2025-2026

Classified, Confidential & Management Benefits

Invest in Yourself

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 Important Plan Information section for more details.

Welcome to Your Benefits Guide

Whether you're enrolling in benefits for the first time, nearing retirement, or somewhere in between, Santa Clarita Community College District (SCCCD) 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 and more.

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

The benefits in this summary are effective October 1, 2025 through **September 30, 2026.**

IMPORTANT NOTE: This is a summary overview and does not provide a complete description of all benefit provisions. While we've made every effort to make sure that this overview is comprehensive, it cannot provide a complete description of all benefits. Specific details and limitations are provided in the plan documents, such as the Summary of Benefits and Coverage (SBC), Evidence of Coverage (EOC), etc. Plan documents contain relevant provisions and determine how benefits are paid. If the information in this overview differs from the plan documents, the plan documents prevail.

Who is Eligible?

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

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

The following dependents are eligible for benefits:

- Legally married spouse.
- Registered Domestic Partner (RDP), where applicable by state law, is eligible for coverage if you have completed a Domestic Partner Affidavit. Review the Affidavit carefully because it will include important information regarding the guidelines for adding, ending or changing your domestic partner.
- 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).

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

- Parents, grandparents, and siblings.

When you can enroll

New Hire Enrollment	New hire coverage begins on first of the month following your date of hire. You must enroll within 30 days of becoming eligible.
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 for an October 1 effective date.
Qualifying Life Event	A qualifying life event is a significant change in your life that allows you to make changes to your benefits outside of open enrollment. See the next page for more information.

Eligibility Documentation Checklist

The following verification documents are required to enroll a subscriber or dependent in health benefit plans. SISC requires the Social Security Numbers for all members to be covered on the plans and reserves the right to request additional documentation to substantiate eligibility.

Dependent Type	Required Documentation
Spouse	▪ Prior year's Federal Tax Form that shows the couple was married (First page only, financial information may be blocked out). ▪ A marriage certificate will be accepted for newly married couples when filing has not yet been required for the current tax year.
Domestic Partner	▪ A Certificate of Registered Domestic Partnership issued by the State of California or a certified copy of the Declaration of Domestic Partnership that includes the dated, signed Secretary of State Certification Stamp. (Enrolling a Domestic Partner may cause the employer contribution to become taxable.)
Children, Stepchildren, and/or Adopted Children up to age 26	▪ Legal Birth Certificate or Hospital Birth Certificate (to include full name of child, parent(s) name & child's DOB) ▪ Legal Adoption Documentation
Legal Guardianship up to age 18	▪ Legal U.S. Court Documentation establishing Guardianship
Unmarried Disabled Dependents over age 26 (requires enrollment in a SISC medical plan)	**ANTHEM BLUE CROSS (All items listed below are required)** ▪ Legal Birth Certificate or Hospital Birth Certificate (to include full name of child, parent(s) name and child's DOB) ▪ Prior year's Federal Tax Form that shows child is claimed as an IRS dependent (First page only, income information may be blocked out) ▪ Proof of 6 months prior creditable coverage under the employee/retiree's plan. There can be no break in coverage ▪ Completed Anthem Disabled Dependent Certification Form **KAISER (All items listed below are required)** ▪ Legal Birth Certificate or Hospital Birth Certificate (to include full name of child, parent(s) name & child's DOB) ▪ Prior year's Federal Tax Form that shows child is claimed as an IRS dependent (First page only, income information may be blocked out) ▪ Proof of 6 months prior creditable coverage under the employee/retiree's plan. There can be no break in coverage.

Changing Your Benefits

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).

Any change you make must be consistent with the change in status. All proper documentation is required to cover dependents (marriage certificates, birth certificates, etc.).

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

Dependent Verification

Making changes to dependents is subject to eligibility. You will be required to provide proof of one or more of the following within 30 days of their eligibility:

- Marriage Certification or License
- Domestic Partners Affidavit
- 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.

Enrolling for Benefits

Benefit Bridge

Benefit Bridge is an online system that enables you to make all your benefit decisions in one place. If you don't have access to a computer, you can access the enrollment portal from a tablet or smartphone.

Before you enroll

- Know the date of birth, social security number, and address for each dependent you will cover.
- Review your enrollment materials to understand your benefit options and costs for the coming year.

Getting started

Need to create login credentials?

In the address bar, type www.benefitbridge.com/scccd (not in the Bing, Google, Yahoo search engine field)

Click the **Enter** key, then follow the instructions below to register:

1. Step 1: Select "Register" to create an Account
    1. You will need to create an account using your first and last name as they appear on your payroll statement
2. Step 2: Create a Username and Password
3. Step 3: Select "Continue" to access BenefitBridge

Already have a CanyonsID?

LOG IN to BenefitBridge

Username: Your CanyonsID login username

Example: Mary Smith login is staff\Smith_m

Password: Your CanyonsID login password

Enrolling in Benefits

- Log in to BenefitBridge
- ADD your personal and dependent information.
- SELECT your benefit plans for the coming year.
- REVIEW your choices and costs before finalizing.

Mid-Year changes

- You have year-round access to a summary of your benefits through Benefit Bridge .
- Mid-year changes should be initiated through Benefit Bridge - HR may reach out for additional verification.

Medical

Our medical plans offer comprehensive coverage. Preventive care is fully covered under all plans if obtained in-network. Your costs for other services will depend on which plan you choose.

Medical Plan Overview

This guide serves as a summary of the medical plans. Please review the plan documents before selecting a plan.

	What you need to know
Kaiser HMO *Kaiser Network*	• Access to Kaiser providers/facilities exclusively • Requires PCP to see specialist • No deductible • Predictable costs
Anthem Blue Cross HMO *Classic Network*	• In-network only • Requires PCP to see specialist • No deductible • Predictable costs
Anthem Blue Cross PPO *Prudent Buyer PPO Network*	• Must meet deductible for some services before the plan begins to pay a % of the cost • Out-of-network coverage; higher costs

Click to play video

Insurance Lingo

Watch this video to review helpful healthcare terms.

SISC HMO Medical – Classified & Confidential

This table shows member cost share.

	Anthem Blue Cross HMO *California Care network*		Kaiser Permanente HMO
	In-Network Only		**In-Network Only**
Accumulation Period	Calendar year from January 1 through December 31		
Calendar Year Deductible	None		None
Calendar Year Out-of-Pocket Maximum[1]			
Individual Coverage	$2,000 per individual		$1,500 per individual
Family Coverage	$2,000 per individual /$4,000 per family		$1,500 per individual /$3,000 per family
Office Visit			
Primary Care (office and virtual)	$20		$15
Specialist (office and virtual)	$40		$15
Virtual Care-Only Providers (cost thru mobile app and website)	Primary, UC, Mental Health: No charge Specialist: $40		No charge
Preventive Services	No charge		No charge
Urgent Care	$20		$15
Emergency Room	$100 per visit (waived if admitted)		$100 per visit (waived if admitted)
Lab and Imaging			
Basic Lab and X-ray	No charge		No charge
Advanced Imaging (CT, MRI, PET)	$100 per service		No charge
Outpatient Surgery			
Hospital	$125 per visit		$15 per procedure
Ambulatory Surgical Center (ASC)	$125 per visit		N/A
Inpatient Hospitalization	$250 per admission		No charge
Chiropractic and Acupuncture			
Medical Network (20 Chiro/20 Acu per year)	$20 per visit		N/A
ASH Network (Chiro & Acu combined per year)	$10 (up to 30 visits/year)		$10 (up to 30 visits/year)
PRESCRIPTION DRUGS	Navitus		Kaiser Permanente
Calendar Year Deductible	$200 individual / $500 family		None
Calendar Year Out-of-Pocket Maximum	$2,500 per individual/$3,500 per family		Combined with medical[2]
Retail	**Walk-in**	**Costco**	
Generic	$10	No charge/No charge	$5
Brand	$35[3]	$35[3] /$90[3]	$20
Specialty	N/A	N/A	$20 (30-day supply only)
Supply Limit	30 days	30 days/90 days	100 days
Mail Order	**Navitus**	**Costco**	
Generic	N/A	No charge	$10
Brand	N/A	$90[3]	$40
Specialty	$35[3]	N/A	N/A
Supply Limit	30 days	90 days	100 days

[1]This family maximum is embedded, meaning that the plan will cover 100% for a member once they reach their individual maximum.
[2]All covered expenses including your medical deductibles and prescription copays accumulate towards the out-of-pocket maximum.
[3]After Deductible

SISC PPO Medical – Classified & Confidential

This table shows member cost share.

	Anthem Blue Cross PPO plan *(Prudent Buyer Network)*	
	In-Network	**Out-of-Network**
Accumulation Period	Calendar year from January 1 through December 31	
Calendar Year Deductible[1]		
Individual Coverage	$100 per individual	
Family Coverage	$100 per individual/$300 per family	
Calendar Year Out-of-Pocket Maximum[2,3]		
Individual Coverage	$1,000 per individual	No limit
Family Coverage	$1,000 per individual/$3,000 per family	No limit
Office Visit		
Primary Care (office and virtual)	$0 for visits 1-3; $20 for visits 4+	All billed amounts exceeding the maximum allowed amount[4]
Specialist (office and virtual)	$20	All billed amounts exceeding the maximum allowed amount[4]
Virtual Care-Only Providers (cost thru mobile app and website)	Primary, UC, Mental Health: No charge Specialist: $20	N/A
Preventive Services	No charge	Not covered
Urgent Care	$20	All billed amounts exceeding the maximum allowed amount[4]
Emergency Room	$100 per visit and 10%[4] (waived if admitted)	
Lab and Imaging		
Basic Lab and X-ray	10%[4]	Not covered
Advanced Imaging (CT, MRI, PET)	10%[4]	All billed amounts exceeding the lessor of the benefit amount or $800[4] per test
Outpatient Surgery		
Hospital	10%[4]	All billed amounts exceeding the maximum allowed amount[4]
Ambulatory Surgical Center (ASC)	10%[4]	All billed amounts exceeding $350 per day[4]
Inpatient Hospitalization	10%[4]	All billed amounts exceeding $600 per day[4]
Chiropractic[5]	10%[4]	Not covered
Acupuncture (up to 12 visits/year)	10%[4]	50% of maximum allowed amount[4]
PRESCRIPTION DRUGS (Navitus)		
Calendar Year Deductible	N/A	N/A
Calendar Year Out-of-Pocket Maximum	$1,500 per individual/$2,500 per family	N/A
Retail - 30 days/90 days	**Walk-in** / **Costco**	Not covered
Generic	$5 / N/A	No charge/No charge
Brand	$20 / N/A	$20 /$50
Specialty	N/A	N/A
Mail Order - 30 days/90 days	**Navitus** / **Costco**	Not covered
Generic	$5 / N/A	N/A / No charge
Brand	$20 / N/A	N/A /$50
Specialty	N/A	N/A

[1]This family deductible is embedded, meaning that the plan begins to make payments for a member once they reach their individual deductible. [2]This family maximum is embedded, meaning that the plan will cover 100% for a member once they reach their individual maximum. [3]All covered expenses including your medical deductibles and prescription copays accumulate towards the out-of-pocket maximum. [4]After deductible. [5]Pre-authorization review by American Specialty Health (ASH) is required after the 5th visit.

SISC PPO Medical – Classified & Confidential

This table shows member cost share.

	Anthem Blue Cross PPO Platinum + *(Prudent Buyer PPO Network)*	
	In-Network	**Out-of-Network**
Accumulation Period	Calendar year from January 1 through December 31	
Calendar Year Deductible[1] Individual Coverage/Family Coverage	None	
Calendar Year Out-of-Pocket Maximum[2,3] Individual Coverage Family Coverage	 $1,000 per individual $1,000 per individual/$3,000 per family	 No limit No limit
Office Visit Primary Care (office and virtual) Specialist (office and virtual) Virtual Care-Only Providers (cost thru mobile app and website)	 $0 $40 Primary, UC, Mental Health: No charge Specialist: $40	 PCP: All billed amounts exceeding the maximum allowed amount[4] SPC: All billed amounts exceeding the maximum allowed amount[4] N/A
Preventive Services	No charge	Not covered
Urgent Care	$0	All billed amounts exceeding the maximum allowed amount[4]
Emergency Room	$300 per visit (waived if admitted)	
Lab and Imaging Basic Lab and X-ray Advanced Imaging (CT, MRI, PET)	 $0-$75 Freestanding Center: $100/ OP Hospital $250	 Basic: Not covered Adv: Maximum benefit allowed of $800[4] per test
Outpatient Surgery Hospital Ambulatory Surgical Center (ASC)	 $600 $200	 Hospital: : All billed amounts exceeding the maximum allowed amount[4] ASC: All billed amounts exceeding $350 allowed amount[4]
Inpatient Hospitalization	$200 per day	Maximum benefit allowed of $600[4]
Chiropractic[5]	$0	Not covered
Acupuncture (up to 12 visits/year)	$0	50% of maximum allowed amount[4]
PRESCRIPTION DRUGS (Navitus)		
Calendar Year Deductible	N/A	N/A
Calendar Year Out-of-Pocket Maximum	$2,500 per individual/$3,500 per family	N/A
Retail - 30 days/90 days Generic Preferred Brand[6] Brand Specialty	**Walk-in** $9 No charge $35 N/A	**Costco** No charge/No charge No charge/No charge $35 /$90 N/A	Not covered
Mail Order - 90 days Generic Preferred Brand[6] Brand Specialty	**Navitus** N/A N/A N/A $35 (30 days)	**Costco** No charge No charge $90 N/A	Not covered

[1]This family deductible is embedded, meaning that the plan begins to make payments for a member once they reach their individual deductible. [2]This family maximum is embedded, meaning that the plan will cover 100% for a member once they reach their individual maximum. [3]All covered expenses including your medical deductibles and prescription copays accumulate towards the out-of-pocket maximum. [4]After deductible. Member may be responsible for costs beyond the permitted amount and the overall charges. [5]Pre-authorization review by American Specialty Health (ASH) is required after the 5th visit. [6]See formulary list for covered medications.

SISC HMO Medical – Management

This table shows member cost share.

	Anthem Blue Cross HMO		Kaiser Permanente HMO
	In-Network Only		In-Network Only
Accumulation Period	Calendar year from January 1 through December 31		
Calendar Year Deductible	None		None
Calendar Year Out-of-Pocket Maximum[1]			
Individual Coverage	$2,000 per individual		$1,500 per individual
Family Coverage	$2,000 per individual /$4,000 per family		$1,500 per individual/$3,000 per family
Office Visit			
Primary Care (office and virtual)	$20		$30
Specialist (office and virtual)	$40		$30
Virtual Care-Only Providers (cost thru mobile app and website)	Primary, UC, Mental Health: No charge Specialist: No charge		No charge
Preventive Services	No charge		No charge
Urgent Care	$20		$30
Emergency Room	$100 per visit (waived if admitted)		$100 per visit (waived if admitted)
Lab and Imaging			
Basic lab and X-ray	No charge		No charge
Advanced Imaging (CT, MRI, PET)	$100 per test		No charge
Outpatient Surgery			
Hospital	$125 per visit		$30 per visit
Ambulatory Surgical Center (ASC)	$125 per visit		N/A
Inpatient Hospitalization	$250 per admission		No charge
Chiropractic and Acupuncture			
Medical Network (20 Chiro/20 Acu/year)	$20 per visit		N/A
ASH Network (Chiro & Acu combined/year)	$10 (up to 30 visits/year)		$10 (up to 30 visits/year)
PRESCRIPTION DRUGS (Carrier)	Navitus		Kaiser Permanente
Calendar Year Deductible	N/A		None
Calendar Year Out-of-Pocket Maximum	$2,500 per individual/$3,500 per family		Combined with medical[2]
Retail	**Walk-in**	**Costco**	
Generic	$9	No charge/No charge	$10
Brand	$35	$35 /$90	$30
Specialty	N/A	N/A	$30 (30-day supply only)
Supply Limit	30 days	30 days/90 days	100 days
Mail Order	**Navitus**	**Costco**	
Generic	N/A	No charge	$10
Brand	N/A	$90	$30
Specialty	$35	N/A	N/A
Supply Limit	30 days	90 days	100 days

[1]This family maximum is embedded, meaning that the plan will cover 100% for a member once they reach their individual maximum.
[2]All covered expenses including your medical deductibles and prescription copays accumulate towards the out-of-pocket maximum.

SISC PPO Medical – Management

This table shows member cost share.

	Anthem Blue Cross PPO plan *(Prudent Buyer PPO Network)*		
	In-Network		**Out-of-Network**
Accumulation Period	Calendar year from January 1 through December 31		
Calendar Year Deductible[1]			
Individual Coverage	$200 per individual		
Family Coverage	$200 per individual/$500 per family		
Calendar Year Out-of-Pocket Maximum[2,3]			
Individual Coverage	$1,000 per individual		No limit
Family Coverage	$1,000 per individual/$3,000 per family		
Office Visit			
Primary Care (office and virtual)	$0 for visits 1-3; $20 for visits 4+		After deductible, the plan pays 100% up to Anthems fee schedule. Member is responsible for billed amounts above the fee schedule.
Specialist (office and virtual)	$20		
Virtual Care-Only Providers (cost thru mobile app and website)	Primary, UC, Mental Health: No charge Specialist: $20		N/A
Preventive Services	No charge		Not covered
Urgent Care	$20		All billed amounts exceeding the maximum allowed amount[4]
Emergency Room	$100 per visit and 10%[4] (waived if admitted)		
Lab and Imaging			
Basic Imaging and X-ray	10%[4]		Not covered
Advanced Imaging (CT, MRI, PET)	10%[4]		All billed amounts exceeding the lessor of the benefit amount or $800[4] per test
Outpatient Surgery			
Hospital	10%[4]		All billed amounts exceeding the maximum allowed amount[4]
Ambulatory Surgical Center (ASC)	10%[4]		All billed amounts exceeding $350 per day[4]
Inpatient Hospitalization	10%[4]		All billed amounts exceeding $600 per day[4]
Chiropractic[5]	10%[4]		Not covered
Acupuncture (up to 12 visits/year)	10%[4]		50% of maximum allowed amount[4]
PRESCRIPTION DRUGS (Navitus)			
Calendar Year Deductible	N/A		N/A
Calendar Year Out-of-Pocket Maximum	$2,500 per individual/$3,500 per family		N/A
Retail - 30 days/90 days	**Walk-in**	**Costco**	
Generic	$9 / N/A	No charge/No charge	Not covered
Brand	$35 / N/A	$35 /$90	
Specialty	N/A	N/A	
Mail Order	**Navitus - 30 day**	**Costco -- 90 day**	
Generic	N/A	No charge	Not covered
Brand	N/A	$90	
Specialty	$35	N/A	

[1]This family deductible is embedded, meaning that the plan begins to make payments for a member once they reach their individual deductible. [2]This family maximum is embedded, meaning that the plan will cover 100% for a member once they reach their individual maximum. [3]All covered expenses including your medical deductibles and prescription copays accumulate towards the out-of-pocket maximum. [4]After deductible. [5]Pre-authorization review by American Specialty Health (ASH) is required after the 5th visit.

SISC PPO Medical – Management

This table shows member cost share.

	Anthem Blue Cross PPO Platinum + *(Prudent Buyer PPO Network)*		
	In-Network		**Out-of-Network**
Accumulation Period	Calendar year from January 1 through December 31		
Calendar Year Deductible[1] Individual Coverage/Family Coverage	None		
Calendar Year Out-of-Pocket Maximum[2,3] Individual Coverage Family Coverage	$1,000 per individual $1,000 per individual/$3,000 per family		No limit No limit
Office Visit Primary Care (office and virtual) Specialist (office and virtual) Virtual Care-Only Providers (cost thru mobile app and website)	$0 $40 Primary, UC, Mental Health: No charge Specialist: $40		PCP: All billed amounts exceeding the maximum allowed amount[4] SPC: All billed amounts exceeding the maximum allowed amount[4] N/A
Preventive Services	No charge		Not covered
Urgent Care	$0		All billed amounts exceeding the maximum allowed amount[4]
Emergency Room	$300 per visit (waived if admitted)		
Lab and Imaging Basic Lab and X-ray Advanced Imaging (CT, MRI, PET)	$0-$75 Freestanding Center: $100/ OP Hospital $250		Basic: Not covered Adv: Maximum benefit allowed of $800[4] per test
Outpatient Surgery Hospital Ambulatory Surgical Center (ASC)	$600 $200		Hospital: : All billed amounts exceeding the maximum allowed amount[4] ASC: All billed amounts exceeding $350 allowed amount[4]
Inpatient Hospitalization	$200 per day		Maximum benefit allowed of $600[4]
Chiropractic[5]	$0		Not covered
Acupuncture (up to 12 visits/year)	$0		50% of maximum allowed amount[4]
PRESCRIPTION DRUGS (Navitus)			
Calendar Year Deductible	N/A		N/A
Calendar Year Out-of-Pocket Maximum	$2,500 per individual/$3,500 per family		N/A
Retail - 30 days/90 days Generic Preferred Brand[6] Brand Specialty	**Walk-in** $9 No charge $35 N/A	**Costco** No charge/No charge No charge/No charge $35 /$90 N/A	Not covered
Mail Order - 90 days Generic Preferred Brand[6] Brand Specialty	**Navitus** N/A N/A N/A $35 (30 days)	**Costco** No charge No charge $90 N/A	Not covered

[1]This family deductible is embedded, meaning that the plan begins to make payments for a member once they reach their individual deductible. [2]This family maximum is embedded, meaning that the plan will cover 100% for a member once they reach their individual maximum. [3]All covered expenses including your medical deductibles and prescription copays accumulate towards the out-of-pocket maximum. [4]After deductible. Member may be responsible for costs beyond the permitted amount and the overall charges. [5]Pre-authorization review by American Specialty Health (ASH) is required after the 5th visit. [6]See formulary list for covered medications.

SISC Value Added Services

Take advantage of these value added services available to SISC plan members 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/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** (855) 380-7828 **Visit** teladoc.com/SISC
Personal Health Coaching **Vida Health**[1] 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**[2] 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** (800) 657-6169 **Visit** mdlive.com/sisc
Free Generic Medications **Costco** Access most generic medications at no cost through Costco retail and mail order pharmacies. You don't need to be a Costco member.	*Anthem members* **Call** (800) 774-2678 (press 1) **Visit** costco.com

[1] Not available to SISC HSA Members. [2] Copays may apply.

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

SISC Value Added Services, Cont.

Benefit Highlights	Availability & How To Get Started
Virtual Expert Menopause Care **Midi Health**[1] Access to expert care for menopause through a specialized virtual clinic. The Midi team can provide personalized care for symptoms like hot flashes, mood changes, poor sleep, and more.	*Anthem PPO members* **Visit** joinmidi.com/sisc
Physical Therapy for Back or Joint Pain **Hinge Health**[1] 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 **Centivo Care**[1] Virtually connect with a primary care physician to manage all your physical and mental healthcare needs. Centivo providers diagnose conditions, manage prescriptions, refer to specialists, and answer follow up questions using video visits or live chat.	*Anthem PPO members* **Visit** centivocare.com or download the app
24/7 Access to Virtual Maternity & Postpartum Support **Maven** Connect with a care advocate who will guide you through various tools and resources related to pregnancy and postpartum care. Get private visits with gynecologists, specialists, therapists, and 30 other maternity and postpartum provider types.	*Anthem PPO members* **Visit** mavenclinic.com/join/SISC
Hip, Knee, & 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** info.carrumhealth.com/sisc
Enhanced Cancer Benefit **Lantern Cancer Care** Get help from a personal oncology nurse who can partner with you on every step of your cancer journey, including a review of your initial diagnosis and development of a care plan.	*Anthem PPO members* **Visit** lanterncare.com

[1] Not available to SISC HSA Members. [2] Copays may apply.

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

SISC PPO Value Based Site-of-care Benefit

Hospitals and Ambulatory Surgery Centers (ASCs)

The facility fees* for outpatient procedures at hospitals can be several times higher than at Ambulatory Surgery Centers (ASCs), for the same service and quality of care provided.

SISC PPO plans limit the maximum benefit amount at an in-network outpatient hospital facility for the following five procedures:

	Maximum benefit	
	In-network Outpatient Hospital Facility	**In-network Ambulatory Service Center (ASC)**
Arthroscopy	$4,500	There is no maximum benefit limit at an in-network ASC.
Cataract Surgery	$2,000	
Colonoscopy	$1,500	
Upper GI Endoscopy with Biopsy	$1,250	
Upper GI Endoscopy without Biopsy	$1,000	

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. If you use an in-network ASC, you will only be responsible for the regular deductible and coinsurance.

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 your health plan.

Exemption Process

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.

Benefits Of Ambulatory Surgery Centers (ASCS)

1. Established track records of providing quality outcomes that are at least as good as or better than hospitals.
2. ASCs tend to be more specialized with less exposure to a wide range of infections
3. Less cumbersome check-in and check-out processes.
4. Outpatient procedures can be safely performed at an ASC more quickly for a fraction of the cost.

SISC Anthem Resources

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.

Active & Fit

Choose from more than 12,000 participating fitness centers and 5,800 premium exercise studios nationwide and receive a discounted membership. This program is offered through American Specialty Health Fitness, Inc. To enroll, visit Special Offers by logging into anthem.com/ca/mcr/sisc and clicking on Discounts.

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 (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".

Finding an Anthem Provider

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

Sydney Mobile App

Use Sydney™ Health to 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.

Kaiser Resources

One Pass Select Affinity by Optum

Through One Pass Select Affinty from Optum members can choose a fitness plan and get unlimited access to all locations available within that plan, plus extensive digital resources. Members can choose the plan that fits their needs, with competitive plans starting at $10 per month. Members that sign up can also access the Optum Additional service include healthy meal delivery and 20% discounts on chiropractors, acupuncturists and massage therapists. Learn more at healthy.kaiserpermanente.org/health-wellness/fitness-offerings.

24/7 care advice

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

Kaiser Away From Home

Kaiser Members are covered for emergency and urgent care anywhere in the world. Visit healthy.kaiserpermanente.org/get-care/traveling to learn about what to do if you need emergency or urgent care during your trip.

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.

Headspace Care App

The Headspace Care app offers immediate 1-on-1 support for coping with many common challenges — from stress and low mood to issues with work and relationships, and more. Headspace Care's highly trained emotional support coaches are ready to help 24/7, and adult Kaiser Permanente members can use Headspace Care for 90 consecutive days at no cost. Get started today at kp.org/selfcareapps.

Target Retail Clinics (SoCal only)

Target Clinics offer care provided by Kaiser Permanente for more than 85 different services, including treatments for common health conditions and minor injuries. The clinics are open 7 days a week for appointments and walk in care. Find a clinic near you using kptargetclinic.org.

Finding a Kaiser Provider

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

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®.

Kaiser Resources, Cont.

Online wellness tools

Visit healthy.kaiserpermanente.org/health-wellness for wellness information, health calculators, fitness videos, podcasts, and recipes from world class chefs. Connect to better health with programs to help you lose weight, quit smoking, and more – all at no cost.

ClassPass

Kaiser members can get access to free on demand video workouts at no cost and reduced rates for in-person fitness classes. To get started, visit healthy.kaiserpermanente.org/health-wellness/fitness-offerings.

Health classes

Sign up for health classes and support groups at many of our facilities. See what's available near you at healthy.kaiserpermanente.org/health-wellness/classes-programs– some may require a fee.

Personal wellness coaching

Get help reaching your health goals. Work one on one with a wellness coach by phone at no cost. Find out more at healthy.kaiserpermanente.org/health-wellness/wellness-coaching or call (866) 862-4295.

Prescription Drugs – Navitus

Anthem HMO and PPO members have access to prescription drug coverage through Navitus. Below is some information to keep in mind regarding this coverage:

Understanding Your Pharmacy Benefits

Members who take stabilized doses of covered long-term maintenance medications — like those used to treat an ongoing condition such as high blood pressure or high cholesterol — can save money by ordering them through Navitus' mail service partner, Costco Pharmacy, instead of using a retail pharmacy.

With the Costco Home Delivery Pharmacy

- You get up to a 90-day supply delivered directly to you — with free standard shipping.
- You can easily order refills online, over the phone or by mail.
- Multiple safety and advanced quality checks are in place to make sure you get the right medication.

Please contact Costco Home Delivery Pharmacy at pharmacy.costco.com. You may also call 1-800-607-6861 for home delivery forms and instructions. Please note that some pharmacies, such as Walgreens®, may not be in your plan. Log into the member home page at navitus.com to find pharmacies that are in your plan, or call (866) 333-2757.

Get the most from your coverage

To get the most out of your prescription drug coverage, note where your prescriptions fall within your plan's drug formulary tiers and ask your doctor for advice. Generic drugs are usually the lowest cost option. Generics are required by the Food and Drug Administration (FDA) to perform the same as brand-name drug equivalents.

Navitus App

You can also use the Navitus app to search for providers. Download from the App Store or Google Play®.

Navitus Formulary

You can also find a list of formulary and preventive medications on navitus.com.

Prescriptions Breaking Your Budget?

Understanding the formulary can save you money

If your doctor prescribes medicine, especially for an ongoing condition, don't forget to check your health plan's drug formulary. It's a powerful tool that can help you make informed decisions about your medication options and identify the lowest cost selection.

What is a formulary?

A drug formulary is a list of prescription drugs covered by your medical plan. Most prescription drug formularies separate the medications they cover into four or five drug categories, or "tiers." These groupings range from least expensive to most expensive cost to you. "Preferred" drugs generally cost you less than "non-preferred" drugs.

Get the most from your coverage

To get the most out of your prescription drug coverage, note where your prescriptions fall within your plan's drug formulary tiers and ask your doctor for advice. Generic drugs are usually the lowest cost option. Generics are required by the Food and Drug Administration (FDA) to perform the same as brand-name drug equivalents.

To find out if a drug is on your plan's formulary, visit the plan's website or call the customer service number on your ID card.

The Formulary Drug Tiers Determine Your Cost

$	Generic Drug
$$	Brand Name Drug
$$$	Specialty Drug

Click to play video

Prescription Drugs

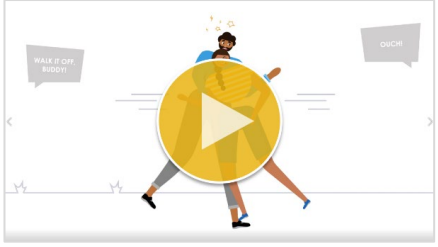
Learn about the best life hacks to help you save when it comes to prescription drug shopping.

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	**$$$$$**

Click to play video



Urgent Care vs ER

ER visits should only be used for very serious medical issues. The cost per visit will be much higher than the other care options.

Alternative Facilities

If you have time to evaluate your options for non-emergency health treatments, these alternative facilities can provide the same results as a hospital at a fraction of the cost.

Need	Alternative	Features	Savings
Surgery	Ambulatory Surgery Center (ASC)	▪ Specializes in same-day surgeries ▪ Cataracts, colonoscopies, upper GI endoscopy, orthopedic surgery and more ▪ Held to same safety standards as hospitals	**Up to 50% over hospital stay***
Physical therapy	Free-standing physical therapy center	▪ Important part of the recovery process after an injury or surgery	**40 to 60% over a hospital setting***
Sleep study	Home testing	▪ Diagnoses sleep apnea and other conditions ▪ Cost is often covered by insurance if considered medically necessary	**Approx. $4,500***
Infusion therapy	Home or outpatient infusion therapy	▪ For drugs that must be delivered by intravenous injections, or epidurals ▪ Delivered by licensed infusion therapy provider ▪ Maintain normal lifestyle and comfort of home or outpatient center	**Up to 90% over hospital stay***

*In-Network

How to find an alternative treatment facility

Ask your doctor if your treatment must be delivered in the hospital. You can also search for surgical centers, physical therapy, etc. on your plan's website; or call member services for assistance.

Online tools such as healthcarebluebook.com and healthgrades.com help you compare costs and doctor ratings. Some alternative services include a facility fee to cover overhead costs. To avoid a surprise on your bill, ask about facility fees before you schedule your appointment.

Preventive Care Screening Benefits

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 healthcare.gov/coverage/preventive-care-benefits/ for recommended guidelines.

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.

Typical screenings for adults

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

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

Turning 65? Understand Your Medicare Options

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

Alliant MEDICARE SOLUTIONS
A Non-Government Entity

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

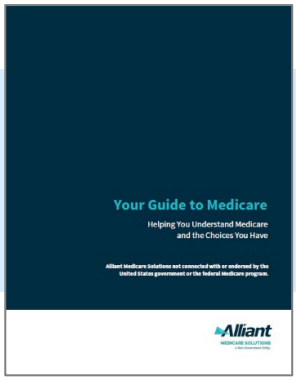
Most people become eligible for Medicare at age 65. When that happens, you'll probably have some time-sensitive decisions to make, based on your individual situation.

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.

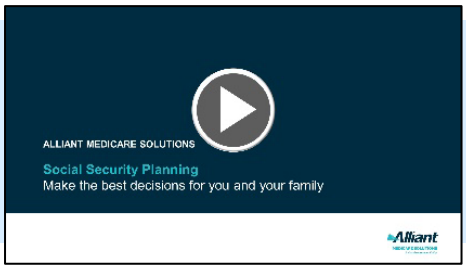
How does it work?

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.



Your Guide to Medicare

Medicare 101 Video



Social Security Planning Video

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.

Employee Assistance Program (EAP)

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 with Lincoln Financial Group 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

Available Resources

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

Contact EmployeeConnect

Phone
888-628-4824

Website
guidanceresources.com
Username: LFGsupport
Password: LFGsupport1

Dental

We offer dental coverage through Delta Dental and United Concordia. Dental insurance makes it easier and less expensive to get the care you need to maintain good oral health.

Dental Plan Overview

This guide serves as a summary of the dental plans. Please review the plan documents before enrolling in coverage.

	What you need to know
Delta Dental (ACSIG) PPO *Delta Dental Network*	• Out-of-network coverage; higher costs
United Concordia Dental HMO *United Concordia Network*	• In-network only • Requires primary care dentist • No deductible • Predictable costs

Dental insurance covers multiple types of treatment:

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

Dental – Delta Dental (ACSIG) PPO

This table shows member cost share.

	Delta Dental (ACSIG) PPO*	
	In-Network	**Out-of-Network**
Annual Deductible	None	
Calendar Year Plan Maximum	$3,000 per person	$2,500 per person
Diagnostic & Preventive Exams, Cleanings, X-rays	70%-100%	70%-100%
Basic Services Fillings, Root Canals, Periodontics	70%-100%	70%-100%
Major Services Crowns, Bridges, Implants[1] Prosthodontics	70%-100% 50%	70%-100% 50%
Dental Accident Benefits Maximum	100% Separate $1,000 per person per year	100% Separate $1,000 per person per year
Orthodontia Adults and Dependent Children	50% up to $2,000 lifetime maximum	

*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

Visit Benefit Bridge or access the Delta Dental website or app for more details!

What you need to know about this 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 percentages increase by 10% each year (to a maximum of 100%) for each enrollees if that person visits the dentist at lease once during the year. If an enrollee does not use the plan during the calendar year, the percentage remains at the same level. If an enrollee becomes ineligible for benefits and later regains eligibility, the percentage will drop back to 70%.

Do I have to select a primary dentist?

No. You can see any provider, but you'll pay more out-of-network.

Dental – United Concordia DHMO

This table shows member cost share.

	United Concordia*
	In-Network
Annual Deductible	None
Calendar Year Plan Maximum	None
Diagnostic & Preventive	
Exams, Cleanings, X-rays	$0-$15 copay
Basic Services	
Fillings	$0-$140 copay
Root Canals	$0-$45 copay
Periodontics	$0-$120 copay
Major Services	$0-$245 copay
Orthodontia	
Adults	$2,000 copay; Lifetime maximum: None
Dependent Children	$1,500 copay; Lifetime maximum: 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

Do I have to select a primary dentist?	Yes
Where can I get more details?	Visit Benefit Bridge or access the United Concordia website or app or call United Concordia at (866) 357-3304.

Vision

We offer vision coverage through VSP. Vision coverage helps with the cost of eyeglasses or contacts.

Vision Plan Overview

This guide serves as a summary of the vision plan. Please review the plan documents before enrolling in coverage.

	What you need to know
VSP Signature Vision (ACSIG) *VSP Signature Network*	• Out-of-network coverage will have higher costs • The plan will reimburse up to a specific dollar amount for most materials

Click to play video

All About Vision

Watch this video to learn more about what to keep an eye out for when it comes to vision insurance.

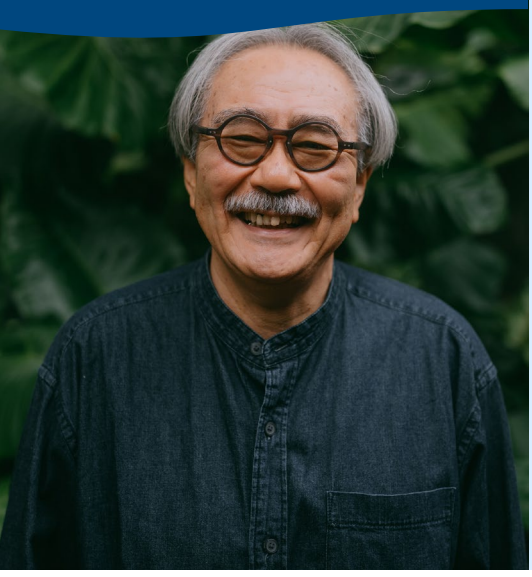
Vision - VSP

This table shows member cost share.

	VSP	
	In-Network	**Out-of-Network Reimbursement**
Network Name	**VSP Signature**	N/A
Exams *Once every 12 months*	$5 copay	Up to $50
Eyeglass Lenses Single Vision Lens Bifocal Lens Trifocal Lens Polycarbonate Lens *Once every 12 months*	 $5 copay $5 copay $5 copay Covered	 Up to $50 Up to $75 Up to $100 Not covered
Frames *Once every 12 months*	$200 allowance + 20% off remaining balance $110 allowance at Costco	Up to $70
Contacts[1] *Once every 12 months*	$200 allowance Save 15% on contact lens exam (fitting and evaluation)	Up to $105 allowance (combined w/ in-network)

[1]In lieu of frames

VSP Perks



What you need to know about this plan

What other services are covered?

The plan can also help you save money on LASIK procedures, sunglasses, computer glasses, and even hearing aids. Visit the VSP.com/offers page for more information!

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. If you participate in a healthcare FSA, you can use your account to pay for vision care and eyewear with tax-free dollars.

Where can I get more details?

Visit Benefit Bridge to view the plan summary or access the VSP website or app. You can also call VSP at 800-877-7195.

Life & Disability

Life, AD&D and disability insurance can fill a number of financial gaps due to a temporary or permanent reduction of income.

Is your family protected?

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.

	Who is covered
Life and AD&D *Employer Paid*	• Employee only
Life and AD&D *Voluntary*	• Employee • Spouse • Child
Long Term Disability (LTD) *Employer Paid*	• Employee only

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.

Life and AD&D Insurance

Company Provided 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 SCCCD.

Employee Life and AD&D Coverage

Employee $50,000

Note: Benefit amount reduces at age 65. *Refer to the plan document for details*.

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.

All About Life Insurance

Watch this video to learn more about what to keep an eye out for when it comes to life insurance.

Additional Features

- **Waiver of Premium** - If you become totally disabled while insured under this plan and under age 60, and complete a waiting period of 180 days, your Basic and Additional Life insurance may continue without premium payment provided you give Lincoln Financial Group satisfactory proof that you remain totally disabled. Please see your certificate of coverage for more details.
- **Accelerated Death Benefit** - If you become terminally ill, you may be eligible to receive increments of $1,000 of your combined Basic and Additional Life benefit to a maximum of $500,000 or 80%.
- **Portability** - If your Voluntary Life and AD&D insurance ends because your employment terminates, you may continue to your life insurance coverage by obtaining the cost directly from Lincoln Financial Group.
- **Conversion** - If your Basic and/or Voluntary insurance ends or reduces, you may be eligible to convert your life insurance to an individual life insurance policy without submitting proof of good health. Premiums for the converted policy will be substantially higher compared to the SCCCD sponsored term plan.

Voluntary Life and AD&D Insurance

Protecting those you leave behind

Voluntary Life and AD&D Insurance allows you to purchase additional coverage to protect your family's financial security.

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

Life and AD&D Coverage

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 (age 1 day to 6 moths: $250) Guaranteed Issue: $5,000

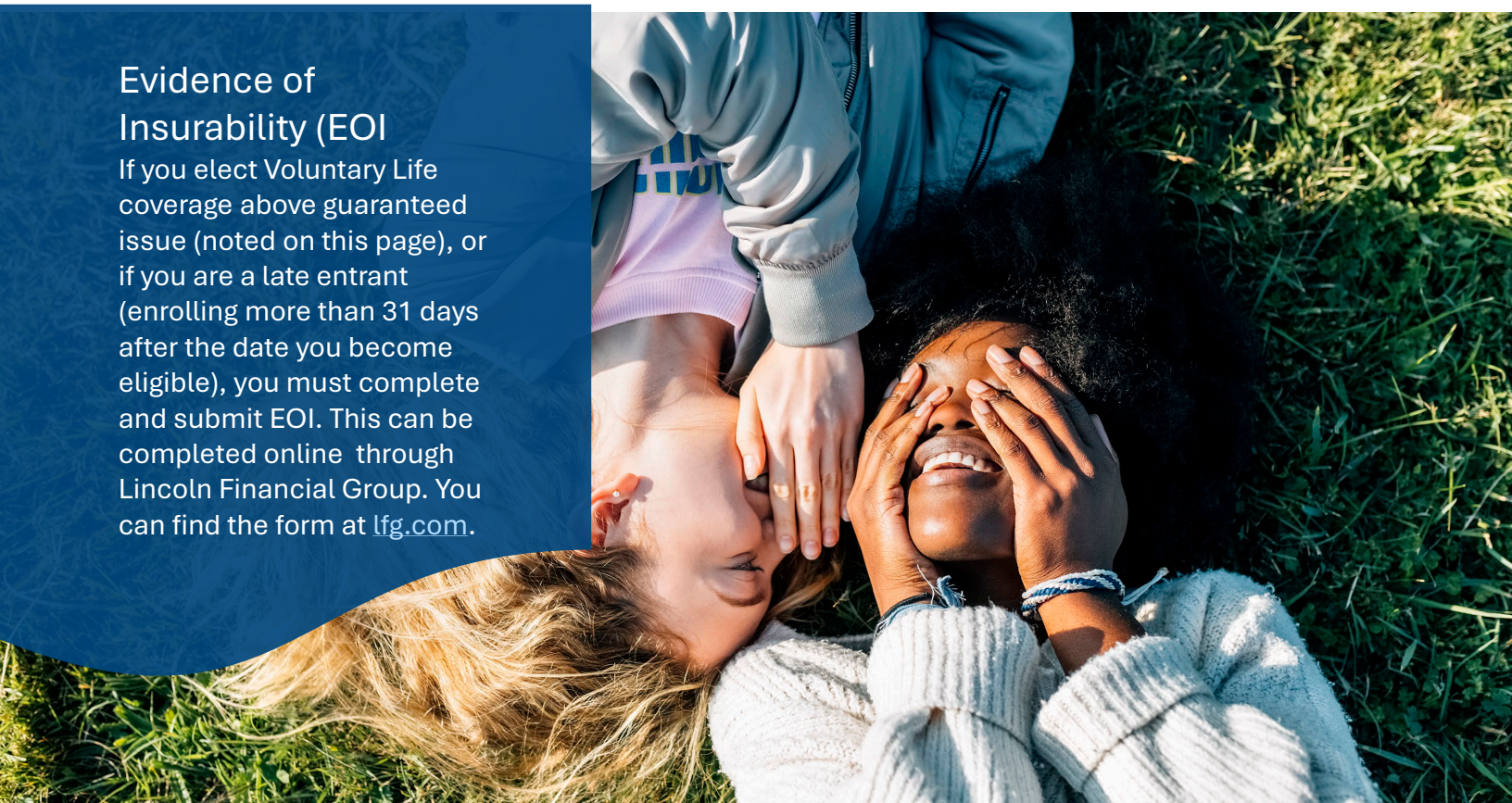
*Benefit amount reduces at age 65.

AD&D Coverage

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 Voluntary AD&D* 60% of employee amount if you do have children enrolled in Voluntary AD&D*
Child(ren)	25% of employee amount if you do not have spouse enrolled in Voluntary AD&D 10% of employee amount if you do have a spouse enrolled in Voluntary AD&D

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.



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
<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

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:

Child Life Insurance

Coverage Amount	Tenthly 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 & Spouse	$0.032
Child(ren)	$0.049

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

Long-Term Disability Insurance

Long-Term Disability Insurance (LTD)

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. SCCCD pays the cost of this coverage. Coverage is provided by Lincoln Financial Group.

Monthly Benefit amount	Plan pays 66.67% of covered monthly earnings up to $6,000
Benefits Begin	After 120 days of Accident/Sickness
Maximum Payment Period[1]	Social Security Normal Retirement Age

[1]The age in which you are disabled may affect the length of the maximum benefit period.

What 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.

Voluntary Plans

Voluntary benefits are optional coverages that help you customize your benefits package to your individual needs. You pay the entire cost for these plans.

For more information regarding costs of coverage benefit offerings please visit the American Fidelity website.

Accident Insurance

Limited Benefit Accident Only Insurance from American Fidelity helps you pay for unexpected costs that can add up due to common injuries such as fractures, dislocations, burns, emergency room or urgent care visits, and physical therapy. If you or a covered family member has an accident, this plan pays a lump-sum, tax-free benefit. The amount of money depends on the type and severity of your injury and can be used any way you choose.

Cancer Insurance

Many people are concerned about the financial impact of a cancer diagnosis. Limited Benefit Cancer insurance provides tax-free benefits for many of the costs associated with cancer treatment such as radiation, chemo, surgery, diagnostic tests, and physician charges. You can cover yourself and your family members if needed. American Fidelity provides coverage for this program.

Critical Illness Insurance

Limited Benefit Critical illness insurance from American Fidelity can help fill a financial gap if you experience a serious illness such as cancer, heart attack or stroke. Upon diagnosis of a covered illness, a lump-sum, tax-free benefit is immediately paid to you. Use it to help cover medical costs, transportation, childcare, lost income, or any other need following a critical illness. You choose a benefit amount that fits your paycheck and can cover yourself and your family members if needed.

Additional Voluntary Benefits

American Fidelity offers these additional voluntary benefits to assist you in your time of need:

- Disability Income Insurance
- Whole Life Insurance
- Term Life Insurance
- Universal Life Insurance

Speak to an American Fidelity representative to inquire about your coverage options.

A SPECIAL ENROLLMENT IS HELD FOR AMERICAN FIDELITY BENEFITS ONLY.

Plans to Keep You and Your Family Secure

Pet Insurance

Pets are members of the family too. When your pet gets sick, bills can add up faster than expected. Pet insurance prevents you from needing to weigh your pet's health against your bank account. Most plans offer coverage for costs associated with both accidents and illnesses—even medications. MetLife provides coverage for this program. You can enroll in this program at any time.

Visit the Plan Contacts section for contact information.

Financial Wellness

We offer benefits and resources to help you make the most of your money now and in the future.

Why Does Financial Wellness Matter?

Financial wellness directly impacts various aspects of your life, including physical and mental health, relationships, and career satisfaction. A strong financial footing reduces stress and anxiety related to money, leading to better mental health and overall quality of life. It enables you to pursue your goals, whether it's buying a home, starting a family, or planning for retirement, without the constant burden of financial worry.

	What you need to know
Healthcare Flexible Spending Account (FSA)	Use tax-free dollars for healthcare related expenses.
Dependent Care Flexible Spending Account (FSA)	Use tax-free dollars for childcare expenses.

Flexible Spending Account (FSA)

IMPORTANT: You must re-enroll in this account each year. Elections do not rollover.

A healthcare FSA allows you to set aside tax-free money to pay for healthcare expenses. This program is administered through American Fidelity.

How the FSA Works

You estimate what you and your family's eligible out-of-pocket costs will be for the coming year, expenses such as office visits, surgery, dental and vision expenses, prescriptions, even eligible drugstore items.

- Use the FSA debit card to pay for eligible services and products. You can also login to your online account or use your mobile app to request a payment be sent directly to your provider or to you.
- Request an itemized receipt for any expenses you plan to pay for with your FSA.
- Elections cannot be changed during the plan year, unless you experience a qualifying event.

2025 IRS Contribution Limits	**You can contribute up to $3,300.** *Contributions are deducted from your pay pre-tax.*
Deadline To Incur Claims	Expenses must be incurred between 10/01/2025 and 09/30/2026.
Deadline To Submit Claims	Claims must be submitted for reimbursement no later than 90 days after the end of the plan year.
Rollover	You can rollover up to $660 to use the following year. Any additional remaining balance will be forfeited.

Are You Eligible?

You don't have to enroll in one of our medical plans to participate in the healthcare FSA.

Do You Pay For Dependent Care?

Review the next page for information on tax savings through the Dependent Care FSA.

Find out more

- American Fidelity site
- Eligible Expenses
- Ineligible Expenses

A SPECIAL ENROLLMENT IS HELD FOR AMERICAN FIDELITY BENEFITS ONLY.

Additional Tax-Saving Accounts

You must re-enroll in this account each year. Elections do not rollover.

Dependent Care Flexible Spending Account (FSA)

Paying For Daycare? Make It Tax-free! A dependent care Flexible Spending Account (FSA) can help families save potentially hundreds of dollars per year on day care. This program is administered by American Fidelity.

How the Dependent Care Flexible Spending Account (FSA) Works

You set aside money from your paycheck, before taxes, to pay for work-related day care expenses. Eligible expenses include not only childcare, but also before and after school care programs, preschool, and summer day camp for children under age 13. The account can also be used for day care for a spouse or other adult dependent who lives with you and is physically or mentally incapable of self-care. You can pay your dependent care provider directly from your FSA account, or you can submit claims to get reimbursed for eligible dependent care expenses you pay out of pocket.

2025-2026 IRS Contribution limits	**You can contribute up to $5,000 per household per year.** If you are married but filing separately, federal regulations limit the use of Dependent Care FSA to $2,500 each year
Deadline to incur expenses	Money contributed to a dependent care FSA must be used for expenses incurred during the same plan year.
Rollover	Unspent funds will be forfeited.

You can't change your Dependent Care FSA election amount mid-year unless you experience a qualifying event.

A SPECIAL ENROLLMENT IS HELD FOR AMERICAN FIDELITY BENEFITS ONLY.

You can't change your Dependent Care FSA election amount mid-year unless you experience a qualifying event.

Important Plan Information

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

	What you need to know
Your Benefit Costs	An overview of your healthcare costs.
Important Contacts	Contact information for our benefit carriers and vendors.
Benefits Glossary	A Benefits Glossary to help you understand important insurance terms.
Important Notices	A summary of the health plan notices you are entitled to receive annually, and where to find them.

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 CLIENT NAME 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/Email
Medical HMO	Kaiser Permanente	(800) 464-4000	kp.org
Medical HMO	Anthem	(800) 825-5541	anthem.com/ca/sisc
Medical PPO	Anthem	See I.D. Card	anthem.com/ca/sisc
24/7 Physicians Line (Anthem Members Only)	MD Live	(888) 632-2738	mdlive.com/sisc
Pharmacy (Anthem Members Only)	Navitus Costco	(866) 333-2757 (800) 607-6869	navitus.com rx.costco.com
Expert Second Opinion Program	Teladoc	(855) 380-7828	teladoc.com/sisc
Dental PPO	Delta Dental	(866) 499-3001	deltadentalins.com
Dental HMO	United Concordia	(866) 357-3304	unitedconcordia.com
Vision	VSP	(800) 877-7195	vsp.com
Life and AD&D **Voluntary Life and AD&D** **Long-Term Disability**	Lincoln Financial Group	(800) 423-2765	lfg.com
Employee Assistance Program (SISC Members)	Anthem EAP	(800) 999-7222	anthemeap.com
Employee Assistance Program (All Employees)	ComPsych	(888) 628-4824	guidanceresources.com Username: LFGsupport Password: LFGsupport1
Human Resources Phone: (661) 362-3427			

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
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

Health Plan Notices

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

- **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
- **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
- **The 'No Surprises' Rules:** Explains rules that protect you from surprise medical bills.
- **Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP):** Describes availability of premium assistance for Medicaid eligible dependents.

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.

Plan Documents

Important documents for our health plan and retirement plan are available in 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 District'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 on Benefit Bridge.

- Anthem Blue Cross Classic $20; Rx $9-$35 HMO plan
- Anthem Blue Cross Classic $20; Rx $200 $10-$35 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
- Anthem Blue Cross Platinum+; $9-$35 Rx PPO plan
- Kaiser Permanente $15 OV; $5-$20 Rx HMO plan
- Kaiser Permanente $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 District'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 Permanente is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

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

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

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your 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 is 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, 2025
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:	(611) 362-3427

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 your plan administrator.

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 your plan administrator.

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 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 and UCCI Dental 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 and UCCI 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 for Anthem Blue Cross.

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 Anthem Blue Cross and Kaiser Permanente plans 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 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 9.02% in 2025 of your modified adjusted household income.

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.

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 **March 17, 2025**. 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://hcpf.colorado.gov/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
Health Insurance Premium Payment Program All other Medicaid Website: https://www.in.gov/medicaid/ | http://www.in.gov/fssa/dfr/ | Family and Social Services Administration Phone: (800) 403-0864 | Member Services Phone: (800) 457-4584
IOWA – Medicaid and CHIP (Hawki)
Medicaid Website: Iowa Medicaid | Health & Human Services | Medicaid Phone: 1-800-338-8366 Hawki Website: Hawki - Healthy and Well Kids in Iowa | Health & Human Services | Hawki Phone: 1-800-257-8563 HIPP Website: Health Insurance Premium Payment (HIPP) | Health & Human Services (iowa.gov) 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/health-care-coverage/ | Phone: 1-800-657-3672
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. 15218 Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov
NEW JERSEY – Medicaid and CHIP
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ | Phone: 800-356-1561 CHIP Premium Assistance Phone: 609-631-2392 | CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710 (TTY: 711)
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 and CHIP
Website: http://healthcare.oregon.gov/Pages/index.aspx | Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP
Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html | 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
Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/ Email: upp@utah.gov | Phone: 1-888-222-2542 | Adult Expansion Website: https://medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/ CHIP Website: https://chip.utah.gov/
VERMONT – Medicaid
Website: 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 March 17, 2025, 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

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.

Notes

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