New Hire Benefits Enrollment Checklist

NEW HIRE ENROLLMENT FORMS ARE DUE **30 DAYS** FROM YOUR BENEFITS START DATE

This checklist is designed to help you make your initial benefit enrollment selections in a timely manner. **The following forms are required in order to complete your benefits enrollment:**

All requires forms are located at our Dinuba Unified School District website:
https://www.dinuba.k12.ca.us/departments/business-services/employee-benefits

- New Hire Health Enrollment Forms

☐ **Calculation Sheet** – Choose a plan, sign, and date

☐ **SISC III Enrollment Form** – This form is to enroll you and your family in Medical, Dental, Vision insurance.

Required Supporting Documentation - required if enrolling your spouse and dependents(s)*:

Spouse

☐ Marriage certification

☐ Social Security card

☐ Most recent Federal Tax Form that shows the couple was married (please black out financial information)

Children, Stepchildren and Adopted Children up to age 26

☐ Legal Birth Certificate

☐ Legal Adoption Documentation

☐ Social Security card(s)

☐ **SISC III Basic Life/AD&D Insurance Enrollment Form** – The Basic Life Insurance includes Accidental Death and Dismemberment benefits covers up to $50,000 *for employees only*. Beneficiary Designation must be submitted to be enrolled.

☐ **American Fidelity Section 125 Benefit Plan** – By setting up your monthly benefits deduction **"pre-tax"** you have the opportunity to reduce taxes and increase your spending income.

☐ **Voluntary Accidental Death and Dismemberment Insurance –** This plan is paid in full by the employee.

*Disabled Dependents over age 26 – Legal Birth Certificate, Federal Tax form that shows child is claimed as an IRS dependent, proof of 6 months prior creditable coverage, complete Anthem Disabled Dependent Certification Form.

There are only three times when you can enroll in benefits or possibly make changes to your benefits. Enrollment or changes outside of these three times are not permitted:

1. As a newly hired benefits-eligible employee.
2. After experiencing a qualified family status change such as birth of a new child, marriage, etc. Benefits must be notified within **30 days** of the qualifying event.
3. During our annual Open Enrollment.

Thank you,
Rosemary Romero– Benefits Technician
559.595.7320

SISC III
SELF-INSURED SCHOOLS OF CALIFORNIA
Schools Helping Schools

Dinuba Unified School District
Certificated Employees
October 1, 2024-25

PPO PLANS	Option #1/40564G 80% G $20	Option #2/40564C 80% E $20	Option #3/40553B 90% - C $20	Option #4/40564D 100% - D $20	Option#5/40564A 100% - A $ 10
MEDICAL - CALENDAR YEAR Deductibles & Maximums	**Member Pays**	**Member Pays**	**Member Pays**	**Member Pays**	**Member Pays**
Individual/Family Deductibles	$500/$1,000	$300/$600	$200/$500	$300/$600	$0/$0
Individual/Family Out-of-Pocket (OOP) Max (**includes medical deductibles, co-insurance and co-pays**)	$2,000/$4,000	$1,000/$3,000	$1,000/$3,000	$1,000/$3,000	$1,000/$3,000
PROFESSIONAL SERVICES					
Office Visit (OV) co-pay (**$0 Copay for 1st 3 cal yr Primary Care OV on Non-H S A PPO plans**)	$20	$20	$20	$20	$10
Urgent Care co-pay	$20	$20	$20	$20	$10
Specialists/Consultants co-pay	$20	$20	$20	$20	$10
Prenatal, postnatal office visit co-pay	$20	$20	$20	$20	$10
Scans: CT, CAT, MRI, PET etc.	20%	20%	10%	0%	0%
Diagnostic X-ray & Laboratory Procedures	20%	20%	10%	0%	0%
Infertility (diagnosis/treatment of causes of infertility)	Not covered	Not covered	Not covered	Not covered	Not covered
Preventive Care Services (includes physical exams & screenings)	0%, Deductible Waived	0%, Deductible Waived	0%, Deductible Waived	0%, Deductible Waived	0%, Deductible Waived
HOSPITAL & SKILLED NURSING FACILITY SERVICES					
Emergency Room visit co-pay (waived if admitted)	20% $100 co-pay	20% $100 co-pay	10% $100 co-pay	0% $100 co-pay	0% $100 co-pay
Inpatient Hospital co-pay (preauthorization required)	20%	20%	10%	0%	0%
Outpatient Hospital co-pay	20%	20%	10%	0%	0%
Surgery, Outpatient (performed in an Ambulatory Surgery Center)	20%	20%	10%	0%	0%
Surgery, Outpatient (performed in a Hospital) - limits may apply	20%	20%	10%	0%	0%
MENTAL HEALTH SERVICES & SUBSTANCE ABUSE TREATMENT					
INPATIENT CARE: Facility based care (preauthorization required)	20%	20%	10%	0%	0%
OUTPATIENT CARE: Facility based care (preauthorization required)	Deductible waived office visit co-pay applies	Deductible waived office visit co-pay applies	Deductible waived office visit co-pay applies	Deductible waived office visit co-pay applies	Deductible waived office visit co-pay applies
OTHER SERVICES					
Acupuncture - Limits apply	20%	20%	10%	0%	0%
Ambulance (Ground or Air)	$100 Co Pay + 20%	$100 Co Pay + 20%	$100 Co Pay + 10%	$100 co Pay	$100 co Pay
Chiropractic - Limits apply	20%	20%	10%	0%	0%
Durable Medical Equipment (DME)	20%	20%	10%	0%	0%
Physical and Occupational Therapy - Limits apply	20%	20%	10%	0%	0%
PRESCRIPTION DRUG PLANS					
Generic co-pay/days supply	$10/30-Days	$10/30-Days	$10/30-Days	$10/30-Days	$9/30-Days
Brand Deductible Individual/Family	$200/$500	$200/$500	$200/$500	$200/$500	Not Applicable
Brand co-pay/days supply	$35/30-Days	$35/30-Days	$35/30-Days	$35/30-Days	$35/30-Days
Mail Order (Generic-Brand co-pay/days supply)	$0-$90/90-Days	$0-$90/90-Days	$0-$90/90-Days	$0-$90/90-Days	$0-$90/90-Days
Individual/Family RX Out-of-pocket (OOP) Max (**Includes Rx deductibles and co-pays**)	$2,500/$3,500	$2,500/$3,500	$2,500/$3,500	$2,500/$3,500	$2,500/$3,500
Vision Service Plan (www.vsp.com)	Plan C, $5 Exam/$25 Materials co-pay Exam, frames & lenses	Plan C, $5 Exam/$25 Materials co-pay Exam, frames & lenses	Plan C, $5 Exam/$25 Materials co-pay Exam, frames & lenses	Plan C, $5 Exam/$25 Materials co-pay Exam, frames & lenses	Plan C, $5 Exam/$25 Materials co-pay Exam, frames & lenses
Delta Dental Plan: (www.deltadentalca.org)	Premier Incentive Plan, Unlimited cal yr max. Ortho 50% up to $1,000 lifetime.	Premier Incentive Plan, Unlimited cal yr max. Ortho 50% up to $1,000 lifetime.	Premier Incentive Plan, Unlimited cal yr max. Ortho 50% up to $1,000 lifetime.	Premier Incentive Plan, Unlimited cal yr max. Ortho 50% up to $1,000 lifetime.	Premier Incentive Plan, Unlimited cal yr max. Ortho 50% up to $1,000 lifetime.

RATES	2023-24	2024-25	2023-24	2024 25	2023-24	2024-25	2023-24	2024-25	2023-24	2024-25
Medical	$1,144.00	$1161.	$1,214.00	1231.00	$1302.00	$1,319.00	$1,345.00	$1,363.00	$1,456.00	$1,525.00
Dental	$132.20	$132.20	$132.20	$132.20	$132.20	$132.20	$132.20	$132.20	$132.20	$132.20
Vision	$20.70	$20.70	$20.70	$20.70	$20.70	$20.70	$20.70	$20.70	$20.70	$20.70
Life Insurance	$7.25	$7.25	$7.25	$7.25	$7.25	$7.25	$7.25	$7.25	$7.25	$7.25
TOTAL PER EMP/MO	**$1,304.15**	**$1,321.15**	**$1,374.15**	**$1,391.15**	**$1,462.15**	**$1479.15**	**$1,505.15**	**$1,523.15**	**$1,668.15**	**$1686.15**
ANNUAL PREMIUM	$15,802.80		$16,642.80		$17698.80		$18,223.80		$20,179.80	
DISTRICT CONTRIBUTION	$15,649.80		$15,649.80		$15,649.80		$15,649.80		$15,649.80	
DIFFERENCE PER EMP/MO (9) (Monthly cost does not include May deduction)	**$17.00**		**$110.33**		**$227.67**		**$286.00**		**$503.33**	

NOTATIONS:

This sheet is only a brief summary of benefits that reflects In-Network benefits. Please review the benefit summaries or plan booklets for details, limitations and exclusions. Benefits may be subject to change due to mid-year legislative changes.

OOP maximum on Anthem plans with a Navitus pharmacy carve out does not include prescription drug co-pays.

Coinsurance and co-pays do NOT carryover to the next calendar year.

Plans with a deductible all have 4th quarter carryover (October 1 - December 31)

For plans with a deductible, co-insurance applies after the deductible has been met unless otherwise noted.

CERTIFICATED
HEALTH AND WELFARE CALCULATION FORM
2024-2025

*****Please return this form to Rosemary Romero*****

23-24 JULY - SEPTEMBER RATES	
PLAN / Group Number	**OLD RATES**
OPTION #1 / 40564G	$1,304.15
OPTION #2 / 40564C	$1,374.15
OPTION #3 / 40553B	$1,462.15
OPTION #4 / 40564D	$1,505.15
OPTION #5 / 40564A	$1,668.15

District Contribution
13,041.50

24-25 OCTOBER - JUNE RATES	
PLAN / Group Number	**NEW RATES**
OPTION #1 / 40564G	$1,321.15
OPTION #2 / 40564C	$1,391.15
OPTION #3 / 40553B	$1,479.15
OPTION #4 / 40564D	$1,523.15
OPTION #5 / 40564A	$1,686.15

ENTER **OLD RATE** AMOUNT (**Use your Anthem ID card to find your GROUP # and enter monthly rate from table above)**	
ENTER AUGUST DEDUCTION- **Found on your May Paystub**	

	DISTRICT CONTRIBUTION	Group #40564G OPTION #1	Group #40564C OPTION #2	Group #40553B OPTION #3	Group #40564D OPTION #4	Group #40564A OPTION #5
JULY						
AUGUST						
SEPTEMBER	$ 1,304.15	$1,304.15	$1,374.15	$1,462.15	$1,505.15	$1,668.15
OCTOBER	$ 1,304.15	$1,321.15	$1,391.15	$1,479.15	$1,523.15	$1,686.15
NOVEMBER	$ 1,304.15	$1,321.15	$1,391.15	$1,479.15	$1,523.15	$1,686.15
DECEMBER	$ 1,304.15	$1,321.15	$1,391.15	$1,479.15	$1,523.15	$1,686.15
JANUARY	$ 1,304.15	$1,321.15	$1,391.15	$1,479.15	$1,523.15	$1,686.15
FEBRUARY	$ 1,304.15	$1,321.15	$1,391.15	$1,479.15	$1,523.15	$1,686.15
MARCH	$ 1,304.15	$1,321.15	$1,391.15	$1,479.15	$1,523.15	$1,686.15
APRIL	$ 1,304.15	$1,321.15	$1,391.15	$1,479.15	$1,523.15	$1,686.15
MAY	$ 1,304.15	$1,321.15	$1,391.15	$1,479.15	$1,523.15	$1,686.15
JUNE	$ 1,304.15	$1,321.15	$1,391.15	$1,479.15	$1,523.15	$1,686.15
TOTAL PLAN PREMIUM		$13,194.50	$13,894.50	$14,774.50	$15,213.50	$16,843.50
LESS DISTRICT CONTRIBUTION	**$ 13,041.50**	**$13,041.50**	**$13,041.50**	**$13,041.50**	**$13,041.50**	**$13,041.50**
EMPLOYEE'S COST		$153.00	$853.00	$1,733.00	$2,172.00	$3,802.00
Less August Deduction		$0.00	$0.00	$0.00	$0.00	$0.00
TOTAL EMPLOYEE COST		$153.00	$853.00	$1,733.00	$2,172.00	$3,802.00
EMPLOYEE MONTHLY PAYMENT	**9**	**$17.00**	**$94.78**	**$192.56**	**$241.33**	**$422.44**

NOTE: If your Monthly payment ends in a negitive amount. Your payment is ZERO.

I have read the enclosed information (also on DUSD's website) regarding the health benefits and have elected the following:

I would like to change to Option or group # _____ **for 2024-2025 plan year.**

Employee Name (PLEASE PRINT) _____ Employee Signature _____ Date _____

Staff Use Only

SISCONNECT:_____

SACS ACA: _____/_____/_____

Balancing sheet: _____/_____/_____

SISC Recap: _____/_____/_____

SACS VOL DED: _____/_____/_____

SISC III ENROLLMENT FORM (DO NOT use for Kaiser members, use Kaiser Permanente enrollment form for Kaiser members)

(Type or print clearly in black ink)

SECTION I: SELECTED COVERAGE – REQUIRED (DISTRICT USE ONLY)

ENROLLMENT REASON: ☐ NEW HIRE ☐ OPEN ENROLLMENT ☐ EMPLOYEE STATUS CHANGE ☐ LOSS OF COVERAGE ☐ COBRA

QUALIFYING DATE: ____________ EFFECTIVE DATE: ____________ HIRE DATE: ______________ DISTRICT APPROVED INITIALS: ________

DISTRICT NAME (DO NOT ABBREVIATE)	EMPLOYEE GROUP (BARGAINING UNIT)	EMPLOYEE TYPE
Dinuba Unified School District	■ Certificated ☐ Classified ☐ Management	■ Full-Time ☐ Part-Time ☐ Variable/Temporary/Seasonal

MEDICAL GROUP NO.	DELTA DENTAL GROUP NO.	VISION GROUP NO.	LIFE GROUP NO.
	7072 2064	253575531ACN	G000ABIH-132B

SECTION II: EMPLOYEE / APPLICANT INFORMATION – REQUIRED

■ MEDICAL ■ DENTAL ■ VISION ■ LIFE

SOCIAL SECURITY NO.	LAST NAME (PRINT)	FIRST NAME (PRINT)	DATE OF BIRTH	☐ MALE ☐ FEMALE

STREET ADDRESS	CITY	STATE	ZIP

TELEPHONE NO.	E-MAIL ADDRESS	IPA (HMO ONLY–REQUIRED)	PCP (HMO ONLY–REQUIRED)	CURRENT PROVIDER? ☐ YES ☐ NO

MEDICARE COVERAGE If you are retired and entitled to Medicare and not enrolled, you may be subject to a premium surcharge.

ARE YOU RETIRED? ☐ YES ☐ NO

IF YES, DO YOU HAVE MEDICARE? ☐YES ☐NO (Copy of Medicare card required)

TOTALLY DISABLED? ☐ YES ☐ NO

DO ANY OF YOUR DEPENDENTS HAVE MEDICARE? ☐ YES ☐ NO (Copy of Medicare card required)

SECTION III: DEPENDENT INFORMATION Proof of eligibility required (i.e. birth/marriage/domestic partner certificate)

☐ MEDICAL ☐ DENTAL ☐ VISION

☐ SPOUSE ☐ DOMESTIC PARTNER GENDER ☐ M ☐ F	LAST NAME (PRINT)		FIRST NAME (PRINT)		SOCIAL SECURITY NO.	
ELIGIBLE FOR OTHER HEALTH PLAN? ☐ YES ☐ NO	ENROLLED IN OTHER HEALTH PLAN? ☐ YES ☐ NO	DATE OF BIRTH	TOTALLY DISABLED? ☐ YES ☐ NO	IPA (HMO ONLY-REQUIRED)	PCP (HMO ONLY-REQUIRED)	IS THIS YOUR CURRENT PROVIDER? ☐ YES ☐ NO

☐ MEDICAL ☐ DENTAL ☐ VISION

☐ SON ☐ DAUGHTER	LAST NAME (PRINT)		FIRST NAME (PRINT)		SOCIAL SECURITY NO.	
ELIGIBLE FOR OTHER HEALTH PLAN? ☐ YES ☐ NO	ENROLLED IN OTHER HEALTH PLAN? ☐ YES ☐ NO	DATE OF BIRTH	TOTALLY DISABLED? ☐ YES ☐ NO	IPA (HMO ONLY-REQUIRED)	PCP (HMO ONLY-REQUIRED)	IS THIS YOUR CURRENT PROVIDER? ☐ YES ☐ NO

☐ MEDICAL ☐ DENTAL ☐ VISION

☐ SON ☐ DAUGHTER	LAST NAME (PRINT)		FIRST NAME (PRINT)		SOCIAL SECURITY NO.	
ELIGIBLE FOR OTHER HEALTH PLAN? ☐ YES ☐ NO	ENROLLED IN OTHER HEALTH PLAN? ☐ YES ☐ NO	DATE OF BIRTH	TOTALLY DISABLED? ☐ YES ☐ NO	IPA (HMO ONLY-REQUIRED)	PCP (HMO ONLY-REQUIRED)	IS THIS YOUR CURRENT PROVIDER? ☐ YES ☐ NO

☐ MEDICAL ☐ DENTAL ☐ VISION

☐ SON ☐ DAUGHTER	LAST NAME (PRINT)		FIRST NAME (PRINT)		SOCIAL SECURITY NO.	
ELIGIBLE FOR OTHER HEALTH PLAN? ☐ YES ☐ NO	ENROLLED IN OTHER HEALTH PLAN? ☐ YES ☐ NO	DATE OF BIRTH	TOTALLY DISABLED? ☐ YES ☐ NO	IPA (HMO ONLY-REQUIRED)	PCP (HMO ONLY-REQUIRED)	IS THIS YOUR CURRENT PROVIDER? ☐ YES ☐ NO

- I understand it is my responsibility to notify my district once a dependent is no longer eligible due to divorce or over age children. If I fail to report loss of eligibility I may be financially liable to SISC if claims were paid on behalf of non-eligible individuals.
- DEDUCTION AUTHORIZATION: If applicable, I authorize my school district to deduct from my wages the required contribution.
- NON-PARTICIPATING PROVIDER: I understand that I am responsible for a greater portion of my medical costs when I use a non-participating provider.
- HIV Testing Prohibited: California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance.
- EFFECTIVE DATE: The effective date of coverage is subject to SISC III approval.
- Any complaints regarding the exemption due to the Knox-Keene Health Care Service Plan Act of 1975 may be directed to the Department of Managed Health Care of the State of California.

SECTION IV: SIGNATURE OF UNDERSTANDING – APPLICANT MUST SIGN

I have read and understood the provisions outlined on this form. All information on this form is correct and true. I understand that it is the basis on which coverage may be issued under the plan. Any misstatements or omissions may result in future claims being denied and/or the policy being rescinded. You are entitled to a copy of this signed authorization for your files. Additionally, any person who knowingly and with intent to injure, defraud, or deceive the district, SISC, or plan service provider, by filing a statement or claim containing false or misleading information may be guilty of a criminal act punishable under law. I attest by signing below that I have reviewed the information provided on this application and to the best of my knowledge and belief; it is true and accurate with no omissions or misstatements.

ARBITRATION AGREEMENT: I UNDERSTAND THAT ANY AND ALL DISPUTES BETWEEN MYSELF (AND/OR ANY ENROLLED FAMILY MEMBER) AND SISC III (INCLUDING CLAIMS ADMINISTRATOR OR AFFILIATE) INCLUDING CLAIMS FOR MEDICAL MALPRACTICE, MUST BE RESOLVED BY BINDING ARBITRATION, IF THE AMOUNT IN DISPUTE EXCEEDS THE JURISDICTIONAL LIMIT OF THE SMALL CLAIMS COURT, AND NOT BY LAWSUIT OR RESORT TO COURT PROCESS, EXCEPT AS CALIFORNIA LAW PROVIDES FOR JUDICIAL REVIEW OF ARBITRATION PROCEEDINGS. UNDER THIS COVERAGE, BOTH THE MEMBER AND SISC III ARE GIVING UP THE RIGHT TO HAVE ANY DISPUTE DECIDED IN A COURT OF LAW BEFORE A JURY. SISC III AND THE MEMBER ALSO AGREE TO GIVE UP ANY RIGHT TO PURSUE ON A CLASS BASIS ANY CLAIM OR CONTROVERSY AGAINST THE OTHER. (FOR MORE INFORMATION REGARDING BINDING ARBITRATION, PLEASE REFER TO YOUR EVIDENCE OF COVERAGE BOOKLET.)

____

Applicant Signature Required   Date

Plan Benefit Highlights for:	PPO Incentive Unlimited with Orthodontic
Group No:	Active, Retirees, and COBRA
Network:	PPO/Premier

In this incentive plan, Delta Dental pays 70% of the contract allowance for covered basic services and major services during the first year of eligibility. The coinsurance percentage will increase by 10% each year (to a maximum of 100%) for each enrollee if that person visits the dentist at least once during the year. If an enrollee does not use the plan during the calendar year, the percentage remains at the level attained the previous year. If an enrollee becomes ineligible for benefits and later regains eligibility, the percentage will drop back to 70%.

Eligibility	Primary enrollee, spouse (includes domestic partner) and eligible dependent children to age **26**	
Deductibles	N/A	
Deductibles waived for D & P?	N/A	
Maximums	The maximum benefit paid per calendar year is **Unlimited** per person out-of-network	
Waiting Period(s)	Basic Benefits None	Major Benefits None

Benefits and Covered Services*	Delta Dental PPO dentists**	Non-Delta Dental dentists**
Diagnostic & Preventive Services (D & P) Exams, 2 cleanings per cal year, x-rays	70-100 %	70-100%
Basic Services Fillings, simple tooth extractions, sealants	70-100 %	70-100%
Endodontics (root canals) Covered Under Basic Services	70-100 %	70-100%
Periodontics (gum treatment) Covered Under Basic Services	70-100 %	70-100%
Oral Surgery Covered Under Basic Services	70-100 %	70-100%
Major Services Crowns, inlays, onlays, and cast restorations	70-100 %	70-100%
Prosthodontics Bridges and dentures	60 %	50%
Implants	60% with separate $2000 annual maximum	50% with separate $2000 annual maximum
Orthodontic Benefits Adults and dependent children	100 %	100%
Orthodontic Maximums	Separate **$1,000** Lifetime maximum per person	
Dental Accident Benefits	100% (separate $1,000 maximum per person per calendar year)	

* Limitations or waiting periods may apply for some benefits; some services may be excluded from your plan. Reimbursement is based on Delta Dental contract allowances and not necessarily each dentist's actual fees.

** Reimbursement is based on PPO contracted fees for PPO dentists, Premier contracted fees for Premier dentists and program allowance for out-of-network dentists.

Delta Dental of California
100 First St.
San Francisco, CA 94105

Customer Service
866-499-3001

Claims Address
P.O. Box 997330
Sacramento, CA 95899-7330

deltadentalins.com

A Look at Your VSP Vision Coverage

With VSP and SELF-INSURED SCHOOLS OF CALIFORNIA, your health comes first.

Enroll in VSP® Vision Care to get access to savings and personalized vision care from a VSP network doctor for you and your family.

vsp vision care | SISC Self-Insured Schools of California *Schools Helping Schools*

Value and savings you love.

Save on eyewear and eye care when you see a VSP network doctor. Plus, take advantage of Exclusive Member Extras which provide offers from VSP and leading industry brands totaling over $3,000 in savings.

Provider choices you want.

vsp PREMIER PROGRAM

Maximize your benefits at a Premier Program location, which is part of our incredible network of doctors.

Shop online and connect your benefits.

eyeconic a vsp vision company

Eyeconic® is the preferred VSP online retailer where you can shop in-network with your vision benefits. See your savings in real time when you shop over 70 brands of contacts, eyeglasses, and sunglasses.

Quality vision care you need.

You'll get great care from a VSP network doctor, including a WellVision Exam®. An annual eye exam not only helps you see well, but helps a doctor detect signs of eye conditions and health conditions, like diabetes and high blood pressure.

Using your benefit is easy!

Create an account on **vsp.com** to view your in-network coverage, find the VSP network doctor who's right for you, and discover savings with Exclusive Member Extras. At your appointment, just tell them you have VSP.

More Ways to Save

Extra

$20

to spend on Featured Brands†

bebe · CALVIN KLEIN · COLE HAAN · DRAGON · FLEXON · LACOSTE · and more

See all brands and offers at **vsp.com/offers**.

+

Up to

40%

Savings on lens enhancements‡

Enroll through your employer today.
Contact us: **800.877.7195** or **vsp.com**

Your VSP Vision Benefits Summary

SELF-INSURED SCHOOLS OF CALIFORNIA and VSP provide you with an affordable vision plan.

PROVIDER NETWORK:
VSP Signature
EFFECTIVE DATE:
01/01/2024

vsp vision care

BENEFIT	DESCRIPTION	COPAY	FREQUENCY
Your Coverage with a VSP Provider			
WELLVISION EXAM	• Focuses on your eyes and overall wellness	$5	Every calendar year
ESSENTIAL MEDICAL EYE CARE	• Retinal screening for members with diabetes • Additional exams and services beyond routine care to treat immediate issues from pink eye to sudden changes in vision or to monitor ongoing conditions such as dry eye, diabetic eye disease, glaucoma, and more. • Coordination with your medical coverage may apply. Ask your VSP doctor for details.	$0 per screening $20 per exam	Available as needed
PRESCRIPTION GLASSES		**$25**	
FRAME[+]	• $170 featured frame brands allowance • $150 frame allowance • 20% savings on the amount over your allowance • $150 Walmart®/Sam's Club®/Costco® frame allowance	Included in Prescription Glasses	Every calendar year
LENSES	• Single vision, lined bifocal, and lined trifocal lenses • Impact-resistant lenses for dependent children	Included in Prescription Glasses	Every calendar year
LENS ENHANCEMENTS	• Standard progressive lenses • Tints/Light-reactive lenses • Premium progressive lenses • Custom progressive lenses • Average savings of 40% on other lens enhancements	$0 $0 $80 - $90 $120 - $160	Every calendar year
CONTACTS (INSTEAD OF GLASSES)	• $150 allowance for contacts and contact lens exam (fitting and evaluation) • 15% savings on a contact lens exam (fitting and evaluation)	$0	Every calendar year
EXTRA SAVINGS	**Glasses and Sunglasses** • Extra $20 to spend on featured frame brands. Go to **vsp.com/offers** for details. • 30% savings on additional glasses and sunglasses, including lens enhancements, from the same VSP provider on the same day as your WellVision Exam. Or get 20% from any VSP provider within 12 months of your last WellVision Exam.		
	Routine Retinal Screening • No more than a $39 copay on routine retinal screening as an enhancement to a WellVision Exam		
	Laser Vision Correction • Average 15% off the regular price or 5% off the promotional price; discounts only available from contracted facilities • After surgery, use your frame allowance (if eligible) for sunglasses from any VSP doctor		

YOUR COVERAGE GOES FURTHER IN-NETWORK

With so many in-network choices, VSP makes it easy to get the most out of your benefits. You'll have access to preferred private practice, retail, and online in-network choices. Log in to **vsp.com** to find an in-network provider.

†Only available to VSP members with applicable plan benefits. Frame brands and promotions are subject to change.
‡Savings based on doctor's retail price and vary by plan and purchase selection; average savings determined after benefits are applied. Ask your VSP network doctor for more details.
+Coverage with a retail chain may be different or not apply.

VSP guarantees member satisfaction from VSP providers only. Coverage information is subject to change. In the event of a conflict between this information and your organization's contract with VSP, the terms of the contract will prevail. Based on applicable laws, benefits may vary by location. In the state of Washington, VSP Vision Care, Inc., is the legal name of the corporation through which VSP does business. TruHearing is not available directly from VSP in the states of California and Washington.

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

Classification: Restricted

DEPENDENT ELIGIBILITY DOCUMENTATION CHART

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

Dependent Type	Required Documentation
Spouse	• Prior year's Federal Tax Form that shows the couple was married (financial information may be blocked out). • For newly married couples where prior year tax return is not available a marriage certificate will be accepted.
Domestic Partner	• Certificate of Registered Domestic Partnership issued by State of California (AB 205 Compliant) • SISC Affidavit of Domestic Partnership (when applicable) (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 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 **Blue Shield (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 Declaration of Disability for Overage Dependent Child **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)

SISC
Self-Insured Schools of California
Schools Helping Schools

Basic Life /AD&D Insurance

Enrollment Form

Underwritten by Lincoln Financial Group

EMPLOYEE SECTION (Please print clearly.)

SOCIAL SECURITY NO.	LAST NAME (PRINT)	FIRST NAME (PRINT)	MI	GENDER ☐ MALE ☐ FEMALE ☐ UNDEFINED

DATE OF BIRTH	STREET ADDRESS	CITY	STATE	ZIP	☐ FULL-TIME ☐ PART-TIME

BENEFICIARY FOR DEATH BENEFITS (Right to change beneficiary is reserved to the insured.)

If more than one beneficiary is named, the beneficiaries shall share benefit equally unless otherwise stated below. If indicating benefit percentages, the percentages must total 100% for Primary Beneficiaries and 100% for Secondary Beneficiaries. Some states have laws regarding beneficiary designation. Please consult your employer/benefits administrator for additional information.

Primary Beneficiary Designation

LAST NAME	FIRST NAME	RELATIONSHIP (Spouse, Child, etc.)	DATE OF BIRTH (MM/DD/YYYY)	ADDRESS OF BENEFICIARY (Address, City, State, Zip)	BENEFIT PERCENTAGE
				Percentage Total:	100%

Secondary Beneficiary Designation

LAST NAME	FIRST NAME	RELATIONSHIP (Spouse, Child, etc.)	DATE OF BIRTH (MM/DD/YYYY)	ADDRESS OF BENEFICIARY (Address, City, State, Zip)	BENEFIT PERCENTAGE
				Percentage Total:	100%

ENROLLMENT INFORMATION

Enrollment must occur within 31 days from the date the employee becomes eligible (or as otherwise stated in the policy). If you are required to pay premiums for any coverage, the enrollment form must be signed and dated to authorize payroll deductions. The premium amounts indicated on this form are estimates, and are subject to change based on the final terms and conditions of the policy as well as your salary and age on the effective date of the policy.

AGREEMENT AND SIGNATURE

I represent that the information I have provided in this enrollment form is complete, true and accurate to the best of my knowledge. I understand that payment of premium does not ensure my eligibility for coverage. I understand and agree that I must satisfy all active work and/or active employment requirements that pertains to the policy to be eligible for coverage. I understand and agree that life insurance coverage for my eligible dependents may be delayed if they are confined in a hospital on the date insurance would otherwise begin, in accordance with the terms of the policy. Should I decline coverage(s), I understand and accept the Waiver of Group Insurance provisions that follow.
By signing below, I acknowledge that I understand and agree to the above statements, and that I have read and understand the benefit summaries provided to me for each line of coverage. I understand that payment of premium does not ensure eligibility for coverage.

SIGNATURE OF EMPLOYEE _____ **DATE** _____/_____/_____

WAIVER OF GROUP INSURANCE

Should I apply for waived coverage(s) in the future (either for myself or my eligible dependent(s)), I understand that evidence of insurability may be required, acceptable to the Insurance Company, at my own expense. Should Voluntary Life Insurance be offered by my employer, my initials here _____ are my acknowledgement that I have chosen to waive such coverage.
The above requirements will apply unless otherwise stated in the policy, or unless prohibited by any applicable state or federal law.

DISTRICT USE ONLY

DISTRICT NAME:	DISTRICT ID #:
Dinuba Unified School District	75531

HIRE DATE:	EFFECTIVE DATE:	HOURS WORKED PER WEEK:	JOB DESCRIPTION/CLASSIFICATION:	AMOUNT OF COVERAGE:
				50,000

Original/District Copy/SISC Copy/Employee

Voluntary Enrollment Form

Underwritten by: Mutual of Omaha Insurance Company

Employer Section

Company Name:
SISC Voluntary AD&D Program

City:		State:	Zip Code:
Sub Group Name:		Location Code:	
Group I.D.:	Sub-group I.D.: / Class:	Effective Date:	Hours worked per week:
Current Base Pay $ ☐ Hourly ☐ Weekly ☐ Biweekly ☐ Monthly ☐ Semimonthly ☐ Annually		Full-Time Employment Date:	Occupation:

Employee Section (Please Print)

Social Security:	Name: Last First M.I.	
Birth Date: Mo. Day Yr.	Gender: ☐ Male ☐ Female	Marital Status:
Street Address:		
City:	State:	Zip Code:

Voluntary AD&D Coverage Election

Review & Check As Applicable

		Yes	No	Benefit Amount	Premium Amount
Voluntary AD&D	Employee Only	☐	☐	$_____	$_____
Voluntary AD&D	Employee & Spouse	☐	☐	$_____	$_____
Voluntary AD&D	Employee & Child(ren)	☐	☐	$_____	$_____
				Total Premium	**$_____**

Dependent Information (Please Print)

Name of Dependent(s)	Gender	Relationship	Birth Date Mo. Day Yr.	Social Security Number
Spouse:				
Child(ren):				

Beneficiary for Death Benefits – Right to Change Beneficiary is Reserved to the Insured.

(If more than one beneficiary is named, the beneficiaries shall share equally unless otherwise stated below.)

Primary Beneficiary Last Name	First	M.I.	Relationship to Insured	**Secondary Beneficiary** Last Name	First	M.I.	Relationship to Insured
_____	_____	____	_____	_____	_____	____	_____
_____	_____	____	_____	_____	_____	____	_____

Instructions: Application must be made within 31 days from the date the employee becomes eligible (or as otherwise stated in the plan). If plan is contributory, form **MUST** be signed and dated to authorize payroll deductions. **Should you decline coverage(s) for either yourself or your eligible dependent(s), you MUST complete the Waiver of Group Voluntary Insurance on the back of this form**.

I represent that the information I have provided in this Enrollment Form is complete, true and accurate, to the best of my knowledge.

Signature of Employee _____ **Date** _____/_____/_____

Waiver of Group Voluntary Insurance

I have been given the opportunity to apply for Group Voluntary AD&D Insurance as offered by the Policyholder, and after careful consideration have decided not to enroll:

For:
- ☐ Myself (and all eligible dependents, if applicable)
- ☐ My eligible dependent spouse only
- ☐ My eligible dependent spouse and children only
- ☐ My eligible dependent children only

I understand and accept the Waiver of Group Insurance provisions.

Signature of Employee_____ **Date**_____/_____/_____

Insurance Company Use Only

Acknowledgement_____Date Recorded _____/_____/_____

VOLUNTARY AD&D INSURANCE BENEFITS SUMMARY

For Employees of: SISC - Dinuba Unified School District

ELIGIBILITY

Employee Eligibility Requirement	You must be an active full-time employee of the Policyholder (working 10 or more hours per week) domiciled in the United States. Employee means a citizen or permanent resident of the United States or a person who is authorized to work in the United States pursuant to the Immigration and Nationality Act and related rules and regulations.
Dependent Eligibility Requirement	You must elect insurance for your dependent(s) to be eligible. Eligible dependent(s) include your spouse and any unmarried dependent child(ren) or foster child(ren) under the age of 19 (26 if enrolled full-time in an accredited college or university or any age if incapacitated).
Premium Payment	You pay 100% of the premium for this insurance.

BENEFIT AMOUNT GUIDELINES

	Employee	**Family Plans**		
		+ Spouse & Child(ren)	**+ Spouse Only**	**+ Child(ren) Only**
Minimum Benefit	$10,000	Spouse Benefit: 50% of Employee's benefit Child Benefit: 10% of Employee's benefit	60% of Employee's benefit	20% of Employee's benefit
Maximum Benefit	$500,000 (amounts over $250,000 are subject to 10 times your annual salary)			
Increment(s)	$10,000			

BENEFITS

About This Insurance	This accidental death and dismemberment (AD&D) insurance plan offers protection on a worldwide basis against any covered accident in the course of business or pleasure, whether on or off the job, or in or away from home. This protection is available 24 hours a day, everyday.	
Benefit Amount (The Principal Sum)	Within the coverage guidelines defined above, you select the amount of AD&D insurance coverage you want. This plan also includes the option to select coverage for your spouse and dependent child(ren). The AD&D benefit amount is also known as the Principal Sum.	
Basic Benefits	Benefits are payable if you (or your dependent, if covered) are injured as a result of an accident, the injury is independent of sickness and all other causes, and a loss occurs within 365 days after the date of the accident. Benefits are paid as indicated below:	
	Loss	**Benefit**
	▪ Life ▪ Both hands, both feet or entire sight of both eyes ▪ One hand and one foot ▪ One hand and entire sight of one eye ▪ One foot and entire sight of one eye ▪ Speech and hearing (both ears)	Principal Sum
	▪ One hand, one foot or entire sight of one eye ▪ Speech or hearing (both ears)	50% of the Principal Sum
	▪ Loss of thumb and index finger of same hand	25% of the Principal Sum

FEATURES

Additional AD&D Benefits	In addition to basic AD&D Benefits, you and your dependents (if applicable) are protected by the following: ▪ Air Bag Benefits ▪ Child Education Benefits ▪ Coma Benefits ▪ Day Care Benefits ▪ Premium Waiver/Extension of Coverage ▪ Seat Belt Usage ▪ Spouse Education Benefit ▪ Paralysis Benefit

Note: *Additional information about the benefits and features of this plan will be included in the certificate on file with the Policyholder. Please contact your employer if you have questions.*

AGE REDUCTIONS

Your AD&D Principal Sum is subject to age reductions. At age 65, amounts reduce to 65% of your original Principal Sum. At age 70, amounts reduce to 40% of your original Principal Sum. At age 75, amounts reduce to 25% of your original Principal Sum. At age 80, amounts reduce to 15% of your original Principal Sum.

EXCLUSIONS

This plan does not cover:

- suicide or any attempt thereat while sane or insane;
- loss caused by an act of declared or undeclared war;
- injuries received while participating in training exercises or maneuvers of an armed service while a member of an armed service;
- injuries received while traveling by air, except as provided by the policy;
- injuries received because the insured person was under the influence of any controlled substance, unless administered on the advice of a physician;
- injuries received because the insured person was intoxicated;
- injuries received while traveling in any aircraft which is owned or leased by: (a) the Policyholder, subsidiary or affiliate of the Policyholder; or (b) a director, officer or employee of the Policyholder, subsidiary or affiliate of the Policyholder.

Information about additional exclusions for this plan will be included in the certificate on file with the Policyholder.

Please contact your employer or benefits administrator if you have questions prior to enrolling.

AD&D BENEFIT AMOUNT SELECTION AND PREMIUM AMOUNTS

To select your benefit amount and determine your tenthly premium, do the following:

1) Determine whether you are electing coverage for yourself only or for yourself and your dependents (Employee & Family Coverage).
2) Locate the benefit amount you want to select from the top row of the appropriate premium table. Your benefit amount must be in an increment of $10,000 (ex. $10,000, $50,000 or $150,000).
3) Locate the corresponding tenthly premium amount in the row below.
4) Enter your benefit amount and tenthly premium amount into their respective areas in the AD&D section of your enrollment form.

If the benefit amount you want to select is not presented in the table, select the benefit amount from the top row that when multiplied by another number results in the benefit amount you want to select. For example, if you want $220,000 in coverage, you obtain your premium amount by multiplying the tenthly premium amount for $10,000 times 22. Deductions may vary due to the rounding of premium based on the Principal Sum and plan selected.

Employee Only Coverage 10thly Premium Table

Benefit Amount	**$10,000**	**$50,000**	**$100,000**	**$150,000**	**$200,000**	**$250,000**	**$300,000**	**$350,000**	**$400,000**	**$450,000**
Tenthly Premium	$0.30	$1.50	$3.00	$4.50	$6.00	$7.50	$9.00	$10.50	$12.00	$13.50

Employee & Family Coverage 10thly Premium Table

Benefit Amount	**$10,000**	**$50,000**	**$100,000**	**$150,000**	**$200,000**	**$250,000**	**$300,000**	**$350,000**	**$400,000**	**$450,000**
Tenthly Premium	$0.54	$2.70	$5.40	$8.10	$10.80	$13.50	$16.20	$18.90	$21.60	$24.30

This information describes some of the features of the benefits plan. Certain benefits within the insurance may not be available in all states. Please refer to the certificate for a full explanation of the plan's benefits, exclusions, limitations and reductions. Should there be any discrepancy between the policy/certificate and this outline, the policy/certificate will prevail. Benefits availability is subject to final acceptance and approval by Mutual of Omaha. Accidental death & dismemberment insurance is underwritten by Mutual of Omaha Insurance Company, Mutual of Omaha Plaza, Omaha, Nebraska 68175.

HealthWise Medical Clinic

Hanford

Visalia

Your Private Healthcare Clinic

Free To All Insured Employees, Spouses, and Dependents.

Some HSA Plans May Require A Small Fee For Visits

ACUTE & EPISODIC MEDICAL CARE

Abrasions	Depression & Anxiety	Nebulizer treatments
Acid Reflux	Dizziness/Fainting	Pneumonia
Allergies	Fever	Pregnancy test
Arthritis	Ear Infections	Rashes
Asthma	Gout	Shingles
Bites (Insect & Animal)	Infections	Strep culture
Bronchitis/Laryngitis	Injections	Sprains & Strains
Colds & Flu	Migraines	Urinary Tract Infections
Constipation & Diarrhea	Nausea & Vomiting	Viral Infections

ON-GOING CARE
Diabetes
COPD
Hyperlipidemia
Hypertension
Thyroid
Stress & Depression
Blood Draws
A1c Test

PREVENTION
Flu Vaccination
Heart Health
Diabetes Prevention
Risk Screenings
Routine Physicals
Yearly, Pap smear
Sports Physicals
Weight Management

PROCEDURES
Drainage of abscess
Wound Care
Ear irrigation
Laceration repair
Removal of skin tags
Skin biopsy
Suture/staple removal
Wart removal

Schedule An Appointment Today

www.healthwise.clinic

Your School District's Private Medical Clinic

HealthWise Medical Clnic

Exclusive Healthcare for
District Members & Insured Dependents

- $0 Co-Pays
- In House Labs
- Onsite Pharmacy
- Flu Vaccinations
- COVID-19 Testing

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Call To Schedule An Appointment Today

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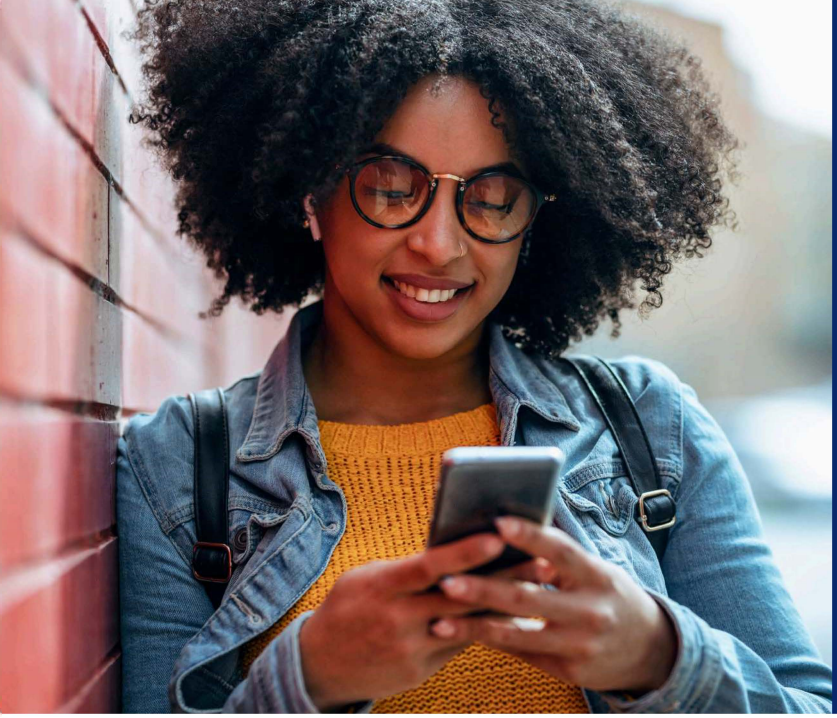
HealthWise Medical Clinic
www.HealthWise.clinic

Visalia
4004 S. Demaree St #A
Visalia, CA 93277
559.272.9549



Anthem

The Sydney Health mobile app makes healthcare easier

Access personalized health and wellness information wherever you are

Use Sydney℠ Health to keep track of your health and benefits — all in one place. With a few taps, you can quickly access your plan details, Member Services, virtual care, and wellness resources. Sydney Health stays one step ahead — moving your health forward by building a world of wellness around you.

Find Care

Search for doctors, hospitals, and other healthcare professionals in your plan's network and compare costs. You can filter providers by what is most important to you, such as gender, languages spoken, or location. You'll be matched with the best results based on your personal needs.

My Health Dashboard

Use My Health Dashboard to find news on health topics that interest you, health and wellness tips, and personalized action plans that can help you reach your goals. It also offers a customized experience just for you, such as syncing your fitness tracker and scanning and tracking your meals.

Chat

If you have questions about your benefits or need information, Sydney Health can help you quickly find what you're looking for and connect you to an Anthem representative.

Virtual Care

Connect directly to care from the convenience of home. Assess your symptoms quickly using the Symptom Checker or talk to a doctor via chat or video session.

Community Resources

This resource center helps you connect with organizations offering no-cost and reduced-cost programs to help with challenges such as food, transportation, and child care.

My Health Records

See a full picture of your family's health in one secure place. Use a single profile to view, download, and share information such as health histories and electronic medical records directly from your smartphone or computer.

Download the Sydney Health app today

Use the app anytime to:

- Find care and compare costs.
- See what's covered and check claims.
- View and use digital ID cards.
- Check your plan progress.
- Fill prescriptions.

Scan the QR code to download the Sydney Health app.

You can also set up an account at anthem.com/ca/register to access most of the same features from your computer.

In addition to using a telehealth service, you can receive in-person or virtual care from your own doctor or another healthcare professional in your plan's network. If you receive care from a doctor or healthcare professional not in your plan's network, your share of the costs may be higher. You may also receive a bill for any charges not covered by your health plan.

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SISC
Self-Insured Schools of California
Schools Helping Schools

Take advantage of no cost benefits to help you get and stay healthy

BENEFIT HIGHLIGHTS

AVAILABILITY AND HOW TO GET STARTED

24/7 Help with Personal Concerns

SISC Employee Assistance Program

Access free, confidential resources for help with emotional, marital, financial, addiction, legal, or stress issues.

All employees at member districts

Call 800-999-7222

Visit anthemEAP.com/SISC

24/7 Virtual Primary Care Doctor

Eden Health

Virtually connect with a primary care physician to manage all your physical and mental healthcare needs. Eden providers diagnose conditions, manage prescriptions, refer to specialists, and answer follow up questions using video visits or live chat.

Anthem and Blue Shield PPO members

Scan the QR code to download the Eden Health app, and register for your Eden Health membership.

Personal Health Coaching

Vida Health

Get one-on-one health coaching, therapy, chronic condition management, health trackers and other tools and resources online or via phone.

Anthem and Blue Shield members

Call 855-442-5885

Visit vida.com/sisc

24/7 Physician Access—Anytime, Anywhere

MDLive

Access to virtual visits with psychiatrists and therapists for members age 10 and up. Virtual urgent care services are available to all members. Physicians can prescribe medication when appropriate. *copays may apply

Anthem and Blue Shield members

Call 800-657-6169

Visit mdlive.com/sisc

Free Generic Medications

Costco

Access most generic medications at no cost through Costco retail and mail order pharmacies. You don't need to be a Costco member.

Anthem and Blue Shield members

Call 800-774-2678 (press 1)

Visit costco.com

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

Continued →

BENEFIT HIGHLIGHTS

AVAILABILITY AND HOW TO GET STARTED

Expert Medical Opinions

Teladoc Medical Experts

Get answers to health care questions and second opinions from world-leading experts.

Anthem, Blue Shield, and Kaiser Permanente members

Call 855-380-7828

Visit teladoc.com/SISC

Physical Therapy for Back or Joint Pain

Hinge Health

Get access to free wearable sensors and monitoring devices, unlimited one-on-one coaching and personalized exercise therapy.

Anthem and Blue Shield PPO members

Call 855-902-2777

Visit hingehealth.com/sisc

24/7 Access to Virtual Maternity and Postpartum Support

Maven

Consult with a care advocate who connects you with trustworthy content delivered by doctors, specialists coaches and other maternity providers to help deal with pregnancy and postpartum concerns.

Anthem and Blue Shield PPO members

Visit mavenclinic.com/join/SISC

Hip, Knee, and Spine Surgical Benefit

Carrum Health

Consult top-quality surgeons on hip and knee replacements and certain spine surgeries. Benefit covers all related travel and medical bills.

Anthem and Blue Shield PPO members

Call 888-855-7806

Visit info.carrumhealth.com/sisc

Enhanced Cancer Benefit

Contigo Health

Consult experts on initial diagnosis and development of a care plan. Benefit includes care coordination services with at home provider, transportation, and more.

Anthem and Blue Shield PPO members

Call 877-220-3556

Visit sisc.contigohealth.com

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

Virtual care designed for you and your family

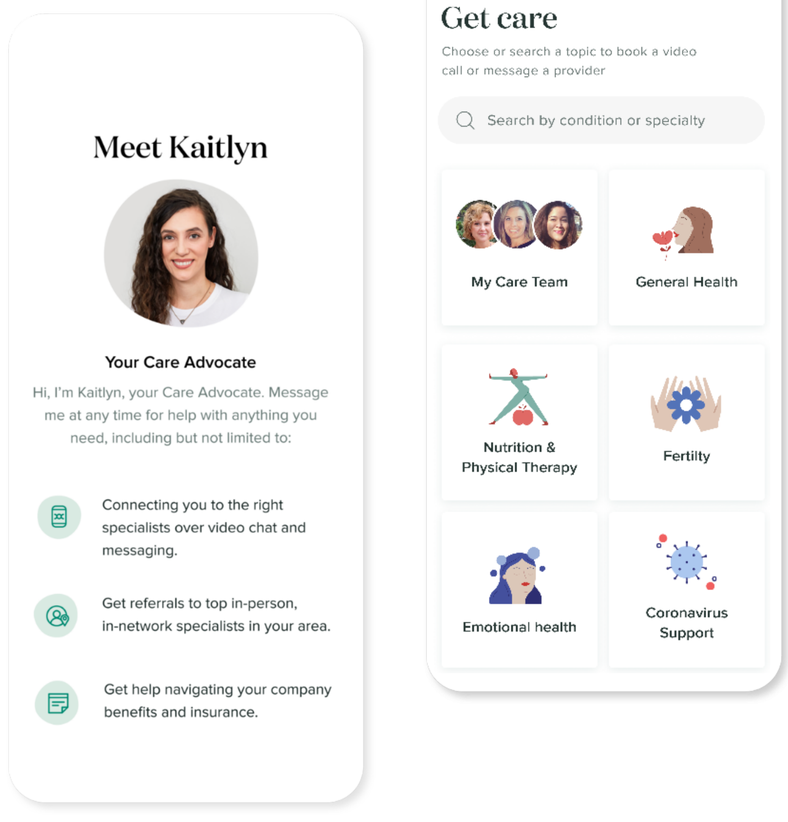
SISC is providing members and their partners with free access to virtual care through Maven for pregnancy, postpartum, and returning to work after parental leave. Use Maven for 24/7 access to doctors, specialists and coaches and trustworthy content tailored to your experience.

Personalized support for every step of your journey:

- Pregnancy
- Postpartum
- Pediatricians
- Infant sleep coaching
- Lactation support
- Return-to-work coaching
- Miscarriage & loss
- Birth planning
- Mental health
- Partner support

Your membership includes:

- A personal Care Advocate who serves as a trusted guide to help you navigate the Maven platform and connect you with providers throughout your journey
- Unlimited video chat and messaging with doctors, nurses, and coaches across 35+ specialties, including OB-GYNs, midwives, high-risk obstetricians, nutritionists, lactation consultants, and career coaches
- Provider-led virtual classes and vetted articles—tailored to your journey



Free diaper subscription from SISC once your baby is born and you complete the Maven Maternity program!

Activate your free membership by scanning the QR code, downloading the Maven Clinic app, or visiting **mavenclinic.com/join/SISC**.

Enrollment in Maven is confidential.

MAVEN | SISC Self-Insured Schools of California *Schools Helping Schools*

Find help today

Receive support when and how you need it.

Call us

Reach us at **800-999-7222**
24/7 for free, confidential help

Visit our website

Go to **anthemEAP.com/SISC**

Your privacy matters. If you contact EAP, no one will know, unless you give permission in writing.* Let us give you a helping hand. Please call **800-999-7222** or go to **anthemEAP.com** and enter **SISC** to log in.

Feeling overwhelmed, stuck or lost?

Lean on EAP, day or night.

What is an Employee Assistance Program (EAP)?
It's a no-cost employee program to help you meet life's challenges. Call **800-999-7222** or visit **anthemEAP.com** and enter **SISC** to log in. Everything you share is confidential.

Anthem

Employee Assistance Program

800-999-7222

anthemEAP.com

Enter **SISC** to log in for free, confidential help, any time, day or night

Anthem

* In accordance with federal and state law, and professional ethical standards.

Language Access Services - (TTY/TDD: 711)
Spanish - Tiene el derecho de obtener esta información y ayuda en su idioma en forma gratuita. Llame al número de Servicios para Miembros que figura en su tarjeta de identificación para obtener ayuda.

Chinese - 您有權使用您的語言免費獲得該資訊和協助。
請撥打您的 ID 卡上的成員服務號碼尋求協助。

Anthem complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

55635CAMENABC VPOD BV Rev. 17/21

Anthem

We're here for your everyday problems and questions, big or small.

The EAP can help you:

- Find child, elder, or pet care.
- Work on achieving work-life balance.
- Parent a child with special needs.
- Deal with addiction and recovery.
- Set retirement goals.
- Find mental health resources and information.
- Address financial or legal issues.

What our clients say

"Every single person that I have spoken to with our EAP has been so very nice and supportive. You have a great staff of caring individuals."

"This is a priceless benefit. I am so thankful to have access to EAP. It means a lot to me and my family."

"It is very helpful to be able to obtain assistance to get over life's bumps now and then. Much appreciated."

"Good to know there are resources out there for everyone who needs assistance and this really helps – just wonderful!"

"I am so glad my employer has this program and I'm able to use it. It is a lifesaver for my family, which does help me perform better at work."

Connect with us by phone, in-person or online. You can:

- Use our toll-free number to speak with an EAP professional.
- Meet with a professional face-to-face.
- Have up to 6 free counseling visits per issue per year.
- Ask us about online visits with LiveHealth Online.

Learn more about how EAP can help you at anthemEAP.com.

Emotional Well-being Resources

These no-cost digital tools can teach you how to manage stress, anxiety, depression, substance use, and sleep issues.

Contact us 24/7.

The EAP is here to make sure you and your household members have the support you need for emotional well-being.

Simply call 800-999-7222 or visit anthemEAP.com to find help right away — at no cost to you.

Anthem

edenhealth + SISC

Need a Primary Care Doctor?

Just ask Eden. You'll get connected to an entire health Care Team.

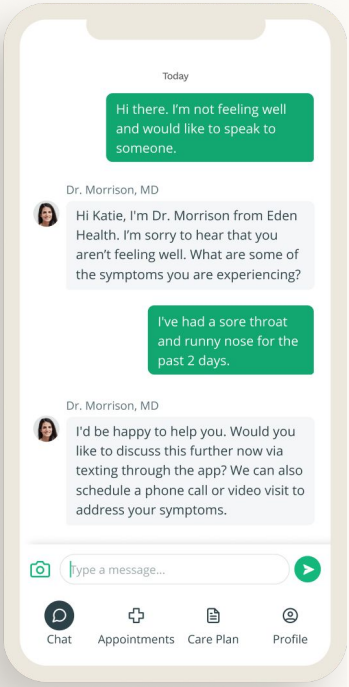
As part of your SISC PPO Medical Benefits, you have 24/7 access to a Care Team who works together to offer you primary care, mental health support, and answers to follow-up care questions through one app. The answer to most of your health questions is now simple: “Just Ask Eden."

WE’RE HERE, 24/7/365

Diagnoses and Treatments

Prescription Refills

Scheduled video visits or live chat with a primary care physician



Answers to follow up care questions

Specialist Referrals

Mental Health Support

IT’S NEVER BEEN EASIER TO STAY ON TOP OF YOUR HEALTH:

Confidential and never shared with your employer	Available at no cost to SISC Anthem and Blue Shield PPO members*	Access for dependents over 18

Scan the QR code to download the Eden Health app, and register for your free Eden Health membership.

*SISC Members enrolled on an HSA plan are not eligible for this benefit.

Self-Insured Schools of California (SISC)

HIPAA Notice of Privacy Practices

Esta noticia es disponible en espanol si usted lo suplica. Por favor contacte el oficial de privacidad indicado a continuación.

Purpose of This Notice

This Notice describes how medical information about you may be used and disclosed and how you may get access to this information. Please review this information carefully.

This Notice is required by law.

The Self-Insured Schools of California (SISC) group health plan consisting of these self-funded benefits: medical PPO plan options including utilization management, prescription benefit management (PBM) and medical plan claims administration services, telemedicine program with MDLIVE, self-funded dental PPO plan options, self-funded vision PPO plan options, Wellness program, Medicare Supplement program, COBRA administration, and Health Flexible Spending Account (FSA) administration, (hereafter referred to as the "Plan"), is required by law to take reasonable steps to maintain the privacy of your personally identifiable health information (called **Protected Health Information or PHI**) and to inform you about the Plan's legal duties and privacy practices with respect to protected health information including:

1. The Plan's uses and disclosures of PHI,
2. Your rights to privacy with respect to your PHI,
3. The Plan's duties with respect to your PHI,
4. Your right to file a complaint with the Plan and with the Secretary of the U.S. Department of Health and Human Services (HHS), and
5. The person or office you should contact for further information about the Plan's privacy practices.
6. To notify affected individuals following a breach of unsecured protected health information.

PHI use and disclosure by the Plan is regulated by the Federal law, Health Insurance Portability and Accountability Act, commonly called HIPAA. You may find these rules in 45 *Code of Federal Regulations* Parts 160 and 164. This Notice attempts to summarize key points in the regulation. The regulations will supersede this Notice if there is any discrepancy between the information in this Notice and the regulations. The Plan will abide by the terms of the Notice currently in effect. The Plan reserves the right to change the terms of this Notice and to make the new Notice provisions effective for all PHI it maintains.

You may receive a Privacy Notice from a variety of the insured group health benefit plans offered by SISC. Each of these notices will describe your rights as it pertains to that plan and in compliance with the Federal regulation, HIPAA. This Privacy Notice however, pertains to your protected health information held by the SISC self-funded group health plan (the "Plan") and outside companies contracted with SISC to help administer Plan benefits, also called "business associates."

Effective Date

The effective date of this Notice is June 24, 2013**,** and this notice replaces notices previously distributed to you.

Privacy Officer

The Plan has designated a Privacy Officer to oversee the administration of privacy by the Plan and to receive complaints. The Privacy Officer may be contacted at:

Privacy Officer: Coordinator Health Benefits
Self-Insured Schools of California (SISC)
2000 "K" Street P.O. Box 1847 - Bakersfield, CA 93303-1847
Phone: 661-636-4410
Confidential Fax: 661-636-4893

Your Protected Health Information

The term **"Protected Health Information" (PHI)** includes all information related to your past, present or future health condition(s) that individually identifies you or could reasonably be used to identify you and is transferred to another entity or maintained by the Plan in oral, written, electronic or any other form.

PHI does not include health information contained in employment records held by your employer in its role as an employer, including but not limited to health information on disability, work-related illness/injury, sick leave, Family or Medical Leave (FMLA), life insurance, dependent care flexible spending account, drug testing, etc.

This Notice does not apply to information that has been de-identified. **De-identified information** is information that does not identify you, and with respect to which there is no reasonable basis to believe that the information can be used to identify you, is not individually identifiable health information.

When the Plan May Disclose Your PHI

Under the law, the Plan may disclose your PHI without your written authorization in the following cases:

- ***At your request.*** If you request it, the Plan is required to give you access to your PHI in order to inspect it and copy it.
- ***As required by an agency of the government.*** The Secretary of the Department of Health and Human Services may require the disclosure of your PHI to investigate or determine the Plan's compliance with the privacy regulations.
- ***For treatment, payment or health care operations.*** The Plan and its business associates will use your PHI (except psychotherapy notes in certain instances as described below) without your consent, authorization or opportunity to agree or object in order to carry out treatment, payment, or health care operations.

The Plan does not need your consent or authorization to release your PHI when you request it, a government agency requires it, or the Plan uses it for treatment, payment or health care operations.

The Plan Sponsor has **amended its Plan documents** to protect your PHI as required by Federal law. The Plan may disclose PHI to the Plan Sponsor for purposes of treatment, payment and health care operations in accordance with the Plan amendment. The Plan may disclose PHI to the Plan Sponsor for review of your appeal of a benefit or for other reasons related to the administration of the Plan.

Definitions and Examples of Treatment, Payment and Health Care Operations	
Treatment is health care.	Treatment is the provision, coordination or management of health care and related services. It also includes but is not limited to coordination of benefits with a third party and consultations and referrals between one or more of your health care providers. • ***For example:*** The Plan discloses to a treating specialist the name of your treating primary care physician so the two can confer regarding your treatment plan.
Payment is paying claims for health care and related activities.	Payment includes but is not limited to making payment for the provision of health care, determination of eligibility, claims management, and utilization review activities such as the assessment of medical necessity and appropriateness of care. • ***For example:*** The Plan tells your doctor whether you are eligible for coverage or what percentage of the bill will be paid by the Plan. If we contract with third parties to help us with payment, such as a claims payer, we will disclose pertinent information to them. These third parties are known as "business associates."
Health Care Operations keep the Plan operating soundly.	Health care operations includes but is not limited to quality assessment and improvement, patient safety activities, business planning and development, reviewing competence or qualifications of health care professionals, underwriting, enrollment, premium rating and other insurance activities relating to creating or renewing insurance contracts. It also includes disease management, case management, conducting or arranging for medical review, legal services and auditing functions including fraud and abuse compliance programs and general administrative activities. • ***For example****:* The Plan uses information about your medical claims to refer you to a disease management program, to project future benefit costs or to audit the accuracy of its claims processing functions.

When the Disclosure of Your PHI Requires Your Written Authorization

Generally, the Plan will require that you sign a valid authorization form in order to use or disclose your PHI **other than**:

- When you request your own PHI
- A government agency requires it, or

- The Plan uses it for treatment, payment or health care operation.

You have the right to revoke an authorization.

Although the Plan does not routinely obtain psychotherapy notes, generally, an authorization will be required by the Plan before the Plan will use or disclose psychotherapy notes about you. Psychotherapy notes are separately filed notes about your conversations with your mental health professional during a counseling session. They do not include summary information about your mental health treatment. However, the Plan may use and disclose such notes when needed by the Plan to defend itself against litigation filed by you.

The Plan generally will require an authorization form for uses and disclosure of your PHI for marketing purposes (a communication that encourages you to purchase or use a product or service) if the Plan receives direct or indirect financial remuneration (payment) from the entity whose product or service is being marketed. The Plan generally will require an authorization form for the sale of protected health information if the Plan receives direct or indirect financial remuneration (payment) from the entity to whom the PHI is sold. The Plan does not intend to engage in fundraising activities.

Use or Disclosure of Your PHI Where You Will Be Given an Opportunity to Agree or Disagree Before the Use or Release

Disclosure of your PHI to family members, other relatives and your close personal friends without your written consent or authorization is allowed if:

- The information is directly relevant to the family or friend's involvement with your care or payment for that care, and
- You have either agreed to the disclosure or have been given an opportunity to object and have not objected.

Note that PHI obtained by the Plan Sponsor's employees through Plan administration activities will NOT be used for employment related decisions.

Use or Disclosure of Your PHI Where Consent, Authorization or Opportunity to Object Is Not Required

In general, the Plan does not need your written authorization to release your PHI if required by law or for public health and safety purposes. The Plan and its Business Associates are allowed to use and disclose your PHI **without** your written authorization (in compliance with section 164.512) under the following circumstances:

1. When ***required by law***.
2. When permitted for ***purposes of public health activities***. This includes reporting product defects, permitting product recalls and conducting post-marketing surveillance. PHI may also be used or disclosed if you have been exposed to a communicable disease or are at risk of spreading a disease or condition, if authorized by law.
3. To a school about an individual who is a student or prospective student of the school if the protected health information this is disclosed is limited to **proof of immunization**, the school is required by State or other law to have such proof of immunization prior to admitting the individual and the covered entity obtains and documents the agreements to this disclosure from either a parent, guardian or other person acting in loco parentis of the individual, if the individual is an unemancipated minor; or the individual, if the individual is an adult or emancipated.
4. When authorized by law to report information about ***abuse, neglect or domestic violence*** to public authorities if a reasonable belief exists that you may be a victim of abuse, neglect or domestic violence. In such case, the Plan will promptly inform you that such a disclosure has been or will be made unless that notice would cause a risk of serious harm. For the purpose of reporting child abuse or neglect, it is not necessary to inform the minor that such a disclosure has been or will be made. Disclosure may generally be made to the minor's parents or other representatives, although there may be circumstances under Federal or state law when the parents or other representatives may not be given access to the minor's PHI.
5. To a public health oversight agency for ***oversight activities authorized by law***. These activities include civil, administrative or criminal investigations, inspections, licensure or disciplinary actions (for example, to investigate complaints against providers) and other activities necessary for appropriate oversight of government benefit programs (for example, to investigate Medicare or Medicaid fraud).
6. When required ***for judicial or administrative proceedings***. For example, your PHI may be disclosed in response to a subpoena or discovery request, provided certain conditions are met, including that:
    - the requesting party must give the Plan satisfactory assurances a good faith attempt has been made to provide you with written Notice, and

- the Notice provided sufficient information about the proceeding to permit you to raise an objection, and
- no objections were raised or were resolved in favor of disclosure by the court or tribunal.

7. When required for ***law enforcement health purposes*** (for example, to report certain types of wounds).

8. For ***law enforcement purposes*** if the law enforcement official represents that the information is not intended to be used against the individual, the immediate law enforcement activity would be materially and adversely affected by waiting to obtain the individual's agreement and the Plan in its best judgment determines that disclosure is in the best interest of the individual. Law enforcement purposes include:
   - identifying or locating a suspect, fugitive, material witness or missing person, and
   - disclosing information about an individual who is or is suspected to be a victim of a crime.

9. When required to be given ***to a coroner or medical examiner*** to identify a deceased person, determine a cause of death or other authorized duties. When required to be given ***to funeral directors*** to carry out their duties with respect to the decedent; for use and disclosures for cadaveric ***organ, eye or tissue donation*** purposes.

10. For ***research***, subject to certain conditions.

11. When, consistent with applicable law and standards of ethical conduct, the Plan in good faith believes the use or disclosure is necessary to prevent or lessen a serious and ***imminent threat to the health or safety*** of a person or the public and the disclosure is to a person reasonably able to prevent or lessen the threat, including the target of the threat.

12. When authorized by and to the extent necessary to comply with ***workers' compensation*** or other similar programs established by law.

13. When required, for ***specialized government functions***, to military authorities under certain circumstances, or to authorized Federal officials for lawful intelligence, counter intelligence and other national security activities.

Any other Plan uses and disclosures not described in this Notice will be made only if you provide the Plan with written authorization, subject to your right to revoke your authorization, and information used and disclosed will be made in compliance with the minimum necessary standards of the regulation.

Your Individual Privacy Rights

A. You May Request Restrictions on PHI Uses and Disclosures

You may request the Plan to restrict the uses and disclosures of your PHI:
- To carry out treatment, payment or health care operations, or
- To family members, relatives, friends or other persons identified by you who are involved in your care.

The Plan, however, is not required to agree to your request if the Plan Administrator or Privacy Officer determines it to be unreasonable, for example, if it would interfere with the Plan's ability to pay a claim.

The Plan will accommodate an individual's reasonable request to receive communications of PHI by alternative means or at alternative locations where the request includes a statement that disclosure could endanger the individual. You or your personal representative will be required to complete a form to request restrictions on the uses and disclosures of your PHI. To make such a request contact the Privacy Officer at their address listed on the first page of this Notice.

B. You May Inspect and Copy Your PHI

You have the right to inspect and obtain a copy (in hard copy or electronic form) of your PHI (except psychotherapy notes and information compiled in reasonable contemplation of an administrative action or proceeding) contained in a "designated record set," for as long as the Plan maintains the PHI. You may request your hard copy or electronic information in a format that is convenient for you, and the Plan will honor that request to the extent possible. You may also request a summary of your PHI.

A **Designated Record Set** includes your medical records and billing records that are maintained by or for a covered health care provider. Records include enrollment, payment, billing, claims adjudication and case or medical management record systems maintained by or for a health plan or other information used in whole or in part by or for the covered entity to make decisions about you. Information used for quality control or peer review analyses and not used to make decisions about you is not included in the designated record set.

The Plan must provide the requested information within 30 days of its receipt of the request, if the information is maintained onsite or within 60 days if the information is maintained offsite. A single 30-day extension is allowed if the Plan is unable to comply with the deadline and notifies you in writing in advance of the reasons for the delay and the date by which the Plan will provide the requested information.

You or your personal representative will be required to complete a form to request access to the PHI in your Designated Record Set. Requests for access to your PHI should be made to the Plan's Privacy Officer at their address listed on the first page of this Notice. You may be charged a reasonable cost-based fee for creating or copying the PHI or preparing a summary of your PHI.

If access is denied, you or your personal representative will be provided with a written denial describing the basis for the denial, a description of how you may exercise those review rights and a description of how you may complain to the Plan's Privacy Officer or the Secretary of the U.S. Department of Health and Human Services.

C. You Have the Right to Amend Your PHI

You or your Personal Representative have the right to request that the Plan amend your PHI or a record about you in a designated record set for as long as the PHI is maintained in the designated record set. The Plan has 60 days after receiving your request to act on it. The Plan is allowed a single 30-day extension if the Plan is unable to comply with the 60-day deadline (provided that the Plan notifies you in writing in advance of the reasons for the delay and the date by which the Plan will provide the requested information).

If the Plan denied your request in whole or part, the Plan must provide you with a written denial that explains the basis for the decision. You or your personal representative may then submit a written statement disagreeing with the denial and have that statement included with any future disclosures of your PHI. You should make your request to amend PHI to the Privacy Officer at their address listed on the first page of this Notice.

You or your personal representative may be required to complete a form to request amendment of your PHI. Forms are available from the Privacy Officer at their address listed on the first page of this Notice.

D. You Have the Right to Receive an Accounting of the Plan's PHI Disclosures

At your request, the Plan will also provide you with an accounting of disclosures by the Plan of your PHI during the six years (or shorter period if requested) before the date of your request. The Plan will not provide you with an accounting of disclosures related to treatment, payment, or health care operations, or disclosures made to you or authorized by you in writing. The Plan has 60 days after its receipt of your request to provide the accounting. The Plan is allowed an additional 30 days if the Plan gives you a written statement of the reasons for the delay and the date by which the accounting will be provided. If you request more than one accounting within a 12-month period, the Plan will charge a reasonable, cost-based fee for each subsequent accounting.

E. You have the Right to Request that PHI be Transmitted to You Confidentially

The Plan will permit and accommodate your reasonable request to have PHI sent to you by alternative means or to an alternative location (such as mailing PHI to a different address or allowing you to personally pick up the PHI that would otherwise be mailed), if you provide a written request to the Plan that the disclosure of PHI to your usual location could endanger you. If you believe you have this situation, you should contact the Plan's Privacy Officer to discuss your request for confidential PHI transmission.

F. You Have the Right to Receive a Paper or Electronic Copy of This Notice Upon Request

To obtain a paper or electronic copy of this Notice, contact the Plan's Privacy Officer at their address listed on the first page of this Notice. This right applies even if you have agreed to receive the Notice electronically.

G. Breach Notification

If a breach of your unsecured protected health information occurs, the Plan will notify you.

Your Personal Representative

You may exercise your rights to your protected health information (PHI) by designating a person to act as your Personal Representative. Your Personal Representative will generally be required to produce evidence (proof) of the authority to act on your behalf **before** the Personal Representative will be given access to your PHI or be allowed to take any action for you. Under this Plan, proof of such authority will include (1) a completed, signed and approved Appoint a Personal Representative form; (2) a notarized power of attorney for health care purposes; (3) a court-appointed conservator or guardian; or, (4) for a Spouse under this Plan, the absence of a Revoke a Personal Representative form on file with the Privacy Officer.

This Plan will automatically recognize your legal Spouse as your Personal Representative and vice versa, without you having to complete a form to Appoint a Personal Representative. However, you may request that the Plan **not** automatically honor your legal Spouse as your Personal Representative by completing a form to Revoke a Personal Representative (copy attached to this notice or also available from the Privacy Officer). **If you wish to revoke your Spouse as your Personal Representative, please complete the Revoke a Personal Representative form and return it to the Privacy Officer and this will mean that this Plan will NOT automatically recognize your Spouse as your Personal Representative and vice versa.**

The recognition of your Spouse as your Personal Representative (and vice versa) is for the use and disclosure of PHI under this Plan and is not intended to expand such designation beyond what is necessary for this Plan to comply with HIPAA privacy regulations.

You may obtain a form to Appoint a Personal Representative or Revoke a Personal Representative by contacting the Privacy Officer at their address listed on this Notice. The Plan retains discretion to deny access to your PHI to a Personal Representative to provide protection to those vulnerable people who depend on others to exercise their rights under these rules and who may be subject to abuse or neglect.

Because HIPAA regulations give adults certain rights and generally children age 18 and older are adults, if you have **dependent children age 18 and older** covered under the Plan, and the child wants you, as the parent(s), to be able to access their protected health information (PHI), that child will need to complete a form to Appoint a Personal Representative to designate you (the employee/retiree) and/or your Spouse as their Personal Representatives.

The Plan will consider a parent, guardian, or other person acting *in loco parentis* as the Personal Representative of an unemancipated minor (a child generally under age 18) unless the applicable law requires otherwise. **In loco parentis** may be further defined by state law, but in general it refers to a person who has been treated as a parent by the child and who has formed a meaningful parental relationship with the child for a substantial period of time. Spouses and unemancipated minors may, however, request that the Plan restrict PHI that goes to family members as described above under the section titled "Your Individual Privacy Rights."

The Plan's Duties

The Plan is required by law to maintain the privacy of your PHI and to provide you and your eligible dependents with Notice of its legal duties and privacy practices. The Plan is required to comply with the terms of this Notice. However, the Plan reserves the right to change its privacy practices and the terms of this Notice and to apply the changes to any PHI maintained by the Plan. In addition, the Plan may not (and does not) use your genetic information that is PHI for underwriting purposes.

Notice Distribution: The Notice will be provided to each person when they initially enroll for benefits in the Plan (the Notice is provided in the Plan's Initial Enrollment material/packets). The Notice is also available on the Plan's website: www.sisc.kern.org. The Notice will also be provided upon request. Once every three years the Plan will notify the individuals then covered by the Plan where to obtain a copy of the Notice. This Plan will satisfy the requirements of the HIPAA regulation by providing the Notice to the named insured (covered employee) of the Plan; however, you are encouraged to share this Notice with other family members covered under the Plan.

Notice Revisions: If a privacy practice of this Plan is changed affecting this Notice, a revised version of this Notice will be provided to you and all participants covered by the Plan at the time of the change. Any revised version of the Notice will be distributed within 60 days of the effective date of a material change to the uses and disclosures of PHI, your individual rights, the duties of the Plan or other privacy practices stated in this Notice. Material changes are changes to the uses and disclosures of PHI, an individual's rights, the duties of the Plan or other privacy practices stated in the Privacy Notice.

Because our health plan posts its Notice on its web site, we will prominently post the revised Notice on that web site by the effective date of the material change to the Notice. We will also provide the revised notice, or information about the material change and how to obtain the revised Notice, in our next annual mailing to individuals covered by the Plan.

Disclosing Only the Minimum Necessary Protected Health Information

When using or disclosing PHI or when requesting PHI from another covered entity, the Plan will make reasonable efforts not to use, disclose or request more than the minimum amount of PHI necessary to accomplish the intended purpose of the use, disclosure or request, taking into consideration practical and technological limitations. However, the minimum necessary standard will not apply in the following situations:

- Disclosures to or requests by a health care provider for treatment,
- Uses or disclosures made to you,
- Disclosures made to the Secretary of the U.S. Department of Health and Human Services in accordance with their enforcement activities under HIPAA,
- Uses of disclosures required by law, and
- Uses of disclosures required for the Plan's compliance with the HIPAA privacy regulations.

This Notice does not apply to information that has been de-identified. **De-identified information** is information that does not identify you and there is no reasonable basis to believe that the information can be used to identify you.

As described in the amended Plan document, the Plan may share PHI with the Plan Sponsor for limited administrative purposes, such as determining claims and appeals, performing quality assurance functions and auditing and monitoring the Plan. The Plan shares the minimum information necessary to accomplish these purposes.

In addition, the Plan may use or disclose "summary health information" to the Plan Sponsor for obtaining premium bids or modifying, amending or terminating the group health Plan. **Summary health information** means information that summarizes claims history, claims expenses or type of claims experienced by individuals for whom the Plan Sponsor has provided health benefits under a group health plan. Identifying information will be deleted from summary health information, in accordance with HIPAA.

Your Right to File a Complaint

If you believe that your privacy rights have been violated, you may file a complaint with the Plan in care of the Plan's Privacy Officer, at the address listed on the first page of this Notice. Neither your employer nor the Plan will retaliate against you for filing a complaint.

You may also file a complaint (within 180 days of the date you know or should have known about an act or omission) with the Secretary of the U.S. Department of Health and Human Services by contacting their nearest office as listed in your telephone directory or at this website (http://www.hhs.gov/ocr/office/about/rgn-hqaddresses.html) or this website: http://www.hhs.gov/ocr/privacy/hipaa/complaints/index.html or contact the Privacy Officer for more information about how to file a complaint.

If You Need More Information

If you have any questions regarding this Notice or the subjects addressed in it, you may contact the Plan's Privacy Officer at the address listed on the first page of this Notice.

Self-Insured Schools of California (SISC)

Form to Revoke a Personal Representative

Complete the following chart to indicate the name of the Personal Representative to be revoked:

	Plan Participant	**Person to be Revoked as my Personal Representative**
Name (print):		
Address (*City, State, Zip*):		
Phone:	( )	( )

I, _____ (*Name of Participant or Beneficiary)* hereby revoke _____ (*Name of Personal Representative)*

☐ to act on my behalf,

☐ to act on behalf of my dependent child(ren), named: _____,

in receiving any protected health information (PHI) that is (or would be) provided to a personal representative, including any individual rights regarding PHI under HIPAA, effective _____, 20____.

I understand that PHI has or may already have been disclosed to the above named Personal Representative prior to the effective date of this form.

_____ _____

Participant or Beneficiary's Signature Date

Return this form to the SISC Privacy Officer (the Coordinator Health Benefits) at:
Self-Insured Schools of California (SISC)
2000 "K" Street P.O. Box 1847 - Bakersfield, CA 93303-1847
Phone: 661-636-4410

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

Your group health plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema).

For more information call the Customer Service phone number on your ID card or the SISC Benefits department at 661-636-4410.

Where to Find a HIPAA Privacy Notice for Our Group Health Plan

HIPAA Privacy pertains to the following group health plan benefits sponsored by the Self-Insured Schools of California (SISC):

- medical PPO plan options including utilization management, prescription benefit management (PBM) and medical plan claims administration services,
- telemedicine program with MD live,
- self-funded dental PPO plan options,
- self-funded vision PPO plan options,
- Wellness program,
- Medicare Supplement program,
- COBRA administration,
- Health Flexible Spending Account (FSA) administration

You are provided with a complete HIPAA Privacy Notice when you enroll for these benefits. You can obtain another copy of the plan's HIPAA Privacy Notice by going to the SISC website at www.sisc.kern.org or you can write or call the SISC Benefits Department at P. O. Box 1847 Bakersfield, CA 93303-1847.

HIPAA Privacy Notices that pertain to the insured medical plan benefits can be obtained by contacting the insurance companies at the Customer Service phone number on your ID card.