STATE CENTER
COMMUNITY COLLEGE DISTRICT

# Employee Benefits Guide

## 2024-2025

Plan Year: October 1, 2024- September 30, 2025

*Revised 7/26/2024*

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This guide provides information about health benefits with State Center Community College District (SCCCD). Employees and new hires should use this guide as your go-to source for health benefits for plan year 2024-2025.

Clovis Community College

Fresno City College

Career and Technology Center

Reedley College

MADERA COMMUNITY COLLEGE

Oakhurst Community College Center
Reedley College

# Contents

# Introduction

Welcome! State Center Community College District ("District") strives to provide you and your family with a comprehensive and valuable health benefits package. We want to make sure you are getting the most out of your health benefits—which is why we have put together this guide. This guide will summarize the employee health benefits and should be your go-to guide when you have health benefit-related questions.

When reviewing plan options, take into consideration where you live, your personal preference regarding physician choice, as well as the type of healthcare environment you prefer, so that you may choose the health care plans that are most suitable for you and your family members.

This guide is not intended to be a contract (expressed or implied), nor is it intended to otherwise create any legally enforceable obligation on the part of the District, its agents, or its employees. If there are any inconsistencies between this document and legal plan documents, the plan documents will prevail.

## Plan Year

Our health insurance plan year is October 1st through September 30th.

Health plan deductibles, out of pocket maximums, and dental plan maximums, all run calendar year – from January 1st through December 31st.

## BenefitBridge

BenefitBridge is the District's web-based benefits administration portal. It is available to eligible employees to enroll in benefits, review benefit elections, find benefit summaries, benefit plan documents, and benefit resources, as well as complete qualifying life event changes. BenefitBridge can be accessed by visiting www.benefitbridge.com/statecenterccd from any computer or mobile device, or through the District's MyPortal app.

## Frequently Asked Questions

You can find answers to frequently asked questions on page 65. If you have a question that is not answered by this guide, please reach out to us.

## Human Resources Benefits Staff

**Location:**
District Office – 7th floor
1171 Fulton Street
Fresno, CA 93721

**Benefits Webpage:** www.scccd.edu/employeebenefits

**Email**: benefits@scccd.edu

**Phone:**

District/Human Resources Main Line: (559) 243-7100

Reina Kemble, Benefits Technician, (559) 243-7134

Frances Garza, Benefits Coordinator, (559) 243-7133

# 2024 Annual Open Enrollment

**The 2024 annual open enrollment period is taking place from July 29, 2024, through August 30, 2024.**

**Open enrollment closes at 4:30 PM on August 30, 2024!**

The annual open enrollment period is the one time each year when employees can change benefit elections, add or remove eligible dependents from their health insurance plans, enroll in a Flexible Spending Account for the upcoming plan year, and enroll in voluntary benefit products.

The benefit elections you make during the annual open enrollment period will stay in effect for the 2024-2025 plan year, as long as you remain eligible for benefits.

**This year's open enrollment period is mandatory for all benefit-eligible employees!**

**All elections/changes must be submitted in BenefitBridge no later than 4:30 PM, August 30, 2024.**

Once open enrollment ends, you can make plan changes ONLY if you have a qualifying event. Please refer to page 4.

## What's new for 2024-2025?

### ASCIP Medical PPO – 90/70 PPO Plan and HDHP Plan A

- **Anthem Blue Cross Network**
- **Navitus RX Program**
- **Health Advocate**
- **Anthem Employee Assistance Program (EAP)**

### Ameritas Dental and Vision (VSP)

Dental and vision benefits will remain the same; however, we will have new group ID numbers.

**The EdCare Modern Care and Bronze PPO Medical Plans will be ending effective 10/1/2024.**

### Flexible Spending Accounts (FSA)

**The Section 125 Flexible Spending Accounts Open Enrollment Period is from July 29, 2024, through August 30, 2024.**

If you wish to enroll or re-enroll in a Flexible Spending Account for the new plan year, October 1, 2024, through September 30, 2025, you must meet with an American Fidelity representative during the open enrollment period. See page 40 to learn more about FSAs.

## Open Enrollment Checklist

- ☐ Visit the annual open enrollment website at www.scccd.edu/openenrollment.
- ☐ Check important dates for open enrollment.
- ☐ If you will be adding an eligible dependent to your health plans, gather the required supporting dependent documents (see page 3).
- ☐ Review your employee payroll deductions taking effect on the September 30, 2024, paycheck.
- ☐ Schedule a meeting with Trustmark if you would like information to enroll in a Universal Life Insurance with Long Term Care Rider plan.
- ☐ Schedule a meeting with American Fidelity if you will be enrolling/re-enrolling in a Flexible Spending Account.
- ☐ Review voluntary benefit product offerings and contact the appropriate vendor – American Fidelity or AFLAC – for more information and/or to enroll.
- ☐ Attend a meeting to learn more about the health benefit offerings and get your questions answered.
- ☐ Log into BenefitBridge to review and make changes to your health plan elections and enrolled dependents, if any.
    - Review the medical plan comparison tool in BenefitBridge.
    - If you are adding an eligible dependent, be sure to upload the required supporting dependent documents in BenefitBridge no later than 4:30 PM, August 30, 2024.

# Eligibility

## Employees

The District offers medical, dental, vision, and group life/accidental death and dismemberment (AD&D) insurances along with an employee assistance program to full-time employees and their eligible dependents.

Employees also have the option to enroll in the voluntary long-term disability insurance plan at cost.

Full-time benefit eligible employees and health plan effective dates are defined in the bargaining unit agreements, Board Policies, and Administrative Regulations.

To view the bargaining unit agreements, visit https://www.scccd.edu/departments/human-resources/collective-bargaining-unit-agreements.html for more information.

To view the board policies and/or administrative regulations, visit https://www.scccd.edu/about/board-of-trustees/policies-and-regulations.html for more information.

## Eligible Dependents

Eligible employees may enroll their eligible dependents in the health insurance plans either at time of hire, during the annual open enrollment period or with a qualifying life event.

Eligible dependents include:

- Legally married spouse
- Legally Registered Domestic Partner
- Child(ren) – *eligible up to age 26*
  Child(ren) includes biological child, stepchild, and child placed under a qualified medical child support order.

**Overage Disabled Child(ren):** A disabled child who reaches age 26 may be eligible to continue coverage. Please contact the District Human Resources benefits staff for more information.

## Overage Dependents

Dependent children can remain on the health care plans up until they attain age 26, at which time they will receive information on how to continue the health insurance plans at cost with Delta Health Systems, as allowed through the Consolidated Omnibus Budget Reconciliation Act (COBRA).

## Required Supporting Documents Needed for Proof of Dependent Eligibility

Below is a list of the supporting documentation **required** in order to establish dependent eligibility.

Employees who wish to add their eligible dependents to the health insurance plans - either at time of initial hire, during the annual open enrollment period, or with a qualifying life event - have 31-days from the event date, including the event date, to complete the enrollment and upload the required supporting dependent documents as listed below in BenefitBridge.

- **Spouse:**
  - Copy of the legal certified marriage certificate.
  - Copy of Prior Year's Tax Federal Tax Form that shows the couple was married (financial information may be blocked out).
  - Copy of the spouse's social security card.
- **Registered Domestic Partner (RDP):**
  - Copy of the Certificate or Registered Domestic Partnership issued by State of California.
  - RDP's social security card.
- **Biological Child(ren):**
  - Copy of legal certified birth certificate(s).
  - Copy of the child's social security card.
- **Stepchild(ren):**
  - Copy of legal certified birth certificate(s) naming the current legally, married spouse or RDP as the child's biological parent.
  - Copy of the child's social security card.
- **Adopted Child(ren):**
  - Copy of the legal birth certificate(s).
  - Copy of the legal adoption documentation.
  - Copy of the child's social security card.
- **Legal guardianship of a child(ren) up to age 18:**
  - Copy of legal certified birth certificate(s).
  - Copy of legal US Court documentation establishing guardianship.
  - Copy of the child's social security card.

If you do not have the required documents, notify the District Human Resources benefits staff immediately.

# Enrollment and Qualifying Life Events

## New Hire Enrollment

Eligible newly hired employees have 31 days from their date of hire, including their date of hire, to enroll in the health insurance plans.

Newly hired employees must complete their new hire health insurance enrollment online using BenefitBridge, our online benefits enrollment administration system.

New employees who do not complete and submit their enrollment elections in BenefitBridge within 31-days from date of hire, including the date of hire, will automatically be enrolled for employee only coverage under the lowest cost health plans for the plan year as per the bargaining unit agreements, board policy and administrative regulation.

To view the bargaining unit agreements, visit https://www.scccd.edu/departments/human-resources/collective-bargaining-unit-agreements.html for more information.

To view the board policies and/or administrative regulations, visit https://www.scccd.edu/about/board-of-trustees/policies-and-regulations.html for more information.

## Changes in Dependent Eligibility/Qualifying Life Events

Outside of the annual open enrollment period, employees have 31-days from the qualifying life event date, including the event date, to make changes to dependent enrollment on the health plans.

Employees who experience a dependent eligibility change/qualifying life event are responsible to complete the online benefit enrollment changes in BenefitBridge. Employees will be required to elect coverage and upload the required supporting dependent documents to establish eligibility in BenefitBridge within 31-days from the qualifying event date, including the event date.

Failure to complete the online enrollment change request and upload the required supporting documents in BenefitBridge will impact dependent eligibility for health insurance, health care continuation under COBRA, and may result in you incurring liability for health care expenses.

Qualifying events include, but are not limited to:

- Change in legal marital status, including marriage, divorce, legal separation, annulment, registration or dissolution of domestic partnership, and death of a spouse.
- Birth, adoption, placement for adoption, or death of a dependent child.
- Change in employment status, including the start or termination of employment by you, your spouse, or your dependent child.
- Permanent change in work schedule, including a significant increase or decrease in hours of employment by you, your spouse, or your dependent child, including a switch between part-time and full-time employment that affects eligibility for benefits.
- Lost eligibility under a prior health plan for reasons other than non-payment of premium or due to fraud or intentional misrepresentation of a material fact.
- Change in an individual's eligibility for Medicare, Medicaid or Children’s Health Insurance Program (CHIP) coverage.
- A court order resulting from a divorce, legal separation, annulment, or change in legal custody (including a Qualified Medical Child Support Order) requiring coverage for your child or dependent foster child.

If you need help to determine what supporting documents are needed, contact the District Human Resources benefits staff.

# Health Benefit Offerings and Costs

The District's health benefit package includes medical, dental, vision, and life and accidental death & dismemberment (AD&D) insurances, along with an employee assistance program. The District also offers a voluntary long-term disability insurance plan, at employee cost.

The District and employees share in the cost of the health insurance coverage. The District Contribution toward the health insurance plans monthly premiums is specified in the bargaining unit agreements, board policy, and/or administrative regulation. The monthly employee portion of the premium is automatically deducted from your paycheck. Employees can elect to have the employee payroll deduction taken out on a pre-tax basis. The pre-tax election can occur at initial time of hire or during the annual open enrollment period.

## Medical Insurance Plans (Monthly Employee Payroll Deduction)

| Plan | Confidential Unrepresented | CSEA Unit Members | Management Unrepresented | POA Unit Members | SCFT Unit Members |
|---|---|---|---|---|---|
| ASCIP Anthem 90/70 PPO | $378.61 | $378.61 | $378.61 | $378.61 | $378.61 |
| ASCIP Anthem HDHP Plan A PPO (HSA Qualified Plan) | $0 | $0 | $0 | $0 | $0 |
| Kaiser High Traditional HMO | $426.28 | $426.28 | $426.28 | $426.28 | $426.28 |
| Kaiser Low Deductible HMO | $123.82 | $123.82 | $123.82 | $123.82 | $123.82 |
| Kaiser HDHP HMO (HSA Qualified Plan) | $0 | $0 | $0 | $0 | $0 |

## Dental Insurance Plan

| Plan | Monthly Employee Payroll Deduction |
|---|---|
| Ameritas PPO Dental | $0, fully paid for by the district. |

## Vision Insurance Plan

| Plan | Monthly Employee Payroll Deduction |
|---|---|
| VSP Vision through Ameritas | $0, fully paid for by the district. |

## Life and Accidental Death & Dismemberment (AD&D) Insurance Plan

| Plan | Monthly Employee Payroll Deduction |
|---|---|
| VOYA Life and Accidental Death & Dismemberment (AD&D) Insurance Plan | $0, fully paid for by the district. |

## Voluntary Long-Term Disability (LTD) Insurance Plan

| Plan | Monthly Employee Payroll Deduction |
|---|---|
| Voya Voluntary Long-Term Disability Insurance Plan | Premium rate varies. Fully paid for by the employee. |

# Coverage Effective Dates

- Medical, dental, vision and life & AD&D insurance as well as the Employee Assistance Program become effective on the first of the month following the date of hire.
- If the voluntary long-term disability plan is elected, coverage becomes effective the first of the month following date of hire.

# Medical Plans

The District offers the choice between five medical plans, two PPO plans and three HMO plans. The medical plan offerings are ASCIP Anthem 90/70 PPO, ASCIP Anthem HDHP Plan A PPO, Kaiser High Traditional HMO, Kaiser Low Deductible HMO (DHMO), and Kaiser HDHP (HSA). The Kaiser HMO plans are fully insured health plans, while the ASCIP PPO plans are self-funded health plans.

## Medical Plan Comparison

The following comparison chart provides a general overview of the medical plan options using in-network benefits. You must read the entire Evidence of Coverage (EOC) to understand the details of the coverage. All EOCs can be found in BenefitBridge (www.benefitbridge.com/statecenterccd) and on the District Human Resources Employee Benefits webpage (www.scccd.edu/employeebenefits).

| Plan Benefits | Anthem 90/70 PPO (ASCIP) In-Network | Anthem HDHP Plan A PPO In-Network | Kaiser High HMO | Kaiser Low DHMO | Kaiser HDHP (HSA Plan) |
|---|---|---|---|---|---|
| Deductible-Individual | $500 | $1,700 | None | $2,000 | $3,200 |
| Deductible-Family | $1,000 | $3,400 | None | $4,000 | $6,400 |
| Coinsurance | 10% | 10% | None | 20% | 10% |
| Office Visit Copay | $0 visits 1-3<br>$20 thereafter | 10% coinsurance after deductible | $25 | $20 | 10% coinsurance after deductible |
| Specialist Copay | $20 | 10% coinsurance after deductible | $25 | $20 | 10% coinsurance after deductible |
| Max Out of Pocket Individual | $1,000 | $3,400 | $1,500 | $4,000 | $5,200 |
| Max Out of Pocket Family | $2,000 | $6,800 | $3,000 | $8,000 | $10,400 |
| X-ray and labs | 10% coinsurance after deductible | 10% coinsurance after deductible | $10 per encounter | $10 per encounter after deductible | 10% coinsurance after deductible |
| Advanced Imaging (MRI, CT) | 10% coinsurance after deductible | 10% coinsurance after deductible | $50 per procedure | 20% up to $50 per procedure | 10% coinsurance after deductible |
| Outpatient Surgery | 10% coinsurance after deductible | 10% coinsurance after deductible | $100 per procedure | 20% coinsurance after deductible | 10% coinsurance after deductible |
| Inpatient Hospital (Mental Health) | 10% coinsurance after deductible | 10% coinsurance after deductible | $500 copay per admit | 20% coinsurance after deductible | 10% coinsurance after deductible |
| Emergency Room | $50 copay<br>+10% coinsurance after deductible | $100 copay<br>+ 10% coinsurance after deductible | $100 | 20% coinsurance after deductible | 10% coinsurance after deductible |
| Ambulance | 10% coinsurance after deductible | $100 per trip and 10% coinsurance after deductible | $100 per trip | $150 per trip after deductible | 10% coinsurance after deductible |
| Urgent Care | $20 | 10% coinsurance after deductible | $25 | $20 | 10% coinsurance after deductible |
| Durable Medical Equipment | 10% coinsurance after deductible | 10% coinsurance after deductible | No charge | 20% coinsurance (deductible does not apply) | 10% coinsurance after deductible |
| Physical, Occupational, and Speech Therapy | 10% coinsurance after deductible | 10% coinsurance after deductible | $25 per visit | $20 per visit after deductible | 10% coinsurance after deductible |
| **Prescriptions-Retail** | | | | | |
| Rx Max Out of Pocket | $2,500/individual<br>$3,500/family | N/A | N/A | N/A | N/A |
| Generic/Tier 1 | $10 copay | $9 copay | $10 copay | $10 copay | $10 copay |
| Preferred Brand/Tier 2 | $20 copay | $35 copay | $30 copay | $30 copay | $30 copay |
| Non-Preferred Brand/Tier 3 | $35 copay | N/A | $30 copay | $30 copay | $30 copay |
| Specialty | Refer to Navitus | Refer to Navitus | 20% coinsurance up to $150 | 20% coinsurance up to $150 | 30% coinsurance up to $150 |

# Kaiser Permanente HMO Medical Plans

This matrix is a brief side-by-side summary of the Kaiser High Traditional HMO, Kaiser Low HMO plan, and Kaiser HDHP (HSA) benefits. You must read the entire Evidence of Coverage (EOC) to understand the details of the coverage. All EOCs can be found in BenefitBridge (www.benefitbridge.com/statecenterccd) and on the District Human Resources Employee Benefits webpage (www.scccd.edu/employeebenefits).

| Plan Benefits | Kaiser High HMO | Kaiser Low DHMO | Kaiser HDHP (HSA Plan) |
|---|---|---|---|
| Deductible-Individual | None | $2,000 | $3,200 |
| Deductible-Family | None | $4,000 | $6,400 |
| Coinsurance | None | 20% | 10% |
| Office Visit Copay | $25 | $20 | 10% coinsurance after deductible |
| Specialist Copay | $25 | $20 | 10% coinsurance after deductible |
| Max Out of Pocket Individual | $1,500 | $4,000 | $5,200 |
| Max Out of Pocket Family | $3,000 | $8,000 | $10,400 |
| X-ray and labs | $10 per encounter | $10 per encounter after deductible | 10% coinsurance after deductible |
| Advanced Imaging (MRI, CT) | $50 per procedure | 20% up to $50 per procedure | 10% coinsurance after deductible |
| Outpatient Surgery | $100 per procedure | 20% coinsurance after deductible | 10% coinsurance after deductible |
| Inpatient Hospital (Mental Health) | $500 copay per admit | 20% coinsurance after deductible | 10% coinsurance after deductible |
| Emergency Room | $100 | 20% coinsurance after deductible | 10% coinsurance after deductible |
| Ambulance | $100 per trip | $150 per trip after deductible | 10% coinsurance after deductible |
| Urgent Care | $25 | $20 | 10% coinsurance after deductible |
| Durable Medical Equipment | No charge | 20% coinsurance (deductible does not apply) | 10% coinsurance after deductible |
| Physical, Occupational, and Speech Therapy | $25 per visit | $20 per visit after deductible | 10% coinsurance after deductible |
| **Prescriptions-Retail** | | | |
| Rx Max Out of Pocket | N/A | N/A | N/A |
| Generic/Tier 1 | $10 copay | $10 copay | $10 copay |
| Preferred Brand/Tier 2 | $30 copay | $30 copay | $30 copay |
| Non-Preferred Brand/Tier 3 | $30 copay | $30 copay | $30 copay |
| Specialty | 20% coinsurance up to $150 | 20% coinsurance up to $150 | 30% coinsurance up to $150 |

# Kaiser Permanente HMO Medical Plans

## About the Kaiser Permanente HMO Medical Plans

- The Kaiser High Plan is a traditional HMO plan.
- The Kaiser Low Plan is a Deductible HMO plan
- The Kaiser High Deductible Health Plan (HDHP) is a Health Savings Account (HSA) qualified plan.
- All plans use Kaiser Hospitals and facilities.
- There are no out-of-network benefits.
- Members of the District's Kaiser HMO plans are part of the Kaiser Northern Region.
- Most Kaiser Facilities and Medical Centers offer one-stop service – primary care, specialists, lab tests, x-rays, and pharmacy.
- With Kaiser, your doctor, nurses, and other specialists all work together to keep you healthy. They are connected to each other and to you through your electronic health record. That way, you get personalized care that is right for you.
- Kaiser makes it easy to find a doctor who is right for you, and you are free to change doctors at any time, for any reason.
- If you have a condition like diabetes or heart disease, you are automatically enrolled in a disease management program for personal coaching and support.
- Kaiser offers self-care apps such as Calm, Ginger, and myStrength, at no additional cost to members.
- Kaiser offers online wellness tools, healthy lifestyle programs, health classes, personal wellness coaching, special rates for members and farmers markets.

## Local Kaiser Facilities

- Clovis Medical Offices
  2071 E. Herndon Ave., Clovis, CA 93611
- First Street Medical Offices
  4785 N. First St., Fresno, CA 93726
- Fresno Medical Center
  7300 N. Fresno St., Fresno, CA 93720
- Cedar Avenue Medical Offices
  7415 N. Cedar #102, Fresno, CA 93720
- Selma Medical Offices
  2651 Highland Ave., Selma, CA 93662
- Oakhurst Medical Offices
  40595 Westlake Dr., Oakhurst. CA 93644

## Kaiser Health Education Departments

Health Education Departments are available at the Fresno Medical Center, Selma Medical Offices, and the Clovis Medical Offices. Kaiser health classes, program and services range from tobacco cessation classes to weight management to stress relief. Kaiser also offers an online health reference center, DVD and online viewing, community resources and referrals and registered dietician appointments (physician referral only).

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# Kaiser Permanente HMO Medical Plans

## Telemedicine Services

Kaiser offers telemedicine services by e-mail, phone, and video visits.

## Cost Estimate Tool

Kaiser members can access a cost estimate calculator for services and benefits through their member portal at www.kp.org.

## Care Options While Traveling

No matter where you get urgent or emergency care around the world, you can file a claim for reimbursement. And at many locations outside of Kaiser Permanente states, you will only play your copay or coinsurance – no need to file a claim. Need help finding care or learning what's covered while you're away? Call the Away from Home Travel Line at 951-268-3900 or visit kp.org/travel.

- Cigna PPO (Shared Administration) Network providers
- MinuteClinics®, including pharmacies*
- Concentra clinics*

**Payment experiences vary by plan*

## Apps


Kaiser members can access a member portal, www.kp.org, online or through the KP Mobile App.

The member portal and mobile app allows members to schedule appointments, view lab results, email your doctor, view Explanation of Benefits, view bills, and access a wealth of health resources and tools.

## Medical ID Cards

All new members to Kaiser will receive a medical ID card issued in his/her name. For newly enrolled members, please allow at least fourteen (14) business days (*from when your enrollment is approved in BenefitBridge*) to receive your medical ID cards.

If a member should lose an ID card, please contact Kaiser Member Services at (800) 464-4000 to request a new one. Members can also log into their Kaiser member portal (www.kp.org) or mobile app to access a virtual ID card.

# ASCIP Anthem 90/70 & HDHP Plan A PPO Medical Plans

This matrix is a brief side-by-side summary of the ASCIP Anthem 90/70 PPO and Anthem HDHP Plan A PPO medical plan benefit. You must read the entire Evidence of Coverage (EOC) to understand the details of the coverage. All EOCs/SPDs can be found in BenefitBridge (www.benefitbridge.com/statecenterccd) and on the District Human Resources Employee Benefits webpage (www.scccd.edu/employeebenefits).

| Plan Benefits | Anthem 90/70 PPO (ASCIP) In-Network | Anthem HDHP Plan A PPO In-Network |
|---|---|---|
| Deductible-Individual | $500 | $1,700 |
| Deductible-Family | $1,000 | $3,400 |
| Coinsurance | 10% | 10% |
| Office Visit Copay | $0 visits 1-3<br>$20 thereafter | 10% coinsurance after deductible |
| Specialist Copay | $20 | 10% coinsurance after deductible |
| Max Out of Pocket Individual | $1,000 | $3,400 |
| Max Out of Pocket Family | $2,000 | $6,800 |
| X-ray and labs | 10% coinsurance after deductible | 10% coinsurance after deductible |
| Advanced Imaging (MRI, CT) | 10% coinsurance after deductible | 10% coinsurance after deductible |
| Outpatient Surgery | 10% coinsurance after deductible | 10% coinsurance after deductible |
| Inpatient Hospital (Mental Health) | 10% coinsurance after deductible | 10% coinsurance after deductible |
| Emergency Room | $50 copay<br>+10% coinsurance after deductible | $100 copay<br>+ 10% coinsurance after deductible |
| Ambulance | 10% coinsurance after deductible | $100 per trip and 10% coinsurance after deductible |
| Urgent Care | $20 | 10% coinsurance after deductible |
| Durable Medical Equipment | 10% coinsurance after deductible | 10% coinsurance after deductible |
| Physical, Occupational, and Speech Therapy | 10% coinsurance after deductible | 10% coinsurance after deductible |
| **Prescriptions-Retail** | | |
| Rx Max Out of Pocket | $2,500/individual<br>$3,500/family | N/A |
| Generic/Tier 1 | $10 copay | $9 copay |
| Preferred Brand/Tier 2 | $20 copay | $35 copay |
| Non-Preferred Brand/Tier 3 | $35 copay | N/A |
| Specialty | Refer to Navitus | Refer to Navitus |

# ASCIP Anthem PPO Medical Plans

## About the ASCIP Anthem PPO Medical Plans

- These plans are part of the ASCIP JPA. SISC is the plan administrator.
- Both PPO plans use the Anthem Blue Cross provider network.
- With a PPO plan, it is the members responsibility to ensure they are using in-network providers and services.
- 90/70 plan – The first three (3) office visits, per benefit period, to an in-network primary care physician are not subject to a copay.
- Value Added Benefits
    - Virtual visits by MD LIVE with a $10 copay.
    - Anthem Employee Assistance Program.
    - Free generic medications at Costco. *For the HDHP Plan A, copays and free generics at Costco apply only after the deductible is met.*
    - Hinge Health – digital exercise therapy program to support back and joint health. *Not available for the HDHP Plan A.*
    - Enhanced Cancer Benefit – free and voluntary program which enables members to obtain expert care and support from City of Hope, a National Cancer Institute designated Center of Excellence. *For HDHP Plan A, this benefit is subject to the deductible.*
- Special facilities (not just Anthem PPO contracted hospitals) are required for the following inpatient surgeries:
    - Transplants and Bariatric procedures use Centers of Medical Excellence (CME). Members must contact the Transplant Department as soon you think you may need a transplant.
    - Hip and knee replacements along with certain Spine surgeries must be performed at a designated Blue Distinction Plus (BD+) hospital facility.
- Surgery centers are required for outpatient Arthroscopy, Cataract Surgery, Colonoscopy, Upper GI Endoscopy with/out Biopsy.
- Microsite available at https://www.anthem.com/ca/sisc/. **All benefits available except "Chiropractic and Acupuncture Benefits for HMO members"; Value Added Benefits may not apply.*

## Value Added Benefits

### Health Advocate

Navigating medical benefits can be confusing and frustrating, but we have some good news. With the ASCIP PPO medical plans, you will have access to a new free service through Health Advocate that provides expert healthcare and insurance support in a variety of areas.

Health Advocate can help you:

- Get answers to your insurance and claims questions and resolve billing issues, including negotiating balance bills from non-network providers
- Find the right in-network doctors through a provider ratings system that includes outcomes, safety scores, experience and patient reviews
- Make appointments and transfer medical records
- Make informed decisions about medical conditions and diagnoses

- Find and explore the latest treatment options and arrange second opinions
- Understand how your benefits work and clarify copays and deductibles
- Compare the costs of providers in your area

You can access Health Advocate by calling them 24/7 at (866) 695-8622, via their mobile app or website, https://healthadvocate.com/members. This program will even provide assistance with your dental and vision benefits.

### MDLive

MDLive allows members age 10 and up to access virtual visits with a licensed doctor, psychiatrist, or therapist. Physicians can prescribe medication when appropriate. There is a $10 copay. MDLive can be used to treat allergies, cold/flu, ear problems, pink eye, UTI, respiratory problems, and more. Visit www.mdlive.com/sisc or call (800) 657-6169.

### Anthem Employee Assistance Program

Enrolled members and their households have access to the Anthem Blue Cross Employee Assistance Program at no extra cost. EAP is designed to help with everyday problems and questions. Individuals who request counseling can get up to 6 visits per issue. EAP services also include a 30-mintue legal consultation, financial consultation, ID recovery assistance, emotional wellbeing resources, and more. Anthem EAP is available 24/7 either online at www.anthemeap.com (enter SISC) or by calling 800-999-7222.

## Prescription Drug Benefits

The PPO medical plans use Navitus pharmacy benefits. Enrolled members should register with Navitus at www.navitus.com to view the most up-to-date formulary.

Members are urged to use generic drugs when available.

Costco is an in-network pharmacy and provides free generic fills on a 30-day supply *(for the HDHP Plan A, copays and free generics at Costco apply only after the deductible is met)*. Some narcotic pain and cough medications are not included in the Costco Free Generic program.

If you or your physician requests the brand name when a generic equivalent is available, you will pay the generic copay plus the difference in cost between the brand and generic. The difference in cost between the brand and generic will not count toward the Annual Out-of-Pocket Maximum.

Some covered medications require step-therapy or prior authorization and some therapeutic classes of medication use preferred medications.

*90/70 Plan*

- 30 Day Supply: $10 generic/$20 Brand / $35 Non-Preferred Brand
- 90 Day Supply (Costco retail and mail order): $0 co-pay for eligible generics; /$20 Brand/$35 Non-Preferred Brand

*HDHP Plan A*

- 30 Day Supply: $9 generic/$35 brand
- 90 Day Supply (Costco retail and mail order): $0 co-pay for eligible generics; $90 brand copay
- Copays and free generics at Costco apply only after the plan deductible is met.

Navitus contracts with most independent and chain pharmacies; however, Walgreens is **NOT** a participating pharmacy in this network. It is always the patient's responsibility to confirm benefits and if providers are in-network or contracting.

**Mail Order Service**

The Mail Order Service allows you to receive a 90-day supply of maintenance medications. Some narcotic pain and cough medications are not included in the 90-day mail order service program. This program is part of your pharmacy benefit and is **VOLUNTARY**.

**Specialty Pharmacy**

Navitus SpecialtyRx helps members who are taking medications for certain chronic illnesses or complex diseases by providing services that offer convenience and support. This program is part of your pharmacy benefit and is **MANDATORY**.

For information regarding the Prescription Drug Program call or visit on-line:

Navitus Customer Care 1-866-333-2757 (toll-free) TTY (toll free) 711 www.navitus.com

The Navitus Member Portal allows you to access personalized pharmacy benefit information online at www.navitus.com. For information specific to your plan, visit the Navitus Member Portal. Activate your account online using the Member Login link and an activation email will be sent to you. The site provides access to prescription benefits, pharmacy locator, drug search, drug interaction information, medication history, and mail order information. The site is available 24 hours a day, seven days a week.

### Apps

ASCIP PPO medical plan members can access the Anthem Blue Cross website at www.anthem.com/ca/sisc to find care, get a virtual ID card, and more. Members can also access the Anthem Sydney Health App to find a doctor, view claims, see health benefits coverage, view a digital ID card and more.

### Medical ID cards

All new members will receive a medical ID card issued in his/her name. For newly enrolled members, please allow at least fourteen (14) business days (*from when your enrollment is approved in BenefitBridge*) to receive your medical ID cards.

If a member should lose an ID card, the member can log into their Anthem Blue Cross member portal or their Sydney Health App to download a digital copy.

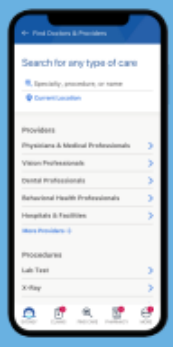
# Connect with the care that's right for you

## The Find Care tool helps you search for doctors/dentists and compare costs

Choosing a provider you trust is important — and choosing one in your plan's network can help keep your costs down. Finding high-quality, cost-effective care is simple when you use the Find Care tool on the Sydney Health mobile app or **anthem.com/ca.**

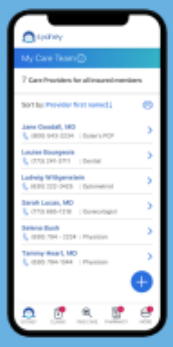
### How to use Find Care

The Find Care tool brings together details about doctors, dentists, hospitals, labs, and healthcare facilities in your plan's network. You can easily compare information such as costs, location, and office hours. You can:




**1**

Search for providers and facilities in your plan's network by name, specialty, or procedure.

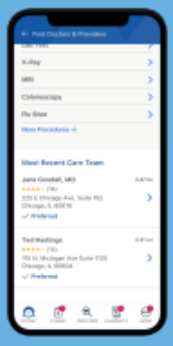


**2**

Customize the list of providers you see in your search based on factors that are most important to you, such as languages spoken, affiliated hospitals, and location.

**3**

Review details about doctors/ dentists such as their specialties, gender, educational background, and contact information.



**4**

Choose a doctor/ dentist from the list to review their patient ratings and compare costs for services.

### Choose with confidence

You can start using **Find Care** by downloading the Sydney Health app to your mobile device or logging in to **anthem.com/ca.** Select **Find Care** and the Find Care tool will guide you through the steps.

### We're ready to help you

The Find Care tool empowers you to take control of your healthcare by helping you connect with high-quality care options. If you have questions, you can reach us using the interactive chat feature on the Sydney Health app or through the Message Center on **anthem.com/ca.**

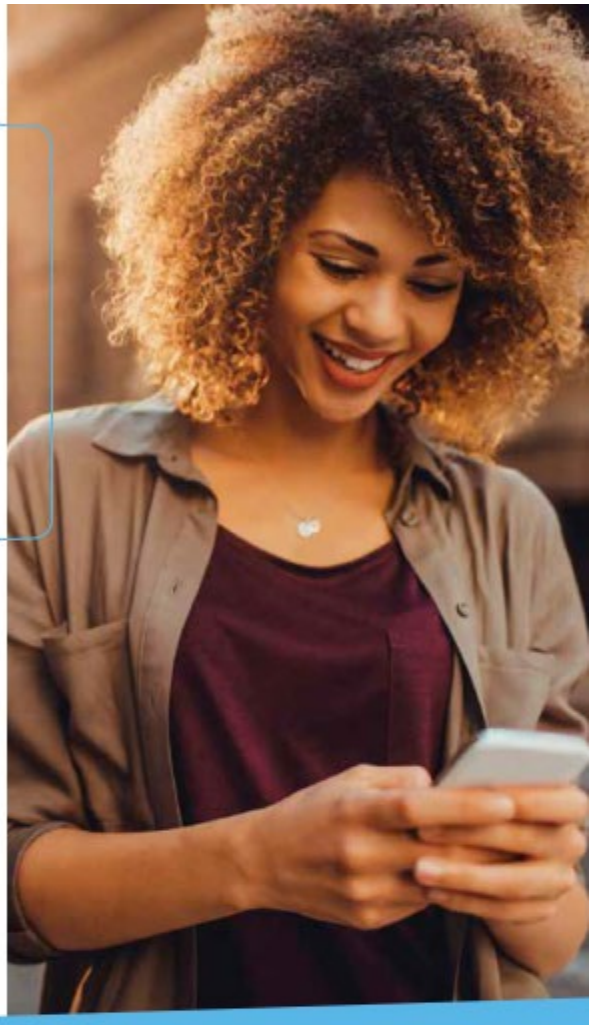
Download Sydney Health today to find a provider that's right for you

Use your smartphone camera to scan this QR code.

# ASCIP Anthem PPO Medical Plans

## Digital ID cards — *always current, always accurate*

### Make sure we have your email so you can get your digital ID card



Have you ever handed your member ID card to a doctor only to find it's expired, or it isn't even the right one? Your digital ID card always has the latest information, so you can be sure you're giving the right details to your doctor or health care professional.

**Your digital ID card can make your life easier**

- No need to wait for your ID card to come in the mail — new ID cards are available faster!
- It's easy to use.
  - Print a copy any time.
  - Email or fax it right from your computer or mobile device.
  - Show it to your doctor from your smartphone. Your digital ID card is always there and works just like a printed ID card.

**Tip:** Download the card to your smartphone, so you'll always have it even if your cell signal or internet connection goes bad.

**Be sure you register at anthem.com/ca/sisc**

There's only one thing you have to do to get your digital ID card: register on **anthem.com/ca/sisc** or the **Sydney** mobile app. While you're logged in, set your ID card preference to digital.

Anthem

SISC
Self-Insured Schools of California

# ASCIP Anthem PPO Medical Plans

## Choosing a lab in your plan's network can save you money

Smart choices can add up to savings on your healthcare. For example, if you need lab work, you can choose where to go to save money.

As a member of a **Self-Insured Schools of California (SISC) preferred provider organization health plan**, lab services are covered by care providers in your plan's network. For even more savings, you can choose an independent lab in your plan's network instead of a hospital lab. There can be a big difference in cost based on whether a lab is in a hospital.*

| Test | Independent lab | Hospital-based lab | Out-of-network lab |
|---|---|---|---|
| Basic metabolic panel | $9 | $36+ | No coverage. You pay the full amount. |
| Lipid (cholesterol) panel | $14 | $65+ | |
| Pap test | $20 | $63+ | |

* Your actual cost depends upon your benefits and whether or not your deductible is met. These costs are examples only.

### Talk to your doctors if they refer you to a lab

Let your healthcare provider know your plan only covers lab work at facilities in your plan's network. Ask them to refer you to an independent lab instead of a hospital lab.

If you're at your care provider's office and they collect a lab sample in the office, ask these questions:

- Will you be processing this lab test here?
- If not, where will you send it?
- Is the lab in my network?
- If you're sending it to a hospital, can you use a lower-cost option, like an independent lab?

To search for labs in your plan's network, visit **anthem.com/ca/sisc/find-care** or call us at the number on your ID card.

Anthem | SISC Self-Insured Schools of California Schools Helping Schools

# ASCIP Anthem PPO Medical Plans

MDLIVE

SISC
Self-Insured Schools of California
School Helping Schools

## Need a doctor? No long wait. No big bill. Always open.

With MDLIVE, you can visit with a doctor 24/7 from your home, office or on-the-go.

### Welcome to MDLIVE! Your anytime, anywhere doctor's office.

Avoid waiting rooms and the inconvenience of going to the doctor's office. Visit a doctor by phone, secure video, or MDLIVE App. Pediatricians are available 24/7, and family members are also eligible.

**U.S. board-certified doctors with an average of 15 years of experience.**

**Consultations are convenient, private and secure.**

**Prescriptions can be sent to your nearest pharmacy, if medically necessary.**

### Your COPAY is just $10

Your copay for medical and behavioral health consultations is $10

* MDLIVE is not available to Kaiser members

### We treat over 50 routine medical conditions including:

- Acne
- Allergies
- Cold / Flu
- Constipation
- Cough
- Diarrhea
- Ear Problems
- Fever
- Headache
- Insect Bites
- Nausea / Vomiting
- Pink Eye
- Rash
- Respiratory Problems
- Sore Throats
- Urinary Problems / UTI
- Vaginitis
- And More

MD **Download the app.**
Join for free. Visit a doctor.

**MDLIVE.com/sisc**
**1-800-657-6169**

# ASCIP Anthem PPO Medical Plans

## LEARN MORE ABOUT YOUR NAVITUS PRESCRIPTION DRUG BENEFITS

### Welcome to Navitus

We are pleased to be your pharmacy benefit manager (PBM) and to manage your pharmacy benefit. Our goal is to improve your health and minimize out-of-pocket costs. We have partnered with SISC to:

- Provide a friendly customer experience to make it easier to understand your benefits
- Enable convenient access to drugs
- Help you take your drugs correctly

### Frequently Asked Questions

**How do I fill my prescription?**

At a Network Pharmacy — Getting your prescription filled is easy. You can find a list of network pharmacies on the member portal at navitus.com/member. Your network includes most independent and all major chain pharmacies except Walgreens.

With Mail Order – If you take a medication month after month, Costco Mail Order may be right for you. A mail order service gives you a 90-day supply of your maintenance medication and ships it right to your door. Many times, this is at a lower cost to you.

You are eligible for Costco Mail Order when:

- You have filled your 30-day prescription a minimum of three times.
- Your prescription, including dosage, has not changed in 90 days.

This ensures the drug and dosage is a good fit for a longer-day supply.

Register online at costco.com/pharmacy to start. You can also call 800-607-6861 to speak to Costco's customer service team. They are available Monday to Friday from 5:00 a.m. to 7:00 p.m. and Saturday from 9:30 a.m. to 2:00 p.m. Pacific Time. Costco will ship your prescription within five business days of receipt.

You do not need to be a Costco member to use Costco pharmacies.

**At Lumicera Specialty Pharmacy** — Navitus' specialty pharmacy partner, Lumicera Health Services, provides a high level of personalized care for members with complex conditions. Our clinical team will help you manage side effects, reduce complications and improve your quality of life.

# ASCIP Anthem PPO Medical Plans

To start, just call 855-847-3553 to speak with a Lumicera patient care specialist. They are available Monday – Thursday from 6:00 a.m. to 5:00 p.m. and Friday from 6:00 a.m. to 4:00 p.m. (Pacific Time).

**Helpful Tips to Save Money**

With drug prices rising, we know how important it is to keep prescriptions affordable. Using generic drugs is one of the best ways to save money. Generics are clinically the same as brand drugs and often available at a fraction of the cost.

Navitus and SISC have teamed up with Costco to help you save. When you fill your generic drugs at Costco, many SISC benefit plans have a $0 copay. Please check your benefit summary for details to see if you are eligible to get them for free or at a reduced copay. Plus, you can get a convenient 90-day supply of your maintenance drugs after you have filled a 30-day prescription for that drug a minimum of three times. You do not need to be a Costco member.

Getting started is easy. Simply visit or call your local Costco and let the pharmacy staff know that you would like to transfer your prescription. In most cases, Costco can contact your current pharmacy to complete the transfer.

## How do I access the member portal?

Our portal gives you easy access to the tools you need to make the most of your drug benefits, including:

- Pharmacy locator — a tool to help you find network pharmacies near you.
- Cost compare — a tool to help you find the best price for your drugs.
- Formulary — a list of drugs that are covered under your plan.

To log in, go to our secure member portal at memberportal.navitus.com. You will find instructions for registering on the page. If you have previously registered for the Navitus app, you can use the same login information for the member portal.

You can also access your benefits, find a nearby pharmacy, view and manage your drugs and more — all on our mobile app.

### Did You Know?

You can get easy access to your prescription benefits using Navitus' convenient mobile app.

Download the App on the App Store or Google Play!

Hover your phone's camera over this code to download the app.

## What is prior authorization?

Some drugs require prior authorization to ensure they are being used correctly. If your drug requires prior authorization, your health care provider can call 866-333-2757 to request approval or find an alternative. We review requests within two business days.

## What is step therapy?

Step therapy helps manage high-cost drugs. With step therapy, you may be asked to try a safe and cost-effective alternative before the other drug is covered. When filling a drug that has step therapy, your pharmacist will be prompted to call your prescriber about the alternative drug. Most members find that the lower-cost drug works well for them. You may also discuss these alternatives with your prescriber.

# ASCIP Anthem PPO Medical Plans

## CONDITIONS/DRUGS THAT MAY REQUIRE PRIOR AUTHORIZATION OR STEP THERAPY

| Prior Authorization | Step Therapy |
|---|---|
| Acne Treatment | Anti-Diabetics |
| Chronic Inflammatory Disease | Asthma (Rescue) |
| Blood Glucose Test Strips (Non-Preferred) | Migraine |
| Diabetes (Non-Preferred Insulin) | Ophthalmic (Glaucoma) |
| Hormone Replacement (Testosterone) | Tetracyclines |
| Oral Cancer Therapy | |
| Topical Steroids | |
| Dermatologic (Specialty) | |

### What is the difference between prior authorization and an exception to coverage (ETC)?

Prior authorization drugs are covered on the formulary. They are approved after certain set criteria are met. An ETC can be requested for drugs that are not covered. For an ETC to be approved, the member and their doctor must show that covered formulary alternatives have been tried and failed. They must also submit an FDA MedWatch form for each alternative drug tried and failed with the reasons the member cannot take that alternative drug.

### Does my drug require prior authorization or step therapy?

Start by logging in to memberportal.navitus.com. The easiest way to find out if your drug is covered, is from the Home page of the portal. Simply log in and enter the name of your drug. If there are any limits or requirements, "See Coverage Details" button will appear.

Click that button, and it will outline the steps you need to take to get your prescription filled. From there, you can also get prices, find pharmacies and see drug information

### Are over-the-counter (OTC) drugs covered?

Only legally required OTC drugs are covered. Covered OTC drugs can be found in the Evidence of Coverage.

Note: These options meet federal requirements for health plans but may not include coverage for Medicare.

### Questions?

We want to make your pharmacy benefits easy and accessible. You may be able to find answers to your questions on the member portal or app. You can visit the member portal at navitus.com/members or download the app by scanning the QR code above. You can also call customer care at 866-333-2757. We are available 24 hours a day, 7 days a week.

To file a claim or submit a grievance, go to www.navitus.com/members. Your rights and responsibilities can be found at navitus.com/members/member-rights.

# Dental Insurance

The District offers a dental insurance plan provided through Ameritas PPO. Dental benefits are available for eligible employees and their eligible dependents.

The Ameritas PPO dental plan has in-network and out-of-network benefits. When you use in-network providers, services are provided at a discounted rate. This means you pay less, and your benefit dollars go further when you use in-network providers. If you should use an out-of-network provider, you may pay more for services.

## Benefit Incentive levels

The Ameritas PPO dental plan is an incentive plan that begins paying member claims at 70% and increases 10% each year until the member reaches 100% for all basic, diagnostic and preventative services. You must use the plan at least once a year for the incentive level to increase; otherwise, the incentive level will remain the same. The incentive level will never decrease and once you reach 100%, it will remain there regardless of usage.

## Lifetime Orthodontia

Orthodontic benefits for an enrollee are limited to $1,250 for each enrollee per lifetime. For orthodontic programs that were covered under the prior plan and are in progress, Ameritas will coordinate benefits between the old plan and the new plan to make sure members get the remaining maximum benefit. Member will need to advise their provider of the group number change so they can submit bills to Ameritas.

## Dental ID Cards

All employees will receive two (2) dental identification cards. The cards will be issued in the employee's name only and can be used by all members enrolled on the plan. Employees will need to provide their ID Card along with the new group number to their provider. For newly enrolled members, please allow at least fourteen (14) business days (*from when your enrollment is approved in BenefitBridge*) to receive your medical ID cards.

If a member should lose their dental ID card, the member can log into their Ameritas account at https://www.ameritas.com/sign-in/ to print a copy.

## Dentist Provider Search

For a listing of Ameritas PPO Dental In-Network Providers, please visit the Ameritas Provider Search webpage at https://dentalnetwork.ameritas.com/.

## Member Portal for Ameritas Dental

Members can access their account on the Ameritas website at https://www.ameritas.com/sign-in/ and review dental benefits, incentive level, explanation of benefits, and claims.

# Dental Insurance

## Summary of Benefits

This matrix is a brief summary of your benefits. You must read the entire Evidence of Coverage (EOC) or Summary Plan Document (SPD) in order to understand the details of the coverage. All EOCs/SPDs can be found in BenefitBridge (www.benefitbridge.com/statecenterccd) and on the District Human Resources Employee Benefits webpage (www.scccd.edu/employeebenefits).

### State Center Community College District

*Dental Care Highlight Sheet*

Ameritas

**Plan 1: Dental Plan Summary** — **Effective Date: 10/1/2024**

| | In Network | Out of Network |
|---|---|---|
| **Plan Benefit** | Initials @ 70% | Initials @ 70% |
| **Type 1** | 70/80/90/100% | 70/80/90/100% |
| **Type 2** | 70/80/90/100% | 70/80/90/100% |
| **Type 3** | 50% | 50% |
| **Deductible** | $0/Calendar Year | $0/Calendar Year |
| | Type 1,2,3 | Type 1,2,3 |
| | No Family Maximum | No Family Maximum |
| **Maximum** *(per person)* | $1,750 per calendar year | $1,500 per calendar year |
| **Allowance** | Discounted Fee | 90th U&C |
| **Waiting Period** | None | None |
| **Annual Eye Exam** | None | None |
| **Annual Open Enrollment** | Included | Included |

**Orthodontia Summary - Adult and Child Coverage**

| | In Network | Out of Network |
|---|---|---|
| **Allowance** | Discounted Fee | U&C |
| **Plan Benefit** | 50% | 50% |
| **Lifetime Maximum** *(per person)* | $1,250 | $1,250 |
| **Waiting Period** | None | None |

***Maximum is lifetime for both in network and out of network.*

**Sample Procedure Listing** (*Current Dental Terminology* © American Dental Association.)

**In Network**

| Type 1 | Type 2 | Type 3 |
|---|---|---|
| • Routine Exam (4 in 12 months) | • Fillings for Cavities | • Prosthodontics (fixed bridge; removable complete/partial dentures) (1 in 5 years) |
| • Bitewing X-rays (1 in 6 months) | • Restorative Composites (anterior and posterior teeth) | |
| • Full Mouth/Panoramic X-rays (1 in 3 years) | • Endodontics (nonsurgical) | |
| • Periapical X-rays | • Endodontics (surgical) | |
| • Cleaning (1 in 6 months) | • Periodontics (nonsurgical) | |
| • Fluoride for Children 13 and under (1 in 5 months) | • Periodontics (surgical) | |
| • Sealants (age 16 and under) | • Denture Repair | |
| • Space Maintainers | • Simple Extractions | |
| | • Complex Extractions | |
| | • Anesthesia | |
| | • Crowns (1 in 5 years per tooth) | |
| | • Onlays | |
| | • Crown repair | |

**Out of Network**

| Type 1 | Type 2 | Type 3 |
|---|---|---|
| • Routine Exam (4 in 12 months) | • Fillings for Cavities | • Prosthodontics (fixed bridge; removable complete/partial dentures) (1 in 5 years) |
| • Bitewing X-rays (1 in 6 months) | • Restorative Composites (anterior and posterior teeth) | |
| • Full Mouth/Panoramic X-rays (1 in 3 years) | • Endodontics (nonsurgical) | |
| • Periapical X-rays | • Endodontics (surgical) | |
| • Cleaning (1 in 6 months) | • Periodontics (nonsurgical) | |
| • Fluoride for Children 13 and under (1 in 5 months) | • Periodontics (surgical) | |
| • Sealants (age 16 and under) | • Denture Repair | |
| • Space Maintainers | • Simple Extractions | |
| | • Complex Extractions | |
| | • Anesthesia | |
| | • Crowns (1 in 5 years per tooth) | |
| | • Onlays | |
| | • Crown Repair | |

# Dental Insurance

## State Center Community College District

*Dental Care Highlight Sheet*

Ameritas

### Ameritas Information

**We're Here to Help**

This plan was designed specifically for the associates of State Center Community College District. At Ameritas Group, we do more than provide coverage - we make sure there's always a friendly voice to explain your benefits, listen to your concerns, and answer your questions. Our customer relations associates will be pleased to assist you 7 a.m. to midnight (Central Time) Monday through Thursday, and 7 a.m. to 6:30 p.m. on Friday. You can speak to them by calling toll-free: 800-487-5553. For plan information any time, access our automated voice response system or go online to ameritas.com.

### Dental Health Scorecard

How would you rate your dental health?

In 2016, you can receive your Dental Health Report Card by signing into your secure member account online. Your assessment is based on claims submitted. The report card also offers suggestions if you strive to improve your dental health. Ameritas members can access the personalized report card by going to ameritas.com, click Account Access in the top right corner and choose the Dental/Vision/Hearing drop down. Select the Secure Member Account link and sign in to see your report.

### Rx Savings

Our valued plan members and their covered dependents can save on prescription medications at over 60,000 pharmacies across the nation including CVS, Walgreens, Rite Aid and Walmart. This Rx discount is offered at no additional cost, and it is not insurance.

To receive this Rx discount, Ameritas plan members just need to visit us at ameritas.com and sign into (or create) a secure member account where they can access and print an online-only Rx discount savings ID card.

### Eyewear Savings

Ameritas plan members may receive up to 10% off eyewear frames and lenses purchased at any Walmart Vision Center nationwide. Members may also bring in their current vision prescription from any vision care provider and purchase eyewear at Walmart. This savings arrangement is not insurance: it is available to members at no additional cost to their plan premium.

To receive the eyewear savings identification card, Ameritas plan members can visit ameritas.com and sign-in (or create) a secure member account. Members must present the Ameritas Eyewear Savings Card at time of purchase to receive the discount.

### Hearing Savings

With your Ameritas plan, you can receive hearing aid discounts through Great Hearing Benefits at their 4,500+ hearing care locations nationwide. Call 877-683-9495 for your free hearing consultation today. This savings arrangement is not insurance. It is available to members at no additional cost to their plan premium.

Highlights include: hearing exam for only $50 (saves you $100 off the industry average of $150), up to 50% off retail pricing on today's top hearing technology, plus a satisfaction guarantee and warranty service. Visit greathearingbenefits.com/ameritas to learn more.

### Dental Network Information

To find a provider, visit ameritas.com and select **FIND A PROVIDER**, then **DENTAL**. Enter your criteria to search by location or for a specific dentist or practice. California Residents: When prompted to select your network, choose the Ameritas Network found on your ID Card or contact Customer Connections at 800-487-5553.

Your provider network is Ameritas Classic Network.

### Pretreatment

While we don't require a pretreatment authorization form for any procedure, we recommend them for any dental work you consider expensive. As a smart consumer, it's best for you to know your share of the cost up front. Simply ask your dentist to submit the information for a pretreatment estimate to our customer relations department. We'll inform both you and your dentist of the exact amount your insurance will cover and the amount that you will be responsible for. That way, there won't be any surprises once the work has been completed.

### Open Enrollment

If a member does not elect to participate when initially eligible, the member may elect to participate at the policyholder's next enrollment period. This enrollment period will be held each year and those who elect to participate in this policy at that time will have their insurance become effective on May 1. If you do not enroll during your company's open enrollment period, then you will be subject to the Late Entrant Provision.

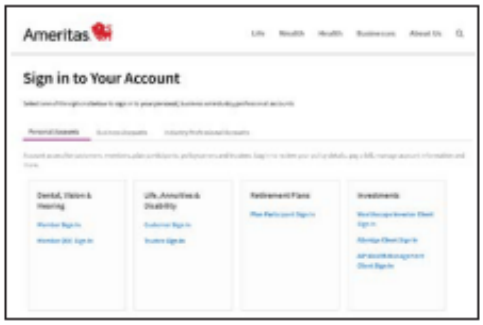
# Dental Insurance

## Find a Dental Provider

Quick reference

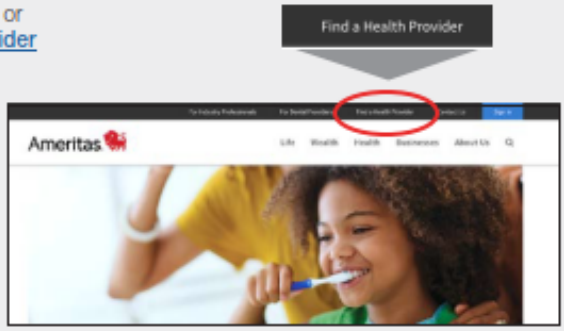
### 1 Step 1: Know your network

- Find the network name by looking at your ID card, plan materials, or calling customer connections at 800-487-5553.



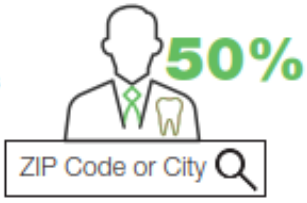

### 2 Step 2: Go online

- Go to dentalnetwork.ameritas.com or ameritas.com – Find a Health Provider
- Enter your location and then choose the network name to search for a dental provider.




### 3 Step 3: Search providers

- Network providers charge 25-50% less than their regular rates. Dentists in green offer the most savings, closer to 50%.
- Use Additional Filters to search by provider name, practice/business name, or specialty.
- **Tip:** If you can't find a specific provider or location by name, search by ZIP Code or city.




**Help us improve**

We do our best to keep our records updated. If you find a phone number that is no longer in service, or if a provider is no longer at that location, you can update us by clicking the Report Inaccuracies link.

Ameritas
fulfilling life.



Ameritas Life Insurance Corp.
Ameritas Life Insurance Corp. of New York

# Dental Insurance

## How to Use Your Orthodontic Benefits

A healthy smile contributes to self-esteem, self-confidence and self-image—important qualities at every age. **About 25% of orthodontic patients are over age 18.[1]**

### Visit an orthodontist for an evaluation

If you visit a provider from the Ameritas contracted network, you will almost always save on out-of-pocket costs.

### Request a pretreatment estimate of benefits

Your orthodontist will submit a treatment plan to Ameritas with details about the planned treatment and expected costs.

Ameritas will review the plan and then let you and your provider know the expected insurance benefits and potential out-of-pocket costs.

### Set up a payment plan

Once you begin your treatment plan, Ameritas will begin making automatic payments based on information from the claim form.

### Important details

Children must start treatment by age 17 to receive the full benefit.

Total estimated cost is prorated by quarter over the estimated length of the program. Benefits are payable at end of each quarter, with the first quarter payment beginning on the date the braces are placed.

For orthodontic programs that were covered under your prior plan and are in progress, Ameritas will coordinate benefits between the old plan and the new plan to make sure members get the remaining maximum benefit.

When beginning new orthodontic treatments, initial visits can be submitted when they are performed as a single date of service and the benefits paid will reduce the orthodontic maximum.

### Understand your benefits

Once your coverage begins, you can set up your member account to view the benefits for each person covered by your plan. Just go to ameritas.com and select Sign In, Dental/Vision/Hearing, Member Sign In and Register Now.

Make sure to check your lifetime maximum benefit and deductible amounts for your orthodontic benefits.

Ameritas
*fulfilling life.*

# Vision Insurance

The District offers a vision insurance plan provided by Vision Service Plan (VSP) through Ameritas. Vision benefits are available for eligible employees and their eligible dependents.

The Plan will provide benefits, up to the amounts shown below, for the vision services and supplies listed below.

## Summary of Benefits

This matrix is a brief summary of your benefits. You must read the entire Evidence of Coverage (EOC) or Summary Plan Document (SPD) in order to understand the details of the coverage. All EOCs/SPDs can be found in BenefitBridge (www.benefitbridge.com/statecenterccd) and on the District Human Resources Employee Benefits webpage (www.scccd.edu/employeebenefits).

**State Center Community College District**

*Eye Care Highlight Sheet*

Ameritas

**Plan 1: Focus® Plan Summary** — **Effective Date: 10/1/2024**

| | VSP Choice Network + Affiliates | Out of Network |
|---|---|---|
| **Deductibles** | $10 Exam<br>$10 Eye Glass Lenses or Frames* | $10 Exam<br>$10 Eye Glass Lenses or Frames |
| **Annual Eye Exam** | Covered in full | Up to $45 |
| **Lenses (per pair)** | | |
| **Single Vision** | Covered in full | Up to $30 |
| **Bifocal** | Covered in full | Up to $50 |
| **Trifocal** | Covered in full | Up to $65 |
| **Lenticular** | Covered in full | Up to $100 |
| **Progressive** | See lens options | NA |
| **Contacts** | | |
| **Fit & Follow Up Exams** | Member cost up to $60 | No benefit |
| **Elective** | Up to $180 | Up to $145 |
| **Medically Necessary** | Covered in full | Up to $210 |
| **Frame Allowance** | $180** | Up to $70 |
| **Frequencies (months)** | | |
| **Exam/Lens/Frame** | 12/12/24<br>Based on date of service | 12/12/24<br>Based on date of service |

**Deductible applies to a complete pair of glasses or to frames, whichever is selected.*
***The Costco and Walmart allowance will be the wholesale equivalent.*

**Lens Options (member cost)***

| | VSP Choice Network + Affiliates (Other than Costco) | Out of Network |
|---|---|---|
| **Progressive Lenses** | Up to provider's contracted fee for Lined Bifocal Lenses. The patient is responsible for the difference between the base lens and the Progressive Lens charge. | Up to Lined Bifocal allowance. |
| **Std. Polycarbonate** | Covered in full for dependent children $33 adults | No benefit |
| **Solid Plastic Dye** | $15 (except Pink I & II) | No benefit |
| **Plastic Gradient Dye** | $17 | No benefit |
| **Photochromatic Lenses (Glass & Plastic)** | $31-$82 | No benefit |
| **Scratch Resistant Coating** | $17-$33 | No benefit |
| **Anti-Reflective Coating** | $43-$85 | No benefit |
| **Ultraviolet Coating** | $16 | No benefit |

**Lens Option member costs vary by prescription, option chosen and retail locations.*

**The VSP network provides additional savings on eyewear and laser vision correction**

| | |
|---|---|
| Amount exceeding retail frame allowance | 20% off |
| Additional prescription glasses | 20-30% off** |
| Non-prescription sunglasses | 20-30% off* |
| Additional savings | Select a featured frame brand and get an extra $20 to spend |
| LASIK or PRK laser vision correction | 15% average of retail, 5% off promotional price at VSP contracted facilities |
| Retinal screening | Member cost $39 or less |

Find more opportunities to save at vsp.com/offers.
Based on applicable laws, reduced costs may vary by doctor location.

*The Costco and Walmart allowance will be the wholesale equivalent.
**30% off if purchased the same day as the WellVision exam
20% off if purchased within 12 months of the exam.

vsp vision care

# Vision Insurance

## State Center Community College District

*Eye Care Highlight Sheet*

Ameritas

### Primary Eyecare

- Retinal screening for members with diabetes
- Additional exams and services for members with diabetes, glaucoma, or age-related macular degeneration
- Treatment and diagnoses of eye conditions, including pick eye, vision loss, and cataracts available for all members
- Limitations and coordination with your medical coverage may apply. Ask your VSP doctor details.
- As needed

### Lightcare Program

Members may use $180 frame allowance for ready-made non-prescription sunglasses or blue light filtering glasses in lieu of prescription glasses or contact lenses.

### Hearing Savings

With your Ameritas plan, you can receive hearing aid discounts through Great Hearing Benefits at their 4,500+ hearing care locations nationwide. Call 877-683-9495 for your free hearing consultation today. This savings arrangement is not insurance. It is available to members at no additional cost to their plan premium.

Highlights include: hearing exam for only $50 (saves you $100 off the industry average of $150), up to 50% off retail pricing on today's top hearing technology, plus a satisfaction guarantee and warranty service. Visit greathearingbenefits.com/ameritas to learn more.

### Eye Care Plan Member Service

Focus eye care from Ameritas Group features the money-saving eye care network of VSP. Customer service is available to plan members through VSP's well-trained and helpful service representatives. Call or go online to locate the nearest VSP network provider, view plan benefit information and more.

VSP Call Center: 1-800-877-7195

- Service representative hours: 5 a.m. to 7 p.m. PST Monday through Friday, 6 a.m. to 2:30 p.m. PST Saturday
- Interactive Voice Response available 24/7

Locate a VSP provider at: ameritas.com
View plan benefit information at: vsp.com

### Language Services

We recognize the importance of communicating with our growing number of multilingual customers. That is why we offer a language assistance program that gives you access to: Spanish-speaking claims contact center representatives, telephone interpretation services in a wide range of languages, online dental network provider search in Spanish and a variety of Spanish documents such as enrollment forms, claim forms and certificates of insurance.

### Domestic Partner

California state law requires that coverage shall be provided to Registered Domestic Partners that is equal to, and subject to the same terms and conditions as, the coverage provided to a spouse. Registered Domestic Partner means a partner of the Insured as long as the partnership meets the requirements for such relationship as defined in Section 297 of the California Family Code or the functional equivalent registration of any other state or local jurisdiction.

**This document is a highlight of plan benefits provided by Ameritas Life Insurance Corp. as selected by your employer. It is not a certificate of insurance and does not include exclusions and limitations. For exclusions and limitations, or a complete list of covered procedures, contact your benefits administrator.**

vsp vision care

# Vision Insurance

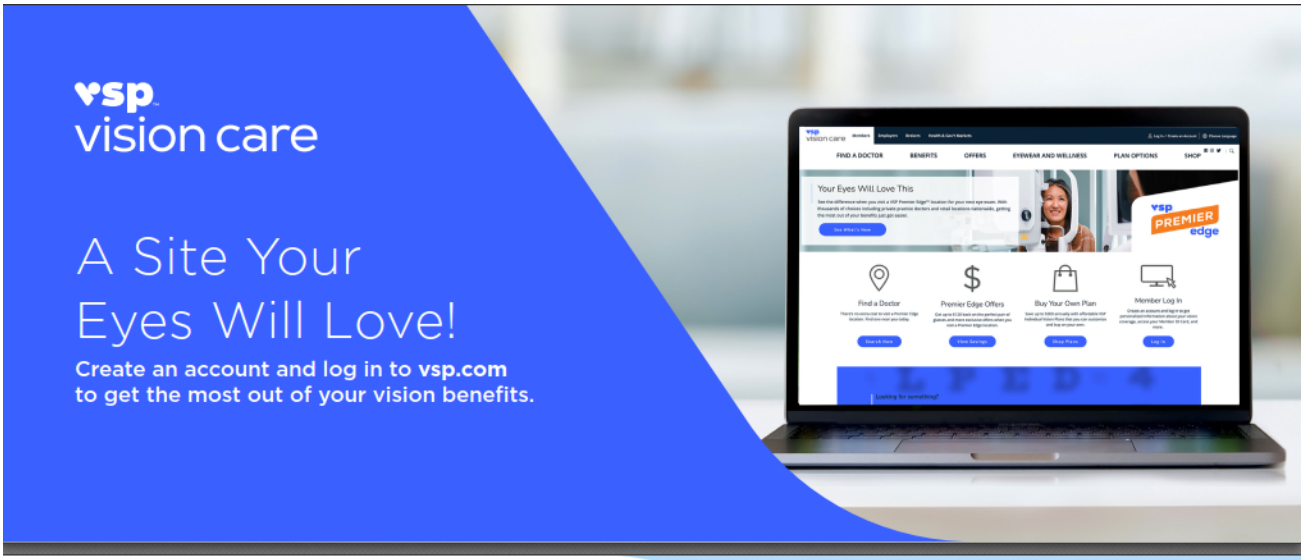
## Vision ID Cards

All employees will receive a new vision ID Card. Employees will need to provide their ID Card along with the new group number to their provider. For newly enrolled members, please allow at least fourteen (14) business days (*from when your enrollment is approved in BenefitBridge*) to receive your medical ID cards.

## Vision Provider Search

To find in-network VSP providers, please visit the VSP Find A Doctor webpage at www.vsp.com/eye-doctor.

## Member Portal for VSP Vision




**View your benefits**
Once logged in, see your benefits, view your claim history, and more in your personalized dashboard.

**Find an in-network doctor**
With thousands of private practice doctors and more than 700 Visionworks® retail locations nationwide, getting the most out of your benefits is easy at a VSP Premier Edge™ location.

vsp PREMIER edge
Get more at preferred in-network doctor locations
private practice doctors
Visionworks

**Save on eyewear and so much more**
Access more than $3,000 in savings with VSP® Exclusive Member Extras.

To learn about your privacy rights and how your protected health information may be used, see the VSP Notice of Privacy Practices on **vsp.com**.



**It's Easy to Create an Account:**

1. Visit **vsp.com**.
2. Click on **Create an Account** at the top-right corner of the site.
3. Fill in all of the required fields to create your account.
4. Click on **Create an Account** to submit the form. You will receive a confirmation email.

**Not online?**
Member services can help create an account. Call **800.877.7195**.

# Employee Assistance Program (EAP)

The District offers an Employee Assistance Program (EAP) through SimpleTherapy SimpleEAP (formerly Halcyon). **EAP services are available to eligible employees and anyone within the eligible employee's household**.

SimpleEAP (formerly Halcyon EAP) provides confidential, professional referrals and face-to-face counseling for a wide array of personal and work-related concerns.

## Benefit Summary

Eligible employees and members of their households can access EAP Benefits. SimpleEAP (formerly Halcyon EAP) benefits are available 24 hours a day, 7 days a week, 365 days a year.

***Counseling***

Available for stress, anxiety, relationship problems, grief and loss, anger management, work-related stress, education guidance, identity theft recovery, substance abuse, and more. The program offers three (3) free sessions in a six-month period, per issue.

***Web based services***

Web based services such as scheduled video, telephonic, and web chat counseling services through the eConnect platform, articles and tip sheets for personal and work-related topics, search engines and directories for childcare, elder care, education, legal, and finance, as well as skill builders, self-assessment tools, and more.

***Work-Life Referrals***

SimpleEAP (formerly Halcyon EAP) can provide you with referrals and information for services such as: childcare, elder care, pet care, adoption assistance, school/college assistance, health and wellness, convenience referrals, stress, substance abuse, and other issues impacting your quality of life.

***Legal Assist***

SimpleEAP (formerly Halcyon EAP) offers up to 30 minutes of free telephonic or face-to-face legal consultation with an attorney.

***Financial Assist***

SimpleEAP (formerly Halcyon EAP) offers referrals and information for services relating to expert financial planning and consultation.

## EAP Provider Search

To get a confidential referral to an in-network provider, please call (888) 425-4800 to speak with an EAP clinical counselor. The clinician will triage you and provide you a referral.

## EAP Member Portal

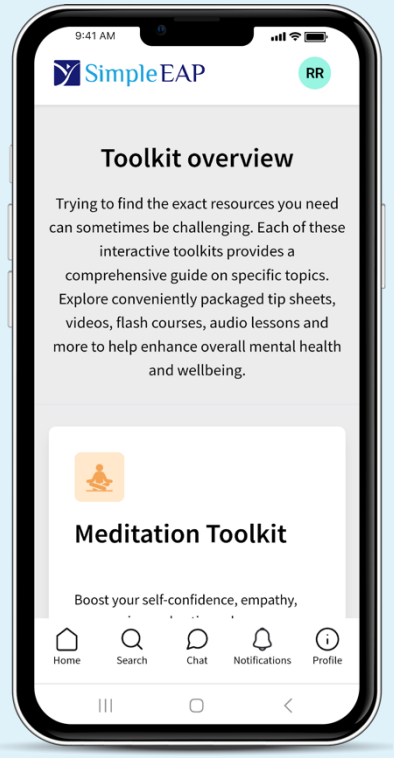
To access the EAP member portal, which includes a wealth of online tools and resources, please visit the SimpleEAP (formerly Halcyon EAP webpage at www.simpleeap.com. The login username is edcare.

# Employee Assistance Program (EAP)

The District offers an Employee Assistance Program through SimpleEAP (formerly Halcyon EAP). These services are available to eligible employees plus anyone residing in their households.

SimpleEAP provides confidential, expert guidance to help you and your family address and resolve everyday issues. Support is available 24/7/365 by calling 888-425-4800.


## Web and Mobile Platform Resources



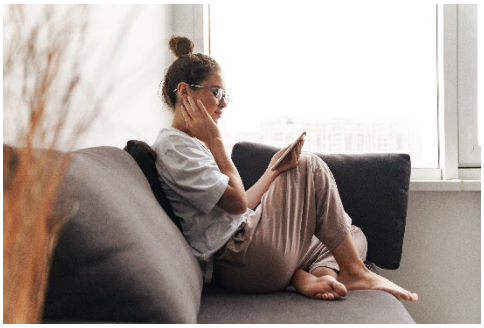

**Interactive Toolkits—**Self-serve training systems for resiliency, mindfulness, sleep fitness, mental health first aid and meditation
**Flash Courses—**50 short educational modules with post-module certificate
**Educational Resources—**Thousands of audio and video lessons, articles, tip sheets, resource links and self-assessments
**Savings Center—**Discount shopping program to make everyday life a little more affordable
**Wellbeing Place Blog—**Fresh resources to help positively impact your health and wellbeing
**Live Chat—**Live chat with licensed mental health counselors
**Additional Resources—**Free will and power of attorney, anti-stigma hub, request information or call-back
**Mindstream™**— tools and guidance to help you face life's challenges and thrive

# Employee Assistance Program (EAP)

# Support and Access

## Counseling

Available for stress, anxiety, relationship problems, grief and loss, anger management, work-related stress, education guidance, identity theft recovery, substance abuse, and more. The program offers three (3) free sessions in a six-month period, per issue.



## EAP Provider Search

To get a confidential referral to an in-network provider, please call 888-425-4800 to speak with a customer care advocate. They'll link you with the help you need, tailored to your preferences (telehealth, text therapy and more).

## EAP Member Portal

Access a wealth of online tools and resources through your EAP member portal. Visit www.simpleeap.com and enter **scccd** as the company code.

You can also download the mobile app today! Group code: **scccd**.

# Support and Access (CONTINUED)

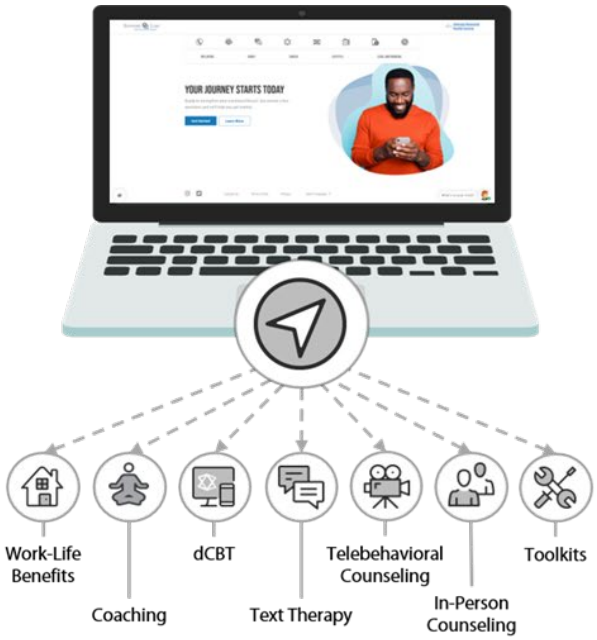
## Mental Health Navigator

Mental Health Navigator simplifies access to meaningful care by providing personalized guidance and advocacy.

Simply visit your web portal or mobile app to complete the short Mental Health Navigator assessment. You'll instantly receive customized guidance to access care and support.

### KEY FEATURES

- Web or Mobile Access
- Personalized Report
- Assistance With Scheduling Care




## Telebehavioral (video) Counseling

With Telebehavioral Counseling, you can receive confidential, timely and effective mental health support, regardless of your location or circumstances. Through video and web chat sessions, you have access to licensed masters- and doctorate-level behavioral health professionals, all of whom are Board Certified Telemental Health Providers.

### KEY FEATURES

- Easy to Access
- Confidential and Secure
- Certified Professionals

# Support and Access (CONTINUED)

## Textcoach®

Textcoach is like having a mental health coach in your pocket! Designed to help address issues like anxiety, depression, burn out and more, Textcoach allows you to begin texting with a licensed clinician on your mobile or desktop device. You can exchange texts, voice notes, videos and other resources to help boost your emotional well-being.

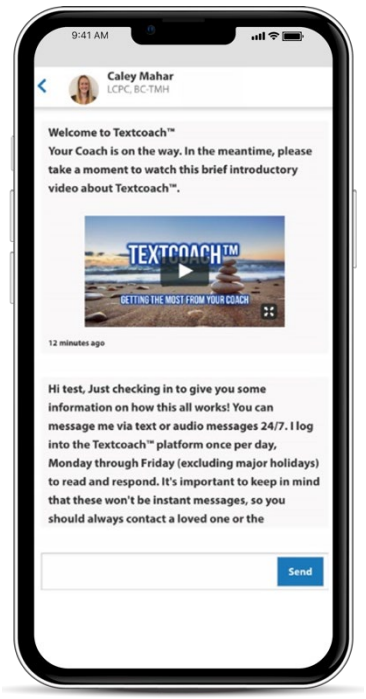
### Key Features

Immediate Support
100% Confidentiality
Licensed Professionals
Stigma-free Access

### Personal Coaching

You can schedule treatment directly with a counselor or coach. Coaching sessions can be scheduled in as little as 24 hours. Online scheduling provides:

The ability to schedule coaching or counseling through desktop and mobile platforms.
Choice of a provider who meets your gender, race, language or specialty preferences.
Access to quality care that helps strengthen your emotional fitness and improve well-being.




**Personalized coaching support is available telephonically,**
as well as through eConnect®, Textcoach® and Animo.

# Employee Assistance Program (EAP)

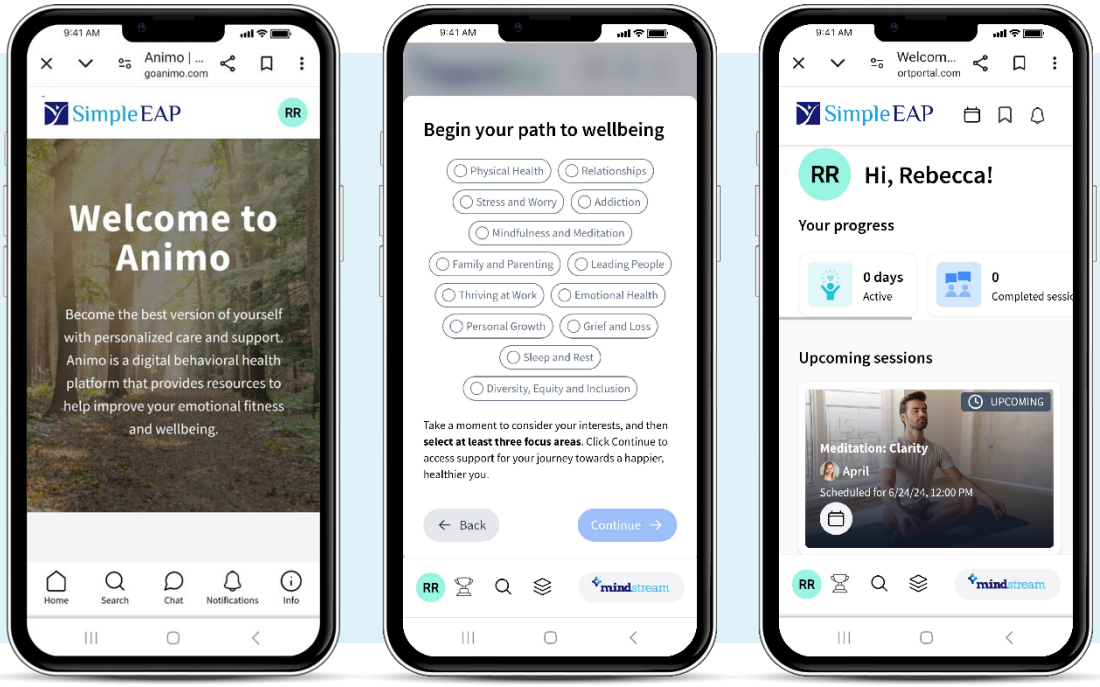
## **Support and Access** (CONTINUED)

## Digital Cognitive Behavioral Therapy (DCBT)

Animo provides web and mobile tools to help you address stress, depression, anxiety and general emotional fitness in a safe and secure self-guided environment. Complete a brief emotional fitness survey and then choose one of the suggested modules.

Each module has five short competency-building sessions that include a combination of videos, audio lessons and coursework designed to help you foster meaningful and lasting behavior change. Download the mobile app or click the Animo icon on your web portal for access to the full library of modules including:

- Coping with Panic
- Perfectionism
- Social Anxiety
- Stress Management
- Depression
- Phobias
- Trauma and Abuse



# Employee Assistance Program (EAP)

## Work-Life Benefits

Receive expert consultations for financial and legal issues. Work-life specialists also provide referrals for everyday needs such as child or elder care, pet care, home improvement or auto repair.

| | |
|---|---|
|  | **Legal Consultation**<br>Offers unlimited access including free in-person legal consultations and immediate telephonic legal advice with experienced attorneys from your home state. |
|  | **Financial Consultation**<br>Provides unlimited access to expert financial advice, including free in-person consultations and immediate telephonic consultations with experienced professionals. |
|  | **Identity Theft Recovery Consultation**<br>Delivers telephonic access to identity recovery professionals who assist you in creating action plans and implementing effective recovery strategies. |
|  | **Dependent Care Referrals**<br>Provides personalized guidance and referrals for childcare, elder care, and other dependent care needs tailored to your specific circumstances. |
|  | **Daily Living and Concierge Referrals (Convenience)**<br>Offers guidance and resources for various daily living needs, including home improvement, entertainment services, pet care, wellness, and more. |

Support is available 24/7/365 by calling 888-425-4800.

# Life Insurance and Accidental Death & Dismemberment (AD&D) Insurance

The District provides Group Term Basic Life Insurance and Accidental Death & Dismemberment (AD&D) insurance for benefit eligible employees. The life and AD&D insurance are offered through VOYA Financial.

## Summary of Benefits

This is a brief summary of your benefits. You must read the entire evidence of coverage in order to understand the details of your coverage. All benefit plan summaries and plan documents are available on BenefitBridge (www.benefitbridge.com/statecenterccd) and on the District Human Resources Employee Benefits webpage (www.scccd.edu/employeebenefits).

***Group Term Life Insurance***

The life insurance plan provides $50,000 of basic life and AD&D insurance to you, the employee, and $5,000 of life insurance coverage for your enrolled spouse/registered domestic partner and dependent(s) on the medical plan, all at no cost to you. Management and Confidential employees also receive an additional employer-paid, age-based benefit under the life insurance plan.

***Benefit Reductions***

Upon reaching the age of 70, the amount of life insurance decreases by 50%.

***Accelerated Death Benefits***

If you have been determined to have a terminal condition and your life expectancy is no more than twelve (12) months, you or your legal representative may apply for the Accelerated Death Benefit, which provides up to 50% of your life insurance amount.

***Accidental Death & Dismemberment (AD&D) Insurance***

If you suffer a covered loss due to a covered accident, you could apply for AD&D benefits. Such covered losses include life, both hands, either feet, or sight of both eyes, and speech. For a full listing of covered losses and additional AD&D benefits, please view the summary plan document for the life insurance plan.

## Additional Services Provided by the Life Insurance Plan

### Voya Travel Assistance

When traveling more than 100 miles from home, VOYA Travel Assistance offers four types of services – travel assistance services, medical assistance services, security assistance services, and emergency medical transportation services. Plan information and account access information can be found in your BenefitBridge account under Resources.

### Funeral Planning and Concierge Services

Members have access to Funeral Planning and Concierge Services to assist with funeral planning and negotiation at time of need as well as pre-planning tools that can be used to research and document decisions and wishes. Plan information and account access information can be found in your BenefitBridge account under Resources.

### Will Preparation Program

Members have access to free online will preparation through Estate Guidance. Plan information and account access information can be found in your BenefitBridge account under Resources.

## Life Insurance Beneficiary Designation

Employees can update their life insurance designated beneficiary information at any time and may do so in BenefitBridge.

# Voluntary Long-Term Disability Insurance


The District provides all benefit eligible employees the opportunity to purchase voluntary long-term disability (LTD) insurance coverage offered through VOYA.

Employees who enroll during their initial time of hire period (within 30-days after date of hire) are provided a guaranteed issued plan.

If you do not enroll at initial time of hire, you may apply during the annual open enrollment period. Enrollment is subject to approval by VOYA. You will be required to go through an Evidence of Insurability (EOI) Questionnaire.

## Summary of Benefits

This is a brief summary of your benefits. You must read the entire evidence of coverage in order to understand the details of your coverage.

Long-term disability insurance is a policy that provides income replacement for employees who become unable to work (unpaid) due to illness or injury for a long period of time. The long-term disability insurance plan provides a monthly disability benefit of 60%, up to a maximum $5,000, of the employee's eligible income after the employee qualified for benefits and has met the elimination period in accordance to the Long-Term Disability Summary Plan Document.

## Premium Rates

The voluntary long-term disability premium rate is based on your age and your salary at the start of the current policy year (October 1). Contributions are deducted on a post-tax basis.

| Long Term Disability monthly rates | |
|---|---|
| Age | 60% benefit percentage rates per $100 of monthly benefit |
| Under 25 | $.095 |
| 25-29 | $.130 |
| 30-34 | $.190 |
| 35-39 | $.270 |
| 40-44 | $.410 |
| 45-49 | $.590 |
| 50-54 | $.820 |
| 55-59 | $1.040 |
| 60 and over | $1.100 |
| 65 + | $1.100 |

# Voluntary Long-Term Disability Insurance

## To calculate your cost:

1. Divide your eligible annual earnings by 12. $

2. Calculate your monthly benefit amount by multiplying the number in Step 1 by your benefit percentage. $

3. If your answer in Step 2 was lower than $5,000 enter it here. If it was higher, enter $5,000 here. $

4. Divide your answer from Step 3 by 100. $

5. Multiply your answer from Step 4 by the rate from the table above. This is your total monthly cost.

6. Multiply your total monthly cost by 12 for your annual premium amount. Then, divide by your number of paychecks per year for your payroll deduction amount.

## Plan Documents and Benefit Summaries

For more information on the voluntary LTD insurance plan benefits, including exclusions, income offsets, pre-existing condition clauses, please review the summary plan document on BenefitBridge (www.benefitbridge.com/statecenterccd) and on the District Human Resources Employee Benefits webpage (www.scccd.edu/employeebenefits).

# Section 125 Flexible Spending Accounts (FSA)

Flexible Spending Accounts (FSA) are a great cost savings tool to help with qualified out of pocket health insurance expenses and/or dependent care expenses. The District offers Flexible Spending Accounts to eligible employees.

The plan administrator is American Fidelity.

Plan year runs October 1 through September 30 of the following year.

## Summary

Section 125 Flexible Spending Accounts (FSA) are governed by the IRS and allow eligible employees to deduct their employee payroll deduction toward the medical plan pre-taxed, as well as set aside pre-tax funds to use toward approved out-of-pocket medical, dental and vision expenses as well as dependent day care expenses.

**Flexible Spending Account funds are a use it or lose it benefits.** This means any unused funds left over in your FSA accounts at the end of the Runoff Period (3 months from the end of the plan year), are no longer yours. Therefore, all claims for FSA reimbursements should be submitted prior to the Runoff Period and incurred prior to the end of the Grace Period, which is two and a half months from the end of the plan year. For more information on the "use it or lose it rule", please contact American Fidelity at (559) 230-2107.

### *Dependent Day Care FSA*

A Dependent Day Care FSA account allows you to contribute pre-tax dollars to qualified dependent care. A Dependent Day Care FSA is used to reimburse yourself for eligible dependent care expenses incurred to allow you (and your spouse if you are married) to work or look for work. For more information about the Dependent Day Care FSA, visit the American Fidelity webpage at https://americanfidelity.com/info/dca or visit the American Fidelity Dependent Care Account Support webpage at https://americanfidelity.com/support/dca/.

The current maximum amount you may contribute to the Dependent Day Care FSA account each year is $5,000 (or $2,500 if married and filing separately). Dependent Day Care FSA account funds are available as contributions are received and payable when services have been provided.

### *Healthcare FSA*

A Healthcare FSA account allows you to set aside pre-taxed dollars to reimburse yourself for qualified health care expenses for you and your qualified dependents. This could include copays, deductibles, prescriptions, glasses, contacts, as well as other expenses allowable under Section 125 guidelines. For more information about a healthcare FSA, visit the American Fidelity webpage at https://americanfidelity.com/info/fsa, or visit American Fidelity's Healthcare FSA Support webpage at https://americanfidelity.com/support/hcfsa.

The current maximum amount you may contribute to the Health FSA each year is $3,200. Healthcare FSA account funds are available to you on October 1st of the plan year.

An itemized document or Explanation of Benefits must be submitted to prove eligibility for health care expenses. Save your receipts!

To discover eligible expenses, visit https://americanfidelity.com/eligible-expenses.

#### *Runoff Period*

Enrolled employees have up to 90-days after the plan year ends to submit claims incurred during the previous plan year that have not already been submitted for reimbursement.

# Section 125 Flexible Spending Accounts (FSA)

***Grace Period***

An additional two and a half months following the end of the plan year in which you can incur and submit claims to receive reimbursements.

## Enrollment

Eligible employees may enroll in a flexible spending account at time of hire, within 30-days from date of hire, or during the annual open enrollment period by contacting American Fidelity at (559) 230-2107.

Employees who choose to elect an FSA account must enroll/re-enroll each year during the annual open enrollment period as these plans and their elections do not renew automatically.

## How to Submit Claims for Reimbursements

American Fidelity offers different ways to be reimbursed from your FSA accounts.

- Electing to use a debit card for your health care expenses. The money you set aside in your FSA account(s) for medical expenses is available on your card. When you pay for these expenses, you do not need to pay out-of-pocket and wait for reimbursement – expenses are automatically deducted from your account on the card. You must still obtain and keep a receipt for the purchase should you need to validate the claim.
- You can submit claims online through American Fidelity's member claim portal. You will need to submit a copy of your receipt, explanation of benefits, or provider bill.
- You can use the AF mobile app to access your FSA account and submit reimbursement claims. You will need to submit a copy of your receipt, explanation of benefits, or provider bill.

For detailed information relating to FSA reimbursements, please review the American Fidelity FSA webpage at https://americanfidelity.com/support/hcfsa.

# Section 125 Flexible Spending Accounts (FSA)

## Healthcare Flexible Spending Accounts

### Plan Today for Tomorrow's Costs

With medical costs continuing to rise, you may be looking for options to help manage out-of-pocket medical expenses.

One option is a Healthcare Flexible Spending Account (HCFSA). HCFSAs allow you set aside money, tax free, for eligible medical costs like doctor visits, prescription drugs, prescription contact lenses, and dental procedures. Additionally, the entire amount you choose to contribute will be available to you at the beginning of your plan year.

### Savings Example

In the example to the right, Jane makes $4,000 per month. By participating in an HCFSA, she would save $82.96 a month.

That's a savings of $995.52 a year.

To calculate your possible savings, visit:
**americanfidelity.com/s125-calculator**

| Earnings & Taxes | Without FSA | With FSA |
|---|---|---|
| *Gross Pay* | $4,000 | $4,000 |
| Health Insurance | -$300 | -$300 |
| HCFSA Contribution | *N/A* | -$300 |
| ***Taxable Income*** | ***$3,700*** | ***$3,400*** |
| Estimated Taxes (Federal & State @ 20%) | -$740 | -$680 |
| Estimated FICA (7.65%) | -$283.05 | -$260.10 |
| Out-of Pocket Medical Expenses | -$300 | *N/A* |
| ***Take Home Pay*** | ***$2,376.95*** | ***$2,459.90*** |

*Example is for illustrative purposes only. Please consult your tax advisor for actual tax savings.*

### How It Works

**Paying Out of Pocket**


**Make** an eligible medical purchase

**Snap** a photo of itemized document(s)

**Submit** claim and documentation via AFmobile or your online account

**Receive** funds via direct deposit*

**Paying with your Benefits Debit Card****


**Make** an eligible purchase with card

**Snap** a photo of itemized document(s)

**Submit** documentation electronically, if requested

**americanfidelity.com/fileaclaim**

** Funds deposit within 3-5 business days after claim approval.*
*** If your employer has elected to provide a Benefits Debit Card, you may use this card to pay for eligible medical expenses or pay out of pocket and file a claim for reimbursement.*

AMERICAN FIDELITY
a different opinion

# Section 125 Flexible Spending Accounts (FSA)

## Using Your Benefits Debit Card

A Benefits Debit Card allows you to pay for eligible medical expenses using the funds in your HCFSA. The card may be used at locations that accept Mastercard® and have been identified as authorized medical merchants.

If you receive a documentation request letter, submit a picture of your itemized document or Explanation of Benefits (EOB) through your online account at **americanfidelity.com/submit-fsa** or through our mobile app, AFmobile®.

Learn more about your debit card at:
**americanfidelity.com/debit-card**


### Documentation must include:

1. Provider Name
2. Recipient Name
3. Date of Service
4. Description of Service
5. Charges

## Internal Revenue Code (IRC) Requirements: What You Need to Know

IRC guidelines are strict when tax breaks are provided. As your plan provider, we are required to follow IRC rules.

**First, the money you set aside operates under a "use or lose" system.**
That means you'll want to use all of your funds prior to the next plan year or you will lose whatever amount is left.

Ask if your employer's plan includes a Runoff Period and Carryover Provision or Grace Period.

- **Runoff Period**
  A period typically up to 90 days after the plan year ends when you can submit claims incurred during the previous plan year that have not already been submitted for reimbursement.
- **Carryover Provision**
  For 2022, this provision allows you to carry over up to $570 of unused contributions from one plan year to the next.
- **Grace Period**
  An additional two and a half months following the end of the plan year in which you can incur and submit claims to receive reimbursement.

**Second, the IRC requires proof for eligible expenses.**
An itemized document or EOB must be submitted to prove eligibility for medical expenses when they aren't verified when filing a claim or at the time of debit card swipe. Submitting documentation through AFmobile is the easiest way to validate a claim.

## Spend Smart & Save on Eligible Medical Expenses

| | | | |
|---|---|---|---|
| Copays/Co-insurance | Prescription contacts | Chiropractic care | Deductibles |
| Physical exams | Asthma treatments | Eye exams/eyeglasses | Over-the-counter medicine |
| Prenatal care | Laser eye surgery | Physical therapy | Menstrual products |

**Discover more ways to spend at americanfidelity.com/eligible-expenses**

American Fidelity Assurance Company
americanfidelity.com

SB-32928-0122

# Voluntary Benefit Products

## Welcome State Center Community College!

Welcome! State Center Community College: This is your opportunity to ensure you choose to apply for the benefits best for you. Aflac offers an array of benefits to help offset your cost in the event of an illness, accident or disability.

**To learn more or to apply for Aflac, call Jodie Bohner**

Jodie Bohner

Contact Your Agent/Producer Directly

(559) 224-5004

jodie_bohner@us.aflac.com

## Voluntary Benefit Products

Aflac

# Scan the QR Code below to see the Aflac Insurance Plans

Aflac helps with expenses health insurance doesn't cover, so you can care about everything else.

Or, visit your benefits page at: www.aflacenrollment.com/StateCenterCommunityCollege/T87411253305

# Voluntary Benefit Products

The District offers a variety of voluntary benefit products and employee payroll deductions. Depending on the product/deduction, enrollment can occur either during the initial enrollment period or during the annual open enrollment period. Please contact the vendor for more information.

## Life Insurance, Accident, Short-Term Disability, Critical Illness, Cancer Insurance, and other Miscellaneous Insurance Products

Employees can purchase voluntary supplemental insurance coverage through American Fidelity or AFLAC.

***AFLAC***

To enroll in an AFLAC product, contact Jodie Bohner at (559) 224-5004 or via email at Jodie_bohner@us.aflac.com.

- Accident Insurance 
- Cancer/Specified Disease Insurance 
- Disability Insurance 
- Hospital Indemnity Insurance 
- Life Insurance 

# Voluntary Benefit Products

## 2024
## ENROLLMENT

**Enrollment Dates:**
7/29/2024 - 08/30/2024

**Trustmark Universal Life/LifeEvents®**
**Insurance with Long-Term Care Benefit**

### Enrollment Assistance

SCAN ME

*Scan QR code to sign up for an enrollment appointment.*

### Financial Security Even After a Loss

Protecting your loved ones is one of life's greatest responsibilities. When a family loses someone, in addition to grief, survivors may suddenly be faced with costly expenses and debts, and even a loss of income. **Universal Life/LifeEvents can help.**

**Universal Life** provides a consistent lifelong benefit for employees 65 and older. The **Universal Life Events** program is available to employees under the age of 65 and offers a higher death benefit during your working years, when your needs and responsibilities are the greatest. You can choose a benefit amount that provides the right protection for you.

# Voluntary Benefit Products

Only available for issue-age 65+

## Trustmark Universal Life Insurance with Long-Term Care Benefit

**Two important coverages in one to help protect you for life.**

### Financial security even after a loss

Protecting your loved ones is one of life's greatest responsibilities. When a family loses someone, in addition to grief, survivors may suddenly be faced with costly expenses and debts, and even a loss of income. **Universal Life can help.**

Whether you are married, a parent or single and starting out, Universal Life **helps take care** of the people important to you if tragedy happens. You can choose a plan and benefit amount that provides the **right protection for you.**

Universal Life insurance can mean those left behind are still able to pursue their own dreams, and help ensure that the **ending** of one story won't stop the **beginning** of another.

### Universal Life sample rates

*Sample ranges of weekly rates for employee-only, non-smoker coverage with long-term care benefit. Your exact rate may depend on additional features selected by you and/or by your employer.*

| Age at purchase | $25,000 Universal Life policy |
|---|---|
| 65 | $25.22 - $46.09 |
| 67 | $28.41 - $47.44 |
| 70 | $34.58 - $59.30 |

*Sample rates are shown for illustrative purposes only. Rates may vary by age, smoking status, state, employer and features selected by you and/or by your employer. An application for insurance must be completed to obtain coverage.*

**Note: your rate is "locked in" at your age at purchase!**
Once you have a policy, your rate will never increase due to age.

### Solving the long-term care issue

At any point in your life, you may need long-term care services, which could cost hundreds of dollars per day. Universal Life includes a **long-term care (LTC)** benefit* that can help pay for these services at any age.

### Here's how it works:

**4%** You can **collect 4% of your Universal Life death benefit per month** for up to 25 months to help pay for long-term care services.

### Flexible features available:

**2x** **PLUS:** if you collect a benefit for LTC, your **full death benefit** is still available for your beneficiaries, as much as **doubling** your benefit.

*The LTC Benefit is an acceleration of the death benefit and is not Long-Term Care Insurance (except in LA and VA, where the LTC benefit is Long-Term Care Insurance). It begins to pay after 90 days of confinement or services, and to qualify you must meet conditions of eligibility for benefits. The LTC benefits provided by this policy may not cover all of the policyholder's LTC expenses. Pre-existing condition limitation may apply. Your policy will contain complete details. You should consult a financial advisor to determine if the long-term care benefits and the retirement benefits provided by this policy are right for you.*

**Policies with issue age 71+ do not include LTC benefits.*

Universal Life is **flexible permanent** life insurance designed to last a lifetime.

The younger you are when you enroll, the **more benefit** you receive for the same premium.

**No medical exams** or blood work – just answer a few simple questions.

*See reverse side for more information on Universal Life insurance from Trustmark Insurance Company.*

# Voluntary Benefit Products

## What would happen if you weren't around?

**1 in 3 households** would have immediate trouble paying for living expenses if they lost their primary earner.[1]

**40% of Americans** live paycheck to paycheck. Could your family afford to stay in your home?[2]

**56% of Americans** have less than $10,000 saved for retirement – **1 in 3** have $0 saved. Wouldn't it be nice to have some protection?[3]

### What can Universal Life benefits help pay for?

- Funeral and burial costs
- Rent or mortgage payments
- Tuition and loans
- Credit card bills
- Medical expenses
- Retirement savings

### Benefit for terminal illness

- **Use part of your death benefit** to help manage costs if you're diagnosed with a terminal illness.

### Additional advantages

- **Keep your coverage** at the same price and benefits if you change jobs or retire.
- **Apply for coverage for family members:** spouse, children and grandchildren.

### Plus: grow your benefit with EZ Value

The EZ Value option can automatically **increase your benefit amount over time** – without any medical questions.

**Example:** $1 increase in weekly premium each year for 5 years.

| Universal Life | $25,000 | $41,299 |
|---|---|---|
| | Initial benefit | After 5 years |

*Example is for age 40, employee only, non-smoker coverage with long-term care benefit and no additional features. Actual values will vary by age, smoking status, benefits selected and interest rates.*

**You care. We listen.**

*[1]2018 Insurance Barometer Study LIMRA/Life Happens. [2] nielsen.com/us/en/insights/news/2015/savingspending-and-living-paycheck-to-paycheck-in-america.html. [3]gobankingrates.com/retirement/1-3-americans-0-saved-retirement. [3]An AM Best rating is an independent opinion of an insurer's financial strength and ability to meet its ongoing insurance policy and contract obligations. Trustmark is rated A (3rd out of 13 possible ratings ranging from A++ to D).*

*This provides a brief description of your benefits under GUL.205/IUL.205 and applicable riders HH/LTC.205, BRR.205, BXR.205, ABR.205, ADB.205, CT.205 and WP.205. Benefits, definitions, exclusions, form numbers and limitations may vary by state. This policy contains a provision that guarantees against lapse for a period of 10 years (14 years in OR; 15 years for Universal LifeEvents) as long as premiums are paid as planned. If you make changes to your coverage during this period, or pay only the minimum premium, you may prevent cash value accumulation or reduce your death benefit amount. If there is negative cash value at the end of the no-lapse period, you must pay enough premium to establish positive cash value. You may also need to maintain your policy with a higher premium than the one you paid to satisfy the no-lapse guarantee or coverage may expire prior to age 100 even if the premium shown is paid as scheduled. A policy illustration will be delivered with your policy. Your policy will contain complete information. For costs and further details of the coverage, including exclusions, any reductions or limitations and terms under which the policy may be continued in force, see your agent or write to the company. For exclusions and limitations that may apply, visit www.trustmarksolutions.com/disclosures/UL/ (A112-2216-UL). In California, review "A Consumer's Guide to Long-term Care from the Department of Aging" at: http://www.aging.ca.gov/aboutcda/publications/Taking_Care_of_Tomorrow_English/. Underwriting conditions may vary, and determine eligibility for the offer of insurance. Trustmark® and LifeEvents® are registered trademarks of Trustmark Insurance Company.*

Products underwritten by Trustmark Insurance Company
Rated A (Excellent) for financial strength by AM Best.[3]

TrustmarkVB.com

Trustmark
benefits beyond benefits



ULLTC_BRR-EZV5_r_65

A112-2425 (8-19)

# Voluntary Benefit Products

## Trustmark Universal LifeEvents® Insurance with Long-Term Care Benefit

**Two important coverages for when you need them the most.**

### Financial security even after a loss

Protecting your loved ones is one of life's greatest responsibilities. When a family loses someone, in addition to grief, survivors may suddenly be faced with costly expenses and debts, and even a loss of income. **Universal LifeEvents can help.**

Universal LifeEvents provides a **higher death benefit during your working years**, when your needs and responsibilities are the greatest. (See reverse for more on how Universal LifeEvents works.) You can choose a plan and benefit amount that provides the **right protection for you.**

Universal LifeEvents insurance can mean those left behind are still able to pursue their own dreams, and help ensure that the **ending** of one story won't stop the **beginning** of another.

### Universal LifeEvents sample rates

*Sample ranges of weekly rates for employee-only, non-smoker coverage with long-term care benefit. Your exact rate may depend on additional features selected by you and/or by your employer.*

| Age at purchase | $25,000 Universal LifeEvents policy |
|---|---|
| 30 | from **$3.49 - $4.59** |
| 40 | from **$5.05 - $6.71** |
| 50 | from **$7.84 - $10.71** |

*Sample rates are shown for illustrative purposes only. Rates may vary by age, smoking status, state, employer and features selected by you and/or by your employer. An application for insurance must be completed to obtain coverage.*

**Note: your rate is "locked in" at your age at purchase!**
Once you have a policy, your rate will never increase due to age.

### Solving the long-term care issue

At any point in your life, you may need long-term care services, which could cost hundreds of dollars per day. Universal LifeEvents includes a **long-term care (LTC)** benefit that can help pay for these services at any age. This benefit **remains at the same** level throughout your life, so the full amount is always available when you most need it.

### Here's how it works:

**4%** You can **collect 4% of your Universal LifeEvents death benefit per month** for up to 25 months to help pay for long-term care services.

### Flexible features available:

**2x** **PLUS:** if you collect a benefit for LTC, your **full death benefit** is still available for your beneficiaries, as much as **doubling** your benefit.

*The LTC Benefit is an acceleration of the death benefit and is not Long-Term Care Insurance (except in LA and VA, where the LTC benefit is Long-Term Care Insurance). It begins to pay after 90 days of confinement or services, and to qualify you must meet conditions of eligibility for benefits. The LTC benefits provided by this policy may not cover all of the policyholder's LTC expenses. Pre-existing condition limitation may apply. Your policy will contain complete details. You should consult a financial advisor to determine if the long-term care benefits and the retirement benefits provided by this policy are right for you.*

Universal LifeEvents is **flexible permanent** life insurance designed to last a lifetime.

The younger you are when you enroll, the **more benefit** you receive for the same premium.

**No medical exams** or blood work – just answer a few simple questions.

*See reverse side for more information on Universal LifeEvents insurance from Trustmark Insurance Company.*

# Voluntary Benefit Products

## What would happen if you weren't around?

**1 in 3 households** would have immediate trouble paying for living expenses if they lost their primary earner.[1]

**40% of Americans** live paycheck to paycheck. Could your family afford to stay in your home?[2]

**56% of Americans** have less than $10,000 saved for retirement – **1 in 3** have $0 saved. Wouldn't it be nice to have some protection?[3]

### How Universal LifeEvents works

- A **higher death benefit** during working years.
- **Long-term care** (LTC) benefits that **stay the same** throughout your life.

**Example: $25,000 policy**

| | |
|---|---|
| **Before age 70** | |
| Death benefit | **$25,000** |
| LTC benefits | **$25,000** |
| **After age 70** | |
| Death benefit | **$8,333** |
| LTC benefits | **$25,000** |

*Universal LifeEvents death benefit reduces to one-third at age 70 or the beginning of the 15th policy year.*

### Benefit for terminal illness

- **Use part of your death benefit** to help manage costs if you're diagnosed with a terminal illness.

### Additional advantages

- **Keep your coverage** at the same price and benefits if you change jobs or retire.
- **Apply for coverage for family members:** spouse, children and grandchildren.

### Plus: grow your benefit with EZ Value

The EZ Value option can automatically **increase your benefit amount over time** – without any medical questions.

**Example:** $1 increase in weekly premium each year for 5 years.

| | Initial benefit | After 5 years |
|---|---|---|
| **Universal Life** | $25,000 | $41,299 |
| **Universal LifeEvents** | $25,000 | $50,414 |

*Example is for age 40, employee only, non-smoker coverage with long-term care benefit and no additional features. Actual values will vary by age, smoking status, benefits selected and interest rates.*

**You care. We listen.**

[1]*2018 Insurance Barometer Study LIMRA/Life Happens.* [2] *nielsen.com/us/en/insights/news/2015/savingspending-and-living-paycheck-to-paycheck-in-america.html.* [3] *gobankingrates.com/retirement/1-3-americans-0-saved-retirement.* [5] *An AM Best rating is an independent opinion of an insurer's financial strength and ability to meet its ongoing insurance policy and contract obligations. Trustmark is rated A (3rd out of 13 possible ratings ranging from A++ to D).*

*This provides a brief description of your benefits under GUL.205/IUL.205 and applicable riders HH/LTC.205, BRR.205, BXR.205, ABR.205, ADB.205, CT.205 and WP.205. Benefits, definitions, exclusions, form numbers and limitations may vary by state. This policy contains a provision that guarantees against lapse for a period of 10 years (14 years in OR; 15 years for Universal LifeEvents) as long as premiums are paid as planned. If you make changes to your coverage during this period, or pay only the minimum premium, you may prevent cash value accumulation or reduce your death benefit amount. If there is negative cash value at the end of the no-lapse period, you must pay enough premium to establish positive cash value. You may also need to maintain your policy with a higher premium than the one you paid to satisfy the no-lapse guarantee or coverage may expire prior to age 100 even if the premium shown is paid as scheduled. A policy illustration will be delivered with your policy. Your policy will contain complete information. For costs and further details of the coverage, including exclusions, any reductions or limitations and terms under which the policy may be continued in force, see your agent or write to the company. For exclusions and limitations that may apply, visit www.trustmarksolutions.com/disclosures/UL/ (A112-2216-UL). In California, review "A Consumer's Guide to Long-term Care from the Department of Aging" at: http://www.aging.ca.gov/aboutcda/publications/Taking_Care_of_Tomorrow_English/. Underwriting conditions may vary, and determine eligibility for the offer of insurance. Trustmark® and LifeEvents® are registered trademarks of Trustmark Insurance Company.*

Products underwritten by Trustmark Insurance Company
Rated A (Excellent) for financial strength by AM Best.[5]

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benefits beyond benefits



ULELTC_BRR-EZV5_r

A112-2425 (9-22)

# Voluntary Benefit Products

State Center Community College District

## Healthcare Flexible Spending Accounts

### Save money on eligible medical expenses.

Healthcare Flexible Spending Accounts (HCFSAs) allow you to save part of your paycheck, before taxes, to pay for eligible medical costs throughout the year.

**Features:**

- Funds available at the beginning of your plan year
- Reduce your taxable income
- Contribute as much, or as little, as you want (up to the annual limit)

**Learn more at**
**americanfidelity.com/fsa**

**Calculate medical costs**
**americanfidelity.com/fsa-worksheet**

### Examples of Eligible Expenses

- Asthma treatments
- Chiropractic care
- Contact lenses
- Copays
- Dental services
- Eye exam/eyeglasses
- Fertility treatments
- Laser eye surgery
- Over-the-counter medications
- First aid kits
- Physical therapy
- Prescriptions
- Prenatal care
- Sunscreen with 15 SPF or higher
- Breast pumps and supplies

**americanfidelity.com/eligible-expenses**

## 24/7 Access to Your Benefits

With AFmobile®, you can manage your reimbursement accounts and insurance benefits from the palm of your hand.

Download AFmobile today.

**americanfidelity.com/afmobile**

Download on the App Store | GET IT ON Google Play

*These products may contain limitations, exclusions, and waiting periods. The following statements only apply if the product is displayed on this document.* ***These products are not appropriate for people who are eligible for Medicaid coverage: Accident Only, Cancer, Critical Illness, Hospital Indemnity, Hospital GAP PLAN® and Hospital GAP Plan Choice® Insurance****. Variable Annuities are offered by American Fidelity Securities, Inc., a registered Broker Dealer. Please contact your tax advisor for information regarding your specific situation. HSA contributions are not subject to federal and most states' income tax. State income tax may apply in California and New Jersey. Please consult a tax advisor for your state's specific rules. HRAs are not part of a Section 125 Plan. Contributions made by employer not employee.*

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**American Fidelity Assurance Company**
**americanfidelity.com**

Central California Branch
**866-504-0010 • 559-230-2107**

AF-2150-0823

# Voluntary Benefit Products

## Child Care Centers

There are several Child Development Centers (CDC) within our District. The District does not offer any benefits toward childcare and there may be a waitlist at the individual CDC sites. For more information, please visit the individual childcare center webpages:

Clovis Community College CDC
https://www.cloviscollege.edu/student-services/child-development-lab-school.html

Fresno City College CDC
https://www.fresnocitycollege.edu/student-services/child-development-center/index.html

Madera Community College Center CDC
https://www.maderacollege.edu/student-services/child-development-center.html

Reedley College CDC
https://www.reedleycollege.edu/campus-life/child-development-center.html

**Faculty/Staff Discounts and Offerings**

Employees can find additional discounts and offerings on the District's Faculty and Staff Discount Offerings webpage at https://www.scccd.edu/departments/information-systems/facultystaff-discount-offerings.html

# Retirement Benefits

## Retiree Health Benefits

Eligible employees who retire from the District may qualify for retiree medical benefits after retirement. Provisions can be found in the bargaining unit agreements, board policies, and administrative regulations.

For employees who do not qualify for retiree medical benefits, information will be provided at time of retirement on how to continue the health insurance plans at cost with P&A Group, under the provisions of the Consolidated Omnibus Budget Reconciliation Act (COBRA). All separated employees will receive COBRA election notices as required by law.

To view the bargaining unit agreements, visit https://www.scccd.edu/departments/human-resources/collective-bargaining-unit-agreements.html for more information.

To view the board policies and/or administrative regulations, visit https://www.scccd.edu/about/board-of-trustees/policies-and-regulations.html for more information.

## Pension Benefits

State Center Community College District offers retirement pension options to eligible employees through different systems – CalPERS, CalSTRS, and Public Agency Retirement Services (PARS).

For more information relating to retirement pension benefits, please contact the individual retirement system or District Payroll at (559) 243-7100.

### *CalPERS*

California Public Employees' Retirement System (CalPERS) manages pensions for California public employees, retirees and their beneficiaries.

Members can access real-time details about their CalPERS account, find educational events, and schedule appointments with the local CalPERS office. To access your member portal, visit the CalPERS webpage at www.calpers.ca.gov.

### *CalSTRS*

California State Teachers' Retirement System (CalSTRS) provides retirement, disability and survivor benefits to California public school educators and their beneficiaries.

Members can access real-time details about their CalSTRS account, find educational events, and schedule appointments with the local CalSTRS office. To access your member portal, visit the CalSTRS webpage at www.calstrs.com.

### *PARS*

Public Agency Retirement Services (PARS ARS) is a retirement account for part-time, seasonal, and temporary employees who work for public agencies.

Members can access real-time details about their PARS account. For more information, visit the PARS webpage at https://myplan.pars.org/ and search for State Center Community College District.

## Tax Sheltered Annuities

As an employee of an educational institution, you may elect to participate in a tax-deferred retirement program as authorized by Internal Revenue Code Section 403(b) and 457. With these programs, you elect to deduct a certain portion of your pay before state and federal income taxes. Funds are taxed when you withdraw.

# Retirement Benefits

***403(b) Plans***

TCG Administrators administers the 403(b) plans. For more information about the 403(b) plans, including a list of vendors, please visit the 403b compare website at www.403bcompare.com.

To start a 403(b), you will need to choose which vendor(s) you wish to invest with and open an account with them directly.  Then call TCG Administrators at (800) 943-9179, let them know you are opening a 403(b) plan for State Center Community College District, which vendor(s) you choose and how much you want deducted from your paycheck.

***457 Plans***

The 457 plan is offered through CalPERS 457. More information can be found on page 56. Should you have questions, please contact CalPERS 457 at (888) 713-8244 or District Payroll at (559) 243-7100.

# Retirement Benefits


The CalPERS 457 Plan is a voluntary retirement savings plan that allows you to automatically save a portion of your salary. As a salaried employee or contracted worker of an agency, school district or community college district that has adopted the CalPERS 457 Plan, **you are eligible to participate**! Even if you are already contributing to a 403(b) plan or if you only work part-time, **you are eligible to participate**.

Many members think that if they are covered by CalSTRS they cannot participate in the CalPERS 457 Plan, **but you can**! See how the CalPERS 457 Plan stacks up as a convenient way to help you save for retirement.

| | CalPERS 457 Plan | 403b |
|---|---|---|
| Pre-Tax Contributions | Yes | Yes |
| Tax Deferred Growth of Earnings | Yes | Yes |
| Reduction to Adjusted Gross Income | Yes | Yes |
| Early Withdrawal Penalty (if distributions made prior to 59½) | No — if separated from service | Yes — 10% |
| Available to Both PERS and STRS Employees | Yes | Yes |
| Roth After-Tax Contributions | Yes — if adopted by employer | Yes — if offered |
| Conversion Option from Pre-Tax to Roth | Yes — if adopted by employer | Yes — if offered |
| Loans | Yes —if adopted by employer | Yes — if offered |
| Maximum Annual Contribution Limit (2020) $19,500 (Age 49 or younger) or $26,000 (Age 50 or older) | Yes | Yes |
| Rollover of Other Retirement Plans (IRA, 401(k), 403(b), 457(b)) | Yes | Yes |
| Unexpected Emergency Withdrawal Provisions | Yes | Yes |
| Third Party Administration | No | Ask your 403b provider |
| Fees Clearly Disclosed and Transparent | Yes | Ask your 403b provider |
| Full Service Program with On-Site Representation | Yes | Ask your 403b provider |

**SPEND SOME TIME WITH YOUR RETIREMENT.**

- Visit **calpers457.com** for more information about the CalPERS 457 Plan. Call **888-713-8244** for questions about the Plan.
- You can also schedule an appointment to discuss your retirement planning and saving strategy with a local CalPERS 457 Account Manager by visiting **calpers457.timetap.com**. With more than 800 California government employers representing many types of public agencies, you're in good company with the CalPERS 457 Plan.

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# Important Notices

### No Surprises Act Notice

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

### Newborns' and Mothers' Health Protection Act (NMHPA)

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

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

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

### Patient Protections

The medical plan requires the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. Until you make this designation, the plan will designate one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, [fill-in the blank].

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

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

### Networks/Claims/Appeals

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

### Notice of Extended Coverage to Children Covered as Students

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

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

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

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

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

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

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

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

### COBRA Continuation Coverage

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

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

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

### WHAT IS COBRA CONTINUATION COVERAGE?

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

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

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

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

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

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

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

### WHEN IS COBRA CONTINUATION COVERAGE AVAILABLE?

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

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

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

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

### NOTICE AND ELECTION PROCEDURES

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

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

## ELECTION AND ELECTION PERIOD

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

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

## HOW IS COBRA CONTINUATION COVERAGE PROVIDED?

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

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

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

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

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

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

## OTHER OPTIONS BESIDES COBRA CONTINUATION COVERAGE

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

## ENROLLMENT IN MEDICARE INSTEAD OF COBRA

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

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

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

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

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

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

## IF YOU HAVE QUESTIONS

[For ERISA Plans] For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans subject to ERISA, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Address and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

For more information about the Marketplace, visit www.healthcare.gov.

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

## KEEP YOUR PLAN INFORMED OF ADDRESS CHANGES

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

## EFFECTIVE DATE OF COVERAGE

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

## COST OF CONTINUATION COVERAGE

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

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

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

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

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

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

### Uniformed Services Employment and Reemployment Rights Act (USERRA)

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

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

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

### Special Enrollment Rights Notice

## CHANGES TO YOUR HEALTH PLAN ELECTIONS

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

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

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

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

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

For information about Special Enrollment Rights, please contact:

**Contact District Human Resources**

**Contact Information benefits@scccd.edu or call 559-243-7100**

### Medicare Part D – Important Notice About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with State Center 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:

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

### WHEN CAN YOU JOIN A MEDICARE DRUG PLAN?

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

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

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

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

If you do decide to join a Medicare drug plan and drop your current [State Center Community College District] coverage, be aware that you and your dependents will be able to get this coverage back.

### WHEN WILL YOU PAY A HIGHER PREMIUM (PENALTY) TO JOIN A MEDICARE DRUG PLAN?

You should also know that if you drop or lose your current coverage with [State Center 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 (i.e., a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

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

Contact the person listed below for further information. **Note:** You will get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through [State Center 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 will get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

### FOR MORE INFORMATION ABOUT MEDICARE PRESCRIPTION DRUG COVERAGE

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

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

### REMEMBER

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

| | |
|---|---|
| Name of Entity / Sender: | State Center Community College District |
| Contact: | District Human Resources |
| Address: | 1171 Fulton Street<br>Fresno, CA 93721 |
| Phone: | 559-243-7100 |
| Email: | beneifts@scccd.edu |

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

[State Center Community College District] Group Health Plan (Plan) maintains a Notice of Privacy Practices that provides information to individuals whose protected health information (PHI) will be used or maintained by the Plan. If you would like a copy of the Plan's Notice of Privacy Practices, please contact [insert name, address or telephone number of person to contact].

### Wellness – Alternative Standards

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

## Health Insurance Marketplace Coverage Options and Your Health Coverage

### PART A: GENERAL INFORMATION

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

### WHAT IS THE HEALTH INSURANCE MARKETPLACE?

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

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

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

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

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

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

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

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

### STATES WITH INDIVIDUAL MANDATE

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

## PART B: INFORMATION ABOUT HEALTH COVERAGE OFFERED BY YOUR EMPLOYER

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

| | | |
|---|---|---|
| **3. Employer name**<br>State Center Community College District | **4. Employer Identification Number (EIN)**<br>94-1574802 | |
| **5. Employer address**<br>1171 Fulton Street | **6. Employer phone number**<br>559-243-7100 | |
| **7. City**<br>Fresno | **8. State**<br>CA | **9. ZIP code**<br>93721 |
| **10. Who can we contact about employee health coverage at this job?**<br>District Human Resources Office | | |
| **11. Phone number (if different from above)** | **12. Email address**<br>benefits@sccd.edu | |

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

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

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

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

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

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

If you live in one of the following States, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2023. Contact your State for more information on eligibility.

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

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

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

**CALIFORNIA – Medicaid**
Health Insurance Premium Payment (HIPP) Program Website:
https://www.dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx
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:
800-221-3943 | TTY: Colorado relay 711
CHP+: https://hcpf.colorado.gov/chp
CHP+ Customer Service:
800-359-1991 | TTY: Colorado relay 711
Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/
HIBI Customer Service: 855-692-6442

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

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

**INDIANA – Medicaid**
Healthy Indiana Plan for low-income adults 19-64
Website: http://www.in.gov/fssa/hip/
Phone: 877-438-4479
All other Medicaid
Website: https://www.in.gov/medicaid/
**Phone: 800-457-4584IOWA – Medicaid and CHIP (Hawki)**
Medicaid Website: https://dhs.iowa.gov/ime/members
Medicaid Phone: 800-338-8366
Hawki Website: http://dhs.iowa.gov/Hawki
Hawki Phone: 800-257-8563
HIPP Website:
https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp
HIPP Phone: 888-346-9562

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

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

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

**MAINE – Medicaid**
Enrollment Website:
https://www.maine.gov/dhhs/oms/mainecare-options
Phone: 800-442-6003 | TTY: Maine relay 711
Private Health Insurance Premium Webpage:
https://www.maine.gov/dhhs/ofi/applications-forms
Phone: 800-977-6740 | TTY: Maine relay 711

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

**MINNESOTA – Medicaid**
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp
Phone: 800-657-3739

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

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

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

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

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

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

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

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

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

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

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

**PENNSYLVANIA – Medicaid and CHIP**
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx
Phone: 800-692-7462
CHIP Website: https://www.pa.gov/en/agencies/dhs/resources/chip.html
CHIP Phone: 800-986-KIDS (5437)

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

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

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

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

**UTAH – Medicaid and CHIP**
Medicaid Website: https://medicaid.utah.gov/
CHIP Website: http://health.utah.gov/chip
Phone: 877-543-7669

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

**VIRGINIA – Medicaid and CHIP**
Website: https://www.dmas.virginia.gov/
https://www.dmas.virginia.gov/for-members/for-children/
Medicaid Phone: 800-432-5924
CHIP Phone: 800-432-5924

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

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

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

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

To see if any other states have added a premium assistance program since July 31, 2023, or for more information on special enrollment rights, contact either:

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

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

# Frequently Asked Questions

This is not an all-inclusive listing of frequently asked questions. For questions not listed here, please contact the District Human Resources benefits staff via email at benefits@scccd.edu or call (559) 243-7100.

### Q: Can I opt out of/waive the District's health insurance plans?

A: No, you cannot opt out or waive coverage for yourself.

### Q: How do I enroll or make changes to my health benefits?

A: All benefit enrollment and elections must be done through your BenefitBridge account.

### Q: How do I access BenefitBridge?

A: Log into your MyPortal account. Once logged in, you can find the BenefitBridge portal under the Apps Catalog. You can also access via the web at www.benefitbridge.com/statecenterccd.

### Q: I am having issues logging into BenefitBridge. Who can assist me?

A: The BenefitBridge Customer Care team can assist you. The BenefitBridge Customer Care team can be reached by phone at 800-814-1962 Monday – Friday, 8:00 AM – 5:00 PM, PST or by e-mail benefitbridge@keenan.com.

### Q: I am having technical issues with BenefitBridge. Who can help me?

A: The BenefitBridge Customer Care team can assist you. The BenefitBridge Customer Care team can be reached by phone at 800-814-1962 Monday – Friday, 8:00 AM – 5:00 PM, PST or by e-mail benefitbridge@keenan.com.

### Q: If I have other insurance from my spouse/registered domestic partner, what plan should I elect?

A: The District Human Resources benefits staff cannot provide advice on which plan to choose. However, the PPO plans will coordinate benefits with other PPO plans and the Kaiser HMO plans will coordinate benefits with other Kaiser HMO plans. It is very important to note that HMO plans do not coordinate with PPO plans and vice versa. Also, your medical plan with the District will be primary for you. If you have questions regarding coordination of benefits, please contact the District Human Resources benefits staff via e-mail benefits@scccd.edu or by phone at (559) 243-7100.

### Q: How do I know if I successfully completed my enrollment in BenefitBridge?

A: To complete your online enrollment process in BenefitBridge, you will be provided a document page - "Summary of Benefits for the Requested Effective Date…" - which you must digitally sign and submit. Once that is completed, please allow at least five (5) business days for the approval/denial process to be completed in BenefitBridge. Ensure to review your BenefitBridge message center. Your BenefitBridge message center will notify you if further information is needed and/or if your enrollment request is approved/denied. If you are still unsure of your enrollment status, and prior to the 31st day of your enrollment period, please reach out to the District Human Resources benefits staff via email at benefits@scccd.edu or by phone at (559) 243-7100.

# Frequently Asked Questions

### Q: What if I do not have copies of the required supporting dependent eligibility documents?

A: In order to enroll your eligible dependents, you must upload the appropriate supporting documents in BenefitBridge within your 31-day enrollment period. If you should need to order documents, you may do so through the local county recorder's office, hall of records, or the Department of Public Health. Failure to submit the required documentation in BenefitBridge will result in denial of the enrollment request.

### Q: I received a provider bill and have questions, who can I contact?

A: Contact the provider directly. If you have questions regarding how the insurance processed the claim for services, review your Explanation of Benefits form from the health insurance plan administrator or reach out to the health insurance plan administrator directly.

### Q: How long can my dependent child remain on the health plans?

A: Children are eligible to remain on your medical, dental and vision plans until the end of the month in which they turn age 26. Please the 'Overage Dependents' section on page 5.

### Q: My enrolled dependent has passed away. Do I need to notify anyone?

A: Yes, please contact the District Human Resources benefits staff at (559) 243-7100.

### Q: Who at the District can assist me with my benefit-related questions or concerns?

A: You can email the District Human Resources benefits staff at benefits@scccd.edu or contact us at (559) 243-7100.

### Q: Who at the District can assist me with leaves?

A: For assistance with the Family Medical Leave Act (FMLA), California Family Rights Act (CFRA), Pregnancy Disability Leave (PDL), or other leaves available under the bargaining unit agreement, board policy or administrative regulations, please reach out to the District Human Resources department at (559) 243-7100. You will be routed to the appropriate Human Resources Technician who can assist you.

# Websites and Contact Information

## Member Websites/Portals

| | Website |
|---|---|
| BenefitBridge Benefit Administration Platform | www.benefitbridge.com/statecenterccd |
| PPO Medical Insurance Member Portal | www.anthem.com/ca/sisc or the Sydney mobile app |
| PPO Prescription Drug Plan Member Portal | www.navitus.com |
| Employee Assistance Program (EAP) | www.simpleeap.com |
| Ameritas PPO Dental Plan Member Portal | www.ameritas.com |
| Ameritas VSP Vision Plan Member Portal | www.ameritas.com |
| Kaiser Permanente Plan Member Portal | https://healthy.kaiserpermanente.org/ |
| Health Advocate | https://members.healthadvocate.com/Account/OrganizationSearch<br>Organization Code: ASCIP |

## Customer Service Contact Information

| Plan | Phone Number/Email Address |
|---|---|
| BenefitBridge Customer Service | (800) 814-1862 |
| ASCIP/Anthem Info | (800) 825-5541 |
| Kaiser Permanente Medical Plans | (800) 464-4000 |
| Ameritas PPO Dental Plan | (800) 487-5553 |
| VSP Vision Plan | (800) 877-7195 |
| Navitas (PPO Plans prescription drug vendor) | (866) 333-2757 |
| Anthem EAP | (800)-999-7222<br>https://www.anthemeap.com/sisc |
| Simple Therapy (formerly Halcyon) Employee Assistance Program | (888) 425-4800 |
| Health Advocate | (866) 695-8622<br>Email: answers@HealthAdvocate.com |
| SCCCD Human Resources Benefits Staff | · Email: benefits@scccd.edu<br>· Reina Kemble, Benefits Technician (559) 243-7134<br>· Frances Garza, Benefits Coordinator (559) 243-7133<br>· District Human Resources Office<br>(559) 243-7100<br>Webpage: www.scccd.edu/employeebenefits |

The information in this guide is presented for illustrative purposes and is based on information provided by the employer. The text contained in this guide was taken from various summary plan descriptions and benefit information. While every effort was taken to accurately report your benefits, discrepancies or errors are always possible. In case of discrepancy between the guide and the actual plan documents, the actual plan documents will prevail. All information is confidential, pursuant to the Health Insurance Portability and Accountability Act of 1996. If you have any questions, contact the District Human Resources Office at (559) 243-7100.