WELCOME TO OPEN ENROLLMENT

EMPLOYEE BENEFIT GUIDE

Plan Year: 2024 - 2025

PICK THE BEST BENEFITS FOR YOU AND YOUR FAMILY.

San Bernardino Community College District (SBCCD) strives to provide you and your family with a comprehensive and valuable benefits package. We want to make sure you're getting the most out of our benefits—that's why we've put together this Open Enrollment Guide.

Open enrollment is a short period each year when you can make changes to your benefits. This guide will outline all of the different benefit offerings, so you can identify which offerings are best for you and your family.

Elections you make during open enrollment will become effective on October 1, 2024. If you have questions about any of the benefits mentioned in this guide, please do not hesitate to reach out to Human Resources at 909-388-6950.

Table of Content

WHO IS ELIGIBLE?

You are eligible for coverage if you are employed at a minimum of 20 hours per week for Classified and Management Employees, or at a minimum of 30 hours per week for Certificated Employees.

DEPENDENT ELIGIBILITY

Your eligible dependents for coverage include:

- Your legal spouse, registered domestic partner, and children to age 26.
- Children include your natural children, children placed for adoption, and stepchildren.
- Fully disabled children defined as (a) incapable of self-sustaining employment by reason of mentalor physical handicap and (b) chiefly dependent upon the eligible employee for economic supportand maintenance.
- Legal guardianship with court filed documents (must be shown as a dependent on most recent federal income tax return).

DEPENDENT ELIGIBILITY AUDIT

During your initial enrollment or if you are adding new dependents, you must provide proof of dependent eligibility based on the above requirements. If proof of eligibility is not received within 30 days from the date of the request, your dependent will be removed from your policy retroactive to the effective date.

Dependent Type	Required Documentation
Spouse	• 2022 or 2023 Federal Tax Form that shows the couple was married (financial information may be blocked out). • In lieu of the tax form, a marriage certificate will be accepted along with a notarized affidavit.
Domestic Partner	• Certificate of Registered Domestic Partnership issued by State of California (Enrolling a Domestic Partner may cause the employer contribution to become taxable)
Children, Stepchildren, and/or Adopted Children up to age 26	• Legal Birth Certificate or Hospital Birth Certificate (to include full name of child, parent(s) name, and child's DOB) • Legal Adoption Documentation
Legal Guardianship up to age 18	• Legal U.S. Court Documentation establishing Guardianship

Disabled Dependents over age 26	Anthem Blue Cross (All items listed below are required) • Legal Birth Certificate or Hospital Birth Certificate (to include full name of child, parent(s) name and child's DOB) • Prior year's Federal Tax Form that shows child is claimed as an IRS dependent (income information may be blocked out) • Proof of 6 months prior creditable coverage • Completed Anthem Disabled Dependent Certification Form Kaiser (All items listed below are required) • Legal Birth Certificate or Hospital Birth Certificate (to include full name of child, parent(s) name and child's DOB) • Prior year's Federal Tax Form that shows child is claimed as an IRS dependent (income information may be blocked out) • Proof of 6 months prior creditable coverage • Completed Disabled Dependent Enrollment Application • Most recent Kaiser Certification notice (if available)

WHEN TO ENROLL

Open enrollment begins on Monday, August 12, 2024 and runs through Friday August 23, 2024. The benefits you choose during open enrollment will be effective on October 1, 2024.

HOW TO ENROLL

Are you ready to enroll? The first step is to review your current benefits. Did you move recently or get married? Verify all your personal information and make any necessary changes.

Once all your information is up to date, it is time to make your benefit elections. The decisions you make during open enrollment can have a significant impact on your life and finances, so it is important to weigh your options carefully.

You can enroll through American Fidelity secure online system that is accessible from any desktop browser. The site also contains educational benefit enrollment preparation videos and to answer questions you may have.

HOW TO LOGIN ON AMERICAN FIDELITY ONLINE ENROLLMENT SYSTEM

A complete step-by-step instruction to enroll and make changes to any of your benefits are on page 19 of this guide.

WHAT HAPPENS IF I DON'T RE-ENROLL IN MY BENEFITS?

If you are not making changes to your plans, the District will automatically re-enroll you and your dependents on the same plan(s) you enrolled in 2024/2025 except for the Anthem Select plan and for the Flexible Spending Account/Dependent Spending Account.

If you and your dependents; if any, are enrolled on Anthem Select HMO and do nothing; you and your dependents will automatically enroll on the Anthem Classic HMO $20, and you will be receiving a new ID card(s) in the mail with the new plan information.

If you are enrolled in the Flexible Spending Account/Dependent Spending Account, you will no longer be enrolled in these benefits as of October 1, 2024. **You must reenroll in these two plans** every Open Enrollment to continue coverage into next plan year per the IRS requirement.

OPEN ENROLLMENT WEBINARS?

During these webinars, the District will discuss the new options and vendors will be available to answer any questions you might have. A link will be provided via email.

Date	Time
Thursday August 15, 2024	10:00 am – 11:30 am
Tuesday August 20, 2024	1:00 pm – 2:30 pm
Wednesday August 21, 2024	4:00 pm – 5:30 pm

QUALIFYING EVENTS

Unless you experience a life-changing qualifying event, you cannot make changes to your benefits until the next open enrollment period. Qualifying events include but are not limited to:

- Marriage, divorce or legal separation.
- Birth or adoption of a child.
- Death of a spouse, child or other qualified dependent.
- Change in employment status or a change in coverage under another employer-sponsored plan.

CAN I WAIVE COVERAGE

You can only waive medical coverage, if:

- You show proof of your other medical coverage.
- You complete a Medical Opt-Out/Waiver form each year.

DO I HAVE TO CONTACT AMERICAN FIDELITY?

Yes, you will need to either call an American Fidelity Enrollment Specialist or enroll online through the American Fidelity enrollment portal if:

- You wish to participate or continue in the Health Care Flexible Spending Account (FSA) or Dependent Day Care Spending Account for 2024–2025.
- You wish to enroll or make change to your Disability, Cancer, Whole Life Insurance Plan or Accident Plans.

Enroll by phone by calling 800-365-9180, ext. 0 or to set up a one-on-one meeting. Customer Services is available Monday through Friday from 5:00 am PDT and 5:00 pm pacific daylight time.

What Is Changing for 2024 – 2025?

The following changes will take effect as of October 1, 2024:

Anthem Blue Cross HMO plans:

- The Anthem Select HMO $10 plan will be replaced with Anthem full-network Classic $20.

Delta Dental PPO Plan:

- The annual in-network plan maximum will increase from $2,500 to $3,000. The out-of-network annual maximum will continue to be $2,500. Both in and out-of-network plan maximums are combined.

SELF-INSURED SCHOOLS OF CALIFORNIA (SISC) VALUE ADDED SERVICES

- TeleDoc Opinions: Advance Medical provides members with access to the best health care possible by assisting patients with any and all healthcare questions. The benefit also provides access to medical opinions from world-leading experts without having to leave home. To find out more you, you can call 800-835-2362 or go to www.teledoc.com/sisc
- Free Generic Medication through *Costco*: Anthem Blue Cross HMO and PPO members can receive free generic medications at Costco and through Costco mail order (excludes certain pain and cough medications). Members take prescriptions to Costco pharmacy; no need to be a Costco member.
- *MD*Live: Anthem Blue Cross PPO and HMO members can consult with doctors and therapists over thephone or using online video for varies medical conditions. Online behavioral health visits are also available for confidential sessions with a licensed therapist or psychiatrist. Copay applies. To find out more, you can call 888-632-2738 or go to www.mdlive.com/sisc
- Enhanced Cancer Benefits: Available to Anthem PPO members. Consult experts who can help you navigate the complex world of cancel treatment. Services include assistance in receiving an accurateinitial diagnosis and developing a comprehensive care plan. To find out more about this program you cancall 877-220-3556 or go to www.sisc.contigonhealth.com

- Vida Health: This is a digital coaching app and available to Anthem HMO and PPO members that are 18 and older. Get one-on-one coaching, therapy and other tools and resources via online or mobile access. To find out more about this program you can call 855-442-5885 or go to www.vida.com/sisc
- Hinge Health: This is available to Anthem PPO members. Get access to free wearable sensors and monitoring devices, unlimited one-on-one coaching and personalized exercise therapy. To find out moreabout this program you can go to www.cancercaredirect.com
- Carrum Health: This is available to Anthem PPO members. Consult top-quality surgeons on hip and knee replacement and certain spine surgeries. Benefit covers all related travel and medical bills. To find out moreabout this program you can call 888-855-7806 or go to www.carrumhealth.com/sisc
- Mavens: This is available to Anthem PPO members. Free access to Maven virtual care for pregnancy and postpartum support including 24/7 access to doctors, specialists, coaches and trustworthy content tailored to your experience. To find out more about this program go to www.mavinclinic.com/join/sisc
- Eden Health Primary Care: Clinical evidence supports that having a relationship with a primary care provider improves health outcomes and lowers costs. That's why we encourage our membership to establish a relationship with a primary care provider. Eden is a way we can expand that access.

EMPLOYEE CONTRIBUTIONS – 2024/2025

Deductions are tenthly

No deductions taken from June and July paychecks

Plan Name	Per Paycheck Deduction
Medical	
Anthem Blue Cross California Care Classic HMO $20	$0.00
Anthem Blue Cross California Care Premier HMO $10	$99.60
Anthem Blue Cross PPO 90C (low)	$314.40
Anthem Blue Cross PPO 100A (high)	$559.20
Kaiser Permanente $30	$210.00
Kaiser Permanente $10	$285.60
Dental	
DeltaCare HMO	$0.00
Delta Dental PPO	$60.72
Vision	
EyeMed	$0.00

MEDICAL INSURANCE

SBCCD will continue to partner with Anthem Blue Cross of California and Kaiser Permanente for your 2024 – 2025 medical plans:

The following options will be available through Anthem Blue Cross of California:

Anthem California Care HMO Premier and Classic plans offer a full network HMO coverage: These plans are designed to provide you and your family with access to one of the largest healthcare provider networks in the state with over 104,000 providers.

Premier HMO $10 Copay: members on this plan experience a lower out of pocket expenses for medical services. Members have lower copayments for primary care office visits, outpatient procedures, lab tests and hospital services.

Classic HMO $20 Copay: members on this plan experience a higher out of pocket expenses for medical services compared to the HMO Premier $10 Copay plan. The same medical services and prescriptions are covered as with the HMO Premier $10 copay plan, except members will have a higher out of pocket cost for most of these same services.

Anthem PPO: These plans will be more affordable and provides direct access to the physicians and specialists in Anthem Blue Cross preferred network, plus the option to go out of network.

Anthem Blue Cross members will have one ID card for both medical and pharmacy services.

The Kaiser Permanente medical plan designs offered are:

HMO $10 Copay: members on this plan experience a lower out of pocket expenses for medical services and prescriptions. Members have lower copayments for primary care office visits, outpatient procedures, lab tests, emergency room care and prescriptions.

HMO $30 Copay: members on this plan experience a higher out of pocket expenses for medical services and prescriptions compared to the HMO $10 Copay plan. The same medical services and prescriptions are covered as with the HMO $10 copay plan, except members might have a higher out of pocket cost for these same services.

Kaiser Permanente members will have one ID card for both medical and pharmacy services.

HMO MEDICAL INSURANCE

HMO Plans Features	Anthem Blue Cross		Kaiser Permanente	
	Premier $10 (Full Network)	Classic $20 (Full Network)	$10	$30
Primacy Doctor & Specialist visits	$10 copay	$20/$40 copay	$10 copay	$30 copay
MDLive consultation (PCP/Specialist)	$0/$10 copay	$0/$40 copay	n/a	n/a
Out-of-Pocket Maximum *(Individual / Family)*	$1,000 / $2,000	$2,000 / $4,000	$1,500 / $3,000	$1,500 / $3,000
Lifetime Plan Maximum	Unlimited			
Annual Physical Exams with Preventive Tests	100%	100%	100%	100%
Diagnostic X-Ray and Lab Tests	100%	100%	100%	100%
Advanced Diagnostic Imaging	$100 copay/test	$100 copay/test	100%	100%
Semi-Private Room & Board; including Services and Supplies	100%	$250 / admission	100%	100%
Prenatal and Post-natal Care	$10 copay	$20 copay	100%	100%
Surgical Services *(Outpatient Facility)*	100%	$125 / visit	$10 / procedure	$30 / procedure
Emergency Services *(Emergency Room)*	$100 copay waived if admitted	$100 copay waived if admitted	$100 copay waived if admitted	$100 copay waived if admitted
Ambulance (Air/Ground)	$100 copay/trip	$100 copay/trip	$50 copay / trip	$50 copay / trip
Urgent Care Facility	$10 copay	$20 copay	$10 copay	$30 copay
Mental Health Benefits				
Inpatient Care	100%	100%	100%	100%
Outpatient Care (routine)	$10 copay	$10 copay	$10 copay / individual visit $5 copay / group	$30 copay / individual visit $15 copay / group
Substance Abuse				
Inpatient Hospitalization	100%	$250 / admission	100%	100%
Outpatient Services (routine)	$10 copay	$20 copay	$10 copay / individual visit $5 copay / group	$30 copay / individual visit $5 copay / group
Durable Medical Equipment	100%	80%	100%	100%
Hearing				
Exam	50% coinsurance/aid/36 months	50% coinsurance/aid/36 months	Amount in Excess of $2,000/Aid/36 months	Amount in Excess of $2,000/Aid/36 months
Aid(s)				

This is a high-level benefit summary and does not override carrier evidence of coverage booklet.

HMO MEDICAL INSURANCE (continued)

HMO Plans Features (Continued)	Anthem Blue Cross		Kaiser Permanente	
	Premier $10 (Full Network)	Classic $20 (Full Network)	$10	$30
Chiropractic & Acupuncture Services	$10 copay 30 visits / cal year; Combined with Acupuncture through ASH	$10 copay 30 visits / cal year; Combined with Acupuncture through ASH	$10 copay limited to 30 visits/year Combined with Acupuncture through ASH	$10 copay limited to 30 visits/year Combined with Acupuncture through ASH
Prescription Drugs				
Retail (up to 30 days)				
Out-of-Pocket Maximum (Individual / Family)	$2,500 / $3,500	$2,500 / $3,500	N/A	N/A
Generic or Tier 1	$9 copay/**Free at Costco***	$9 copay/**Free at Costco***	$10 copay	$10 copay
Brand or Tier 2	$35 copay	$35 copay	$10 copay	$30 copay
Specialty Drugs (through Navitus)	$35 copay#	$35 copay#	$10 copay	$30 copay
Mail Order *(90-day Supply with Anthem BC and up to 100 days with Kaiser)*				
Generic or Tier 1	Free through Costco*	Free through Costco*	$10 copay	$10 copay
Brand or Tier 2	$90 copay	$90 copay	$10 copay	$30 copay

This is a high-level benefit summary and does not override carrier evidence of coverage booklet.

* Some narcotic pain and cough medications are not included in the Costco Free Generic or 90-day supply programs.

Specialty drugs are only available through Navitus pharmacy. Maximum 30 day supply

Walgreen is not part of SISC/Anthem pharmacy network

PPO MEDICAL INSURANCE

PPO Plans Features	Anthem Blue Cross PPO 100-A		Anthem Blue Cross PPO 90-C	
	In-Network Provider	Non-Network Provider	In-Network Provider	Non-Network Provider
Annual Deductible (4th QTR carryover)	$0 single/ $0 family	N/A	$200 single/ $500 family	
Coinsurance	0% coinsurance	Varies based on service	90% coinsurance	Varies based on service
Primary Care (PCP)/Specialist visit	$10 copay (1st 3 visits $0 for PCP only)	See footnote 1	$20 copay (1st 3 visits $0 for PCP only)	See footnote 1
MDLive Consultation	$10 copay	Not Covered	$10 copay	Not Covered
Out-of-Pocket Maximum	$1,000 Individual / $3,000 Family	No Limit	$1,000 Individual / $3,000 Family	No Limit
Lifetime Plan Maximum	Unlimited		Unlimited	
Diagnostic X-Ray and Lab Test	100%	Not Covered	90%	Not Covered
Advanced Diagnostic Imaging	100%	Limited to $800 maximum per test	90%	Limited to $800 maximum per test
Semi-Private Room & Board; including Services and Supplies	100%	See footnote 1	90%	See footnote 1
Pregnancy & Maternity Care *(Pre-Natal Care)*	$10 copay	See footnote 1	$20 copay	See footnote 1
Outpatient Facility Services	100%; - exceptions to certain procedures apply[2]	See footnote 1 - Ambulatory Center is limited to $350 maximum per day	90%; - exceptions to certain procedures apply[2]	See footnote 1 - Ambulatory Center is limited to $350 maximum per day
Emergency Services *(Emergency Room)*	$100 copay (waived if admitted)		$100 copay + 10% coinsurance (waived if admitted)	
Ambulance (Air or Ground)	$100 copay per trip	Covered as in-network for true emergency	$100 copay + 10% per trip	Covered as in-network for true emergency
Durable Medical Equipment	100%	Not Covered	90%	Not Covered
Chiropractic Services	100% (subject to medical necessity)	Not Covered	90% (subject to medical necessity)	Not Covered
Acupuncture	100% (limited to 12 visits/cal year) combined with non-network	50% of maximum allowed amount (limited to 12 visits/cal year) combined with network	90% (limited to 12 visits/cal year and combined with non-network)	50% of maximum allowed amount (limited to 12 visits/cal year) combined with network
Hearing Aid	Limited to $700/24 months	Not Covered	Limited to $700/24 months	Not Covered
Prescription Drugs				
Out-of-Pocket Maximum	$2,500 Individual / $3,500 Family	N/A	$2,500 Individual / $3,500 Family	N/A
Retail (up to 30 days)				
Generic or Tier 1	$9 copay/Free at Costco*	Not Covered	$9 copay/Free at Costco*	Not Covered
Brand or Tier 2	$35 copay	Not Covered	$35 copay	Not Covered
Specialty Drugs (throught Navitus)	$35 copay#	Not Covered	$35 copay#	Not Covered
Mail Order (90-day Supply)				
Generic or Tier 1	Free at Costco*	Not Covered	Free at Costco*	Not Covered
Brand or Tier 2	$90 copay	Not covered	$90 copay	Not covered

This is a high-level benefit summary and does not override carrier evidence of coverage booklet.

[1] When using Non-Network PPO Providers, members are responsible for any difference between the maximum allowed and actual charges, as well as any deductible & percentage copay

2 Services such arthroscopy, cataract surgery, colonoscopy, Upper GI with and without biopsy have a limited benefit amount. Make sure you contact Anthem before services rendered or review Anthem Benefit Summary

* Some narcotic pain and cough medications are not included in the Costco Free Generic or 90-day supply programs.

Specialty drugs are only available through Navitus pharmacy

Not all services apply towards the deductible. Please review the detailed benefit summary for each plan to determine what applies towards the deductible.

Walgreen is not part of SISC/Anthem pharmacy network

DENTAL INSURANCE

DELTA DENTAL®

In addition to protecting your smile, dental insurance helps pay for dental care and usually includes regular checkups, cleanings and X-rays. Several studies suggest that oral diseases, such as periodontitis (gum disease), can affect other areas of your body—including your heart. Receiving regular dental care can protect you and your family from the high cost of dental disease and surgery.

We are excited to inform you that Delta Dental PPO Plan: the in-network plan calendar year maximums will increase to $3,000/member as of October 1, 2024. The out-of-network plan calendar year will continue to be $2,500. In and out-of-network calendar year maximums are combined maximums.

We will continue to offer Delta Dental HMO and PPO plans. The following chart outlines the dental benefits offered:

Dental Plans Features	DeltaCare Dental (HMO)	Delta Dental (PPO)	
		In-Network	Out-of-Network
Annual Deductible *(Individual / Family)*	$0 / $0	$0 / $0	$0 / $0
Waived for Preventive	N/A	N/A	Yes
Annual Plan Maximum	Unlimited	$3,000 / person (combined with Out-of-network)	$2,500 / person(combined with In-network)
Orthodontia (PPO Lifetime Maximum)	Various copays apply	$2,000 / person	
Covered Services			
Diagnostic and Preventive Services	100%	100%	80%
Basic Services	Various copays apply	90%	80%
Endodontics	Various copays apply	90%	80%
Periodontics	Various copays apply	90%	80%
Major Services	Various copays apply	80%	50%
Orthodontia Services Adult Dependent Children	 Various copays apply Various copays apply	 50% 50%	 50% 50%
Dental Implants	N/A N/A	2,000 / person 50%	 50%

This is a high-level benefit summary and does not override carrier evidence of coverage booklet.

VISION INSURANCE

San Bernardino Community College District's vision insurance entitles you to specific eye care benefits. Our policy covers routine eye exams and other procedures, and provides specified dollar amounts or discounts for the purchase of eyeglasses and contact lenses.

EyeMed vision plan is offered to all benefit eligible employees.

SBCCD plan will continue to offer EyeMed Freedom Pass[1]. That means employees will incur no cost on frames from top leading brands such as Oakley, Coach, Ray-Ban, Michael Kors and others purchased from LensCrafters or Target Optical stores.

If you seek the services of a provider listed in the EyeMed Preferred Provider online directory, your benefits include the following:

Plan Features	EyeMed	
	In-Network	Out-of-Network
Copay *(Exam)*	$10 copay	Covered up to $40 allowance
Frequency:		
Eye Exam	Once every plan year	Once every plan year
Lenses	Once every plan year	Once every plan year
Frames	Once every plan year	Once every plan year
Contacts	Once every plan year (in lieu of lenses and frames)	Once every plan year (in lieu of lenses and frames)
Lenses:		
Single Vision	100%	Covered up to $35 allowance
Bifocal	100%	Covered up to $49 allowance
Trifocal	100%	Covered up to $74 allowance
Standard Progressive	$50 copay	Covered up to $60 allowance
Contact Lenses:		
Non-elective	100%	Covered up to $210 allowance
Elective	Covered up to $200 plus 15% off remaining balance in lieu of lenses and frames	Covered up to $160 in lieu of lenses and frames
Frames	Covered up to $300 from participating provider	Covered up to $150 allowance

This is a high-level benefit summary and does not override carrier evidence of coverage booklet.

1. *This offers excludes Chanel, Cartier, Tiffany, Prada, Gucci, Tom Ford and Giorgio Armani frames.*

BASIC LIFE INSURANCE

Prudential

Life insurance can help provide for your loved ones if something where to happen to you. San Bernardino Community College District will provide full-time employees with $50,000 in group life and $50,000 in accidental death and dismemberment (AD&D) insurance through Prudential.

San Bernardino Community College District pays for the full cost of this benefit—meaning you are not responsible for paying any monthly premiums. Contact HR if you would like to update your beneficiary information.

SUPPLEMENTAL LIFE AND AD&D INSURANCE

Prudential

While San Bernardino Community College District offers basic life insurance through Prudential, some employees may want to purchase additional coverage. Think about your personal circumstances. Are you the sole provider for your household? Depending on your needs, you may want to consider buying supplemental coverage.

With supplemental life insurance, you are responsible for paying the full cost of coverage through payroll deductions. You can purchase coverage for yourself or for your spouse in $10,000 increments.

The employee's minimum coverage level is $10,000 and the maximum is $500,000 or five times your annualsalary. For new hires, the guaranteed issue coverage is $200,000 and may not exceed three times the employee's annual salary. Employees can also purchase optional life coverage for their spouse/domestic partner up to 100% of their coverage with a maximum guaranteed issuance of $30,000.

If you decline coverage during this open enrollment period and you would like to enroll at a later time, you will need to provide evidence of insurability for any amount you select.

You can also select coverage for your child(ren) up to $10,000.

SUPPLEMENTAL LIFE AND AD&D INSURANCE (continued)

EMPLOYEE/SPOUSE SUPPLEMENTAL LIFE ONLY RATE INFORMATION

The rate is based on your age on October 1 and will automatically increase when you advance into the next higher age bracket. The spouse rate will be based on the employee's age.

- Rates are calculated assuming you receive 10 paychecks per year

Employee / Spouse Age	**Tenthly Rate per $1,000**
Less than 30	$0.048
30-34	$0.048
35-39	$0.072
40-44	$0.108
45-49	$0.180
50-54	$0.276
55-59	$0.468
60-64	$0.780
65-69	$1.308
70+	$2.220

Rates above do not include Accidental Death and Dismemberment, which is available as separate coverage below.

At age 65 the employee's benefit amount will reduce to 65% and 50% when they reach age 70. Qualified dependent benefits will reduce proportionately independent of age when the employee reaches age 65 or 70.

DEPENDENT CHILDREN LIFE RATE INFORMATION

If you are covered for Supplemental Life, you may enroll your Qualified Dependents for the following plan.

Dependent Children	Amount of Insurance*	Tenthly Rate
Option 1	$2,500	$0.60
Option 2	$5,000	$1.20
Option 3	$10,000	$2.40

* The amount of insurance on a dependent will not exceed 100% of the amount for which you are insured under the Optional Employee Term Life coverage.

EXAMPLE: Ann Smith is a 35-year-old who applies for $100,000 of Voluntary Life Coverage. Steps to calculate her voluntary coverage:

- $100,000 divided by 1,000 = 100
- 100 times $0.072 = $7.20
- Her 10thly premium for $100,000 of voluntary life is $7.20

SUPPLEMENTAL LIFE AND AD&D INSURANCE (continued)

SUPPLEMENTAL ACCIDENTAL DEATH & DISMEMBERMENT (AD&D)

Each eligible employee may purchase additional amounts of coverage on a voluntary basis. The cost of the benefit is $0.022 per $1,000 of coverage on a monthly basis regardless of age.

EXAMPLE: Robert Smith applies for $10,000 in voluntary AD&D, $6,000 for his spouse and $2,500 for his child(ren). Steps to calculate his voluntary AD&D coverage:

- ($10,000 + $6,000 +$ 2,500) divided by 1,000 = 18.5
- 18.5 times $0.022 = $0.407
- His 10thly premium for himself, spouse and child is $0.49

QUALIFIED DEPENDENTS

If employee elects to cover their spouse and dependent children, benefit amounts will be as follows:

- Spouse or Registered Domestic Partner – 60% of employee's principal amount
- Child(ren) – 25% of employee's principal amount (not to exceed $10,000)

EMPLOYEE ASSISTANCE PROGRAM

Anthem Blue Cross

The following services are provided by Anthem Blue Cross EAP services at no additional cost to SBCCD employees and their household. Below is a summary of the plan offered:

WHAT IS AN EAP?

An Employee Assistance Program, or EAP, is designed to help you cope with emotional health, family and other personal problems. Employers provide an EAP to help their employees be happy, healthy and productive.

WHO CAN USE THESE SERVICES?

Any family members, in any state, can call and use the services. EAP services are not limited to family members on your health plan. They must only identify that their family member works at San Bernardino CCD or is associated with SISC.

EMPLOYEE ASSISTANCE PROGRAM (continued)

WHAT KINDS OF CONCERNS ARE COVERED?

The EAP is designed to help with any concern or problem affecting your behavioral health, well-being, or even job performance. Typical concerns may include, but are not limited to emotional, marital, financial, interpersonal addiction and recovery, legal, stress, and more. Daycare and eldercare referral services.

HOW WILL THE EAP HELP ME?

Call (800) 999-7222 to speak with an EAP professional or visits www.anthemEAP.com and enter SISC

EAP is available 24/7 including holidays.

This plan may include assessment, brief sessions, and / or referral to other helpful resources. All contact with the EAP is strictly confidential.

FLEXIBLE SPENDING ACCOUNTS

AMERICAN FIDELITY
a different opinion

Paying for health care can be stressful. That's why SBCCD offers an employer-sponsored flexible spending account (FSA).

WHAT ARE THE BENEFITS OF AN FSA?

There are a variety of different benefits of using an FSA, including the following:

- It saves you money. Allows you to put aside money tax-free that can be used for qualified medical expenses.
- It's a tax-saver. Since your taxable income is decreased by your contributions, you'll pay less in taxes.
- It is flexible. You can use your FSA funds at any time, even if it's the beginning of the year.

You cannot stockpile money in your FSA. If you do not use it, you lose it except for a rollover up to $640. You should only contribute the amount of money you expect to pay out of pocket that year.

HOW DO I ENROLL?

In order to participate in the plan for 2024-2025, you must enroll with an American Fidelity Representative during Open Enrollment. For a complete list of what the IRS considers eligible health care expenses, go to www.afadvantage.com. Up to $3,200 pre-tax income per plan year may be withheld from your paycheck to use for eligible medical expenses.

FLEXIBLE SPENDING ACCOUNTS (continued)

WHAT IS A DEPENDENT CARE FSA?

Dependent Care FSAs allow you to contribute pre-tax dollars to qualified dependent care. The maximum amount you may contribute each year is $5,000 (or $2,500 if married and filing separately). In order to participate in the plan for 2024-2025, you must enroll with an American Fidelity Representative during Open Enrollment.

You can make a virtual appointment with an American Fidelity representative at: https://enroll.americanfidelity.com/F8DD86F6

SMARTFLEX DEBIT CARD

The SmartFlex Debit Card will be provided to you at no charge if you choose to receive one. For more information, speak with an American Fidelity representative.

EXAMPLE	Paying Bill with After-Tax Dollars	Paying $1,000 with Pre-Tax Dollars, Paying Taxes Only on the Difference
Money Earned	$1,587	$1,587
Income Taxes Withheld	$587	$217
Amount of Bill Paid	$1,000	$1,000
Money Left Over as Extra Spending Money	$0	$370

QUESTIONS & ANSWERS

How do I enroll in my benefits?

To access the online enrollment site:

- Go to: https://www.afenroll.com/enroll
  - At the login screen, you will enter the site using the following information:
  - Type in your user ID – your Employee ID and Social Security Number (SSN)
  - Type in your PIN – the last four digits of your SSN and your eight digit date of birth . For example, for SSN 123-45-6789 and birth year 11/11/1974, you would type in 67891111174
  - Click the 'Log On' button
    - You will be asked to change your PIN and complete security questions, after your initial login to the system. Make sure you click "Save New PIN" button. Your new PIN will be your electronic signature
  - Follow the prompts and choose the plan that fits your needs
  - Social Security Numbers and Dates of Birth are required for all employees and dependents
- Be sure to print your confirmation. Once you confirm your enrollment, you may click on the confirmation link at the bottom of the "Sign/Submit Complete" to print your confirmation statement
- If you decide to Opt-Out, you must enter each product module and make that choice
- If you are adding a dependent as a beneficiary, their Social Security Number is required
- The online system offers a step-by-step video on how to enroll

What changes are effective OCTOBER 1, 2024?

The following changes will take effect as of October 1, 2024:

Anthem Blue Cross HMO plans:

- The Anthem Select HMO $10 plan will be replaced with Anthem full-network Classic $20.

Delta Dental PPO Plan:

- The annual in-network plan maximum will increase from $2,500 to $3,000. The out-of-network annual maximum will continue to be $2,500. Both in and out-of-network plan maximums are combined.

I am not making any changes to my benefits do I need to re-enroll again?

If you are not making changes to your plans, the District will automatically re-enroll you and your dependents on the same plan(s) you enrolled in 2024/2025 except for the Anthem Select plan and for the Flexible Spending Account/Dependent Spending Account.

If you and your dependents; if any, are enrolled on Anthem Select HMO and do nothing; you and your dependents will automatically enroll on the Anthem Classic HMO $20, and you will be receiving a new ID card(s) in the mail with the new plan information.

If you are enrolled in the Flexible Spending Account/Dependent Spending Account, you will no longer be enrolled in these benefits as of October 1, 2024. You must reenroll in these two plans every Open Enrollment to continue coverage into next plan year per the IRS requirement.

What is the difference between Anthem Premier HMO $10 and Anthem Classic HMO $20?

Page 9 provides a high-level summary of the plan differences; however, you can request a complete plan summary from HR or go to www.sbccd.edu/district-services/human-resources/human-resources-forms.php for a complete plan summary of each plan.

What is the difference between the Anthem Select HMO and Anthem HMO Classic $20?

As of October 1, 2024, the Anthem Select HMO Plan will no longer be offered by our District and will be replaced by the Anthem HMO Classic $20 as the no-cost plan. The Anthem HMO Classic plan offers the Anthem's full network of doctors, medical groups and hospitals. This network offers the same doctors and medical groups as the current Anthem CaliforniaCare HMO $10 including Loma Linda Medical Groups and doctors.

Can I stay with my current doctor and medical group when we switch the Anthem Classic HMO Plan $20?

Yes. You will be receiving a new ID card from Anthem in late September or early October. It is most important you look at the card to make sure the doctor showing on the card is your primary care doctor as well as the medical group you are currently with unless you made the change. If that is not the case, then will contact Anthem immediately at the number in the back of the card to make the change and make sure it is retro to October 1, 2024. If you wait, this might cause you to be billed for services. So please make sure you review your card for you and your family.

I was covered under the Select Anthem plan and now I am covered under the Anthem HMO Classic $20, can I switch my primary care doctor and medical group to different medical group?

Yes, please contact Anthem customer service at the number on the back of the card to make the change. You can change your primary care doctor at any time by calling Anthem customer services prior to seeing the new doctor. Otherwise, you will be responsible for the medical services.

Will my pharmacy and medication change by changing from the Anthem Select HMO to the Anthem Classic HMO plan?

No, this change should not affect your pharmacy or medications.

Do I need to re-enroll in the Prudential supplemental life if I am enrolled now and approved?

No. If you are currently enrolled in this program and if you were approved for an amount over the guaranteed issue, you do not have to re-enroll again.

Are there any forms to complete?

No, all changes must be made via American Fidelity online portal. If you have any questions, you can contact Human Resources at 909-388-6950.

What is the last day I can make changes during open enrollment?

All changes are due no later than Friday August 23rd. Please make sure you adhere to this timeline due to IRS Section 125 guidelines.

I have been on my current medication for quite a while, but the prescription was denied, and I was told that I needed to go through Step Therapy, what do I do?

Many Brand name prescriptions have equivalent medications with the same clinical outcome at a fraction of the cost. To contain costs for both the District and its members, Navitus has determined that patients should try the lower cost drugs before they will approve the higher cost drugs. The first step is to call Navitus at 1 (866) 333-2757, to get a list of lower cost alternatives, then talk to your doctor about which is the best option for you. If you have been through Step Therapy before, or there is a medical reason you cannot take the lower cost drug, you and your doctor will need to provide information to Navitus to obtain an exception.

Can I call American Fidelity customer service to enroll in my medical, dental, vision and life benefit?

No. All benefit enrollments must be completed online via https://www.afenroll.com/enroll

If you would need to enroll or re-enroll in the FSA program or in an American Fidelity product such as cancerpolicy, whole life, disability or accident then you can contact their customer service or schedule a one-on-oneappointment to discuss your options.

American Fidelity cannot assist you to enroll in medical, dental, vision or life coverages. If you have any questions, you can contact SBCCD Benefit Team.

I received my new Anthem ID card and it is showing the incorrect primary care physician, what should I do?

You will need to contact Anthem Blue Cross member services at 800-825-5511 as soon as possible and before you receive services to make the correction. Do not wait until to make the change and check your card as soon as you receive it.

Can my family have different primary care physician and medical groups under the Anthem Blue Cross HMO plans?

Yes. Make sure you contact Anthem Blue Cross to make any primary care physician changes. Every family member that is on the Anthem HMO will receive their own ID card showing their own medical group and primary care physician names.

Can I change primary care physician on Anthem HMO plans?

Yes, you can make the change monthly. Make sure you contact Anthem Blue Cross to make any primary care physician changes and before you receive services by the new primary care physician.

I did not receive my new Anthem ID card when I enrolled on the plan, what should I do?

Anthem Blue Cross will be sending electronic ID card via email to each employee. If you would like a card to be mailed to you; you will need to contact Anthem Blue Cross member services at 800-825-5511 to request one.

Annual Required Notifications

Women's Health and Cancer Rights Act of 1998 (WHCRA)

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 an individual receiving mastectomy-related benefits, coverage will be provided in a manner determined by consultation with the attending physician and patient for:

- All stages of reconstruction of the breast on which the mastectomy was performed
- Surgery and reconstruction of the other breast to produce an asymmetrical appearance
- Prostheses
- Treatment of physical complications of the mastectomy, including lymphedema in a mannerdetermined in consultation with the attending physician and the patient

Our plan complies with these requirements. Benefits for these items generally are comparable to those provided under our plan for similar types of medical services and supplies. Of course, the extent to which any of these items is appropriate following mastectomy is a matter to be determined by the patient and her physician.

San Bernardino Community College District plans neither imposes penalties (for example, reducing or limiting reimbursements) nor provides incentives to induce attending providers to provide care inconsistent with these requirements. If you would like more information, please contact the Benefit Team at 909-388-6950.

Newborns' & Mothers' Health Protection Act

Your Rights Under Newborns' and Mothers' Health Protection Act of 1996 ("NMHPA") 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, plansand 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).

Health Insurance Portability and Accountability Act of 1996 - HIPAA

You have certain rights under the federal Health Insurance Portability and Accountability Act of 1996 (HIPPA) related to the confidentiality of your personal health information. Information about these rights, as well as information about how the health plan m ay use or disclose your medical information for treatment, payment for services, or business operations can be found in the Notice of Privacy Practices. If a use or disclosure is not outlined in the Notice of Privacy Practices, the health plan must obtain your permission before releasing this information.

You can obtain a paper copy of this Notice free of charge upon your written request to the Plan PrivacyOfficer at the following address:

San Bernardino CCD

550 E Hospitality Lane, Suite 200

San Bernardino, CA 92408

909-388-6942

For a copy of the HIPAA Privacy Notice applicable to your fully insured health care plan(s), please contactyour insurance carrier. Contact information for San Bernardino CCD's insurance carrier is listed in your SummaryPlan Description (SPD).

Michelle's Law

Michelle's Law prohibits the termination of health coverage if the child takes a medically necessary leaveof absence from school or changes to part-time status. The leave of absence must:

- Be medically necessary (and certified by a physician as medically necessary)
- Commence while the child is suffering from a serious illness or injury
- Cause the child to lose student status for the purposes of coverage under the plan (either from anabsence from school or reducing his/her course load to part time)

To take advantage of the extension, the child must be enrolled in the group health plan by being a studentat a post-secondary educational institution immediately before the first day of the leave.

Coverage must extend for one year after the first day of the leave (or, if earlier, the date coverage would otherwise terminate under the plan). The student on leave is entitled to the same benefits as if they had not taken a leave. If coverage changes during the student's leave, then this law applies in the same manner as the prior coverage.

Medicare Secondary Payer Data Collection

If you currently carry one of the San Bernardino Community College District Insurance Plans, and you and/or yourspouse have Medicare Insurance Coverage, as part of the Medicare Secondary Payer (MSP) provisions of the Social Security Act, commonly known as the "MSP Rules," Anthem Blue Cross of California and Kaiser Permanente requires a Medicare Secondary Payer Employee Status Form to be completed by the employee.

NOTICE OF SPECIAL ENROLLMENT RIGHTS

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributingtoward the other coverage).

If you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you maybe able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

If you decline enrollment for yourself or for an eligible dependent (including your spouse) while Medicaid coverage or coverage under a state children's health insurance program is in effect, you may be able to enrollyourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage.

However, you must request enrollment within 60 days after your or your dependents' coverage ends underMedicaid or a state children's health insurance program.

If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy fromMedicaid or through a state children's health insurance program with respect to coverage under this plan, youmay be able to enroll yourself and your dependents in this plan. However, you must request enrollment within60 days after your or your dependents' determination of eligibility for such assistance. To request special enrollment or obtain more information, contact Marcela Navarro at mnavarro@sbccd.edu or (909) 388-6945.

Important Notice from San Bernardino CCD 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 San Bernardino 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 joina 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. San Bernardino Community College District has determined that the prescription drug coverage offered by the San Bernardino Community College District Health Care Plan is , on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

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

If you decide to join a Medicare drug plan, your current San Bernardino Community College District coverage will not be affected. If you do decide to join a Medicare drug plan and drop your current San Bernardino Community College District coverage, be aware that you and your dependents may not be able to get this coverage back.

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

You should also know that if you drop or lose your current coverage with San Bernardino 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.

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

Contact the person listed below for further information. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through San Bernardino 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 **www.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 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at **www.socialsecurity.gov** or call them at 1-800-772-1213 (TTY 1-800-325-0778).

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

Date:	October 1, 2024
Name of Entity/Sender:	San Bernardino Community College District
Contact-Position/Office:	Marcela Navarro, HR Analyst
Address:	550 E Hospitality Lane, Suite 200
	San Bernardino, CA 91408
Phone:	(909) 388-6945

CMS Form 10182-CC Updated April 1, 2011

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collec-tion is 0938-0990. The time required to complete this information collection is estimated to average 8 hours per re- sponse initially, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time esti- mate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

COBRA Continuation Coverage Notice **Introduction**

This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it. When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

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

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

What is COBRA continuation coverage?

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

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

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

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

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

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

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

When is COBRA continuation coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

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

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to Human Resources.

How is COBRA continuation coverage provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an Independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

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

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage

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

Second qualifying event extension of 18-month period of continuation coverage

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

Are there other coverage options besides COBRA Continuation Coverage?

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

If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit **www.dol.gov/ebsa**. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.**HealthCare.gov.**

Keep your Plan informed of address changes

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

Plan contact information

Medical:

Self-Insured Schools of California (SISC III)
P.O. Box 1847
Bakersfield, CA 93303-1847

All other plans and COBRA related questions:

San Bernardino Community College District
550 E Hospitality Lane, Suite 200
San Bernardino, CA 92408
Phone 909-388-6950

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).

For more information on special enrollment rights, you can contact your state Medicaid office or either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/ebsa
1-866-444-EBSA (3272)
OMB Control Number 1210-0137 (expires 1/31/2026)

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

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" describes providers and facilities that haven't signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called "**balance billing**." This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

You are protected from balance billing for:

Emergency services
If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan's in-network cost-sharing amount (such as copayments and coinsurance). You **can't** be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center. When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **can't** balance bill you and may **not** ask you to give up your protections not to be balance billed.
If you get other services at these in-network facilities, out-of-network providers **can't** balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also aren't required to get care out-of-network. You can choose a provider or facility in your plan's network.

Additionally, California law protects consumers from surprise medical bills when they receive emergency services or, when receiving non-emergency services, they go to an in-network health facility and receive care from an out-of-network provider without their consent. Visit this Surprise Medical Bill Fact Sheet issued by the California Department of Managed Health Care for more information: https://www.dmhc.ca.gov/Portals/0/HealthCareInCalifornia/FactSheets/fsab72.pdf

When balance billing isn't allowed, you also have the following protections:

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.
- Your health plan generally must:
- Cover emergency services without requiring you to get approval for services in advance (prior authorization).
- Cover emergency services by out-of-network providers.
- Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
- Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

If you believe you've been wrongly billed, you may contact the Department of Health and Human Services' No Surprises Helpdesk at 1-800-985-3059.

Visit www.cms.gov/nosurprises for more information about your rights under federal law.

For more information about your rights under California law, or to file a complaint if you believe you've been wrongly billed, visit:

California Department of Insurance
https://www.insurance.ca.gov/01-consumers/110-health/60-resources/NoSupriseBills.cfm

California Department of Managed Health Care
http://www.dmhc.ca.gov/

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB 1210-0149
(expires No. 12-31-2026)

PART A: General Information

Even if you are offered health coverage through your employment, you may have other coverage options through the Health Insurance Marketplace ("Marketplace"). To assist you as you evaluate options for you and your family, this notice provides some basic information about the Health Insurance Marketplace and health coverage offered through your employment.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options in your geographic area.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium and other out-of-pocket costs, but only if your employer does not offer coverage, or offers coverage that is not considered affordable for you and doesn't meet certain minimum value standards (discussed below). The savings that you're eligible for depends on your household income. You may also be eligible for a tax credit that lowers your costs.

Does Employment-Based Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that is considered affordable for you and meets certain minimum value standards, you will not be eligible for a tax credit, or advance payment of the tax credit, for your Marketplace coverage and may wish to enroll in your employment-based health plan. However, you may be eligible for a tax credit, and advance payments of the credit that lowers your monthly premium, or a reduction in certain cost-sharing, if your employer does not offer coverage to you at all or does not offer coverage that is considered affordable for you or meet minimum value standards. If your share of the premium cost of all plans offered to you through your employment is more than 9.12%[1] of your annual household income, or if the coverage through your employment does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit, and advance payment of the credit, if you do not enroll in the employment-based health coverage. For family members of the employee, coverage is considered affordable if the employee's cost of premiums for the lowest-cost plan that would cover all family members does not exceed 9.12% of the employee's household income. [1] [2]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered through your employment, then you may lose access to whatever the employer contributes to the employment-based coverage. Also, this employer contribution -as well as your employee contribution to employment-based coverage- is generally excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis. In addition, note that if the health coverage offered through your employment does not meet the affordability or minimum value standards, but you accept that coverage anyway, you will not be eligible for a tax credit. You should consider all of these factors in determining whether to purchase a health plan through the Marketplace.

[1] Indexed annually; see https://www.irs.gov/pub/irs-drop/rp-22-34.pdf for 2023.

[2] An employer-sponsored or other employment-based health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs. For purposes of eligibility for the premium tax credit, to meet the "minimum value standard," the health plan must also provide substantial coverage of both inpatient hospital services and physician services.

WELCOME TO SAN BERNARDINO COMMUNITY COLLEGE DISTRICT OPEN ENROLLMENT

When Can I Enroll in Health Insurance Coverage through the Marketplace?

You can enroll in a Marketplace health insurance plan during the annual Marketplace Open Enrollment Period. Open Enrollment varies by state but generally starts November 1 and continues through at least December 15.

Outside the annual Open Enrollment Period, you can sign up for health insurance if you qualify for a Special Enrollment Period. In general, you qualify for a Special Enrollment Period if you've had certain qualifying life events, such as getting married, having a baby, adopting a child, or losing eligibility for other health coverage. Depending on your Special Enrollment Period type, you may have 60 days before or 60 days following the qualifying life event to enroll in a Marketplace plan.

There is also a Marketplace Special Enrollment Period for individuals and their families who lose eligibility for Medicaid or Children's Health Insurance Program (CHIP) coverage on or after March 31, 2023, through July 31, 2024. Since the onset of the nationwide COVID-19 public health emergency, state Medicaid and CHIP agencies generally have not terminated the enrollment of any Medicaid or CHIP beneficiary who was enrolled on or after March 18, 2020, through March 31, 2023. As state Medicaid and CHIP agencies resume regular eligibility and enrollment practices, many individuals may no longer be eligible for Medicaid or CHIP coverage starting as early as March 31, 2023. The U.S. Department of Health and Human Services **is offering a temporary Marketplace Special Enrollment period to allow these individuals to enroll in Marketplace coverage.**

Marketplace-eligible individuals who live in states served by HealthCare.gov and either- submit a new application or update an existing application on HealthCare.gov between March 31, 2023 and July 31, 2024, and attest to a termination date of Medicaid or CHIP coverage within the same time period, are eligible for a 60-day Special Enrollment Period. That means that if you lose Medicaid or CHIP coverage between March 31, 2023, and July 31, 2024, you may be able to enroll in Marketplace coverage within 60 days of when you lost Medicaid or CHIP coverage. In addition, if you or your family members are enrolled in Medicaid or CHIP coverage, it is important to make sure that your contact information is up to date to make sure you get any information about changes to your eligibility. To learn more, visit HealthCare.gov or call the Marketplace Call Center at 1-800-318-2596. TTY users can call 1-855-889-4325.

What about Alternatives to Marketplace Health Insurance Coverage?

If you or your family are eligible for coverage in an employment-based health plan (such as an employer-sponsored health plan), you or your family may also be eligible for a Special Enrollment Period to enroll in that health plan in certain circumstances, including if you or your dependents were enrolled in Medicaid or CHIP coverage and lost that coverage. Generally, you have 60 days after the loss of Medicaid or CHIP coverage to enroll in an employment-based health plan, but if you and your family lost eligibility for Medicaid or CHIP coverage between March 31, 2023 and July 10, 2023, you can request this special enrollment in the employment-based health plan through September 8, 2023. Confirm the deadline with your employer or your employment-based health plan.

Alternatively, you can enroll in Medicaid or CHIP coverage at any time by filling out an application through the Marketplace or applying directly through your state Medicaid agency. Visit https://www.healthcare.gov/medicaid-chip/gettingmedicaid-chip/ for more details.

How Can I Get More Information?

For more information about your coverage offered through your employment, please check your health plan's summary plan description or contact Marcela Navarro, HR Analyst, (909) 388-6945, mnavarro@sbccd.cc.ca.us

_____
_ _____.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

Employer name San Bernardino Community College District	Employer Identification Number (EIN) 95-6002754	
Employer address 550 E Hospitality Lane, Suite 200	Employer phone number (909) 388-6950	
City San Bernardino	State CA	ZIP code 92408
Who can we contact at this job? Marcela Navarro, Human Resources Analyst		
Phone number (if different from above) (909) 388-6944	Email address: mnavarro@sbccd.cc.ca.us	

Here is basic information about health coverage offered by San Bernardino Community College District.

- As your employer, we offer a health plan to:

  ☑ All employees. Eligible employees are:

  Classified and Management Employees working a minimum of 20 hours per week and a minimum of 30 hours per week for Certified Employees

  ☐ Some employees. Eligible employees are:

- With respect to dependents:

  ☑ We do offer coverage. Eligible dependents are:
  Legal Spouse, registered domestic partner, and children to the age of 26.

  ☐ We do not offer coverage.

☑ If checked, this coverage meets the minimum value standard, and the cost of this coverage to you, is intended to be affordable, based on employee wage.

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee, or you work on a commission basis), if you are newly employed mid-year, or if you have other income loses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, HealthCare.gov will guide you through the process. Here's the employer information you'll enter when you visit HealthCare.gov to find out if you can get a tax credit to lower your monthly premiums.

If you are not eligible for health insurance coverage through this employer. You and your family may be able to obtain health coverage through the Marketplace, with a new kind of tax credit that lowers your monthly premiums and with assistance for out-of-pocket costs.

Contact Information

SBCCD Benefit Team

Marcela Navarro - HR Analyst (909) 388.6945 or mnavarro@sbccd.edu

Insurance Carriers /Administrators

Anthem Blue Cross of California
HMO / PPO Customer Service (800) 825.5541
www.anthem.com/ca/sisc

Kaiser California
Customer Service (800) 464.4000
www.kp.org

Navitus Rx - Anthem Members
Customer Service (866) 333.2757
www.navitus.com

EyeMed Vision
Customer Service (866) 939.3633
www.eyemed.com

Anthem Blue Cross EAP Program
Customer Service (800) 999.7222
www.anthemeap.com

Teledoc Medical Expert Opinions
Customer Service (800) 835.2362
www.teledoc.com/sisc

Delta Dental
DeltaCare Dental (800) 422.4234
Delta Dental PPO (866) 499.3001
www.deltadentalins.com

American Fidelity
Customer Service (800) 662.1113
www.afadvantage.com

American Specialty Health
Customer Service (800) 848.3555
www.ashcompanies.com

Prudential
Customer Service (800) 778.2255
www.prudential.com

MDLive (SISC PPO and HMO)
Customer Service (800) 657.6169
www.mdlive.com/sisc

This guide was created by PWE Insurance Services for San Bernardino Community College District. The information in this Enrollment Guide is presented for illustrative purposes and is based on information provided by SBCCD or their insurance carriers. The text contained in this guide was taken from various summary plan descriptions and benefit information. While every effort was taken toaccurately report your benefits, discrepancies or errors are always possible. In case of discrepancy between the guide and actual plan documents, the actual plan documents will prevail. All information is confidential, pursuant to the Health Insurance Portability and Accountability Act of 1996. If you have any questions about the guide, please contact SBCCD Benefit Team.