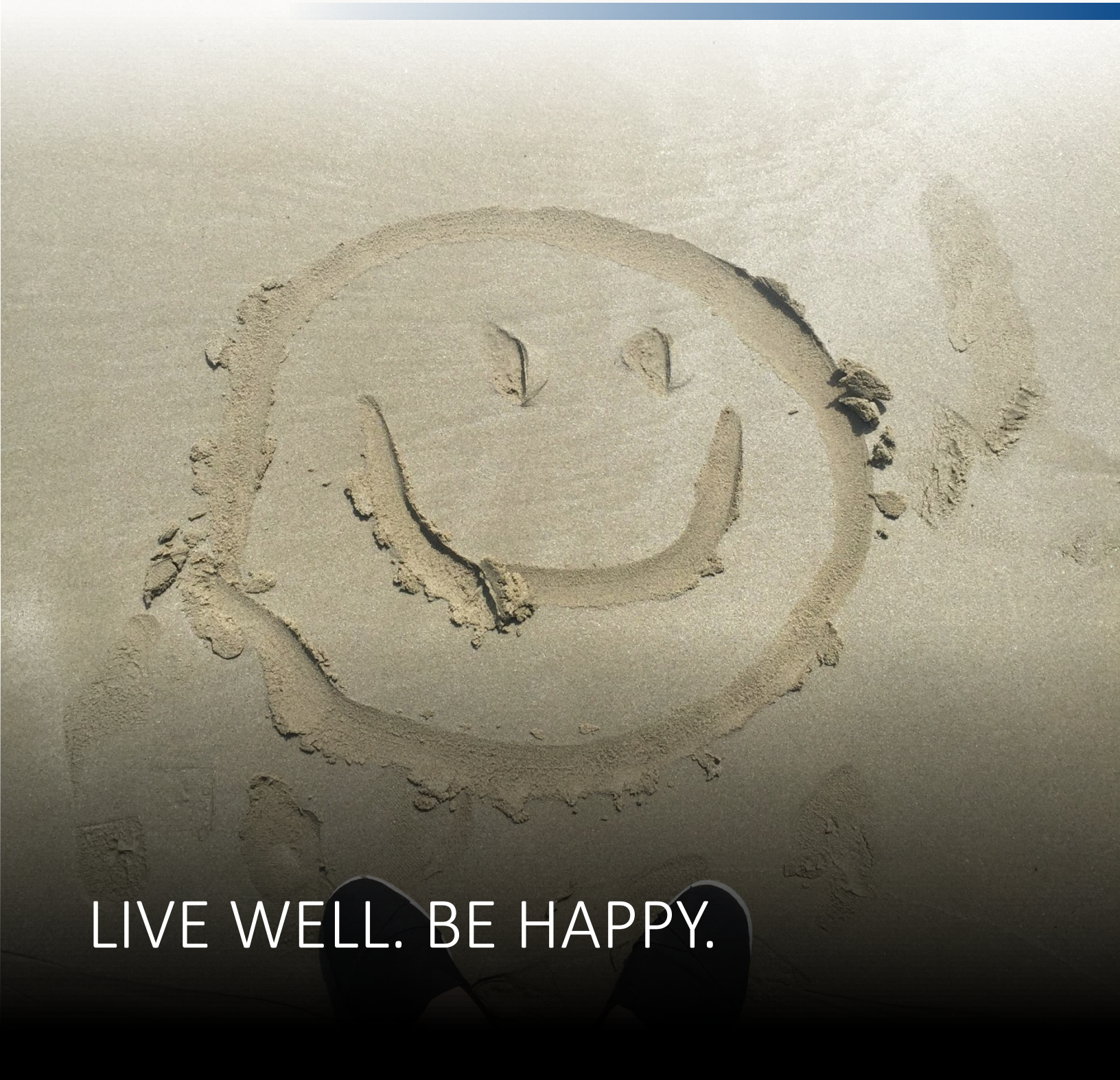
South Orange County Community College District

2025-2026 RETIREE BENEFITS



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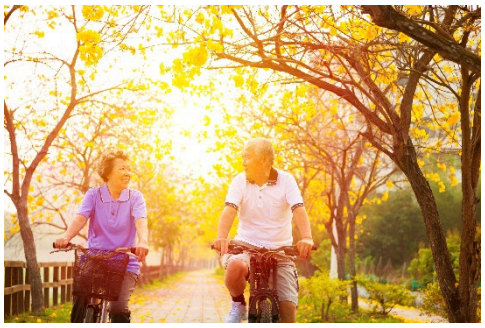


MEDICARE PART D NOTICE

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a federal law gives you more choices about your prescription drug coverage. Please see the Important Plan Information section for more details.

GETTING STARTED

2025-26 BENEFITS

October 1, 2025
through
September 30, 2026

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

Planning for Retirement? We've Got You Covered. Whether you're getting ready to retire, recently retired, or planning for the next chapter, South Orange County Community College District offers comprehensive benefit programs to support your well-being today and into the future.

This guide outlines key retiree benefits—including healthcare, dental, vision, and retirement resources—with a special focus on what matters most in retirement. Inside, you'll find:

- Insights on how your medical coverage works alongside Medicare
- Ways to save on healthcare costs through retiree programs.
- Tools to help you navigate retirement planning, manage healthcare expenses, and make the most of every benefit available.

Your benefits are designed not just to support your health and peace of mind, but to help you transition smoothly into retirement—and thrive in it.

FREQUENTLY ASKED QUESTIONS

WHO IS ELIGIBLE?

Retirees who meet the below minimum age requirements and were employed full-time with the District for ten consecutive years immediately preceding the date of retirement are eligible for the benefits outlined in this overview. Concurrent retirement from your applicable retirement system (STRS or PERS) and the District is required.

Minimum age requirements:

- Classified Managers & Administrators: Age 50
- Faculty / Police Officer Association: Age 55
- Classified: Age 60

You can enroll the following family members in our medical, dental and vision plans.

- Your spouse (the person who you are legally married to under state law, including a same-sex spouse or common law spouse).
- Your registered same or opposite sex domestic partner is eligible for coverage. Any premiums for your domestic partner by South Orange County Community College District are taxable income and will be included on your W-2. Any premiums you pay for your domestic partner will be deducted on an after-tax basis.
- Your children:
    - Under the age of 26 are eligible to enroll in medical coverage. They do not have to live with you or be enrolled in school. They can be married and/or living and working on their own.
    - Over age 26 ONLY if they are incapacitated due to a disability and primarily dependent on you for support.
    - Named in a Qualified Medical Child Support Order (QMCSO) as defined by federal law.

WHEN CAN I ENROLL?

Coverage for new Retirees begins on the 1st of month following your retirement date.

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

Make sure to notify Benefits right away if you do have a qualifying life event and need to make a change (add or drop) to your coverage election.

These changes include (but are not limited to):

- Loss of other healthcare coverage
- Eligibility for new healthcare coverage
- Marriage
- Divorce

You have 30 days to make your change.

WHAT BENEFITS ARE AVAILABLE?

If you are a Retiree under age 65, you and your eligible dependents are provided the District paid medical, dental, and vision plans you are currently enrolled in. The District will continue to pay 100% of the premiums until the 1st of the month in which you turn 65, or when you become Medicare eligible, whichever is sooner.

Classified / POA: If you are a Retiree age 65+, you and your eligible dependent(s) are able to purchase a medical plan, dental plan and/or vision plan through the District on a self-pay basis provided that you enroll in Medicare A and B, and supply the District with a copy of your Medicare Card. All Retirees are eligible to purchase Dental and Vision once they reach age 65 and are eligible for Retiree benefits.

Classified Managers & Administrators / Faculty: If you are a Retiree age 65+, you are eligible to receive the District paid Blue Shield COB PPO plan, Blue Shield COB HMO plan, CompanionCare 65+ Medicare Supplement plan, Blue Shield 65+ HMO Medicare Advantage plan or the Kaiser Senior Advantage HMO Medicare plan provided that you enroll in Medicare A and B, and supply the District with a copy of your Medicare Card. Your eligible dependent(s) is eligible to purchase a medical plan through the District on a self-pay basis. Effective 4/1/2026, you are eligible to receive the District paid VSP vision plan. Your eligible dependents are eligible to purchase the District vision plan on a self pay basis. You and your eligible dependent(s) are eligible to purchase the District dental plan on a self-pay basis.

FREQUENTLY ASKED QUESTIONS

WHAT HAPPENS WHEN I TURN 65, BUT MY SPOUSE/DOMESTIC PARTNER IS STILL UNDER 65 AND/OR MY DEPENDENT IS UNDER AGE 26?

The District shall provide retired employees who qualify for continuation of benefits with the option to purchase (at employee expense) medical coverage, provided the Retiree has obtained Medicare A and B coverage. The Retiree and dependent must stay on the under age 65 Retiree plan and will be responsible to pay the District's cost of the under age 65 Retiree medical coverage for the Retiree and dependent(s). The Retiree must submit proof of Medicare Parts A and B.

WHAT IF MY SPOUSE/DOMESTIC PARTNER TURNS 65, BUT I AM STILL UNDER 65?

Your spouse/domestic partner must enroll in Medicare A and B, and provide a copy of their Medicare card to the District. You and your eligible dependents which include your spouse/domestic partner, and children up to age 26, will remain on the District paid benefits plan until the 1st of the month in which you turn 65.

WHAT HAPPENS IF I OR MY SPOUSE/DOMESTIC PARTNER DOES NOT ENROLL IN MEDICARE WHEN ELIGIBLE?

If the Retiree or spouse/domestic partner does not enroll in Medicare A and/or B when eligible, or fails to provide the District with a copy of their Medicare card, the Retiree shall pay any penalty, fee, or other cost imposed by the insurance carrier. If the Retiree fails to pay any costs associated with coverage, the coverage will be terminated.

IMPORTANT!

You and your spouse/domestic partner must supply a copy of your/their Medicare part A and B card to the District no later than 15 days prior to the first of the month in which you/they turn 65. Members must NOT enroll in Medicare D.

WHAT DO I DO IF MY ADDRESS CHANGED?

If your address has changed, please call to notify the Benefits Department at (949) 582-4898.

HOW MUCH DOES MEDICARE COST?

Medicare A: Most people receive Part A premium-free because they or their spouse paid Medicare taxes while working. If you do not qualify for premium-free Part A, you could pay up to $518/month (2025 rate). If you pay a late enrollment penalty, this amount is higher. In most cases, if you choose to buy Part A, you must also purchase Part B.

Medicare B: Most people pay the standard premium amount. However, if your modified adjusted gross income as reported on your IRS tax return from 2 years ago is above a certain amount, you may pay more. Premium amounts can change each year depending on your income. Current Medicare Part B premium amounts are listed in the following table. These numbers are based on your 2023 annual income.

File Individual Tax Return	File Joint Tax Return	You Pay/Month (in 2024)
$106,000 or less	**$212,000 or less**	$185
Above $106,000 up to $133,000	**Above $212,000 up to $266,000**	$259
Above $133,000 up to $167,000	**Above $266,000 up to $334,000**	$370
Above $167,000 up to $200,000	**Above $334,000 up to $400,000**	$480.90
Above $200,000 and less than $500,000	**Above $400,000 and less than $750,000**	$591.90
$500,000 or above	**$750,000 and above**	$628.90

If you have questions about your Medicare premiums, you can contact Social Security at (800) 772-1213.

FREQUENTLY ASKED QUESTIONS

WHAT ARE MY OPTIONS FOR DENTAL & VISION COVERAGE AFTER RETIREMENT?

If you are a Retiree under age 65, Dental and Vision benefits will continue to be paid by the District for you and your eligible dependents until the 1st of the month in which you turn 65 or are eligible for Medicare, whichever comes first.

If you are a Retiree age 65+, Dental benefits are available through the District on a self-pay basis. You are eligible to purchase Dental benefits for yourself and your eligible dependents. VSP Vision benefits will be paid by the District for Classified Managers, Administrators, and Faculty retirees. Your eligible dependents are able purchase Vision benefits on a self-pay basis.

Effective 7/1/2026, eligible Classified retirees will receive District-paid retiree-only medical and vision coverage at age 65. You will be able to purchase coverage for your eligible dependents on a self pay basis.

WHEN DO I ENROLL IN THE VOLUNTARY SELF-PAY BENEFITS?

You must enroll when first eligible. You cannot enroll at a future date. If you do not elect coverage in a voluntary self-pay plan when first eligible, then you will not be given the opportunity to enroll during open enrollment. All payments are due by the 15th of the month prior to the month of coverage. If you elect to discontinue participation in the plan, or fail to make timely payments, your benefits will terminate and you will be unable to re-enroll in the plan at a later date.

WHAT BENEFITS END UPON RETIREMENT WITH THE DISTRICT?

Your MetLife Legal Plan, The Hartford Ability Assist EAP, The Hartford Empathy Program (funeral planning, beneficiary assist, will prep, bereavement), Travel Assistance with ID Theft Protection, The Hartford Life & Disability Insurance, Navia Flexible Spending Account, and UNUM Long Term Care Insurance (if applicable) will all end on the last day of the month in which you retire.

UNUM Long Term Care Insurance (if applicable) is the only portable benefit available to Retirees. A UNUM Long Term Care portability form will be mailed to your home after retirement. In order to keep your coverage through UNUM on a self-pay basis, you must return the portability form to UNUM within 30 days of your benefits end date.

CLASSIFIED & POA: WHAT BENEFITS ARE AVAILABLE WHEN I BECOME MEDICARE ELIGIBLE?

The District shall provide retired employees who qualify for continuation of benefits the option to purchase at employee expense supplemental medical coverage, provided the Retiree has obtained Medicare A and B coverage. Qualifying members must submit proof that they have obtained Medicare A and B. This benefit is subject to the approval of the District Insurance carrier. The Retiree may select from Options A or B subject to the conditions set forth herein.

Option A: The current District supplemental medical plan is available to Retirees. The cost for the plan to the retired employee shall be the actual cost paid by the District which is to be paid monthly by the Retiree in advance to the District. Payment must be received by the 15th of the month prior to the month of coverage. If payment is not received by the first day of the month of coverage the employee shall be dropped from the coverage and unable to participate in the future. The District reserves the right to establish a separate medical insurance pool for Retirees who qualify under this section.

Option B: The Companion Care Medicare Supplemental Plan, the Blue Shield 65+ HMO Medicare Advantage Plan, and the Kaiser Permanente 65+ Senior Advantage HMO Medicare Plan will also be offered to Retirees as long as the District is covered by the Self-Insured Schools of California (SISC). This program is directly administered by SISC. If a retired member elects one of these plans they cannot return to the District sponsored Supplement plan

FREQUENTLY ASKED QUESTIONS

CSEA Retiree 65+ Voluntary Medical

WHAT PLANS ARE AVAILABLE?

- District PPO COB Plan
- District HMO COB Plan
- Companion Care Supplement Plan (individual plan that is available only to eligible Retirees and their spouses who have Medicare Parts A and B. Enrollment takes a minimum of 45 days.)
- Blue Shield 65+ HMO Medicare Advantage Plan (individual plan that is available only to eligible Retirees who have Medicare Parts A and B. Enrollment takes a minimum of 45 days.)
- Kaiser Permanente 65+ Senior Advantage HMO Medicare Plan (individual plan that is available only to eligible Retirees who have Medicare Parts A and B. Enrollment takes a minimum of 45 days.)

WHAT ABOUT MEDICARE?

District PPO and HMO COB Plans: Members must supply proof of Medicare part A and B to the District prior to the first of the month in which the member turns age 65.

Companion Care, Blue Shield, and Kaiser 65+ HMO Medicare Advantage Plans: Members must submit proof of part A and B with application at least a minimum of 45 days prior to coverage effective date.

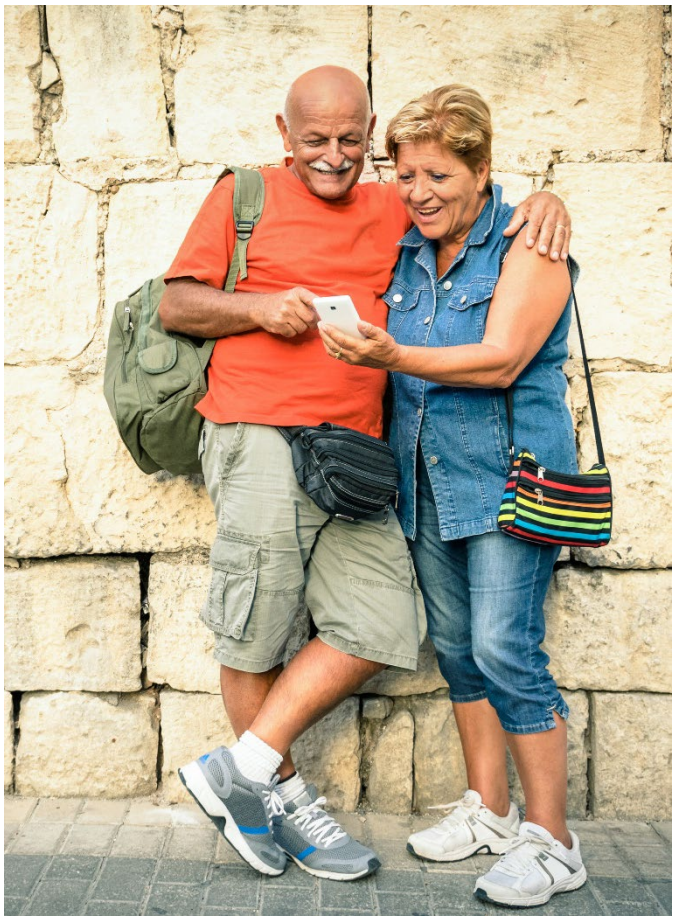
Proof of Medicare must be submitted on all enrolled members who are age 65+ (including spouses in the case of Companion Care). If a member is missing part A or B or both, they will only be allowed to enroll in the COB PPO or HMO plan and will pay a higher rate.

Members must NOT enroll in Medicare D. This is because prescription drug coverage is included in the COB PPO and HMO plans, and Medicare Part D enrollment is automatic with Companion Care and Medicare Advantage plans.

Please Note: Retiree members with spouses who are under age 65 will remain on the under age 65 Retiree PPO plan until that spouse becomes Medicare eligible. The Retiree member will be charged the under age 65 Retiree composite rate and must submit proof of Medicare Parts A and B.

WHAT IS CHANGING FOR CSEA MEMBERS?

Effective July 1, 2026, CSEA bargaining unit members who retire after July 1, 2026, will receive the District offered medical and vision benefits. This is only applicable for those retirees who retire July 1, 2026, or thereafter, who were employed full-time by the District for ten (10) years immediately preceding the date of retirement and who have reached the age of fifty-five (55), and who meet all requirements listed in the CSEA Bargaining Unit Agreement.



FREQUENTLY ASKED QUESTIONS

HOW DO I USE MY CHIROPRACTIC AND ACUPUNCTURE BENEFITS?

Kaiser Permanente HMO

You can obtain Services from any American Specialty Health (ASH) Plans Participating Providers without a referral from a Kaiser Permanente Plan Physician.

When you need chiropractic or acupuncture care, follow these simple steps:

1. Find an American Specialty Health Plans (ASH) Plans Participating Provider near you:
- Go to **ashlink.com/ash/kp**, or
- Call 1-800-678-9133 (TTY 711), Monday through Friday, from 5 a.m. to 6 p.m. PST
1. Schedule an appointment.
2. Pay for your office visit when you arrive for your appointment.

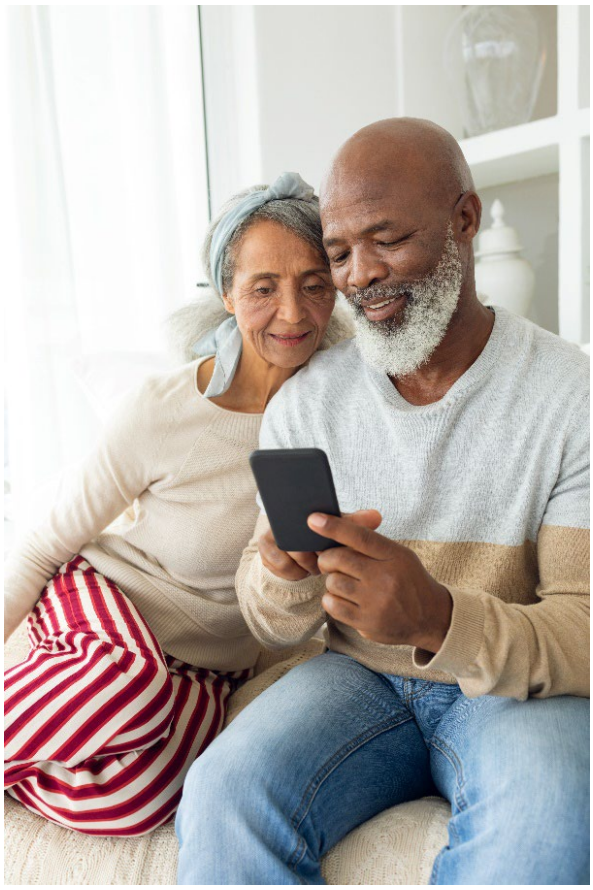
Blue Shield HMO

Chiropractic Care and Acupuncture providers must be part of the ASH Network. Providers can be found by accessing the blueshieldca.com website, or by visiting ashlink.com

You can visit any participating chiropractors or acupuncturists in California from the ASH Plans network without a referral from your HMO or POS Personal Physician. Simply call a participating provider to schedule an initial exam. At the time of your first visit, you'll present your Blue Shield ID card and pay only your copayment. Because participating chiropractors and acupuncturists bill ASH Plans directly, you'll never have to file claim forms.

Blue Shield PPO

Chiropractic Care and Acupuncture providers do not have to be within in the ASH Network. To find a provider visit **blueshieldca.com/SISC**, click **Find a provider**, under Find a PPO Network provider , click **Doctor specialist**, click **Alternative medicine**, enter your location, and select either **Acupuncture** or **Chiropractor**



RETIREE TURNING 65+ BENEFITS CHECKLIST

This checklist lists all the steps required to ensure your benefits continue once you turn 65.

- Please turn in all required documents to the Benefits Department.
- Any questions, email benefitsinfo@soccccd.edu or call the Benefits Department at (949) 582-4898

Please note:

If electing any of the Medical Plans listed, do not enroll in Medicare Part D. Enrolling in Medicare Part D may jeopardize your benefits with the District. Please consult with the District Benefits office if you have any questions regarding Medicare Part D.

Checklist for Retirees turning 65+

- ☐ Apply for Medicare Part A & B
  - You may apply for Medicare as early as 3 months prior to turning age 65 by making an appointment at the social security office or applying online.
    - Medicare can answer questions regarding coverage at 800-633-4227 or visit https://www.medicare.gov
- ☐ Supply a copy of Medicare Card with Part A & B for you and any eligible dependent.
  - Only required if electing to stay on a Medical Plan with the District.
- ☐ Complete the Retiree Benefit Election Form.
- ☐ Complete the SISC III Change form.
  - Only required if removing a dependent from your medical plan.
- ☐ Complete Dental and/or Vision enrollment form.
  - Only required if electing to continue the dental and/or vision coverage on a self-pay basis.
- ☐ Complete Medicare Supplement/Advantage Enrollment Forms.
  - Only required if you and/or any eligible dependent are electing:
    - CompanionCare 65+ Medicare Supplement
    - Blue Shield 65+ HMO Medicare Advantage
    - Kaiser 65+ Senior Advantage HMO Medicare
  - Copy of Medicare Card with Part A & B are required to be submitted with form.
  - Enrollment forms and copy of Medicare card are due to the Benefits Department no later than two months prior to you turning 65.
- ☐ Send completed documents to Benefits Department.
  - Mail documents to:

    SOCCCD
    Attn: Benefits
    28000 Marguerite Parkway
    Mission Viejo, CA 92692
  - Or fax to (949) 364-9447

If electing Self-Pay benefits, payments will be made to WEX Inc. (previously known as Discovery Benefits). A new enrollee packet will be mailed to your home with instructions on how to make your payment.

NEWLY RETIRING BENEFITS CHECKLIST

This checklist lists all the steps required to ensure your benefits continue after you retire.

- Please turn in all required documents to the Benefits Department.

Contact the Benefits Department with any questions at benefitsinfo@socccd.edu

Checklist for All Retirees

- ☐ Contact your retirement system and complete any necessary paperwork.
  - To retire with CalPERS, go to https://www.calpers.ca.gov/page/home
  - To retire with CalSTRS, go to https://www.calstrs.com
- ☐ Notify your Human Resources Specialist.
- ☐ Once you receive your Benefits packet:
  - Complete Retiree Benefit Election Form (required).
  - Complete SISC III Subscriber Change Form.
    - Only required if deleting dependents from coverage.
  - Complete and Mail Long Term Care Portability Form.
    - Only required if you are currently enrolled and planning to keep your Long-Term Care Coverage.
  - Complete and Mail Life Insurance Conversion Form.
    - Only required if you are planning to keep your Life Insurance Coverage.
  - Submit Flexible Spending Receipts for Reimbursement, if applicable.
  - Utilize MetLife Legal Benefits, if needed. Visit www.legalplans.com for more information.
  - If Spouse or Domestic Partner is 65+ provide a copy of Medicare Card with Parts A & B.

Checklist for Retirees 65+

- ☐ Complete all items above.
- ☐ Apply for Medicare Part A & B.
  - You may apply for Medicare as early as 3 months prior to your retirement by making an appointment at the social security office or applying online.
    - Medicare can answer questions regarding coverage at 800-633-4227 or visit https://www.medicare.gov
- ☐ Supply a copy of Medicare Card with Part A & B for you and any eligible dependent.
  - Only required if electing to stay on a Medical Plan with the District.
- ☐ Complete Dental and/or Vision enrollment form.
  - Only required if electing to continue the dental and/or vision coverage on a self-pay basis.
- ☐ Complete Medicare Supplement/Advantage Enrollment Forms.
  - Only required if you and/or spouse are electing:
    - Companioncare 65+ Medicare Supplement
    - Blue Shield 65+ HMO Medicare Advantage
    - Kaiser 65+ Senior Advantage HMO Medicare
  - Copy of Medicare Card with Part A & B are required to be submitted with form.

Enrollment forms and copy of Medicare card are due to the Benefits Department no later than two months before you turn 65.

WHERE TO GO FOR CARE

The Emergency Room and Urgent Care aren't your only options! With many options for getting care, how do you choose? The chart below helps you understand your care options and how you can save money when your illness or injury is not as emergent.

Where to go	What is it	What can be treated	Your cost
Advice Nurse (SISC Kaiser members)	Kaiser advice nurses are registered nurses who can assess medical problems and provide advice over the phone 24/7.	• Minor medical concerns • Advise on next steps • Help making appointments • Treatment options	No cost!
Teladoc Medical Experts (All SISC members)	All SISC members, including Kaiser, can get answers to health care questions and medical opinions from world-leading experts through Teladoc.	• Diagnosis or treatment help • Expert advice on medical questions • Finding a specialist • Guidance on hospital admission	No cost!
MDLive (SISC Blue Shield members)	MDLIVE gives you 24/7 access to a Board Certified doctor by phone or secure video to help treat any non-emergency medical conditions. Doctors can diagnose your symptoms, prescribe medication, and send prescriptions to your pharmacy of choice.[1]	• Flu and cold symptoms • Allergies • Diarrhea/Vomiting • Pink eye • Nausea • Rashes • Respiratory problems	No cost!
Doctor's Office	Go to a doctor's office when you need preventive or routine care. Your doctor can access your medical records, manage your medications and refer you to a specialist, if needed.	• Annual physical • Checkups • General health management • Preventive services • Minor skin conditions • Vaccinations	$5 -10 copay
Urgent Care (UC)	The UC is ideal for when you need care quickly, but it is not an emergency (and your doctor isn't available). Urgent care centers treat issues that aren't life threatening.	• Sprains • Strains • Minor burns • Minor infections • Minor broken bones • Cuts that require stitches	$5 -10 copay
Emergency Room (ER)	The ER is for serious life-threatening or very serious conditions that require immediate care. This is also when to call 911.	• Breathing difficulty • Chest pain • Heavy bleeding • Major broken bones • Head and spinal injuries	$100+ copay

[1] Some state laws require that doctors can only prescribe medication in certain situations & subject to certain limitations.

MEDICAL

OUR PLANS

Kaiser Permanente HMO (SISC) Plan

Blue Shield HMO (SISC) Plan

Blue Shield PPO (SISC) Plan

Age 65+ CompanionCare

Age 65+ Blue Shield Advantage Plan

Age 65+ Kaiser Senior Advantage Plan

We have a variety of medical plan options for those under 65, over 65, and Coordination of Benefits with Medicare. Review the network provider information and out-of-pocket costs such as deductible, coinsurance and prescription drugs so you can choose the best fit for your health concerns and budget/understand how the plan works.

Which Plan Is Right For You?

That depends on your healthcare needs, favorite doctors, and budget. Here are some considerations.

Consider an HMO (Health Maintenance Organization) if:

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

Consider a PPO (Preferred Provider Organization) if:

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

MEDICAL PLANS – UNDER AGE 65

South Orange County Community College District gives you a choice between three medical plans through either Blue Shield of California/SISC or Kaiser/SISC. You can find in-network providers by visiting blueshieldca.com/sisc or blueshieldca.com directly and selecting "Find a provider." You will search under the "Access+ HMO" network for the HMO plan and "Blue Shield of California PPO Network" for the PPO plan.

	Kaiser Permanente HMO (SISC)	Blue Shield HMO (SISC)	Blue Shield PPO (SISC)	
	In-Network	In-Network	In-Network	Out-of-Network
Calendar Year Deductible Individual Family	None None	None None	$100/individual $300/family	$100/individual* $300/family*
Calendar Year Out-of-Pocket Maximum Individual Family	$1,500 Self-Only Coverage $1,500 Individual within a Family $3,000 Family Coverage	$1,000/individual $2,000/family	$400/individual $1,200 family	$400/individual* $1,200/family*
Office Visit Primary Care Specialist Access+ Specialist	$10 copay per visit $10 copay per visit N/A	$5 copay $5 copay $30 copay for self-referred Access+ Specialist	$10 copay[3] $10 copay[3] N/A	10%[1] 10%[1] N/A
Preventive Services	No Charge	No Charge	No Charge[3]	Not Covered
Chiropractic	$10 copay (up to 30 visits per year combined w/ Acu)[4]	$10 copay (up to 30 visits per year combined w/ Acu)[4]	$25 copay (up to 20 visits per year)	10%[1] (up to 20 visits per year)
Acupuncture	$10 copay (up to 30 visits per year combined with Chiro)	$10 copay (up to 30 visits per year combined with Chiro)	$25 copay (up to 20 visits per year)	$25 copay[1] (up to 20 visits per year)
Lab and X-ray	No Charge	No Charge	10%	10%[1]
Emergency Room	$100 copay per visit (waived if admitted)	$100 copay per visit (waived if admitted)	$100 copay plus 10% (waived if admitted)	$100 copay plus 10% (waived if admitted)
Inpatient Hospitalization	No Charge	No Charge	10%	No Charge[2] (up to $600/day)
Outpatient Surgery	$10 per procedure	No Charge	10%	No Charge[2] (up to $350/day)

* Combined with in-network

1. Copayments/Coinsurance marked with this footnote do not accrue to Calendar Year out-of-pocket maximum. Copayments/Coinsurance and charges for services not accruing to the member's Calendar Year out-of-pocket maximum continue to be the member's responsibility after the Calendar Year out-of-pocket maximum is reached. This amount could be substantial. Please refer to the Plan Contract for exact terms and conditions of coverage.
2. Members are responsible for all charges in excess of the per day maximum payment.
3. Not subject to the Calendar Year deductible
4. Chiropractic Care and Acupuncture providers must be part of the American Specialty Health Network. Providers can be found by accessing the blueshieldca.com website or visiting https://www.ashlink.com/ASH/public/applications/providersearch/default.aspx. Kaiser members can find participating providers at www.ashlink.com/ash/kp

PRESCRIPTION DRUGS

If you enroll in medical coverage, you will automatically receive coverage for prescription drugs. Employees enrolled in the Blue Shield HMO plan will have prescription drug coverage through Navitus. If you are taking prescription medications on a regular basis, you may save time and money by using the mail service pharmacy. If you have any questions, you may call Navitus Member Services 24 hours a day, seven days a week toll free at (866) 333-2757 or visit the Navitus website at navitus.com.

For the Blue Shield PPO plan with prescription drug coverage through Navitus, a 90-day supply is available through Costco retail or mail-order pharmacies (Costco membership not required). At other in-network pharmacies, you will only be able to obtain a 30-day supply. For questions, call Navitus at (866) 333-2757. To register online with Costco mail-order pharmacy, visit Costco.com/pharmacy or call (800) 607-6861.

Have your prescription delivered from your local Costco for free with Instacart. When you get a text from Costco that your prescription is ready, simply choose the delivery option. To qualify for free Instacart delivery, use the link in the Costco Rx confirmation text. Instacart home delivery distance restrictions may apply.

Navitus SpecialtyRx is a specialty pharmacy program offered through a partnership with **Lumicera Health Services** that helps manage high-cost and injectable drugs with a focus on patient care. To start using Navitus SpecialtyRx, please call (855) 847-3553.

	Kaiser Permanente HMO (SISC)	Blue Shield HMO (SISC) through Navitus	Blue Shield PPO (SISC) through Navitus
	In-Network	In-Network	In-Network
Prescription Deductible	None	None	None
Annual Out-of-Pocket Limit	Medical Out-of-Pocket Limit Applies	$1,500/individual[2] $2,500/family[3]	$1,500/individual $2,500/family
Pharmacy/Retail			
Generic	$10 copay	$5 copay	$5 copay
Costco Generic	N/A	$0 copay	$0 copay
Brand	$10 copay	$10 copay[3]	$10 copay
Specialty	$10 copay	N/A	N/A
Supply Limit	100 Days (Generic & Brand) 30 Days (Specialty Item)	30 Days	30 Days
Mail Order			
Generic	$10 copay	N/A	N/A
Costco Generic	N/A	$0 copay	$0 copay
Brand	$10 copay	N/A	N/A
Costco Brand	N/A	N/A	$20 copay
Specialty	N/A	$10 copay	$10 copay through Navitus
Supply Limit	100 Days	90 Days (Generic & Brand) 30 Days (Specialty)	90 Days (Costco Generic & Brand) 30 Days (Specialty)

1. Copayments/Coinsurance marked with this footnote do not accrue to Calendar Year out-of-pocket maximum. Copayments/Coinsurance and charges for services not accruing to the member's Calendar Year out-of-pocket maximum continue to be the member's responsibility after the Calendar Year out-of-pocket maximum is reached. This amount could be substantial. Please refer to the Plan Contract for exact terms and conditions of coverage.
2. Members are responsible for all charges in excess of the per day maximum payment.
3. Not subject to the Calendar Year deductible

MEDICARE COORDINATION OF BENEFITS PPO W/ BLUE SHIELD

When you have other insurance (like employer group health coverage), there are rules that decide whether Medicare or your other insurance pays first. Use this chart to see who pays first. Please keep in mind that your benefits will remain with Blue Shield but Medicare will pay primary. The monthly premium for this plan is $959.00 for Retiree Only, $1,918.00 for Retiree + 1, and $2,450.00 for Retiree + Family. If eligible, the district pays the Retiree Only premium.

If you have Retiree insurance (insurance from your or your spouse's former employment)…	**Medicare pays first.**
If you're 65 or older, have group health plan coverage based on your or your spouse's current employment, and the employer has 20 or more employees…	**Your group health plan pays first.**
If you're 65 or older, have group health plan coverage based on your or your spouse's current employment, and the employer has less than 20 employees…	**Medicare pays first.**
If you're under 65 and disabled, have group health plan coverage based on your or a family member's current employment, and the employer has 100 or more employees…	**Your group health plan pays first.**
If you're under 65 and disabled, have group health plan coverage based on your or a family member's current employment, and the employer has less than 100 employees…	**Medicare pays first.**
If you have Medicare because of End-Stage Renal Disease (ESRD)…	**Your group health plan will pay first for the first 30 months after you become eligible to enroll in Medicare. Medicare will pay first after this 30-month period.**
If you have Retiree insurance (insurance from your or your spouse's former employment)…	**Medicare pays first.**
If you're 65 or older, have group health plan coverage based on your or your spouse's current employment, and the employer has 20 or more employees…	**Your group health plan pays first.**
If you're 65 or older, have group health plan coverage based on your or your spouse's current employment, and the employer has less than 20 employees…	**Medicare pays first.**
If you're under 65 and disabled, have group health plan coverage based on your or a family member's current employment, and the employer has 100 or more employees…	**Your group health plan pays first.**
If you're under 65 and disabled, have group health plan coverage based on your or a family member's current employment, and the employer has less than 100 employees…	**Medicare pays first.**

Here are some important facts to remember about the PPO COB:

- The insurance that pays first (primary payer) pays up to the limits of its coverage.
- The insurance that pays second (secondary payer) only pays if there are costs the primary insurer didn't cover.
- The secondary payer (which may be Medicare) might not pay all of the uncovered costs.
- If your employer insurance is the secondary payer, you might need to enroll in Part B before your insurance will pay
- If you have questions about who pays first, call Medicare's Benefits Coordination & Recovery Center (BCRC) at (855) 798-2627.

MEDICARE COORDINATION OF BENEFITS HMO W/ BLUE SHIELD

Similar to the PPO COB Plan, when you have other insurance (like employer group health coverage), there are rules that decide whether Medicare or your other insurance pays first. The chart below will help you do determine who pays first. Please keep in mind that your benefits will remain with Blue Shield but Medicare will pay primary. The monthly premium for this plan is $964.00 for Retiree Only, $1,928.00 for Retiree + 1, and $2,409.00 for Retiree + Family. If eligible, the district pays the Retiree Only premium.

If you have Retiree insurance (insurance from your or your spouse's former employment)…	**Medicare pays first.**
If you're 65 or older, have group health plan coverage based on your or your spouse's current employment, and the employer has 20 or more employees...	**Your group health plan pays first.**
If you're 65 or older, have group health plan coverage based on your or your spouse's current employment, and the employer has less than 20 employees...	**Medicare pays first.**
If you're under 65 and disabled, have group health plan coverage based on your or a family member's current employment, and the employer has 100 or more employees...	**Your group health plan pays first.**
If you're under 65 and disabled, have group health plan coverage based on your or a family member's current employment, and the employer has less than 100 employees...	**Medicare pays first.**
If you have Medicare because of End-Stage Renal Disease (ESRD)...	**Your group health plan will pay first for the first 30 months after you become eligible to enroll in Medicare. Medicare will pay first after this 30-month period.**
If you have Retiree insurance (insurance from your or your spouse's former employment)...	**Medicare pays first.**
If you're 65 or older, have group health plan coverage based on your or your spouse's current employment, and the employer has 20 or more employees...	**Your group health plan pays first.**
If you're 65 or older, have group health plan coverage based on your or your spouse's current employment, and the employer has less than 20 employees...	**Medicare pays first.**
If you're under 65 and disabled, have group health plan coverage based on your or a family member's current employment, and the employer has 100 or more employees...	**Your group health plan pays first.**
If you're under 65 and disabled, have group health plan coverage based on your or a family member's current employment, and the employer has less than 100 employees...	**Medicare pays first.**

Here are some important facts to remember about the HMO COB:

- The insurance that pays first (primary payer) pays up to the limits of its coverage.
- The insurance that pays second (secondary payer) only pays if there are costs the primary insurer didn't cover.
- The secondary payer (which may be Medicare) might not pay all of the uncovered costs.
- If your employer insurance is the secondary payer, you might need to enroll in Part B before your insurance will pay.
- You must seek care from a provider who accepts the HMO Access+ Network
- You may self-refer to a specialist within your HMO medical group. Should you self-refer to a specialist that accepts Medicare but is outside of your HMO medical group and/or network, you will be responsible for any amount that Medicare may not cover.

MEDICAL – AGE 65+ COMPANIONCARE

This Medicare Supplement plan is only available to Retirees and their spouses/domestic partners who are 65+ and have enrolled in Medicare Parts A & B. Enrollment forms must be turned into the District no later than 45 days prior to effective date. The monthly premium for this plan is $469.00 and payments are made directly to SISC. If eligible, the district pays the Retiree Only premium.

CompanionCare pays for medically necessary services and procedures that are considered a Medicare Approved Expense. SISC will automatically enroll CompanionCare Members into Medicare Part D. No additional premium is required. Please do NOT enroll in another Medicare Part D plan as you will be subject to penalties if you do so. SISC plans are NOT subject to the "doughnut hole" (coverage gap).

Eligibility: Member must be retired and enrolled in Medicare Part A (hospital) and Medicare Part B (medical) coverage. Retirees under age 65 with Medicare for the disabled (Parts A & B) may enroll in CompanionCare.

Provider Network: Physicians who accept Medicare assignment.

	Medicare 2025 Benefits	CompanionCare
Inpatient Hospital (Part A)	Pays all but first $1,676 for 1st 60 days Pays all but $419 a day for the 61st to 90th day Pays all but $838 a day Lifetime Reserve for 91st to 150th day Pays nothing after Lifetime Reserve is used (refer to Evidence of Coverage)	Pays $1,676 Pays $419 a day Pays $838 a day Pays 100% after Medicare and Lifetime reserve are Exhausted up to 365 days per lifetime
Skilled Nursing Facilities (Must be approved by Medicare)	Pays 100% for 1st 20 days Pays all but $209.50 a day for 21st to 100th day Pays nothing after 100th day	Pays nothing Pays $209.50 a day for 21st to 100th day Pays nothing after 100th day
Deductible (Part B)	$257 Part B deductible per year	Pays $257
Basis of Payment (Part B)	80% Medicare Approved (MA) charges after Part B deductible	Pays 20% MA charges including 100% of Medicare Part B deductible
Medical Services (Part B) Doctor, x-ray, appliances, & ambulance lab	80% MA charges 100% MA charges	Pays 20% MA charges Pays nothing
Physical/Speech Therapy (Part B)	80% MA charges up to the Medicare annual benefit amount	Pays 20% MA charges up to the Medicare annual benefit amount (PT & ST combined)
Blood (Part B)	80% MA charges after 3 pints	Pays 1st 3 pints un-replaced blood and 20% MA charges
Travel Coverage	Not Covered	Pays 80% inpatient hospital, surgery, anesthetist, and in-hospital visits for the medically necessary services for 90 days of treatment per lifetime.

For additional Medicare benefit information, please go to **medicare.gov** or call (800) 633-4273.

MEDICAL – AGE 65+ ADVANTAGE PLAN

This medical plan is only available to Retirees and their spouses/domestic partners who are 65+ and have enrolled in Medicare Parts A & B. Enrollment forms must be turned into the District no later than 45 days prior to effective date. The monthly premium for this plan is $418.00 and payments are made directly to SISC. If eligible, the district pays the Retiree Only premium.

The Blue Shield 65+ HMO is a Medicare Advantage Plan that is offered through a Health Maintenance Organization (HMO) in lieu of Medicare benefits. Retirees cannot use their Medicare benefits while enrolled in this plan. If a member is missing a part of Medicare or does not assign their Medicare to Blue Shield, then the member would not be eligible. Members enrolled in this plan must have continuous Medicare Part A and Part B coverage and must live in an approved Zip Code of the Blue Shield of California GMA-PD Service Area. For more information, visit blueshieldca.com/sisc or go to medicare.gov for additional Medicare benefit information.

Blue Shield 65+ HMO pays for medically necessary services and procedures that are considered a Medicare Approved Expense. SISC will automatically enroll Blue Shield 65+ HMO Members into Medicare Part D. No additional premium is required. Please do NOT enroll in another Medicare Part D plan as you will be subject to penalties if you do so. SISC plans are NOT subject to the "doughnut hole" (coverage gap).

	Blue Shield HMO Medicare Advantage Plan (SISC)
Ambulance	$0 copay
Annual Physical Exam	$0 copay*
Durable Medical Equipment (DME) Medicare covered services	$0 copay
Hospitalization Inpatient Outpatient Hospital Services Emergency Room	 $0 copay $0 copay $50 copay (copay waived if admitted within 24 hours for the same condition)
Immunizations Includes flu shots and all Medicare approved immunizations	$0 copay*
Laboratory Services	No Charge
X-rays	$0 copay*
Manual Manipulation of the Spine	$20 copay (subject to medical necessity)
Office Visit Primary/Specialist Provider	 $20 copay

*Office visit copay may apply.

For additional information regarding the Blue Shield/SISC HMO Medicare Advantage plan, please go to blueshieldca.com or call (800) 776-4466.

MEDICAL – AGE 65+ SENIOR ADVANTAGE

This medical plan is only available to Retirees and their spouses/domestic partners who are 65+ and have enrolled in Medicare Parts A & B. Enrollment forms must be turned into the District no later than 45 days prior to effective date. The monthly premium for this plan is $230.00 for Retiree Only, $460.00 for Retiree + 1 and $1,073.00 for Retiree + Family and payments are made directly to SISC.

Kaiser Senior Advantage HMO pays for medically necessary services and procedures that are considered a Medicare Approved Expense. SISC will automatically enroll Kaiser Senior Advantage HMO Members into Medicare Part D. No additional premium is required. Please do NOT enroll in another Medicare Part D plan as you will be subject to penalties if you do so. SISC plans are NOT subject to the "doughnut hole" (coverage gap).

	Kaiser Permanente Senior Advantage HMO Medicare Plan (SISC)
Ambulance	$50 copay per trip
Annual Physical Exam	No Charge
Durable Medical Equipment (DME) Medicare covered services	100%
Hospitalization Inpatient Emergency Room	 $0 copay/admit $50 copay (waived if admitted)
Immunizations Includes flu shots and all Medicare approved immunizations	No charge (office visit copay may apply if administered as part of a physician office visit)
Laboratory Services	No Charge
X-rays	No Charge
Manual Manipulation of the Spine	$10 copay (subject to medical necessity)
Office Visit Primary/Specialist Provider	 $10 copay
Hearing Aids	Up to $500 allowance/device; 1 device/ear; 2 devices/36 months

REMINDER: This plan also includes vision benefits! Please refer to page 27 of this booklet for more information.

For additional information regarding the Kaiser/SISC Senior Advantage HMO Medicare Plan, please visit **kp.org** or call (800) 464-4000.

PRESCRIPTION DRUGS – AGE 65+

Below are the prescription drug plans offered with the medical plans for retirees age 65+.

	Blue Shield COB PPO Medicare Part D Plan (SISC) through Navitus[1]	CompanionCare[2]	Blue Shield HMO Medicare Advantage Plan	Blue Shield COB HMO (SISC) through Navitus[3]
	In-Network	In-Network	In-Network	In-Network
Out of Pocket Limit:	$2,000 per individual	N/A	N/A	$1,500/individual $2,500/family
Pharmacy/ Retail				
Generic	$0 copay	$9 copay	$10 copay	$5 copay
Preferred Brand	$10 copay	$35 copay	$30 copay	$10 copay[4]
Supply Limit	30 Days	30 days	30 days	30 days
Mail Order				
Generic	$0 copay	$18 copay	$20 copay	$0 copay
Preferred Brand	$0 copay	$90 copay	$60 copay	$10 copay
Specialty (30 Day Supply)	$0 copay			
Supply Limit	90 Days	90 days	90 days	90 days

Due to Medicare restrictions the following programs are not available with CompanionCare:

- $0 generic copay at Costco
- Diabetic Supplies for Generic copay

[1]This enhanced employer group Medicare Part D Rx plan is administered through Navitus Health Solutions. Specialty prescription drugs will have a $40 copay through specialty mail order only. Most major and independent pharmacies, including Walgreens, are included in the network. Covered non-specialty prescriptions can be filled in either 30- or 90-day supply.

[2]Pharmacy benefits are administered through Navitus Health Solutions Medicare Rx using a Med D formulary. Some exclusions and prior authorizations may apply. Members that have questions regarding their medication coverage can call Navitus Solutions Medicare Rx at (866) 270-3877 or TYY users please call 711

[3] Members may receive up to 30 days and/or up to 90 days supply of medication at participating pharmacies. Some narcotic pain and cough medications are not included in the Costco Free Generic or 90-day supply programs. Navitus contracts with most independent and chain pharmacies with the exception of Walgreens. Due to Medicare Part D restrictions, this program does not apply to the CompanionCare pharmacy benefit.

[4] If the member requests a brand-name drug and a generic drug equivalent is available, the member is responsible for paying the difference between the cost to Blue Shield of California of the brand-name drug and its generic drug equivalent, as well as the applicable generic drug copayment.

	Kaiser Senior Advantage HMO Medicare Plan
	Using Kaiser Pharmacy (Not subject to doughnut hole)
Generic	$10 copay
Preferred Brand	$20 copay
Supply Limit	Up to a 100 Days

APPLICABLE TO PARTICIPANTS ELIGIBLE FOR MEDICARE BENEFITS

The prescription drug plan for members 65+ will be an Employer Group Medicare Part D Prescription Plan. Unlike some Part D prescription plans, there is no coverage gap or "doughnut hole." Members will automatically be enrolled in Medicare Part D. The Centers for Medicare and Medicaid Service (CMS) permits members to be enrolled in only one Medicare Part D plan. Enrollment in any other Medicare Part D prescription drug plan will result in disenrollment from the medical and prescription drug plan.

Please always carefully read and promptly and appropriately respond to any letters you may receive from CMS, Medicare, or Social Security. The federal government may assess an **Income-Related Adjustment Amount (IRMAA).** These are fees associated with individuals enrolled in Medicare Part D whose incomes exceed certain thresholds. If you receive a IRMAA invoice, you will need to pay it in order to remain enrolled in your plan. For additional information, please go to https://www.medicare.gov/drug-coverage-part-d/costs-for-medicare-drug-coverage/monthly-premium-for-drug-plans

MEDICAL CARRIER RESOURCES

SOLERA4ME DIABETES PREVENTION

SOLERA4ME is a diabetes prevention benefit for the Blue Shield PPO and HMO members. It's a 16-week, cutting-edge program that can help members with prediabetes lose weight, adopt healthy habits and significantly reduce their risk of developing diabetes. It's available at no cost to members that qualify. If you qualify, programs may include health coaching, weekly lessons, integrated devices such as Fitbit, and group support. For more information and to see if you qualify, visit www.solera4me.com to take a quick, 1-minute test.

CENTIVO CARE (EDEN HEALTH)

All SISC Blue Shield PPO members and dependents over 18 have 24/7 access to a Care Team who works together to offer you primary care, mental health support, and answers to follow - up care questions through one app.

- Diagnoses and treatments
- Prescription refills
- Scheduled video visits or live chat with a primary care physician
- Answers to follow up care questions
- Specialist referrals
- Mental health support

Visit http://centivocare.com/sisc to get started.

MDLIVE

SISC Blue Shield members can access 24/7 virtual urgent care services and appointment-based mental health services (psychiatry and therapy available for ages 10 and up). Physicians can prescribe medication when appropriate. Consult with doctors and pediatricians over the phone or using online video for medical conditions such as cold, fever, sore throat, flu, infection, and children's health issues. Physicians can prescribe medication when appropriate. Online behavioral health visits are also available.

Register by calling (800) 657-6169 or go to mdlive.com/sisc to activate your account.

TELADOC

All SISC members, including Kaiser, can get answers to health care questions and medical opinions from world-leading experts through Teladoc. Use Teladoc Medical Experts when you or your eligible dependents:

- Are unsure about a diagnosis or need help choosing treatment
- Have medical questions or concerns and want a leading expert's advice
- Need help finding a local expert who specializes in treating your condition
- Have been admitted to the hospital and want expert guidance

Call (855) 380-7828 or go to teladoc.com/SISC.

MEDICAL CARRIER RESOURCES CONT.

CARRUM HEALTH

Carrum Health provides PPO members with surgery benefits that waives co-insurance and deductibles for hip/knee replacements and many spine surgeries when utilizing "Center of Excellence."

This benefit is separate from and in addition to the benefits already provided under the Blue Shield PPO plan. This benefit must be accessed through Carrum. How your Carrum Health surgery benefit works:

- Register by calling (888) 855-7806 or visiting https://my.carrumhealth.com/sisc
- Meet your personally assigned Care Concierge
- Review and select your top-quality surgeon
- Receive full support preparing for your surgery
- Recover smoothly with total care coordination

HINGE HEALTH

Hinge Health offers PPO members digital programs for back, knee, hip, shoulder and neck pain. Members can save time and money while overcoming pain anytime, anywhere.

All the care you need is in your Hinge Health toolkit, which includes the following:

- **Free tablet and wearable sensors:** Feel confident in your form. Our app and sensors give you live feedback during stretches and exercises.
- **Personalized exercise therapy:** You'll be guided through 15-minute sessions, and the level of difficulty will increase when you're ready.
- **Unlimited 1-on-1 health coaching:** Your coach will be there to provide personalized support via text, email, or call to help you reach your goals.

To learn more, go to www.hingehealth.com/sisc or call (855) 902-2777.

ONCOLOGY PROGRAM – LANTERN (CANCER CARE DIRECT)

SISC Blue Shield PPO members with a cancer diagnosis may access Lantern (previously called Cancer Care Direct) where they're connected to an oncology nurse who will guide them through their journey and provider support. Participating members receive:

- Support on if a second opinion is needed and connect you to Teladoc
- Top specialists for your cancer type and coordinate travel as needed
- Help with managing symptoms
- Answers to all questions about diagnosis and treatment plan
- Overall patient support

MEDICAL CARRIER RESOURCES CONT.

CONDITION MANAGEMENT

Condition Management is a program for PPO plan members and designed to help people with specific conditions to stay as healthy as possible for as long as possible. This program is confidential, voluntary and at no cost to you. Health management nurses work with you over the phone who are living with Diabetes or Coronary Artery Disease (CAD). For more information, call (866) 954-4567.

BLUECARD OUT OF STATE

PPO members may access these benefits when you're traveling or temporarily living outside your home state with the BlueCard program. The BlueCard also covers enrolled dependents, including students and family members, who temporarily reside outside your home state. To locate BlueCard providers, call BlueCard Access® at 800-810-BLUE (2583) or call collect at 804-673-1177.

1. Call your Blue Cross Blue Shield Plan.

2. Visit www.bcbsglobalcore.com

3. Call the Blue Cross Blue Shield Global Core

HMO plan members have coverage for emergency and urgent care services, or authorized medical follow-up care, when they are out of their HMO service area.

MIDI HEALTH

SISC is proud to offer Midi Health's virtual menopause care benefit to eligible employees and dependents covered under the Blue Shield PPO plan.

Midi connects you to expert clinicians via virtual visits. After discussing your symptoms and health history, they help you get any necessary lab tests and create a personalized care plan. Your regimen may include:

- FDA-approved hormonal medications
- Non-hormonal medications
- Supplements and botanicals
- Lifestyle coaching
- Wellness therapies

Start your Midi journey at joinmidi.com/sisc.

TRANSPORTATION AND MEAL SERVICES

SISC members enrolled in a Kaiser 65+ Senior Advantage plan will have access to the following new benefits:

✓ Medical Transportation: Make it easier to access care and never miss an important medical appointment! This new benefit provides up to 24 one-way rides to go to lab visits, doctor appointments, or to the pharmacy to pick up medications or medical equipment.

✓ Meal Delivery: After an inpatient stay at a hospital or skilled nursing facility, you can get back to health more quickly with fresh and nutritious meal deliveries. This new benefit includes:

- 3 dietitian-designed meals a day, for up to 4 weeks – a total of 84 meals
- Delivery to any address in coverage region
- More than 70 entrée options, including heart-healthy, diabetic-friendly, and gluten-free meals.

DENTAL

OUR PLANS

Delta Dental PPO (ACSIG)

DID YOU KNOW?

Keeping your teeth and gums healthy isn't the only reason you should practice preventive dental care. With good dental hygiene, you can greatly reduce your risk of getting cavities, gingivitis, periodontitis, and other dental problems.

You can also reduce your risk of secondary problems caused by poor oral health such as diabetes, heart disease, osteoporosis, respiratory disease and even cancer.

We offer a dental plan through Delta Dental/ACSIG.

Why Sign Up For Dental Coverage?

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

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

Dental insurance covers four types of treatments:

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

DENTAL

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

South Orange County Community College District provides Retirees 65+ with a voluntary comprehensive dental coverage through Delta Dental of California/ACSIG. If you are a Retiree under age 65, dental benefits will continue to be paid by the District for you and your eligible dependents until the 1st of the month in which you turn 65.

Log on to Delta's website at deltadentalins.com or call (866) 499-3001 for more information.

	Delta Dental PPO (ACSIG)	
	In-Network	**Out-of-Network**
Calendar Year Deductible	$25/individual $75/family	$25/individual (combined with in-network) $75/family (combined with in-network)
Annual Plan Maximum	$3,500	$3,000
Diagnostic & Preventive[1] Oral Exam	Plan pays 100% 3	Plan pays 90% 3
Basic Services Fillings Root Canals Periodontics	Plan pays 90% after deductible Plan pays 90% after deductible Plan pays 90% after deductible	Plan pays 90% after deductible Plan pays 90% after deductible Plan pays 90% after deductible
Major Services Crowns Inlays/Onlays Prosthodontics*	Plan pays 90% after deductible Plan pays 90% after deductible Plan pays 90% after deductible	Plan pays 90% after deductible Plan pays 90% after deductible Plan pays 90% after deductible
Orthodontia Adult & Children	Plan pays 50%	Plan pays 50%
Ortho Lifetime Max	$2,000	$2,000 (combined with in-network)

*Implant surgical placement and removal and for implant supported prosthetics, including implant repair and re-cementation. Bone graft may or may not be covered.

SmileWay Program

As part of Delta Dental's SmileWay program, members or covered dependents diagnosed with chronic medical conditions such as diabetes, cancer, or rheumatoid arthritis will have access to additional teeth and gum cleanings. Members can opt in by visiting deltadentalins.com/smileway.

What you need to know about this plan

Diagnostic and Preventive Maximum Waiver[1]

Costs for covered diagnostic and preventive dental services don't accrue against plan year maximums. Routine exams, cleanings, and x-rays are waived from the annual plan maximum, having more dollars to use for other needed dental services.

VISION

OUR PLANS

Vision Service Plan (VSP/ACSIG)

Kaiser Vision Care

Click to play video

We offer two vision plans through VSP/ACSIG and Kaiser.

Why Sign Up For Vision Coverage?

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

You'll even find discounts on services like LASIK and PRK, rebates on contact lenses, and money off on hearing aids and other related services. Visit the plan's website to check out these extra savings.

VISION

Routine vision exams are important, not only for correcting vision but because they can detect other serious health conditions. South Orange County Community College District provides Retirees 65+ with a comprehensive vision coverage through Vision Service Plan (VSP). If you are a Retiree under age 65, vision benefits will continue to be paid by the District for you and your eligible dependents until the 1st of the month in which you turn 65. After age 65, District-paid vision may also be available, depending on your bargaining unit and eligibility. Log on to VSP's website at vsp.com or call (800) 877-7195 for more information.

	Vision Service Plan (ACSIG) VSP Vision	
	In-Network	**Out-of-Network**
Exams Benefit Materials Frequency	 $10 copay Combined with exam Once every 12 months	 Plan pays up to $50 Varies based on materials selected Once every 12 months
Eyeglass Lenses Single Vision Lens Bifocal Lens Trifocal Lens Frequency	 Combined with exam Combined with exam Combined with exam Once every 12 months	 Plan pays up to $50 Plan pays up to $75 Plan pays up to $100 Once every 12 months
Frames Benefit Second Pair Frequency	 Up to $200 + 20% off over your allowance $20 copay Once every 12 months	 Plan pays up to $70 Plan pays up to $70 Once every 12 months
Contacts (Elective) Conventional Frequency	 $50 copay (in addition to eyeglasses, eyeglasses and contacts are allowed in the same year) Once every 12 months	 $50 copay then plan pays up to $250 (in addition to eyeglasses, eyeglasses and contacts are allowed in the same year) Once every 12 months

	Kaiser Vision Care
	In-Network
Examination for Eyeglasses	$10 copay per visit
Glaucoma Testing	$10 copay per visit
Standard frame/lenses	$150 frame and lens allowance every 24 months

Extra Savings:

- Extra $20 to spend on featured frame brands. Go to vsp.com/specialoffers for details and information on additional discounts.
- 30% savings on additional glasses and sunglasses, including lens enhancements, from the same VSP provider on the same day as your WellVision Exam. Or get 20% from your VSP provider within 12 months of your last WellVision Exam.

Retinal Screening

- No more than a $39 copay on routine retinal screening as an enhancement to a WellVision Exam.

Laser Vision Correction

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

Hearing Aids

- Save up to $2,400 on a pair or hearing aids with TruHearing pricing. Go to truhearing.com/vsp or call (877) 396-7194 with questions.

WELLBEING & BALANCE

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

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

A Happier, Healthier You

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

We offer programs to help you:

- Manage stress, chemical dependency, mental health and family issues
- Maximize your health and physical well-being

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

MENTAL HEALTH RESOURCES

ACCESSING MENTAL HEALTH SERVICES

Mental health resources are available through your medical plan.
Call or visit the website below to schedule an appointment and make sure to review the mental health programs on this page.

SISC Blue Shield Members

- For HMO, call (877) 263-9952
- For PPO, call (800) 378-1109
- Website: blueshieldca.com/sisc

SISC Kaiser Members

- Call (833) 579-4848 to make an appointment with a mental health or addiction specialist (no referral needed).
- For 24-7 crisis intervention and urgent metal health advice, call (800) 900-3277.
- Website: kaiserpermanente.org/health-wellness/mental-health

ANTHEM BLUE CROSS EAP

The Anthem Blue Cross Employee Assistance Program (EAP) offers customized online programs to learn effective ways to manage stress, depression, anxiety, and more. Arrange up to six free visits per issue with licensed professionals. Help is available 24/7, 365 days a year. Call (800) 999-7222 or visit anthemeap.com (Company Code: SISC).

Anthem EAP also offers Talkspace, a digital platform that supports behavioral health and emotional wellness. All employees and household members ages 13 and older are eligible to use Talkspace for up to six counseling sessions per situation, through video, audio and unlimited messaging. Call the 24/7 EAP Call Center (800) 999-7222 or visit talkspace.com/associatecare (Organization name: SISC).

MDLIVE

SISC Blue Shield members can get 24/7/365 virtual access to behavioral health therapists. Connect with a therapist either by phone or secure video to assist with common issues such as martial problems, parenting counseling, coping with loss and grief, financial hardship and more. Register by calling (888) 632-2738 or go to mdlive.com/sisc to activate your account.

RULA – MENTAL HEALTH

Rula partners with SISC to find affordable, accessible care focusing on quality of network providers. Rula has a network of 9,500+ mental health providers who can support you and your family with virtual therapy, psychiatry, or a combination of both. Rula will help you find an in-network provider and schedule your first appointment in minutes.

For more, go to rula.com/SISC or call (323) 676-7360.

HEADSPACE CARE (PREVIOUSLY GINGER)

Support is just a text message away. The Headspace Care app, previously known as Ginger, is available to Kaiser members to receive 24/7 text-based emotional support coaching. Talk with your support coach to discuss goals, share challenges and create a personalized action plan based off your specific need. Members also receive on-demand activities, podcasts, videos, and more. This app is available at no additional charge. For more information, visit healthy.kaiserpermanente.org/health-wellness/mental-health/coaching-apps.

FITNESS PROGRAMS

Tivity Health Fitness Your Way

Fitness Your Way™ is a program available to SISC Blue Shield members through Tiivity Health™. This program offers you the flexibility to work out at any network fitness location. There are multiple tier options to choose from to best fit your need, such as a Digital Only package for $10/month per person and the Base Gym package for $19/month per person. Members may get started with Fitness Your Way either online or by phone:

- Online: fitnessyourway.tivityhealth.com/bsc
    - Click *Enroll*
    - Complete the five easy steps to enrollment
- By phone at (833) 283-8387 Monday through Friday, 5 a.m. to 5 p.m. PST

Vida Digital Health Coaching

Vida Health, gives Blue Shield members age 18 and older access to a personal health coach or therapist at no cost to you. Vida's coaches and therapists can help you lose weight, cope with depression or anxiety, manage stress, prevent diabetes, and much more.

With Vida, members set goals and see real results. For members who are focused on managing stress, they're able to reduce their stress by 50% after 6 months. If you're looking to lose weight, Vida members lose an average of 5-7% of their body weight. And many of those working to manage chronic health conditions are able to reduce or eliminate medications.

Here's what to expect when you sign up:

- ✓ Choose your personal health coach or therapist. Vida health coaches include registered dietitians, certified diabetes educators, licensed therapists, and other specially trained health experts.
- ✓ Your coach will work with you to create a personalized plan to help prevent diabetes, lose weight, manage stress, and more.
- ✓ Talk to your health coach each week by phone or video. You can also send messages to your coach anytime using the secure Vida app.
- ✓ Track your progress through connected devices, with Apple Health or other smart devices — like scales and blood sugar meters — directly to the Vida app.

To learn more about Vida Health, call (855) 442-5885 or go to vida.com/sisc

FITNESS PROGRAMS CONT.

GET STARTED WITH SILVER FIT

1. Go to www.SilverandFit.com
2. Register to use the site
3. Choose a participating fitness center or sign up for the Home Fitness Program
4. Print out your fitness card, take it to the fitness facility, and start exercising

To learn more, find a fitness center near you or to enroll into the Home Fitness program, visit www.SilverandFit.com or call Silver&Fit toll-free at 1-877-427-4788 (TTY/TDD 711), Monday through Friday, 5 a.m. to 6 p.m. PST

GET STARTED WITH ONE PASS

1. Visit youronepass.com
2. Click "Get Started" to register. Enter in your First Name, Last Name, Date of Birth, and Health Plan Member ID.
3. Once you've registered, you'll receive a Member Code. Be sure to write down your code and keep it handy. You will need to enter it each time you register for a new fitness location or other One Pass service.
4. Start searching for gyms by clicking on the "Find a gym" page.

You may also call **1-877-614-0618** (TTY **711**), Monday through Friday, 6 a.m. to 7 p.m. PST, to receive your member code.

Silver & Fit for Blue Shield Members

The Silver&Fit® Exercise and Healthy Aging Program is available to all who are enrolled in our Blue Shield 65+ HMO Medicare Advantage or CompanionCare plans.

Did you know that as a Silver&Fit member, you can go to a fitness center and not pay a thing? It's true! Some have classes designed for older adults that you might like. They may also offer dance or yoga studios and/or swimming pools[1].

Don't want to go to a fitness center? No problem! You can enroll in the Home Fitness program and choose up to 2 Home Fitness Kits each benefit year. These kits may include DVDs, guides, and other items to help you get fit on your own terms.

All members can also get:

- ✓ Healthy Aging classes 4 times a year (online or by mail)
- ✓ The Silver Slate® newsletter 4 times a year (online, by email, or by mail)
- ✓ The Silver&Fit Connected!™ program, a fun and easy way to track your exercise at a fitness center or through a wearable fitness device or app and earn rewards[2].
- ✓ Other web tools like a fitness center search, challenges[2], and online classes

[1] Services that call for an added fee are not part of the Silver&Fit program and any additional fees are not included.
[2] Rewards subject to change; purchase of a wearable fitness device or application may be required and is not reimbursed by the Silver&Fit program.

One Pass for Kaiser Permanente Members

The One Pass Fitness Program can help Kaiser Senior Advantage (HMO) plan members find a fitness routine that's right for you. Whether you work out at home or at the gym, stay active and thrive, at no additional cost to you. Work out your way and find your fit:

- ✓ At the Gym: Choose from the largest nationwide network of gyms and fitness locations. Visit any place in the network and create a routine just for you.
- ✓ Brain Training: Get a complete brain workout, including an initial cognitive test and an ongoing brain training program.
- ✓ At Home: Work out at home with live, digital fitness classes or on-demand workouts. Plus, use the custom workout builder to create routines tailored to your fitness level and interests.
- ✓ With New Friends: Join a group class or find local clubs and social events that match your interests.

IMPORTANT PLAN INFORMATION

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

- Your Cost of Coverage
- Plan Contacts
- Mobile Resources
- A Benefits Glossary to help you understand important insurance terms.

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

COST OF COVERAGE – CLASSIFIED & POLICE OFFICERS ASSOCIATION (POA)

South Orange County Community College District pays for the full cost of medical, dental, and vision coverage for Retirees under the age of 65. Retirees 65+ are eligible to purchase these plans through the District on a self-pay basis provided that you enroll in Medicare A and B. The costs shown below are monthly.

MEDICAL

RETIREE PAID (Voluntary/Self-Pay)				
	Retiree	Retiree + 1	Retiree + Family	Composite
Blue Shield PPO (Retirees 65+ with dependents under age 65)	N/A	N/A	N/A	$2,476.00
Medicare PPO COB w/ Blue Shield (when enrolled in Medicare A and B)	$959.00	$1,918.00	$2,450.00	N/A
Medicare HMO COB w/ Blue Shield (when enrolled in Medicare A and B)	$964.00	$1,928.00	$2,409.00	N/A
CompanionCare 65+ Medicare Supplement (when enrolled in Medicare A & B)	$469.00	N/A	N/A	N/A
Blue Shield 65+ HMO Medicare Advantage (when enrolled in Medicare A & B)	$418.00	N/A	N/A	N/A
Kaiser 65+ Senior Advantage HMO Medicare (when enrolled in Medicare A & B)	$230.00	$460.00	$1,073.00	N/A

Available to Spouse/Domestic Partner 65+	Spouse/Domestic Partner 65+
Blue Shield COB PPO (when enrolled in Medicare A & B)	$959.00
Blue Shield COB HMO (when enrolled in Medicare A & B)	$964.00
CompanionCare 65+ Medicare Supplement (when enrolled in Medicare A & B)	$469.00
Blue Shield 65+ HMO Medicare Advantage (when enrolled in Medicare A & B)	$418.00
Kaiser 65+Senior Advantage HMO Medicare (when enrolled in Medicare A & B)	$230.00

DENTAL

	Retiree	Retiree + 1	Retiree + Family
Delta Dental PPO	$123.90	$210.70	$322.30

VISION

	Retiree	Retiree + 1	Retiree + Family
Vision Service Plan (VSP)	$38.90	$77.90	$91.50

COST OF COVERAGE – FACULTY / CLASSIFIED MANAGERS & ADMINISTRATORS

South Orange County Community College District pays for the full cost of medical, dental, and vision coverage for Retirees under the age of 65 and their dependents. Retirees 65+ will receive the District paid Blue Shield COB PPO or HMO medical plan provided that you enroll in Medicare A and B, as well as VSP vision benefits for you as the Retiree. You also have the option of enrolling in either the CompanionCare 65+ Medicare Supplement plan, the Blue Shield 65+ HMO Medicare Advantage plan, or the Kaiser 65+ Senior Advantage HMO Medicare plan on a self-pay basis. Please note that once you enroll in one of the self-pay plans, you cannot return to the District paid Blue Shield COB PPO or HMO plan. Eligible dependents for Retirees 65+ are able to purchase a medical plan through the District on a self-pay basis. You can purchase the District dental and dependent vision coverage on a self-pay basis. The costs shown below are monthly.

MEDICAL

DISTRICT PAID (Retiree Only)	
Blue Shield COB PPO (when enrolled in Medicare A & B)[1]	$959.00
Blue Shield COB HMO (when enrolled in Medicare A & B)[1]	$964.00
RETIREE PAID (Voluntary/Self-pay)	
CompanionCare 65+ Medicare Supplement (when enrolled in Medicare A & B)	$469.00
Blue Shield 65+ HMO Medicare Advantage (when enrolled in Medicare A & B)	$418.00
Kaiser 65+ Senior Advantage HMO Medicare (when enrolled in Medicare A & B)	$230.00
Available to Spouse/Domestic Partner 65+ on a Voluntary/Self-pay Basis[2]	
Blue Shield PPO (for Spouse/DP under age 65)	$1,517.00[3]
Blue Shield COB PPO (when enrolled in Medicare A & B)	$959.00
Blue Shield COB HMO (when enrolled in Medicare A & B)	$964.00
CompanionCare 65+ Medicare Supplement (when enrolled in Medicare A & B)	$469.00
Blue Shield 65+ HMO Medicare Advantage (when enrolled in Medicare A & B)	$418.00
Kaiser (for Spouse/DP under age 65)	$2,033.00[3]
Kaiser 65+ Senior Advantage HMO Medicare (when enrolled in Medicare A & B)	$230.00

1. The District will provide supplemental medical coverage for the eligible retiree provided the Retiree has purchased Medicare A and B coverage. If the Retiree has not purchased Medicare A and B coverage, the Retiree pays the difference between the cost of the insurance and the cost of the District paid insurance, including any penalty, fee, or other cost imposed by the insurance carrier unless the Retiree elects to decline coverage.
2. The Retiree must pay for their dependent's coverage if the Retiree wishes to continue such coverage.
3. Rate assumes enrollment with Retiree, and not offered as a stand-alone. You, the Retiree, must enroll in Medicare A and B, and supply the District with a copy of your Medicare Card. You are then able to purchase the Blue Shield PPO medical plan for your dependent(s) at the current cost of ($1,517) per month. The cost of dependent coverage is usually calculated by subtracting the District's cost of the Blue Shield COB PPO medical plan ($959) from the cost of the Blue Shield PPO medical plan ($2,476). For Kaiser HMO, you pay the difference between the Kaiser Active composite rate ($2,263) per month and the Kaiser HMO 65+ ($230) per month, so you can purchase the Kaiser HMO medical plan for your dependent(s) at the current cost of ($2,033) per month.

DENTAL

	Retiree	Retiree + 1	Retiree + Family
Delta Dental PPO	$123.90	$210.70	$322.30

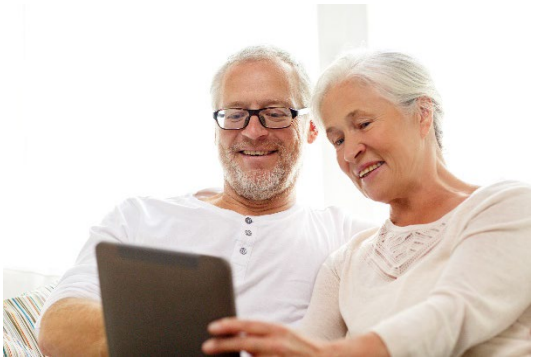
VISION

	Retiree	Retiree + 1	Retiree + Family
Vision Service Plan (VSP)	$38.90	$39.00	$52.60

PLAN CONTACTS

Provider	Phone Number	Website	Policy/Group #
Blue Shield/SISC HMO	(855) 256-9404	blueshieldca.com/SISC	See ID Card
Blue Shield 65+ HMO Medicare Advantage	(800) 776-4466	blueshieldca.com	N/A
Blue Shield/SISC PPO	See ID Card	blueshieldca.com/SISC	See ID Card
Blue Shield Concierge	(855) 599-2657	blueshieldca.com/SISC	See ID Card
CalPERS	(888) 225-7377	calpers.ca.gov	N/A
Carrum Health	(888) 855-7806	carrumhealth.com	N/A
CompanionCare	(800) 825-5541	blueshieldca.com	N/A
Costco Mail Order Pharmacy (for Blue Shield HMO members)	(800) 774-2678 (press 1)	costco.com	N/A
Costco Pharmacy (for Blue Shield PPO Members)	(800) 607-6861	costco.com/home-delivery	N/A
Delta Dental/ACSIG DPPO	(866) 499-3001	deltadentalins.com	0928
District Benefits	(949) 582-4898	socccd.edu/humanresources /Employee-Benefits.html	N/A
Fitness Your Way through Tivity Health (for Blue Shield members)	(833) 283-8387	fitnessyourway.tivityhealth.com/bsc	N/A
Kaiser Permanente	(800) 464-4000	kp.org/sisc	231876
Medicare	(800) 633-4273	www.medicare.gov	N/A
Medicare Prescriptions	(866) 270-3877	N/A	N/A
MDLIVE 24/7 Program (for Blue Shield PPO and HMO members)	(800) 657-6169	mdlive.com/sisc	N/A
Navitus Prescriptions (for Blue Shield PPO and HMO members)	(866) 333-2757	navitus.com	N/A
NurseHelp 24/7 Program (for Blue Shield HMO members)	See ID Card	blueshieldca.com	N/A
One Pass Fitness Program (Kaiser)	(877) 614-0618	youronepass.com	Kaiser Member ID
Silver&Fit Fitness Program (Blue Shield 65+)	(877) 427-4788	SilverandFit.com	N/A
STRS	(800) 228-5453	calstrs.com	N/A
Teladoc Medical Experts	(800) 835-2362	teladoc.com/sisc	N/A
Vision by VSP/ACSIG	(800) 877-7195	vsp.com	30098994
WEX Inc.	(866) 451-3399	wexinc.com	23192

MOBILE RESOURCES



ACCESS YOUR BENEFITS ANYTIME, ANYWHERE

Most of our carriers and vendors have mobile apps available making accessing your benefits information easier than ever.

Just download the apps via the Apple App Store and Google Play and make sure to share with your dependents!

Download on the App Store

GET IT ON Google Play

- **BLUE SHIELD:** Blue Shield members have quick and easy access to important benefits information anytime, anywhere with the Blue Shield of California mobile website and mobile apps. View your deductible and co-payment year-to-date totals, benefits information, view claims, view ID cards, and find a p provider or urgent care. Visit blueshieldca.com or download the Blue Shield of California mobile app.
- **KAISER:** Kaiser's website and mobile app makes it easier to engage in your own well-being – you can also avoid unnecessary office visits and time away from work. Download the Kaiser Permanente app at no cost from your preferred app site. Use convenient features such as:
    - Email your doctor's office
    - View most test results or past visits
    - Schedule or cancel routine appointments
    - Refill most prescriptions
- **DELTA DENTAL:** Delta Dental's mobile website and mobile application allows members to find a dentist, user musical timer to brush teeth for the recommended 2 minutes, view your benefits, eligibility, deductibles and maximums, and check claims. Visit deltadentalins.com or download the free app titled **Delta Dental** by Delta Dental Plan Association on the App Store or Google Play.
- **VSP:** VSP's mobile website, vsp.com, allows members to find a doctor, access your member vision card, view exclusive member extras, and get important information on a variety of topics regarding eye care to maintain optimal eye health.

GLOSSARY

-A-

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

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

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

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

-B-

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

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

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

-C-

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

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

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

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

-D-

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

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

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

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

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

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

-E-

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

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

-F-

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

-G-

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

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

-H-

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

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

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

GLOSSARY

-I-

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

-L-

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

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

-M-

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

-O-

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

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

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

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

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

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

-P-

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

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

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

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

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

-S-

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

-T-

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

-U-

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

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

-V-

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

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

IMPORTANT PLAN INFORMATION

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

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

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

View a sample notice and consent form (PDF).

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

IMPORTANT PLAN INFORMATION

HEALTH PLAN NOTICES

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

- **Medicare Part D Notice:** Describes options to access prescription drug coverage for Medicare eligible individuals
- **Women's Health and Cancer Rights Act:** Describes benefits available to those that will or have undergone a mastectomy
- **Newborns' and Mothers' Health Protection Act:** Describes the rights of mother and newborn to stay in the hospital 48-96 hours after delivery
- **HIPAA Notice of Special Enrollment Rights:** Describes when you can enroll yourself and/or dependents in health coverage outside of open enrollment
- **HIPAA Notice of Privacy Practices:** Describes how health information about you may be used and disclosed
- **Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP):** Describes availability of premium assistance for Medicaid eligible dependents.
- **Notice of Choice of Providers:** Notifies you that your plan requires you to name a Primary Care Physician (PCP) or provides for you to select one

COBRA CONTINUATION COVERAGE

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

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

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

Medicare Part D Notice

Important Notice from South Orange County Community College District About Your Prescription Drug Coverage and Medicare

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

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

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

When Can You Join A Medicare Drug Plan?

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

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

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

If you decide to join a Medicare drug plan, your South Orange County Community College District coverage will not be affected. See below for more information about what happens to your current coverage if you join a Medicare drug plan.

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

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

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

You should also know that if you drop or lose your current coverage with South Orange County Community College District and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

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

For More Information About This Notice Or Your Current Prescription Drug Coverage...

Contact the Benefits department listed below for further information. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through South Orange County Community College District changes. You also may request a copy of this notice at any time.

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

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

For more information about Medicare prescription drug coverage:

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

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

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

Date:	October 1, 2025
Name of Entity/Sender:	South Orange County Community College District
Contact-Position/Office:	Benefits Department
Address:	28000 Marguerite Parkway, Mission Viejo, CA 92692
Phone Number:	(949) 582-4898

Women's Health and Cancer Rights Act

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

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Contact your health plan's Member Services for more information.

Newborns' and Mothers' Health Protection Act

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

HIPAA Notice of Special Enrollment Rights

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

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

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

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

Availability of Privacy Practices Notice

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

Availability of Summary Information

As an employee, the health benefits provided by South Orange County Community College District represent a significant component of your compensation package. They also provide important protection for you and your family in the case of illness or injury.

South Orange County Community College District offers a variety of benefit plans to eligible employees. The federal health care reform law requires that eligible members of an employer plan receive a Summary of Benefits and Coverage (SBC) for any medical and pharmacy plans available. The SBC is intended to provide important plan information to individuals, such as common benefit scenarios and definitions for frequently used terms. The SBC is intended to serve as an easy-to-read, informative summary of benefits available under a plan. SBCs and any revisions or amendments of the plans offered by South Orange County Community College District are available by contacting Benefits.

Notice of Choice of Providers

The Blue Shield and Kaiser Permanente HMO plan generally requires the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. Until you make this designation, Blue Shield designates one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact your insurance carriers directly.

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

ACA Disclaimer

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

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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of **March 17, 2025**. Contact your State for more information on eligibility—

ALABAMA – Medicaid
Website: http://myalhipp.com/ | Phone: 1-855-692-5447
ALASKA – Medicaid
The AK Health Insurance Premium Payment Program | Website: http://myakhipp.com/ | Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com | Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid
Website: http://myarhipp.com/ | Phone: 1-855-MyARHIPP (855-692-7447)
CALIFORNIA – Medicaid
Health Insurance Premium Payment (HIPP) Program website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 | Fax: 916-440-5676 | Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943 | State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991 | State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ | HIBI Customer Service: 1-855-692-6442
FLORIDA – Medicaid
Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268
GEORGIA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra | Phone: 678-564-1162, press 2

INDIANA – Medicaid
Health Insurance Premium Payment Program All other Medicaid Website: https://www.in.gov/medicaid/ | http://www.in.gov/fssa/dfr/ | Family and Social Services Administration Phone: (800) 403-0864 | Member Services Phone: (800) 457-4584
IOWA – Medicaid and CHIP (Hawki)
Medicaid Website: Iowa Medicaid | Health & Human Services | Medicaid Phone: 1-800-338-8366 Hawki Website: Hawki - Healthy and Well Kids in Iowa | Health & Human Services | Hawki Phone: 1-800-257-8563 HIPP Website: Health Insurance Premium Payment (HIPP) | Health & Human Services (iowa.gov) HIPP Phone: 1-888-346-9562
KANSAS – Medicaid
Website: https://www.kancare.ks.gov/ | Phone: 1-800-792-4884 | HIPP Phone: 1-800-967-4660
KENTUCKY – Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx | Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kynect.ky.gov | Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms
LOUISIANA – Medicaid
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 | TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 800-977-6740 | TTY: Maine relay 711
MASSACHUSETTS – Medicaid and CHIP
Website: https://www.mass.gov/masshealth/pa | Phone: 1-800-862-4840 | TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid
Website: https://mn.gov/dhs/health-care-coverage/ | Phone: 1-800-657-3672
MISSOURI – Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm | Phone: 573-751-2005
MONTANA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 | email: HHSHIPPProgram@mt.gov
NEBRASKA – Medicaid
Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 | Lincoln: 402-473-7000 | Omaha: 402-595-1178
NEVADA – Medicaid
Medicaid Website: http://dhcfp.nv.gov | Medicaid Phone: 1-800-992-0900
NEW HAMPSHIRE – Medicaid
Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 | Toll-free number for the HIPP program: 1-800-852-3345, ext. 15218 Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov
NEW JERSEY – Medicaid and CHIP
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ | Phone: 800-356-1561 CHIP Premium Assistance Phone: 609-631-2392 | CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710 (TTY: 711)
NEW YORK – Medicaid
Website: https://www.health.ny.gov/health_care/medicaid/ | Phone: 1-800-541-2831

NORTH CAROLINA – Medicaid
Website: https://medicaid.ncdhhs.gov/ | Phone: 919-855-4100
NORTH DAKOTA – Medicaid
Website: https://www.hhs.nd.gov/healthcare | Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP
Website: http://www.insureoklahoma.org | Phone: 1-888-365-3742
OREGON – Medicaid and CHIP
Website: http://healthcare.oregon.gov/Pages/index.aspx | Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP
Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html | Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) | CHIP Phone: 1-800-986-KIDS (5437)
RHODE ISLAND – Medicaid and CHIP
Website: http://www.eohhs.ri.gov/ | Phone: 1-855-697-4347 or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid
Website: https://www.scdhhs.gov | Phone: 1-888-549-0820
SOUTH DAKOTA – Medicaid
Website: http://dss.sd.gov | Phone: 1-888-828-0059
TEXAS – Medicaid
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493
UTAH – Medicaid and CHIP
Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/ Email: upp@utah.gov | Phone: 1-888-222-2542 | Adult Expansion Website: https://medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/ CHIP Website: https://chip.utah.gov/
VERMONT – Medicaid
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427
VIRGINIA – Medicaid and CHIP
Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select or https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid
Website: https://www.hca.wa.gov/ | Phone: 1-800-562-3022
WEST VIRGINIA – Medicaid and CHIP
Website: https://dhhr.wv.gov/bms/ or http://mywvhipp.com/ Medicaid Phone: 304-558-1700 | CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm | Phone: 1-800-362-3002
WYOMING – Medicaid
Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ | Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since March 17, 2025, or for more information on special enrollment rights, contact either:

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

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

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