WELCOME TO OPEN ENROLLMENT

EMPLOYEE BENEFIT GUIDE

Plan Year: 2026 - 2027

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 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, 2026. 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.

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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	• 2024 or 2025 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 10, 2026, and runs through Friday August 22, 2026. The benefits you choose during open enrollment will be effective on October 1, 2026.

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 18 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 2026/2027 except for the Flexible Spending Account/Dependent Spending Account.

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, 2026. **You must re-enroll 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
Tuesday, August 11, 2026	10:00 am – 11:30 am
Thursday, August 13, 2026	1:00 pm – 2:30 pm
Thursday, August 20, 2026	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 2026-2027.
- You wish to enroll or make a 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 representatives are available Monday through Friday from 5:00 am PDT and 5:00 pm PST.

What Is Changing for 2026– 2027?

The following changes will take effect as of October 1, 2026:

Anthem Blue Cross HMO & Kaiser Permanente plans only:

- These plans will cover in-vitro fertilization (IVF) including evaluation, treatment and preservations up three egg retrieval cycles. This benefit is not available for members on the PPO plans.

Delta Dental PPO Plan:

- Enrolled individuals will receive a teeth whitening benefit once every 24 months, available for either in-office dentist procedures or at-home applications.

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

- Teladoc 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.teladoc.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 urgent care and therapists over the phone 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
- Lantern Cancer Benefits: Available to Anthem PPO members. Get help from a personal oncology nurse who can partner with you on every step of your cancer journey, including a review of your initial diagnosis and development of a care plan. To find out more about this program you can go to www.lanterncare.com
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- WellTheory: Available to Anthem HMO, PPO and Kaiser Permanente members. supports members with autoimmune and inflammatory conditions —whether or not a formal diagnosis has been made. Visit www.welltheory.com/partner/sisc
- 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 more about 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
- Maven: 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
- Centivo Care: This is available to all Anthem PPO members. Virtually connect with a primary care team to manage all of your healthcare needs. Centivo Care providers diagnose conditions, manage prescriptions, refer to specialists, and answer follow-up questions using video visits or live chat. Visit www.centivocare.com/sisc/

EMPLOYEE CONTRIBUTIONS – 2026/2027

Deductions are tenthly

No deductions taken from June and July paychecks

Plan Name	Per Paycheck Deduction
Medical	
Anthem Blue Cross Classic HMO $20	$0.00
Anthem Blue Cross Premier HMO $10	$116.40
Anthem Blue Cross PPO Gold - Copay Only Plan	$0.00
Anthem Blue Cross PPO 90C (low)	$366.00
Anthem Blue Cross PPO 100A (high)	$655.20
Kaiser Permanente $30	$236.40
Kaiser Permanente $15	$201.60
Dental	
DeltaCare HMO	$0.00
Delta Dental PPO	$64.99
Vision	
EyeMed	$0.00

MEDICAL INSURANCE

SBCCD will continue to partner with Anthem Blue Cross of California and Kaiser Permanente for your 2026 – 2027 medical plans:

Anthem Blue Cross

You can choose from several Anthem Blue Cross plans, including HMO and PPO options, designed to give you access to quality care through one of the largest provider networks in California—with more than 104,000 providers statewide.

The **Premier HMO plan ($10 Copay)** plan offers lower out-of-pocket costs. You'll pay less for doctor visits, lab work, outpatient procedures, and hospital services.

The **Classic HMO plan ($20 Copay)** plan covers the same services as the Premier HMO, but with higher out-of-pocket expenses.

The **Anthem PPO plans** give you the flexibility to see any provider. You'll have direct access to doctors and specialists in the preferred network and can also choose out-of-network care, typically at a much higher cost except for the PPO Copay Only plan which offers in-network coverage only.

All Anthem Blue Cross members receive one ID card for both medical and pharmacy benefits.

KAISER PERMANENTE

Kaiser Permanente offers HMO plans that provide comprehensive care and convenience with one ID card for both medical and pharmacy services.

The **HMO $15 Copay** plan offers lower out-of-pocket costs for medical services and prescriptions. You'll pay less for primary care visits, outpatient procedures, lab tests, emergency room care, and medications.

The **HMO $30 Copay** plan includes the same coverage as the $15 Copay plan but with higher out-of-pocket costs for most services and prescriptions.

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	Classic $20	$15	$30
Primacy Doctor	$10 copay	$20 copay	$15 copay	$30 copay
Specialist visits	$10 copay	$40 copay	$15 copay	$30 copay
MDLive consultation	$0 copay	$0 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	$0 copay	$0 copay	$0 copay	$0 copay
Diagnostic X-Ray and Lab Tests	$0 copay	$0 copay	$0 copay	$0 copay
Advanced Diagnostic Imaging	$100 copay/test	$100 copay/test	$0 copay	$0 copay
Inpatient Hospital - Room & Board	$0 copay	$250/admission	$0 copay	$0 copay
Surgical Services *(Outpatient Facility)*	$0 copay	$125/visit	$15 / 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	$15 copay	$30 copay
Mental Health & Substance Abuse				
Inpatient Hospitalization	100%	$250/admission	100%	100%
Outpatient Services (routine)	$10 copay	$20 copay	$15 copay	$30 copay
Durable Medical Equipment	$0 copay	20% coinsurance	$0 copay	$0 copay
Hearing Aid	50% coinsurance	50% coinsurance	You pay any amount in excess of $2,000/aid/36 months	You pay any amount in excess of $2,000/aid/36 months
Chiropractic & Acupuncture Services	$10 copay limited to 30 visits /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	$10 copay limited to 30 visits /year Combined with Acupuncture through ASH
Pharmacy Retail (up to 30 days)				
Out-of-Pocket Maximum (Individual / Family)	$2,500 / $3,500	$2,500 / $3,500	N/A	N/A
Generic	$9 copay/Free at Costco*	$9 copay/Free at Costco*	$5 copay	$10 copay
Brand	$35 copay	$35 copay	$20 copay	$30 copay
Specialty Drugs (through Navitus)	$35 copay#	$35 copay#	$20 copay	$30 copay
Pharmacy Mail Order *(90-day Supply with Anthem BC and up to 100 days with Kaiser)*				
Generic	Free through Costco*	Free through Costco*	$10 copay	$10 copay
Brand	$50 copay	$50 copay	$40 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	Anthem Blue Cross PPO Gold - Copay Only
	In-Network Provider	In-Network Provider	In-Network Provider
Out-of-Pocket Maximum	$1,000 Individual / $3,000 Family	$1,000 Individual / $3,000 Family	$3,000 Individual / $6,000 Family
Lifetime Plan Maximum	Unlimited	Unlimited	Unlimited
Annual Deductible (4th QTR carryover)	$0 single/ $0 family	$200 single/ $500 family	$0 single/ $0 family
Coinsurance (member pays)	No coinsurance	10% coinsurance	No Coinsurance - Copayment Only
Primary Care Physician (PCP)	$10 copay (1st 3 visits $0 for PCP only)	$20 copay (1st 3 visits $0 for PCP only)	$0 copay
Specialist visit	$10 copay	$20 copay	$100 copay
Urgent Care Facility	$10 copay (deductible waived)	$20 copay (deductible waived)	$0 copay
MDLive Consultation	$0 copay	$0 copay	$0 copay
Diagnostic X-Ray (Radiology Center/Outpatient hospital)	0% coinsurance	10% coinsurance	$75/$225 copay
Lab Test (Independent Lab/Hospital Lab)	0% coinsurance	10% coinsurance	$0/$150 copay
Advanced Diagnostic Imaging (Radiology Center)	0% coinsurance	10% coinsurance	$300/$750 copay
Semi-Private Room & Board; including Services and Supplies (PA required)	0% coinsurance	10% coinsurance	$600/day
Pregnancy & Maternity Care *(Pre-Natal Care)*	$10 copay	$20 copay	$0 copay
Outpatient Facility Services	0% coinsurance; - exceptions to certain procedures apply[2]	10%; - exceptions to certain procedures apply[2]	$300/$1,800
Emergency Services *(Emergency Room)*	$100 copay (waived if admitted)	$100 copay + 10% coinsurance (waived if admitted)	$700 (waived if admitted)
Ambulance (Air or Ground)	$100 copay per trip	$100 copay + 10% per trip	$700 per trip
Durable Medical Equipment	0% coinsurance	10% coinsurance	$0 copay
Chiropractic Services	0% coinsurance (subject to medical necessity)	10% (subject to medical necessity)	0% coinsurance (subject to medical necessity)
Acupuncture	0% coinsurance (limited to 12 visits/cal year) combined with non-network	10% (limited to 12 visits/cal year and combined with non-network)	0% (limited to 12 visits/cal year and combined with non-network)
Hearing Aid	Limited to $700/24 months	Limited to $700/24 months	Limited to $700/24 months
Prescription Drugs			
Out-of-Pocket Maximum	$2,500 Individual / $3,500 Family	$2,500 Individual / $3,500 Family	$2,500 Individual / $3,500 Family
Retail (up to 30 days)			
Generic or Tier 1	$9 copay/Free at Costco*	$9 copay/Free at Costco*	$9 copay/Free at Costco*
Brand or Tier 2	$35 copay	$35 copay	$35 copay
Specialty Drugs (through Navitus)	$35 copay#	$35 copay#	$35 copay#
Mail Order (90-day Supply)			
Generic or Tier 1	Free at Costco*	Free at Costco*	Free at Costco*
Brand or Tier 2	$90 copay	$90 copay	$90 copay

This is a high-level benefit summary and does not override carrier evidence of coverage booklet.
For out-of-network coverage please refer to the Summary of Benefits and Coverage on the District HR website or contact Anthem Blue Cross.

[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 are 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 routine and preventive dental care—typically covering services such as checkups, cleanings, and X-rays. Beyond oral health, research has shown a strong connection between dental wellness and overall health.

Receiving regular dental care not only helps you and your family maintain healthier smiles but also protects against the high costs associated with dental diseases and complex procedures.

We are pleased to announce an enhancement to your dental benefits under the Delta Dental PPO Plan. Effective October 1, 2026, a teeth-whitening benefit will be added as a non-standard plan. This benefit will be covered under the basic services category. Employees may receive external bleaching, either performed in a dentist's office or for at-home application, once every 24 months.

This expanded coverage is part of our commitment to supporting your health and reducing financial burdens related to orthodontic care.

We will continue to offer both the **Delta Dental PPO and HMO plans** to provide flexibility in how you access dental care.

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	$2,500 / 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

Your vision plan through San Bernardino Community College District helps lower your out-of-pocket costs by covering or discounting key eye care services:

- Eye Exams: Fully covered routine exams and procedures.
- Eyewear: Fixed dollar allowances and percentage discounts for eyeglasses and contact lenses.

EyeMed vision plan is offered to all benefit eligible employees.

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.

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 an 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 such as financial, marital, stress and more. 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.

HOW WILL THE EAP HELP ME?

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

EMPLOYEE ASSISTANCE PROGRAM (continued)

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.

Calm Mental Wellness Platform

San Bernardino Community College District joined Calm Health as an additional no cost resource that supports your mental and physical wellbeing with evidence-based programs that help you navigate a variety of health experiences, life stages, and mental health challenges.

To download the Calm Health app, scan the QR code or visit the App Store or Google Play Store. After you download the app, log in with your existing Calm account or create a new Calm account. Enter “sbccd” as your access code and verify your eligibility by entering your 4-digit PIN number.

PET INSURANCE

Your pets are part of your family — help protect their health and your wallet with **MetLife Pet Insurance**. This voluntary benefit provides coverage options designed to help manage eligible veterinary expenses and give you peace of mind when your furry family members need care.

With MetLife Pet Insurance, you can choose from plan options that fit your needs and budget, helping provide financial support for unexpected accidents, illnesses, and other eligible veterinary services. Whether you have a dog, cat, or other eligible pet, MetLife offers flexible coverage options to help you care for the pets you love.

As an employee, you can receive **up to a 30% discount off standard rates**. Enrollment is simple — review plan options, customize your coverage, and receive your personalized quote.

HOW CAN I GET A QUOTE?

Visit **metlife.com/getpetquote4**

You can also call **855-615-5176** to speak with a MetLife Pet Insurance representative.

Give your pets the protection they deserve with MetLife Pet Insurance.

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 $680. 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 2026-2027, 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 $3,400 pre-tax income per plan year may be withheld from your paycheck to use for eligible medical expenses.

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 $7,500 (or $3,750 if married and filing separately). In order to participate in the plan for 2026-2027, 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

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 birth date in eight-digit format; mmddyyyy For example, for SSN 123-45-6789 and date of birth is 11/25/1974, you would type in 678911251974
  - 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, 2026?

The following changes will take effect as of October 1, 2026:

Anthem Blue Cross HMO & Kaiser Permanente plans only:

- These plans will cover in-vitro fertilization (IVF) including evaluation, treatment and preservations.

Delta Dental PPO Plan:

- Enrolled individuals will receive a teeth whitening benefit once every 24 months, available for either in-office dentist procedures or at-home applications.

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

If you do not make any changes to your benefits, the District will automatically re-enroll you and your dependents in the same plan(s) for the 2026/2027 plan year—except for the Flexible Spending Account (FSA) and Dependent Care Spending Account, which require re-enrollment.

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, 2026. **You must re-enroll in these two plans** every Open Enrollment to continue coverage into next plan year per the IRS requirement.

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 were approved for an amount above the guaranteed issue limit, you do not need to re-enroll. However, if you previously waived this coverage and would now like to enroll, you will need to complete a medical questionnaire. Please contact HR to request a copy of the form.

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.

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 and Kaiser HMO plans?

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

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 22nd. Please make sure you adhere to this timeline due to IRS Section 125 guidelines.

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, 2026
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/

Patient Protection Provider Disclosure

Both Kaiser and Blue Cross of California require the designation of a primary care provider. You have the right to designate any primary care provider who participates in their network and who is available to accept you or your family members. Until you make this designation, Kaiser and Anthem Blue Cross of California may designate one for you, and you can change that selection. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact Kaiser or Anthem Blue Cross of California. For children, you may designate a pediatrician as the primary care provider.

Primary Care Providers may be:

- General practitioners
- Family practitioners
- Internists
- Obstetrician/gynecologists; or
- Pediatricians

For a list of participating providers, please contact Kaiser or Anthem Blue Cross of California

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.

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

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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.ca.com/sisc

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

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

American Specialty Health
Customer Service (800) 848.9180
www.ashcompanies.com

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

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

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

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

TeleDoc Medical Expert Opinion
Customer Service (800) 835.2362
www.teledoc.com/sisc

MetLife Pet Insurance
Customer Service (855) 615.5176
www.metlife.com/getpetquote4

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

This guide was created by Premier AZCA 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 to accurately 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.