCE COSTS

If you elect voluntary coverage, your monthly premium rate is calculated based on your age and the amount of coverage. Use the tables below to estimate the premium amount that will be deducted from your paycheck.

VOLUNTARY LIFE INSURANCE – TENTHLY RATE PER $1,000 OF COVERAGE

AGE	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

CHILD LIFE INSURANCE

COVERAGE AMOUNT	Rate per $1,000 of coverage
$3,000	$0.15
$5,000	$0.25

Premium includes all eligible children. Eligible children include dependent children under age 26 as long as you apply for and are approved for coverage for yourself.

VOLUNTARY AD&D – TENTHLY RATE PER $1,000 OF COVERAGE

Employee	$0.032
Employee + Family	$0.049

To calculate your per paycheck AD&D cost, follow the same steps as the table above.

CALCULATE YOUR LIFE INSURANCE COST

1. Desired Coverage ($1,000 Increments)

You:	Spouse:

2. Divide Step 1 by 1,000 =

You:	Spouse:

3. Multiply Step 2 by Rate from Table =

You:	Spouse:

4. Add You + Spouse from Step 4:

TOTAL COST PER PAYCHECK:

LONG-TERM DISABILITY INSURANCE (LTD)

3 THINGS TO KNOW ABOUT LTD INSURANCE

1. It can protect you from having to tap into your retirement savings.
2. You can use LTD benefits however you need, for housing, food, medical bills, etc.
3. Benefits can last a long time—from weeks to even years—if you remain eligible.

LTD benefits cushion the financial impact of a disability

Long-Term Disability (LTD) insurance replaces part of your income for longer term issues such as:

- Debilitating illness (cancer, heart disease, etc.)
- Serious injuries (accident, etc.)
- Heart attack, stroke
- Mental disorders.

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

If you qualify, LTD benefits begin after short-term disability benefits end. Payments may be reduced by state, federal, or private disability benefits you receive while disabled. Santa Clarita Community College District pays the cost of this coverage. Coverage is provided by Lincoln Financial Group.

Monthly Benefit Amount	Plan pays 66.67% of covered monthly earnings
Maximum Monthly Benefit	$6,000
Benefits Begin After Accident Sickness	 120 days of disability 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.

WELLBEING & BALANCE

THE KEY TO KEEPING YOUR BALANCE IS KNOWING WHEN YOU'VE LOST IT

The challenges of daily life can be hard to balance. Whether it's work, school or family obligations, it's no wonder that many of us sometimes have trouble managing the ups and downs of our day-to-day lives.

A Happier, Healthier You

Creating a healthy balance between work and play is a major factor in leading a happy and productive lifestyle, but it's not always easy.

Taking care of yourself will help you be more effective in all areas of your life. Be sure to take advantage of the program to stay at your best.

EMPLOYEE ASSISTANCE PROGRAM (EAP)

CONTACT THE EAP

Phone
1-888-628-4824

Website
Login to www.guidanceresources.com with the below credentials:
Username: LFGsupport
Password: LFGsupport1

Help for you and your household members

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

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

No cost EAP resources

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

- Unlimited phone access 24/7
- In-person or video counseling for short-term issues; up to 5 visits per issue
- Unlimited web access to helpful articles, resources, and self-assessment tools

COUNSELING BENEFITS

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

PARENTING & CHILDCARE

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

FINANCIAL COACHING

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

LEGAL CONSULTATION

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

ELDERCARE RESOURCES

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

ONLINE RESOURCES

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

IMPORTANT PLAN INFORMATION

In this section, you'll find important plan information, including:

- Contact information for our benefit carriers and vendors
- A summary of the health plan notices you are entitled to receive annually, and where to find them
- A Benefits Glossary to help you understand important insurance terms.

Please note that unless your domestic partner is your tax dependent as defined by the IRS, contributions for domestic partner coverage must be made after-tax. Similarly, the company contribution toward coverage for your domestic partner and his/her dependents will be reported as taxable income on your W-2. Contact your tax advisor for more details on how this tax treatment applies to you. Notify Santa Clarita Community College District if your domestic partner is your tax dependent.

PLAN CONTACTS

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 Physicians 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			

GLOSSARY

-A-

AD&D Insurance
An insurance plan that pays a benefit to you or your beneficiary if you suffer from loss of a limb, speech, sight, or hearing, or if you have a fatal accident.

Allowed Amount
The maximum amount your plan will pay for a covered healthcare service.

Ambulatory Surgery Center (ASC)
A healthcare facility that specializes in same-day surgical procedures such as cataracts, colonoscopies, upper GI endoscopy, orthopedic surgery, and more.

Annual Limit
A cap on the benefits your plan will pay in a year. Limits may be placed on particular services such as prescriptions or hospitalizations. Annual limits may be placed on the dollar amount of covered services or on the number of visits that will be covered for a particular service. After an annual limit is reached, you must pay all associated health care costs for the rest of the plan year.

-B-

Balance Billing
In-network providers are not allowed to bill you for more than the plan's allowable charge, but out-of-network providers are. This is called balance billing. For example, if the provider's fee is $100 but the plan's allowable charge is only $70, an out-of-network provider may bill YOU for the $30 difference (the balance).

Beneficiary
The person (or persons) that you name to be paid a benefit should you die. Beneficiaries are requested for life, AD&D, and retirement plans. You must name your beneficiary in advance.

Brand Name Drug
A drug sold under its trademarked name. For example, Lipitor is the brand name of a common cholesterol medicine.

-C-

COBRA
A federal law that may allow you to temporarily continue healthcare coverage after your employment ends, based on certain qualifying events. If you elect COBRA (Consolidated Omnibus Budget Reconciliation Act) coverage, you pay 100% of the premiums, including any share your employer used to pay, plus a small administrative fee.

Claim
A request for payment that you or your health care provider submits to your healthcare plan after you receive services that may be covered.

Coinsurance
Your share of the cost of a healthcare visit or service. Coinsurance is expressed as a percentage and always adds up to 100%. For example, if the plan pays 70%, your coinsurance responsibility is 30% of the cost. If your plan has a deductible, you pay 100% of the cost until you meet your deductible amount.

Copayment
A flat fee you pay for some healthcare services, for example, a doctor's office visit. You pay the copayment (sometimes called a copay) at the time you receive care. In most cases, copays do not count toward the deductible.

-D-

Deductible
The amount of healthcare expenses you have to pay for with your own money before your health plan will pay. The deductible does not apply to preventive care and certain other services.

Family coverage may have an ***aggregate*** or ***embedded*** deductible. Aggregate means your family must meet the entire family deductible before any individual expenses are covered. Embedded means the plan begins to make payments for an individual member as soon as they reach their individual deductible.

Dental Basic Services
Services such as fillings, routine extractions and some oral surgery procedures.

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

Dental Major Services
Complex or restorative dental work such as crowns, bridges, dentures, inlays and onlays.

Dependent Care Flexible Spending Account (FSA)
An arrangement through your employer that lets you pay for eligible child and elder care expenses with tax-free dollars. Eligible expenses include day care, before and after-school programs, preschool, and summer day camp for children underage 13. Also included is care for a spouse or other dependent who lives with you and is physically incapable of self-care.

-E-

Eligible Expense
A service or product that is covered by your plan. Your plan will not cover any of the cost if the expense is not eligible.

Excluded Service
A service that your health plan doesn't pay for or cover.

-F-

Formulary
A list of prescription drugs covered by your medical plan or prescription drug plan. Also called a drug list.

-G-

Generic Drug
A drug that has the same active ingredients as a brand name drug but is sold under a different name. For example, Atorvastatin is the generic name for medicines with the same formula as Lipitor.

Grandfathered
A medical plan that is exempt from certain provisions of the Affordable Care Act (ACA).

-H-

Health Reimbursement Account (HRA) An account funded by an employer that reimburses employees, tax-free, for qualified medical expenses up to a maximum amount per year. Sometimes called Health Reimbursement Arrangements.

Healthcare Flexible Spending Account (FSA)
A health account through your employer that lets you pay for many out-of-pocket medical expenses with tax-free dollars. Eligible expenses include insurance copayments and deductibles, qualified prescription drugs, insulin, and medical devices, and some over-the-counter items.

High Deductible Health Plan (HDHP) A medical plan with a higher deductible than a traditional insurance plan. The monthly premium is usually lower, but you pay more health care costs (the deductible) before the insurance company starts to pay its share. A high deductible plan (HDHP) may make you eligible for a health savings account (HSA) that allows you to pay for certain medical expenses with money free from federal taxes.

GLOSSARY

-I-

In-Network
In-network providers and services contract with your healthcare plan and will usually be the lowest cost option. Check your plan's website to find doctors, hospitals, labs, and pharmacies. Out-of-network services will cost more or may not be covered.

-L-

Life Insurance
An insurance plan that pays your beneficiary a lump sum if you die.

Long Term Disability Insurance
Insurance that replaces a portion of your income if you are unable to work due to a debilitating illness, serious injury, or mental disorder. Long term disability generally starts after a 90-day waiting period.

-M-

Mail Order
A feature of a medical or prescription drug plan where medicines you take routinely can be delivered by mail in a 90-day supply.

-O-

Open Enrollment
The time of year when you can change the benefit plans you are enrolled in and the dependents you cover. Open enrollment is held one time each year. Outside of open enrollment, you can only make changes if you have certain events in your life, like getting married or adding a new baby or child in the family.

Out-of-Network
Out-of-network providers (doctors, hospitals, labs, etc.) cost you more because they are not contracted with your plan and are not obligated to limit their maximum fees. Some plans, such as HMOs and EPOs, do not cover out-of- network services at all.

Out-of-Pocket Cost
A healthcare expense you are responsible for paying with your own money, whether from your bank account, credit card, or from a health account such as an HSA, FSA or HRA.

Out-of-Pocket Maximum
Protects you from big medical bills. Once costs "out of your own pocket" reach this amount, the plan pays 100% of most remaining eligible expenses for the rest of the plan year.

Family coverage may have an *aggregate* or *embedded* maximum. Aggregate means your family must meet the entire family out-of-pocket maximum before the plan pays 100% for any member. Embedded means the plan will cover 100% for an individual member as soon as they reach their individual maximum.

Outpatient Care
Care from a hospital that doesn't require you to stay overnight.

-P-

Participating Pharmacy
A pharmacy that contracts with your medical or drug plan and will usually result in the lowest cost for prescription medications.

Plan Year
A 12-month period of benefits coverage. The 12-month period may or may not be the same as the calendar year.

Preferred Drug
Each health plan has a preferred drug list that includes prescription medicines based on an evaluation of effectiveness and cost. Another name for this list is a "formulary." The plan may charge more for non-preferred drugs or for brand name drugs that have generic versions. Drugs that are not on the preferred drug list may not be covered.

Preventive Care Services
Routine healthcare visits that may include screenings, tests, check-ups, immunizations, and patient counseling to prevent illnesses, disease, or other health problems. Many preventive care services are fully covered. Check with your health plan in advance if you have questions about whether a preventive service is covered.

Primary Care Provider (PCP)
The main doctor you consult for healthcare issues. Some medical plans require members to name a specific doctor as their PCP and require care and referrals to be directed or approved by that provider.

-S-

Short Term Disability Insurance
Insurance that replaces a portion of your income if you are temporarily unable to work due to surgery and recovery time, a prolonged illness or injury, or pregnancy issues and childbirth recovery.

-T-

Telehealth / Telemedicine / Teledoc
A virtual visit to a doctor using video chat on a computer, tablet or smartphone. Telehealth visits can be used for many common, non-serious illnesses and injuries and are available 24/7. Many health plans and medical groups provide telehealth services at no cost or for much less than an office visit.

-U-

UCR (Usual, Customary, and Reasonable)
The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service. The UCR amount sometimes is used to determine the allowed amount.

Urgent Care
Care for an illness, injury or condition serious enough that care is needed right away, but not so severe it requires emergency room care. Treatment at an urgent care center generally costs much less than an emergency room visit.

-V-

Vaccinations
Treatment to prevent common illnesses such as flu, pneumonia, measles, polio, meningitis, shingles, and other diseases. Also called immunizations.

Voluntary Benefit
An optional benefit plan offered by your employer for which you pay the entire premium, usually through payroll deduction.

IMPORTANT PLAN INFORMATION

WHAT YOU NEED TO KNOW ABOUT THE "NO SURPRISES" RULES

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

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

View a sample notice and consent form (PDF).

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

IMPORTANT PLAN INFORMATION

HEALTH PLAN NOTICES

These notices must be provided to plan participants on an annual basis and are available in the Annual Notices document, located within this guide:

- **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
- **HIPAA Notice of Privacy Practices:** Describes how health information about you may be used and disclosed
- **Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP):** Describes availability of premium assistance for Medicaid eligible dependents.
- **Notice of Choice of Providers:** Notifies you that your plan requires you to name a Primary Care Physician (PCP) or provides for you to select one
- **Michelle's Law:** Describes right to extend dependent medical coverage during student leaves

COBRA CONTINUATION COVERAGE

You and/or your dependents may have the right to continue coverage after you lose eligibility under the terms of our health plan. Upon enrollment, you and your dependents receive a COBRA Initial Notice that outlines the circumstances under which continued coverage is available and your obligations to notify the plan when you or your dependents experience a qualifying event. Please review this notice carefully to make sure you understand your rights and obligations.

DEADLINE FOR FILING LAWSUIT UNDER ERISA AFTER EXHAUSTION OF ALL CLAIMS PROCEDURES

Any lawsuit must be filed within 36 months of the final decision on the claim. Exhaustion of all claims and appeals procedure is required prior to filing suit. Please refer to the WRAP Summary Plan Description for the plan specific statute of limitations.

PLAN DOCUMENTS

Important documents for our health plan and retirement plan are available from Human Resources. Paper copies of these documents and notices are available if requested. If you would like a paper copy, please contact the Plan Administrator.

SUMMARY PLAN DESCRIPTIONS (SPD)

The legal document for describing benefits provided under the plan as well as plan rights and obligations to participants and beneficiaries.

- Santa Clarita Community College's Group Health Plan

SUMMARY OF BENEFITS AND COVERAGE (SBC)

A document required by the Affordable Care Act (ACA) that presents benefit plan features in a standardized format. SBC documents are available from Human Resources.

- Anthem Blue Cross Priority Select HMO Plan
- Anthem Blue Cross 90-A $20; $5-$20 Rx Classic PPO Plan
- Anthem blue Cross 90-C $20; $9-$35 Rx Classic PPO Plan
- Kaiser $20 OV; $10-$20 Rx HMO Plan
- Kaiser $30 OV; $10-$30 Rx HMO Plan

STATEMENT OF MATERIAL MODIFICATIONS

This enrollment guide constitutes a Summary of Material Modifications (SMM) to the 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.

DETERMINING ELIGIBILITY

MONTHLY MEASUREMENT METHOD

The information below explains how your eligibility for healthcare coverage is determined, in accordance with the rules of the Affordable Care Act (ACA).

You and your dependents are eligible for the plan if you are a full-time employee. A full-time employee is generally an employee who works on average 130 hours per month, as defined by the ACA. Hours that count toward full-time status include each hour for which an employee is paid or entitled to payment for the performance of duties for the employer, and each hour for which an employee is paid or entitled to payment for a period of time during which no duties are performed due to vacation, holiday, illness, incapacity (including disability), layoff, jury duty, military duty, or leave of absence.

ACA full-time status can affect or determine major medical benefits eligibility but is not a guarantee of benefits eligibility. Santa Clarita Community College District uses the monthly measurement method to determine whether an employee meets this eligibility threshold.

TERMINATION OF COVERAGE FOR INELIGIBLE DEPENDENTS

Knowingly enrolling an ineligible dependent or intentionally keeping a dependent on the plan when they have lost eligibility constitutes insurance fraud and is a material misrepresentation of fact. When the plan discovers any such ineligible depend it will terminate coverage retroactively and reprocess any claims, making them payable by such an individual. The employer plan sponsor will also explore disciplinary action against any employee who engages in this misconduct including but not limited to termination of employment.

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 Anthem Blue Cross and Kaiser Permanente 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 Permanente 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, 2024
Name of Entity/Sender:	Santa Clarita 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 30 days after the marriage, birth, adoption, or placement for adoption.
- Lose Medicaid or Children's Health Insurance Program (CHIP) coverage because you are no longer eligible. You must request medical plan enrollment within 60 days after the loss of such coverage.

If you request a change due to a special enrollment event within the 30-day timeframe, coverage will be effective the date of birth, adoption or placement for adoption. For all other events, coverage will be effective the first of the month following your request for enrollment. In addition, you may enroll in 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 right, you may add the dependent to your current coverage or change to another health plan.

Availability of Privacy Practices Notice

We maintain the HIPAA Notice of Privacy Practices for Santa Clarita Community College District describing how health information about you may be used and disclosed. You may obtain a copy of the Notice of Privacy Practices by contacting Human Resources.

Notice of Choice of Providers

The Anthem Blue Cross HMO Plan 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

Anthem Blue Cross and Kaiser Permanente 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 Human Resources 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.

ACA Disclaimer

This offer of coverage may disqualify you from receiving government subsidies for an Exchange plan even if you choose not to enroll. To be subsidy eligible you would have to establish that this offer is unaffordable for you, meaning that the required contribution for employee only coverage under our base plan exceeds 8.39% in 2024 of your modified adjusted household income.

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, 2024. Contact your State for more information on eligibility—

ALABAMA – Medicaid
Website: http://myalhipp.com/ | Phone: 1-855-692-5447
ALASKA – Medicaid
The AK Health Insurance Premium Payment Program | Website: http://myakhipp.com/ | Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid
Website: http://myarhipp.com/ | Phone: 1-855-MyARHIPP (855-692-7447)
CALIFORNIA – Medicaid
Health Insurance Premium Payment (HIPP) Program website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 | Fax: 916-440-5676 | Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943 | State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991 | State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442
FLORIDA – Medicaid
Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

GEORGIA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra | Phone: 678-564-1162, press 2
INDIANA – Medicaid
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 | HIPP Phone: 1-800-967-4660
KENTUCKY – Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx | Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kynect.ky.gov | Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms
LOUISIANA – Medicaid
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 | TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 800-977-6740 | TTY: Maine relay 711
MASSACHUSETTS – Medicaid and CHIP
Website: https://www.mass.gov/masshealth/pa | Phone: 1-800-862-4840 | TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid
Website: https://mn.gov/dhs/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 | email: HHSHIPPProgram@mt.gov
NEBRASKA – Medicaid
Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 | Lincoln: 402-473-7000 | Omaha: 402-595-1178
NEVADA – Medicaid
Medicaid Website: http://dhcfp.nv.gov | Medicaid Phone: 1-800-992-0900
NEW HAMPSHIRE – Medicaid
Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 | Toll-free number for the HIPP program: 1-800-852-3345, ext. 5218
NEW JERSEY – Medicaid and CHIP
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ | Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html | 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://medicaid.ncdhhs.gov/ | Phone: 919-855-4100
NORTH DAKOTA – Medicaid
Website: https://www.hhs.nd.gov/healthcare | Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP
Website: http://www.insureoklahoma.org | Phone: 1-888-365-3742
OREGON – Medicaid
Website: http://healthcare.oregon.gov/Pages/index.aspx | Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx | Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) | CHIP Phone: 1-800-986-KIDS (5437)
RHODE ISLAND – Medicaid and CHIP
Website: http://www.eohhs.ri.gov/ | Phone: 1-855-697-4347 or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid
Website: https://www.scdhhs.gov | Phone: 1-888-549-0820
SOUTH DAKOTA – Medicaid
Website: http://dss.sd.gov | Phone: 1-888-828-0059
TEXAS – Medicaid
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493
UTAH – Medicaid and CHIP
Medicaid Website: https://medicaid.utah.gov/ | CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
VERMONT – Medicaid
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427
VIRGINIA – Medicaid and CHIP
Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select or https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid
Website: https://www.hca.wa.gov/ | Phone: 1-800-562-3022
WEST VIRGINIA – Medicaid and CHIP
Website: https://dhhr.wv.gov/bms/ or http://mywvhipp.com/ Medicaid Phone: 304-558-1700 | CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm | Phone: 1-800-362-3002
WYOMING – Medicaid
Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ | Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since January 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
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

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SANTA CLARITA COMMUNITY COLLEGE DISTRICT
COLLEGE OF THE CANYONS