2025- 2026

Roseland Public Schools

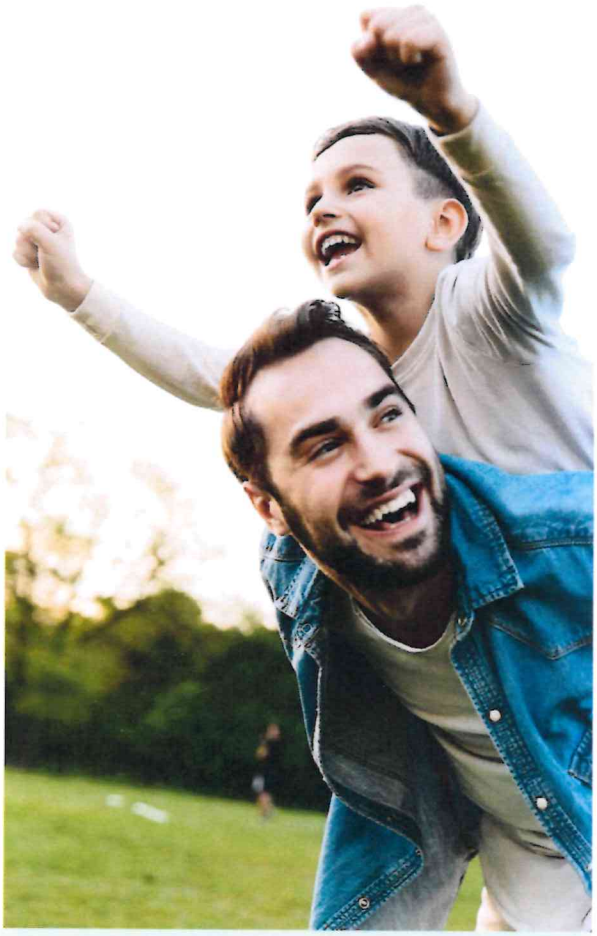
Employee Benefits Overview & Open Enrollment Guide

BENEFITTING A BETTER YOU



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MEDICARE PART D NOTICE

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

Welcome to Your Benefits Guide

The benefits in this summary are effective October 1, 2025, through September 30, 2026

Whether you're enrolling in benefits for the first time, nearing retirement, or somewhere in between, Roseland School District supports you with benefit programs and resources to help you thrive today and prepare for tomorrow.

This guide provides an overview of your healthcare coverage and more.

You'll find tips to help you understand your medical coverage, save time and money on healthcare, reduce taxes, and balance your work and home life. Review the coverage and tools available to you to make the most of your benefits package.

IMPORTANT NOTE: This is a summary overview and does not provide a complete description of all benefit provisions. While we've made every effort to make sure that this overview is comprehensive, it cannot provide a complete description of all benefits. Specific details and limitations are provided in the plan documents, such as the Summary of Benefits and Coverage (SBC), Evidence of Coverage (EOC), etc. Plan documents contain relevant provisions and determine how benefits are paid. If the information in this overview differs from the plan documents, the plan documents prevail.

Who is Eligible?

Certificated / Confidential / Classified Management Employees: You are eligible if you are a full-time employee working 1.0FTE. Employees who work .50 FTE or more are eligible for pro-rated benefits.

Classified Employees: You are eligible if you work .75 FTE. Employees who work .50 FTE or more are eligible for pro-rated benefits.

The following dependents are eligible for benefits:

- Legally married spouse.
- Registered Domestic Partner (RDP)
- Natural, adopted, or stepchildren, or children of a domestic partner up to age 26
- Children over age 26 who are disabled and depend on you for support
- Children named in a Qualified Medical Child Support Order (QMCSO)

Members who are NOT eligible for coverage include (but are not limited to):

- Parents, grandparents, and siblings.



When you can enroll

New Hire Enrollment	New employees should be added on the first of the month following their Date of Hire (DOH). If the DOH is the first working day of the month, the employee may be added the first of that month or the first of the following month.
Open Enrollment	The one time each year that you can make changes to your benefits for any reason. Open enrollment is generally held in August or September every year for a 10/1 effective date.
Qualifying Life Event	A qualifying life event is a significant change in your life that allows you to make changes to your benefits outside of open enrollment. See page 5 for more information.

Changing Your Benefits

Outside of open enrollment, you may be able to enroll or make changes to your benefit elections if you have a big change in your life, including:

- Change in legal marital status
- Change in the number of dependents or dependent eligibility status
- Change in employment status that affects eligibility for you, your spouse, or dependent child(ren)
- Change in residence that affects access to network providers
- Change in your health coverage or your spouse's coverage due to your spouse's employment
- Change in an individual's eligibility for Medicare or Medicaid
- Court order requiring coverage for your child
- "Special enrollment event" under the Health Insurance Portability and Accountability Act (HIPAA), including a new dependent by marriage, birth or adoption, or loss of coverage under another health insurance plan
- Event allowed under the Children's Health Insurance Program (CHIP) Reauthorization Act (you have 60 days to request enrollment due to events allowed under CHIP).

Any change you make must be consistent with the change in status. All proper documentation is required to cover dependents (marriage certificates, birth certificates, etc.)

You must submit your change within 30 days after the event

Dependent Verification

You may only make changes to dependent coverage if certain eligibility criteria are met. To complete the change, you must submit proof of eligibility within 30 days from the qualifying event. Acceptable documents are listed on page 6.

Eligibility Documentation Checklist

The following verification documents are required to enroll a subscriber or dependent in health benefit plans. SISC 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 (First page only, financial information may be blocked out). ▪ A marriage certificate will be accepted for *newly* married couples (12 months) ▪ All other couples are required to submit the page 1 of their most recent 1040.
Domestic Partner	▪ A Certificate of Registered Domestic Partnership issued by the State of California or a certified copy of the Declaration of Domestic Partnership that includes the dated, signed Secretary of State Certification Stamp. (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 & child's DOB) ▪ Legal Adoption Documentation
Legal Guardianship up to age 18	▪ Legal U.S. Court Documentation establishing Guardianship
Unmarried Disabled Dependents over age 26 (requires enrollment in a SISC medical plan)	**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 (First page only, income information may be blocked out) ▪ Proof of 6 months prior creditable coverage under the employee/retiree's plan There can be no break in 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 (First page only, income information may be blocked out) ▪ Proof of 6 months prior creditable coverage under the employee/retiree's plan. There can be no break in 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 & child's DOB) ▪ Prior year's Federal Tax Form that shows child is claimed as an IRS dependent (First page only, income information may be blocked out) ▪ Proof of 6 months prior creditable coverage under the employee/retiree's plan. There can be no break in coverage. ▪ Physician's Declaration of Disabled Dependent Status
Retirees and/or Dependents on a Retiree Plan Age 65 or Over	▪ Proof of enrollment in Medicare Part A & Part B (copy of current Medicare card or Medicare enrollment confirmation letter showing effective dates of Part A and Part B, and the MBI {Medicare Beneficiary Identifier})



Medical

Preventive care is fully covered under all plans if obtained in-network. Your costs for other services will depend on which plan you choose.

Preventive services which become diagnostic in nature will be subject to applicable plan deductibles, cost shares & co-pays. Please refer to your plan documents for specific plan details.

Medical Plan Overview

This guide serves as a summary of the medical plans available to you. Please thoroughly review the plan documents before selecting a plan.

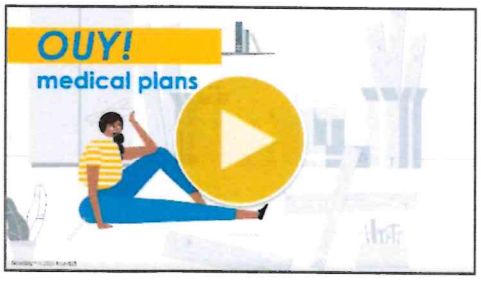
	What you need to know
Kaiser $10 OV, Traditional HMO *Kaiser Network*	• Access to Kaiser providers/facilities exclusively • Requires PCP to see specialist • No deductible • Predictable costs
Kaiser $500 (DHMO) *Kaiser Network*	• Access to Kaiser providers/facilities exclusively • Requires PCP to see specialist • Must meet deductible for applicable services before plans begins to pay a % of the cost (Emergency, in-patient/out-patient procedures)
Kaiser 1700 High-Deductible Health (HDHP) *Kaiser Network*	• HSA (Health Savings Account) compatible HDHP • EE and/or ER HSA contributions can be used to off-set out-of-pocket costs • Must meet deductible for most services before the plan begins to pay a % of the cost
Blue Shield 100%, 90% & 80% PPO *Full PPO Network*	• Must meet deductible for some services before the plan begins to pay a % of the cost: 100%, 90% & 80% PPO • Out-of-network coverage for some services; higher costs
Blue Shield High-Deductible Health Plan (HDHP) 3400 *Full PPO Network*	• HSA (Health Savings Account) compatible HDHP • EE and/or ER HSA contributions can be used to off-set out-of-pocket costs • Must meet deductible for most services before the plan begins to pay a % of the cost • Out-of-network coverage for some services; higher costs

Understanding Plan Types

The following medical plan types are available so that you can pick the plan that best fits your budget and healthcare needs.

Some plans (like HMOs) restrict you to in-network doctors. Other plans (like PPOs) allow you to see any doctor, but you will pay a higher coinsurance percentage if the doctor is out-of-network.

	HMO Health Maintenance Organization	**PPO** Preferred Provider Organization	**HDHP** High-Deductible Health Plan
Deductible	Maybe	✔	✔
Out-of-Network Care Covered		✔	✔
Referral Needed to see Specialist	✔		
Primary Care Physician Required	Maybe		
Eligible to Enroll in an HSA			✔
Eligible to Enroll in a Healthcare FSA	✔	✔	
Pros	• More predictable costs	• You have access to in and out-of-network providers • You can self-refer to Specialists without seeing a PCP	• An HMO, or PPO with a "qualifying" high deductible that is HSA (Health Savings Account) compatible
Cons	• Less flexibility • No out-of-network coverage • May have to visit Primary Care Physician for referral to Specialists	• You have access to, but limited insurance payments for out-of-network provider services • Deductibles & co-insurance apply, not all costs are predictable	• Must pay 100% of the cost of incurred services* until the deductible is satisfied • After deductible, there are usually cost-shares which aren't always predictable ** Not applicable for preventive services*



All About Medical Plans

Medical plans can seem hard to understand, but once you understand the building blocks you will be able to choose the best plan for you and your dependents.

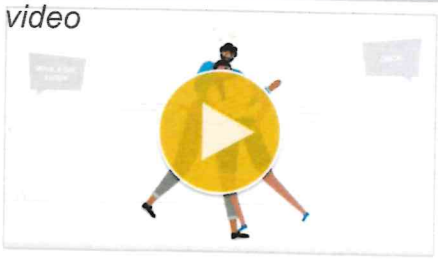
Click to play video

Know Where To Go

Where you get medical care can have a significant impact on the cost. Here's a quick guide to help you know where to go, based on your condition, budget, and time.

Type	Appropriate for	Examples	Access	Cost
Nurseline	Quick answers from a trained nurse	▪ Identifying symptoms ▪ Decide if immediate care is needed ▪ Home treatment options and advice	24/7	**$0**
Online visit	Many non-emergency health conditions	▪ Cold, flu, allergies ▪ Headache, migraine ▪ Skin conditions, rashes ▪ Minor injuries ▪ Mental health concerns	24/7	**$**
Office visit	Routine medical care and overall health management	▪ Preventive care ▪ Illnesses, injuries ▪ Managing existing conditions	Office Hours	**$$**
Urgent care, walk-in clinic	Non-life-threatening conditions requiring prompt attention	▪ Stitches ▪ Sprains ▪ Animal bites ▪ Ear-nose-throat infections	Office Hours, or up to 24/7	**$$$**
Emergency room	Life-threatening conditions requiring immediate medical expertise	▪ Suspected heart attack or stroke ▪ Major bone breaks ▪ Excessive bleeding ▪ Severe pain ▪ Difficulty breathing	24/7	**$$$$$**
Ambulatory Surgical Center	Less complex outpatient surgeries	▪ Lower cost when compared to same procedure at a hospital facility	Office Hours	**$$$$**

Click to play video



Urgent Care vs ER

ER visits should only be used for very serious medical issues. The cost per visit will be much higher than the other care options.

Medical – Kaiser Permanente HMO Plans

You always pay the deductible and copayment ($). The coinsurance (%) shows what you pay after the deductible.

	Kaiser Permanente Traditional HMO $10
	In-Network
Calendar Year Deductible Individual Individual in a family Family	 $0 $0 $0
Calendar Year Out-of-Pocket Maximum[1,2,3] Individual Individual in a family Family	 $1,500 $1,500 $3,000
Office Visit Primary Care Specialist	 $10 copay $10 copay
Preventive Services	$0 copay
Chiropractic (up to 30 visits/year combined with acupuncture)	$10 copay
Lab and X-ray	$0 copay
Urgent Care	$10 copay
Emergency Room	$100 copay (waived if admitted)
Inpatient Hospitalization	$0 copay
Outpatient Surgery	$10 copay
PRESCRIPTION DRUGS	
Calendar Year Deductible	N/A
Out-of-Pocket Maximum	Combined w/ medical
Retail Generic Brand Specialty	 $10 copay up to 100-day supply $10 copay up to 100-day supply $10 copay up to 30-day supply
Mail Order- 100 Day Supply Generic Brand	 $10 copay $10 copay

[1]Out-of-pocket maximums accumulate on a calendar year from January 1 through December 31.
[2]This plan has an embedded family maximum which means the plan will cover 100% for an individual member as soon as they reach their individual maximum.
[3]All covered expenses including your medical deductibles and prescription copays accumulate towards the out-of-pocket maximum.

Medical – Kaiser Permanente HMO Plans

You always pay the deductible and copayment ($). The coinsurance (%) shows what you pay after the deductible.

	Kaiser Permanente Deductible HMO $500 Hospital ONLY
	In-Network
Calendar Year Deductible[1,2] Individual Individual in a family Family	 $500 $500 $1,000
Calendar Year Out-of-Pocket Maximum[1,3,4] Individual Individual in a family Family	 $3,000 $3,000 $6,000
Office Visit Primary Care Specialist	 $20 copay $20 copay
Online Visit	$0 copay
Preventive Services	$0 copay
Chiropractic	$10 copay (up to 30 visits/year combined w/ acupuncture)
Lab and X-ray	$10 copay
Urgent Care	$20 copay
Emergency Room	10%[5] (waived if admitted)
Inpatient Hospitalization	10%[5]
Outpatient Surgery	10%[5]
PRESCRIPTION DRUGS	
Calendar Year Deductible	N/A
Out-of-Pocket Maximum	Combined w/ medical
Retail- 30 Day Supply Generic Brand Specialty	 $10 copay $30 copay $30 copay
Mail Order- 100 Day Supply Generic Brand	 $20 copay $60 copay

[1]Deductibles and out-of-pocket maximums accumulate on a calendar year from January 1 through December 31.
[2] This plan has n embedded family deductible which means the plan begins to make payments for a member when they reach their individual deductible.
[3]This plan has an embedded family maximum which means the plan will cover 100% for an individual member as soon as they reach their individual maximum.
[4]All covered expenses including your medical deductibles and prescription copays accumulate towards the out-of-pocket maximum.
[5]After deductible.

Medical – Kaiser Permanente HMO Plans

You always pay the deductible and copayment ($). The coinsurance (%) shows what you pay after the deductible.

	Kaiser Permanente HSA $1700
	In-Network
Calendar Year Deductible[1,2] Individual Individual in a family Family	$1,700 $3,200 $3,400
Calendar Year Out-of-Pocket Maximum[1,3,4] Individual Individual in a family Family	$3,400 $3,400 $6,800
Office Visit Primary Care Specialist	10%[5] 10%[5]
Online Visit	$0[5]
Preventive Services	$0 copay
Chiropractic	Not covered
Lab and X-ray	10%[5]
Urgent Care	10%[5]
Emergency Room	10%[5] (waived if admitted)
Inpatient Hospitalization	10%[5]
Outpatient Surgery	10%[5]
PRESCRIPTION DRUGS	
Calendar Year Deductible	Combined w/ medical
Out-of-Pocket Maximum	Combined w/ medical
Retail- 30 Day Supply Generic Brand Specialty	$10 copay[5] $30 copay[5] $30 copay[5]
Mail Order- 100 Day Supply Generic Brand	$20 copay[5] $60 copay[5]

[1]Deductibles and out-of-pocket maximums accumulate on a calendar year from January 1 through December 31.
[2] This plan has n embedded family deductible which means the plan begins to make payments for a member when they reach their individual deductible.
[3]This plan has an embedded family maximum which means the plan will cover 100% for an individual member as soon as they reach their individual maximum.
[4]All covered expenses including your medical deductibles and prescription copays accumulate towards the out-of-pocket maximum.
[5]After deductible.

Kaiser Resources

One Pass Select Affinity by Optum

Through One Pass Select Affinty from Optum members can choose a fitness plan and get unlimited access to all locations available within that plan, plus extensive digital resources. Members can choose the plan that fits their needs, with competitive plans starting at $10 per month. Members that sign up can also access the Optum Additional service include healthy meal delivery and 20% discounts on chiropractors, acupuncturists and massage therapists. Learn more at kp.org/exercise.

24/7 care advice

Get medical advice and care guidance in the moment from a Kaiser Permanente provider at (833) 574-2273.

Kaiser Away From Home

Kaiser Members are covered for emergency and urgent care anywhere in the world. Kaiser's travel website will explain what to do if you need emergency or urgent care during your trip.

Calm App

The Calm app uses meditation and mindfulness to help lower stress, reduce, anxiety, and improve sleep quality. Adult members can get Calm at kp.org/selfcareapps.

Headspace Care App

The Headspace Care app offers immediate 1-on-1 support for coping with many common challenges — from stress and low mood to issues with work and relationships, and more. Headspace Care's highly trained emotional support coaches are ready to help 24/7, and adult Kaiser Permanente members can use Headspace Care for 90 consecutive days at no cost. Download the app from the App Store℠ or Google Play®.

Target Retail Clinics (Southern California Only)

Target Clinics offer care provided by Kaiser Permanente for more than 85 different services, including treatments for common health conditions and minor injuries. The clinics are open 7 days a week for appointments and walk in care. Find a clinic near you using kptargetclinic.org.

Online wellness tools

Visit kp.org/healthyliving for wellness information, health calculators, fitness videos, podcasts, and recipes from world class chefs. Connect to better health with programs to help you lose weight, quit smoking, and more – all at no cost.

Finding a Kaiser Provider

To find a Kaiser Permanente provider near you, please visit www.kp.org or call (800) 464-4000.

My Health Manager

Stay engaged with your health and simplify your busy life by using the Kaiser Website or download the Kaiser Permanente app from the App Store℠ or Google Play®.

Kaiser Resources, Cont.

ClassPass

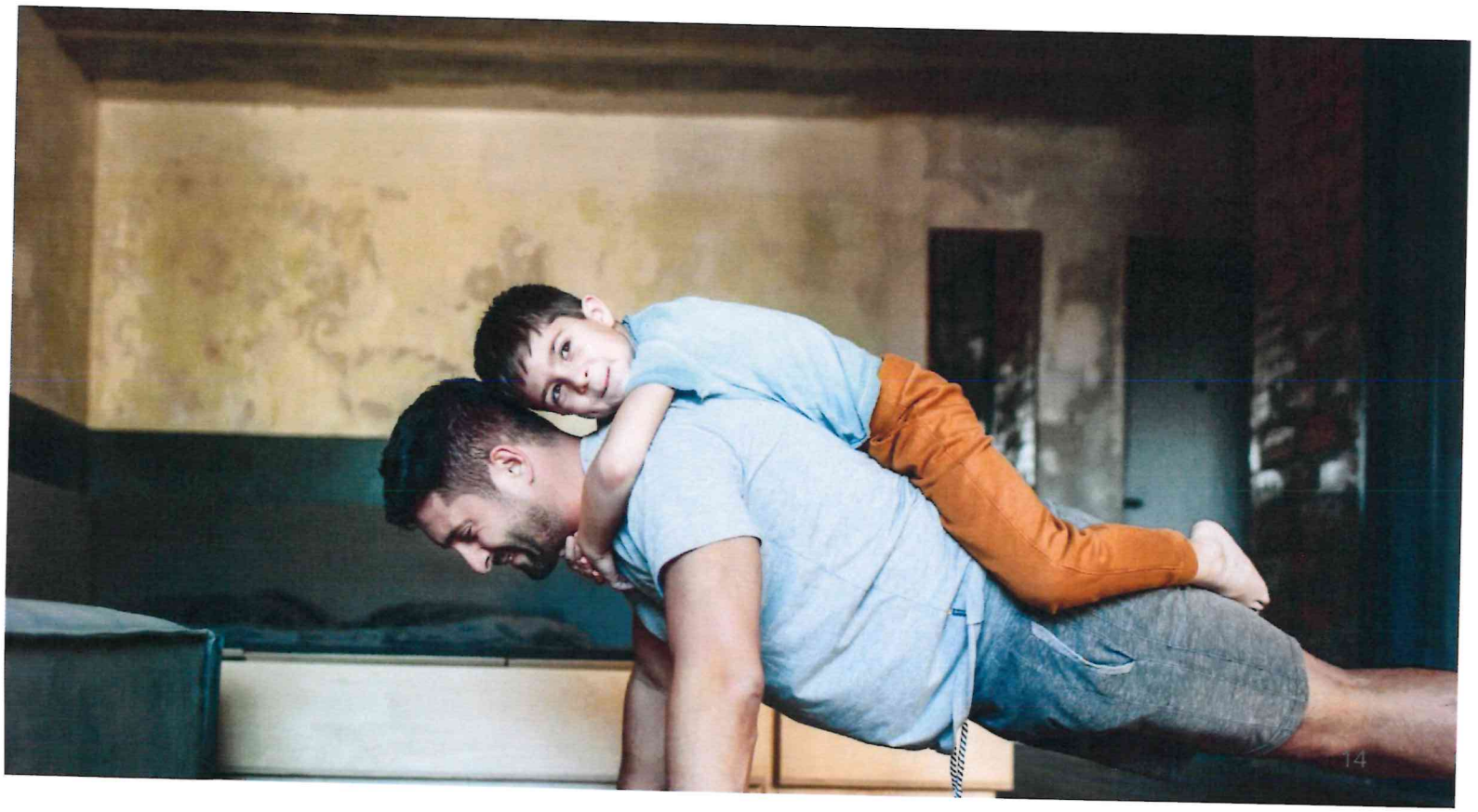
Kaiser members can get access to free on demand video workouts at no cost and reduced rates for in-person fitness classes. To get started, visit kp.org/exercise.

Health classes

Sign up for health classes and support groups at many of our facilities. See what's available near you at kp.org/classes – some may require a fee.

Personal wellness coaching

Get help reaching your health goals. Work one on one with a wellness coach by phone at no cost. Find out more at kp.org/wellnesscoach.



Medical – Blue Shield PPO Plans

You always pay the deductible and copayment ($). The coinsurance (%) shows what you pay after the deductible.

	Blue Shield 100-B $20 Copay	
	In-Network	**Out-of-Network**
Calendar Year Deductible[1,2] Individual Individual in a family Family	 $100 $100 $300	 $100 $100 $300
Calendar Year Out-of-Pocket Maximum[1,3,4] Individual Individual in a family Family	 $1,000 $1,000 $3,000	 $1,000 $1,000 $3,000
Office Visit Primary Care Specialist	 $20 copay $20 copay	 50%[5] 50%[5]
Preventive Services	$0 copay	Not covered
Chiropractic – (up to 20 visits/year)	$0 copay	Not covered
Lab and X-ray	0%[5]	Not covered
Urgent Care	$20 copay	50%[5]
Emergency Room	$100 copay[5] (waived if admitted)	$100 copay[5] (waived if admitted)
Inpatient Hospitalization	0%[5]	All charges over $600[5]
Outpatient Surgery	0%[5]	All charges over $350[5]
PRESCRIPTION DRUGS		
Calendar Year Deductible	N/A	N/A
Out-of-Pocket Maximum (individual/family)	$1,500/$2,500	$1,500/$2,500
Retail- 30 Day Supply Generic (Costco/Network) Brand(Costco and Network)	 $0/$7 copay[5] $25 copay[5]	Member must pay the entire cost up front and apply for reimbursement. Not covered for specialty.
Mail Order Generic- 90 Day Supply (Costco) Brand-90 Day Supply (Costco) Specialty - 30 Day Supply (Navitus Mail)	 $0 copay[5] $60 copay[5] $25 copay[5]	Not covered

[1]Deductibles and out-of-pocket maximums accumulate on a calendar year from January 1 through December 31.
[2]This plan is an embedded family deductible which means the plan begins to make payments for a member when they reach their individual deductible.
[3]This plan is an embedded family maximum which means the plan will cover 100% for an individual member as soon as they reach their individual maximum.
[4]All covered expenses including your medical deductibles and prescription copays accumulate towards the out-of-pocket maximum.
[5]After deductible.

Medical – Blue Shield PPO Plans

You always pay the deductible and copayment ($). The coinsurance (%) shows what you pay after the deductible.

	Blue Shield 90-E $20 Copay	
	In-Network	**Out-of-Network**
Calendar Year Deductible[1,2] Individual Individual in a family Family	$300 $300 $600	$300 $300 $600
Calendar Year Out-of-Pocket Maximum[1,3,4] Individual Individual in a family Family	$1,000 $1,000 $3,000	$1,000 $1,000 $3,000
Office Visit Primary Care Specialist	 $20 copay $20 copay	 50%[5] 50%[5]
Preventive Services	$0 copay	Not covered
Chiropractic – (up to 20 visits/year)	10%[5]	Not covered
Lab and X-ray	10%[5]	Not covered
Urgent Care	$20 copay	50%[5]
Emergency Room	$100 copay + 10%[5] (waived if admitted)	$100 copay + 10%[5] (waived if admitted)
Inpatient Hospitalization	10%[5]	All charges over $600[5]
Outpatient Surgery	10%[5]	All charges over $350[5]
PRESCRIPTION DRUGS		
Calendar Year Deductible	N/A	N/A
Out-of-Pocket Maximum (individual/family)	$1,500/$2,500	$1,500/$2,500
Retail- 30 Day Supply Generic (Costco/Network) Brand(Costco and Network)	$0/$7 copay[5] $25 copay[5]	Member must pay the entire cost up front and apply for reimbursement. Not covered for specialty.
Mail Order Generic- 90 Day Supply (Costco) Brand-90 Day Supply (Costco) Specialty - 30 Day Supply (Navitus Mail)	$0 copay[5] $60 copay[5] $25 copay[5]	Not covered

[1]Deductibles and out-of-pocket maximums accumulate on a calendar year from January 1 through December 31.
[2]This plan is an embedded family deductible which means the plan begins to make payments for a member when they reach their individual deductible.
[3]This plan is an embedded family maximum which means the plan will cover 100% for an individual member as soon as they reach their individual maximum.
[4]All covered expenses including your medical deductibles and prescription copays accumulate towards the out-of-pocket maximum.
[5]After deductible.

Medical – Blue Shield PPO Plan

You always pay the deductible and copayment ($). The coinsurance (%) shows what you pay after the deductible.

	Blue Shield 80-G $30 Copay	
	In-Network	Out-of-Network
Calendar Year Deductible[1,2] Individual Individual in a family Family	$500 $500 $1,000	$500 $500 $1,000
Calendar Year Out-of-Pocket Maximum[1,3,4] Individual Individual in a family Family	$2,000 $2,000 $4,000	$2,000 $2,000 $4,000
Office Visit Primary Care Specialist	$30 copay $30 copay	50%[5] 50%[5]
Preventive Services	$0 copay	Not covered
Chiropractic – (up to 20 visits/year)	20%[5]	Not covered
Lab and X-ray	20%[5]	Not covered
Urgent Care	$30 copay	50%[5]
Emergency Room	$100 copay + 20%[5] (waived if admitted)	$100 copay+ 20%[5] (waived if admitted)
Inpatient Hospitalization	20%[5]	All charges over $600[5]
Outpatient Surgery	20%[5]	All charges over $350[5]
PRESCRIPTION DRUGS		
Calendar Year Deductible	N/A	N/A
Out-of-Pocket Maximum (individual/family)	$2,500/$3,500	$2,500/$3,500
Retail- 30 Day Supply Generic (Costco/Network) Brand(Costco and Network)	$0/$9 copay[5] $35 copay[5]	Member must pay the entire cost up front and apply for reimbursement. Not covered for specialty.
Mail Order Generic- 90 Day Supply (Costco) Brand-90 Day Supply (Costco) Specialty - 30 Day Supply (Navitus Mail)	$0 copay[5] $90 copay[5] $35 copay[5]	Not covered

[1]Deductibles and out-of-pocket maximums accumulate on a calendar year from January 1 through December 31.
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[3]This plan is an embedded family maximum which means the plan will cover 100% for an individual member as soon as they reach their individual maximum.
[4]All covered expenses including your medical deductibles and prescription copays accumulate towards the out-of-pocket maximum.
[5]After deductible.

Medical – Blue Shield PPO Plan

You always pay the deductible and copayment ($). The coinsurance (%) shows what you pay after the deductible.

	Blue Shield HDHP HSA-$3400	
	In-Network	**Out-of-Network**
Calendar Year Deductible[1,2] Individual Individual in a family Family	 $3,400 $3,400 $6,800	 $3,400 $3,400 $6,800
Calendar Year Out-of-Pocket Maximum[1,3,4] Individual Individual in a family Family	 $6,000 $6,000 $12,000	 $6,000 $6,000 $12,000
Office Visit Primary Care Specialist	 10%[5] 10%[5]	 50%[5] 50%[5]
Preventive Services	$0 copay	Not covered
Chiropractic - (up to 20 visits/year)	10%[5]	Not covered
Lab and X-ray	10%[5]	Not covered
Urgent Care	10%[5]	50%[5]
Emergency Room	$100 copay + 10%[5] (waived if admitted)	$100 copay + 10%[5] (waived if admitted)
Inpatient Hospitalization	10%[5]	All charges over $600
Outpatient Surgery	10%[5]	All charges over $350
PRESCRIPTION DRUGS		
Calendar Year Deductible	Combined w/ medical	Combined w/ medical
Out-of-Pocket Maximum	Combined w/ medical	Combined w/ medical
Retail- 30 Day Supply Generic (Costco/Network) Brand(Costco and Network)	 $0/$9 copay[5] $35 copay[5]	Member must pay the entire cost up front and apply for reimbursement. Not covered for specialty.
Mail Order Generic- 90 Day Supply (Costco) Brand-90 Day Supply (Costco) Specialty - 30 Day Supply (Navitus Mail)	 $0 copay[5] $90 copay[5] $35 copay[5]	Not covered

[1]Deductibles and out-of-pocket maximums accumulate on a calendar year from January 1 through December 31.
[2]This plan is an embedded family deductible which means the plan begins to make payments for a member when they reach their individual deductible.
[3]This plan in an embedded family maximum which means the plan will cover 100% for an individual member as soon as they reach their individual maximum.
[4]All covered expenses including your medical deductibles and prescription copays accumulate towards the out-of-pocket maximum.
[5]After deductible.

Medical – Blue Shield PPO Plans

You always pay the deductible and copayment ($). The coinsurance (%) shows what you pay after the deductible.

	Blue Shield 2-Tier HSA 5000	
	In-Network	Out-of-Network
Calendar Year Deductible[1,2] Individual Individual in a family Family	 $5,000 $5,000 $10,000	 $5,000 $5,000 $10,000
Calendar Year Out-of-Pocket Maximum[1,3,4] Individual Individual in a family Family	 $6,350 $6,350 $12,700	 $6,350 $6,350 $12,700
Office Visit Primary Care Specialist	 30%[5] 30%[5]	 50%[5] 50%[5]
Preventive Services	$0 copay	Not covered
Chiropractic – (up to 20 visits/year)	30%[5]	Not covered
Lab and X-ray	30%[5]	Not covered
Urgent Care	30%	50%[5]
Emergency Room	$100 copay + 30%[5] (waived if admitted)	$100 copay+ 30%[5] (waived if admitted)
Inpatient Hospitalization	30%[5]	All charges over $600[5]
Outpatient Surgery	30%[5]	All charges over $350[5]
PRESCRIPTION DRUGS		
Calendar Year Deductible	Combined w/ medical	Not covered
Out-of-Pocket Maximum (individual/family)	Combined w/ medical	Not covered
Retail- 30 Day Supply Generic (Costco/Network) Brand(Costco and Network)	 $0/$9 copay[5] $35 copay[5]	 Not covered
Mail Order Generic- 90 Day Supply (Costco) Brand-90 Day Supply (Costco) Specialty - 30 Day Supply (Navitus Mail)	 $0 copay[5] $90 copay[5] $35 copay[5]	 Not covered

[1]Deductibles and out-of-pocket maximums accumulate on a calendar year from January 1 through December 31.
[2]This plan is an embedded family deductible which means the plan begins to make payments for a member when they reach their individual deductible.
[3]This plan is an embedded family maximum which means the plan will cover 100% for an individual member as soon as they reach their individual maximum.
[4]All covered expenses including your medical deductibles and prescription copays accumulate towards the out-of-pocket maximum.
[5]After deductible.

SISC PPO Value Based Site-of-Care Benefit

Hospitals and Ambulatory Surgery Centers (ASCs)

The facility fees* for outpatient procedures at hospitals can be several times higher than at Ambulatory Surgery Centers (ASCs), for the same service and quality of care provided.

SISC PPO plans limit the maximum benefit amount at an in-network outpatient hospital facility for the following five procedures:

	Maximum benefit	
	In-network Outpatient Hospital Facility	**In-network Ambulatory Service Center (ASC)**
Arthroscopy	$4,500	There is no maximum benefit limit at an in-network ASC.
Cataract Surgery	$2,000	
Colonoscopy	$1,500	
Upper GI Endoscopy with Biopsy	$1,250	
Upper GI Endoscopy without Biopsy	$1,000	

If you use an in-network outpatient hospital facility, you will be responsible for the regular deductible and coinsurance PLUS any amount by which the hospital charge exceeds the maximum benefit. If you use an in-network ASC, you will only be responsible for the regular deductible and coinsurance.

IMPORTANT: Most physicians have privileges at both hospitals and ASCs. If you need one of the outpatient procedures on the list shown above, it will be up to you to either request treatment at the in-network ASC or have your doctor obtain an advance certification from your health plan.

Exemption Process

The benefit includes a simple process to exempt the member if the physician provides clinical justification for using a hospital. It also allows exceptions when a member lives more than 30 miles from an ASC and a hospital that offers the service for less than the maximum benefit or if a procedure cannot be scheduled in a medically appropriate timely manner due to available ASCs not having capacity.

Benefits Of Ambulatory Surgery Centers (ASCS)

1. Established track records of providing quality outcomes that are at least as good as or better than hospitals.
2. ASCs tend to be more specialized with less exposure to a wide range of infections
3. Less cumbersome check-in and check-out processes.
4. Outpatient procedures can be safely performed at an ASC more quickly for a fraction of the cost.

Blue Shield Resources

Teladoc

Teladoc's U.S. board-certified doctors are available 24/7/365 to resolve many non-emergency medical issues through phone or video consults. Contact Teladoc online at teladoc.com/bsc, on the phone at 800-teladoc (835-2362).

MinuteClinic (PPO plans only)

You can get virtual and in-person non-emergency healthcare seven days a week by board-certified nurse practitioners at CVS and Target Clinics across California through MinuteClinic. You can find hours of operation and a list of services at cvs.com/minuteclinic and target.com/clinic.

Solera4Me – Diabetes Prevention

With the Diabetes Prevention Program, you can learn more about wellness, makes changes to start losing weight and reduce your risk of developing type 2 diabetes. When you enroll, you get to choose the type of support you prefer, whether it's in-person, online, or even through a smartphone app. For more information visit solera4me.com.

Finding A Blue Shield Provider

To find a provider in your plan network, please visit blueshieldca.com/provider.

BlueshieldCA.com & Mobile App

Register at blueshieldca.com or download the Blue Shield app from the App Store℠ or Google Play® to access tools to help you improve your health, make informed decisions about your care, and find options to save you money.



Blue Shield Wellness Resources

Save on fitness club memberships

This program gives you access to more than 800 fitness centers in California and more than 10,000 nationwide starting at $19 a month. The wellness discount programs also include acupuncture and chiropractic services; therapeutic massage; and eye exams, frames, contact lenses, and LASIK surgery. Learn more at blueshieldca.com/wellnessdiscounts.

Care Management Program

Get support managing your health needs for conditions such as diabetes, depression, chronic pain, cancer, as well as other conditions. Services include personalized health coaching, care plan development, provider coordination, plus more. To learn more, go to blueshieldca.com and click on Conditions and care programs, and then select Shield Support. You can also call (877) 455-6777 to find out if you're eligible.

Maven Maternity Program

The Maven Maternity Program, to support you every baby step of the way. With Maven, you and your partner can get access to virtual care for pregnancy, postpartum, and returning to work after parental leave. Plus, you'll enjoy 24/7 access to Care Advocates, specialists, and coaches – as well as content tailored to your experience. To learn more, go to blueshieldca.com/maven.

Headspace

As the world's most science-backed meditation app, Headspace can help you reduce stress, increase resilience, and get a better night's rest. By dedicating just a few minutes a day you can join 70 million Headspace members worldwide using meditation to improve mental well-being. Visit wellvolution.com/mentalhealth to get started.

Learn about preventive care

Find out what screenings, services, and immunizations we recommend for you and your family. Visit blueshieldca.com/preventive.

Get your flu shot and more

Blue Shield's large network of retail pharmacies offers several preventive vaccines, including the annual flu shot, at no extra charge without a prescription. For more information, go to blueshieldca.com/pharmacy or call the customer service number on your ID card.

Prescription Drugs – Navitus

Blue Shield & Anthem members have access to prescription drug coverage through Navitus. Below is some information to keep in mind regarding this coverage:

Understanding Your Pharmacy Benefits

Members who take stabilized doses of covered long-term maintenance medications — like those used to treat an ongoing condition such as high blood pressure or high cholesterol — can save money by ordering them through Navitus' mail service partner, Costco Pharmacy, instead of using a retail pharmacy.

With the Costco Home Delivery Pharmacy

- You get up to a 90-day supply delivered directly to you — with free standard shipping.
- You can easily order refills online, over the phone or by mail.
- Multiple safety and advanced quality checks are in place to make sure you get the right medication.

Please contact Costco Home Delivery Pharmacy at pharmacy.costco.com. You may also call 1-800-607-6861 for home delivery forms and instructions. ***Please note that some pharmacies, such as Walgreens®, may not be in your plan.*** Log into the member home page at navitus.com to find pharmacies that are in your plan, or call (866) 333-2757.

Get the most from your coverage

To get the most out of your prescription drug coverage, note where your prescriptions fall within your plan's drug formulary tiers and ask your doctor for advice. Generic drugs are usually the lowest cost option. Generics are required by the Food and Drug Administration (FDA) to perform the same as brand-name drug equivalents.

Navitus App
You can also use the Navitus app to search for providers. Download from the App Store or Google Play®.

Navitus Formulary
You can also find a list of formulary and preventive medications on
navitus.com



SISC Value Added Services

Take advantage of these value added services available to SISC plan members to help you get and stay healthy.

Benefit Highlights	Availability & 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* **Call** 800-999-7222 **Visit** anthemEAP.com/SISC
Online Counseling and Therapy **Talkspace** Digital platform that supports behavioral health and emotional wellness needs from a secure, HIPAA-compliant app. Up to 6 counseling sessions per situation.	*All employees* **Call** 800-999-7222 **Visit** talkspace.com/associatecare and enter SISC as your organization name
Expert Medical Opinions **Teladoc Medical Experts** Get answers to health care questions and second opinions from world-leading experts.	*All employees* **Call** 855-380-7828 **Visit** teladoc.com/SISC
Personal Health Coaching **Vida Health**[1] 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**[2] 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.	*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

[1] Not available to SISC HSA Members. [2] Copays may apply.
Per IRS guidelines, SISC HSA & MEC $9000 Members may not be eligible for these programs.

SISC Value Added Services, Cont.

Benefit Highlights	Availability & How To Get Started
Virtual Expert Menopause Care **Midi Health**[1] Access to expert care for menopause through a specialized virtual clinic. The Midi team can provide personalized care for symptoms like hot flashes, mood changes, poor sleep, and more.	*Anthem and Blue Shield PPO members* **Visit** joinmidi.com/sisc
Physical Therapy for Back or Joint Pain **Hinge Health**[1] 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 Virtual Primary Care Doctor **Centivo Care**[1] Virtually connect with a primary care physician to manage all your physical and mental healthcare needs. Centivo 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* **Visit** centivocare.com or download the app
24/7 Access to Virtual Maternity & Postpartum Support **Maven** Connect with a care advocate who will guide you through various tools and resources related to pregnancy and postpartum care. Get private visits with gynecologists, specialists, therapists, and 30 other maternity and postpartum provider types.	*Anthem and Blue Shield PPO members* **Visit** mavenclinic.com/join/SISC
Hip, Knee, & 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 **Lantern Cancer Care** 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.	*Anthem and Blue Shield PPO members* **Visit** lanterncare.com

[1] Not available to SISC HSA Members. [2] Copays may apply.

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

Health Savings Account (HSA)

IMPORTANT: You must be enrolled in a *qualified* HDHP to be eligible for an HSA

A Health Savings Account (HSA) is a powerful tool for managing healthcare costs and saving for the future. This program is administered through RESIG.

How the HSA Works

You can use your HSA debit card to pay for eligible expenses like office visits, lab tests, prescriptions, dental and vision care, and even some drugstore items. You will need to open your HSA account during the SISC Open Enrollment period to receive the company contribution.

You are ELIGIBLE for an HSA if:

- You are currently enrolled in HDHP Plan. You are not enrolled in any other non-HDHP medical coverage.
- You do not have a general-purpose healthcare FSA through your own or your spouse's benefit plan. Limited purpose FSAs, which cover dental and vision expenses only, are allowed.

You are NOT ELIGIBLE for an HSA if:

- You are enrolled in Medicare, Medicaid or Tricare, or if you are someone else's tax dependent.

What about using your HSA for your dependents? Review this article to learn more: alliantbenefits.cld.bz/HSA-Eligibility .

Unlock the Power of Your HSA

Tax Advantages
Contributions, growth and eligible withdrawals are all tax-free.*

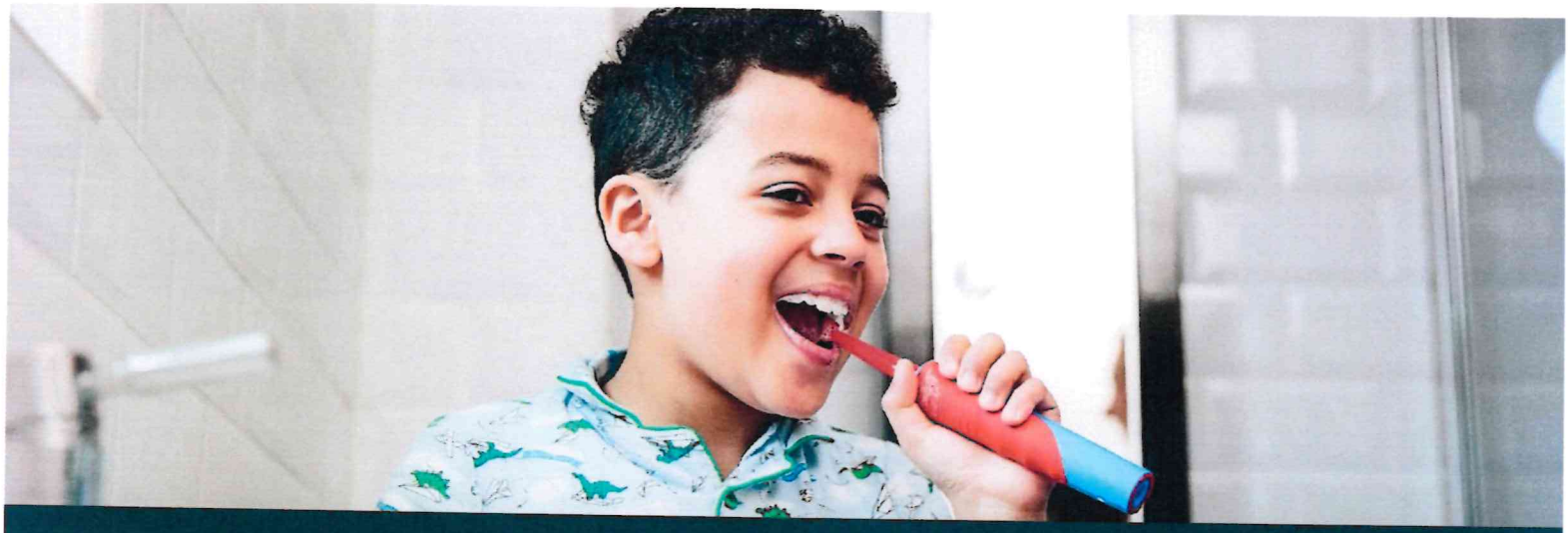
Rollover Capability
Unused funds roll over from year to year, so you don't lose them.

Retirement Savings
You can use HSA funds for healthcare expenses in retirement.**

Flexibility
Use funds for a wide range of qualified healthcare expenses.

Portability
Keep your HSA even if you change jobs or health plans.

*California and New Jersey tax HSA contributions and interest.
**For more information regarding HSAs, Retirement and Medicare, please contact your tax advisor for advice.



Dental

We offer dental coverage through Delta Dental. Dental insurance makes it easier and less expensive to get the care you need to maintain good oral health.

Dental Plan Overview

This guide serves as a summary of the dental plan. Please review the plan documents before enrolling in coverage.

	What you need to know
Delta Dental	• **PPO Providers:** In-network offering the highest level of savings • **Premier Providers:** In-network with a high level of savings • **Out-of-network Providers:** No discounts available. You may be responsible for paying the full cost of services up front, could be subject to balance billing, and must wait for reimbursement for covered services • **Digital ID card available on the app, though no ID card is required**—Let your dental provider know you are covered by Delta Dental and they will verify your eligibility • **No referrals necessary** • **Visit deltadentalins.com** to create an account, track claims, and find a provider

Dental insurance covers multiple types of treatment:

1. **Preventive** care includes exams, cleanings, and x-rays
2. **Basic** care focuses on repair and restoration with services such as fillings, root canals, and gum disease treatment
3. **Major** care goes further than basic and includes bridges, crowns, and dentures

Delta Dental PPO

	This table shows member cost share.	
	1900-1500 No Ortho PPO	
	Delta Dental PPO Dentists	Non-Delta Dental PPO Dentists
Annual Deductible	None	None
Annual Plan Maximum	$1,900	$1,500
Diagnostic & Preventive Exams, X-rays & Cleanings	70-100%	70-100%
Basic Services Fillings, Root Canals & Periodontics	70-100%	70-100%
Major Services Crowns, Onlays & Cast Restorations	70-100%	70-100%
Orthodontia Adults/ Children	N/A	N/A
COST OF COVERAGE – Per Month/Pay Period		
Employee Only	$	
Employee + 1	$	
Employee + Child(ren)	$	
Employee + Family	$	

Delta Dental Perks



- **Virtual Dentistry** - members can set up a virtual dental screening or even send in photos for non-emergency dental issues
- **Amplifon Discount** - members get an average savings of 66% off the latest retail hearing aid price.
- **Qualsight Discount** - members get an average savings of 35% off the national average price of LASIK eye surgery.

Visit deltadentalins.com/enrollees to access all of these perks and more!

Delta Dental Resources

SmileWay® Wellness Benefits

If you or a covered family member has been diagnosed with a chronic medical condition like diabetes, cancer or rheumatoid arthritis, you may benefit from additional teeth and gum cleanings. Opt in by visiting deltadentalins.com/smileway or by calling Customer Service Monday through Friday.

Delta Dental Mobile App

Anyone can use Delta Dental Mobile without logging in to access our Find a Dentist and Toothbrush Timer tools, conveniently located on the home screen. You also have the option to save your ID card to the home screen for easy access without logging in. Log into the app to view your personal benefits.

Toothpic

Toothpic is a photo-based tele-dentistry app for PPO. Although Toothpic is not available for dental emergencies, members can set up a virtual dental screening or even send in photos for dental issues. A Delta Dental dentist that is part of the PPO, can highlight issues from the photos, such as cavities, gum disease, oral hygiene, or other dental concerns. The dentist can then assist with next steps or possible treatments or a home care regimen.

Cost Estimator

Members can plan visits and compare costs before they receive their treatments. Estimates for each member are personalized based on benefits. Members can compare procedure costs at nearby dentists should members need to plan in terms of costs. Members can also receive a detailed explanation of their costs based on upcoming treatment.

Amplifon & Qualsight Discounts

With the Amplifon discount, Delta Dental members get an average savings of 66% off the latest retail hearing aid price. PPO members may even be able to use their plan benefits in coordination with Amplifon discounts. There is also a QualSight discount for Delta Dental members. Members receive 35% off the national average price of tradi
experienced QualSight LASIK surgeon.

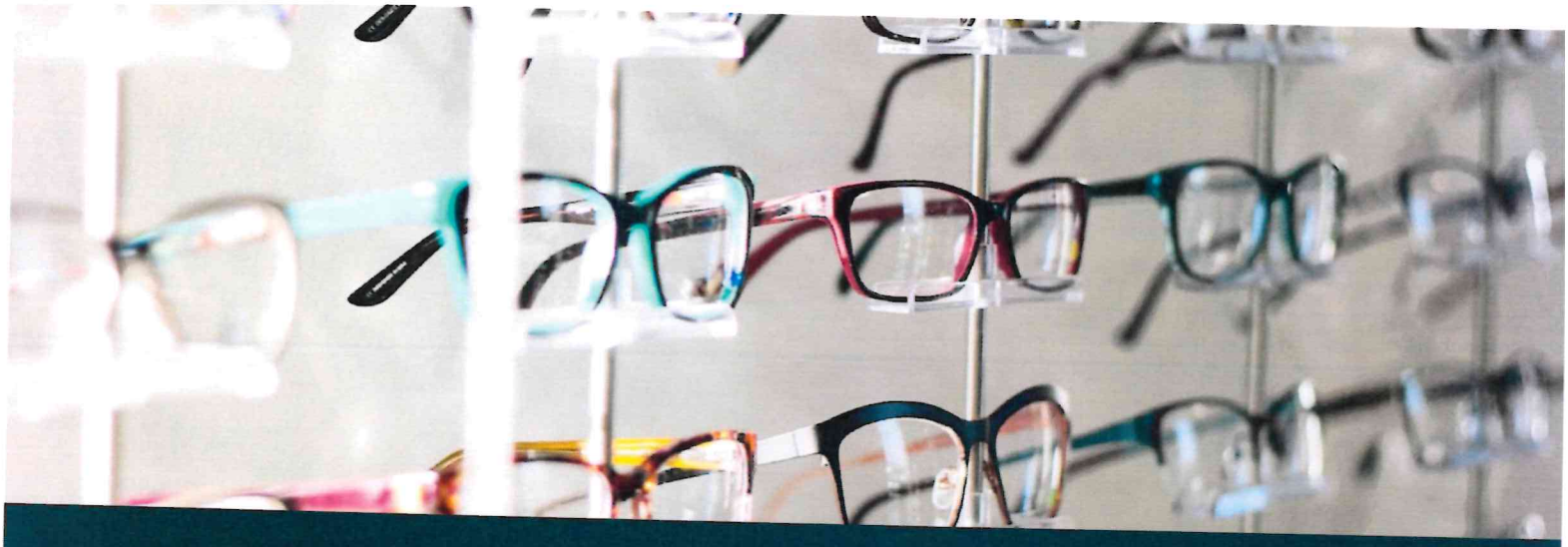
Finding a Delta Provider

To find a Delta Dental provider near you, please visit deltadentalins.com and click "Find a Dentist". For PPO plans choose "Delta Dental PPO"

LifePerks

As a Delta Dental member, you have access to a
discounts to help you care for your whole body an
about LifePerks at discountmember.lifecare.com.





Vision

We offer vision coverage through VSP. Vision coverage helps with the cost of eyeglasses or contacts.

Vision Plan Overview

This guide serves as a summary of the vision plan. Please review the plan documents before enrolling in coverage.

	What you need to know
VSP *VSP Signature Network*	• In-network only/Out-of-network coverage will have higher costs
Routine Eye Exams	• Included annually. Helps detect early signs of over 270 health conditions like diabetes, high blood pressure, and glaucoma.
Glasses	• Lenses are covered each year and include options like single vision, lined bifocal, and lined trifocal. Impact-resistant lenses available for children.
Frames	• An allowance is provided toward frames. Additional savings may apply at certain retailers, including extra discounts when choosing Featured Frame Brands.
Lens Enhancements	• Standard options like scratch-resistant coating, light-reactive lenses, and progressive lenses are included. Additional upgrades may be discounted.
Contacts (Instead of Glasses)	• Members can choose contacts instead of glasses, including fitting and evaluation.
LightCare™ Option	• Instead of prescription glasses or contacts, members can apply benefits toward non-prescription sunglasses or blue light glasses.
Provider Flexibility	• Choose from thousands of private practice doctors, national retailers, or shop online at eyeconic.com. You'll get the most value at a VSP Premier Edge™ location.
Extras & Member Offers	• Get discounts on extra glasses or sunglasses, LASIK procedures, and hearing aids through TruHearing®. Exclusive savings are available at vsp.com/offers.
Need Help?	• Visit vsp.com or call 800-877-7195. You can create an account to find a provider and check your personalized benefits.

vsp vision care

Make Eye Health a Priority with VSP!

Your health comes first with VSP and Roseland SD. Take a look at your VSP vision care coverage.



VSP members save an annual average of

$471*

More Ways to Save

Extra $20 to spend on Featured Frame Brands†

bebe Calvin Klein COLE HAAN
DRAGON. FLEXON LONGCHAMP PARIS
and more

Up to 40% Savings on lens enhancements‡

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

Enroll through your employer today. Questions?

vsp.com or **800.877.7195**

Scan QR code or visit **vsp.com** to learn more.

Routine eye exams have saved lives.

Did you know an eye exam is the only non-invasive way to view blood vessels in your body? Your VSP® network eye doctor can detect signs of over 270 health conditions during an eye exam.**

Savings you'll love.

See and look your best without breaking the bank. VSP members get exclusive savings on popular frame brands and contact lenses, and they get additional discounts on things like LASIK, and more.

The choice is yours!

VSP gives you thousands of in-network choices, including private practice doctors, regional and national optical retail chains, or online at **eyeconic.com®**. You'll get the most out of your benefits at a VSP Premier Edge™ location.

vsp PREMIER edge

Preferred private practice and retail in-network choices

private practice doctors Visionworks

Getting started is easy!

Let your plan do the most it can. When you create an account on **vsp.com**, you can view your in-network coverage details, find a VSP network doctor that is right for you, and discover extra savings to maximize your benefits.

†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.
*Based on state and national averages for eye exams and most commonly purchased brands. This represents the average savings for a VSP member with a full-service plan at an in-network provider. Your actual savings will depend on the eyewear you choose, the plan available to you, the eye doctor you visit, your copays, your premium, and whether it is deducted from your paycheck pre-tax. Source: VSP book-of-business paid claims data for Aug-Jan of each prior year. **Full Picture of Eye Health, American Optometric Association, 2020. +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. Premier Edge™ is not available for some members in the state of Texas.

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**. Visionworks and Eyeconic are VSP-affiliated companies.

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VSP, Eyeconic, and WellVision Exam are registered trademarks, and VSP LightCare™ and VSP Premier Edge are trademarks of Vision Service Plan. All other brands or marks are the property of their respective owners. 102898 VCCM

Classification: Restricted

Your VSP Vision Benefits Summary

Prioritize your health and your budget with a VSP plan through Roseland SD.

Provider Network:
VSP Signature

vsp vision care

BENEFIT	DESCRIPTION	COPAY	FREQUENCY
YOUR COVERAGE WITH A VSP DOCTOR			
WELLVISION EXAM	• Focuses on your eyes and overall wellness • Routine retinal screening	$10 for exam and glasses Up to $39	Every 12 months
ESSENTIAL MEDICAL EYE CARE	• Retinal imaging for members with diabetes covered-in-full • 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 network doctor for details.	$20 per exam	Available as needed
PRESCRIPTION GLASSES			
FRAME[+]	• $195 Featured Frame Brands allowance • $175 frame allowance • 20% savings on the amount over your allowance	Combined with exam	Every 24 months
LENSES	• Single vision, lined bifocal, and lined trifocal lenses • Impact-resistant lenses for dependent children	Combined with exam	Every 12 months
LENS ENHANCEMENTS	• Standard progressive lenses • Premium progressive lenses • Custom progressive lenses • Average savings of 40% on other lens enhancements	$0 $80 - $90 $120 - $160	Every 12 months
CONTACTS (INSTEAD OF GLASSES)	• $130 allowance for contacts; copay does not apply • Contact lens exam (fitting and evaluation)	Up to $60	Every 12 months
VSP LIGHTCARE™[+]	• $175 allowance for ready-made non-prescription sunglasses, or ready-made non-prescription blue light filtering glasses, instead of prescription glasses or contacts	Combined with exam	Every 24 months
ADDITIONAL SAVINGS	**Glasses and Sunglasses** • Discover all current eyewear offers and savings at **vsp.com/offers**. • 30% savings on unlimited additional pairs of prescription or non-prescription glasses/sunglasses, including lens enhancements, from the same VSP provider on the same day as your WellVision Exam. Or get 20% savings from a VSP provider within 12 months of your last WellVision Exam.		
	Laser Vision Correction • Average of 15% off the regular price; discounts available at contracted facilities.		
	Exclusive Member Extras for VSP Members • Contact lens rebates, lens satisfaction guarantees, and more offers at **vsp.com/offers**. • Save up to 60% on digital hearing aids with TruHearing®. Visit **vsp.com/offers**/special-offers/hearing-aids for details. • Enjoy everyday savings on health, wellness, and more with VSP Simple Values.		

COVERAGE WITH AN OUT-OF-NETWORK DOCTOR

With so many in-network choices, VSP makes it easy to maximize your benefits. Choose from our large doctor network including private practice and retail locations. Plus, you can shop eyewear online at Eyeconic®. Log in to **vsp.com** to find an in-network doctor. Your plan provides the following out-of-network reimbursements:

Exam ..... up to $50	Lined Bifocal Lenses ..... up to $75	Progressive Lenses ..... up to $75
Frame ..... up to $70	Lined Trifocal Lenses ..... up to $100	Contacts ..... up to $105
Single Vision Lenses ..... up to $50		

VSP Savings and Resources

Extra Savings on Glasses and Sunglasses

Get an extra $20 to spend on featured frame brands. Go to vsp.com/specialoffers for details. You can also save 30% 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.

TruHearing® Hearing Aid Discount

VSP® Vision Care members can save up to 60% on a pair of hearing aids with TruHearing. What's more, your dependents and even extended family members are eligible, too. TruHearing also provides members with:

- 3 provider visits for fitting, adjustments, and cleanings
- A 45-day trial
- 3-year manufacturer's warranty for repairs and one-time loss and damage
- 48 free batteries per hearing aid

Learn more about this VSP Exclusive Member Extra at truhearing.com/vsp or call (877)396-7194.

Retinal Screening

You won't pay more than a $39 copay on routine retinal screening as an enhancement to a WellVision Exam.

LASIK - Laser Vision Correction

Save up to an average of 15% off the regular price of LASIK or 5% off the promotional price. Discounts are only available from contracted facilities. After surgery, use your frame allowance (if eligible) for sunglasses from any VSP doctor.

VSP Diabetic Eyecare Plus Program

This program provides coverage of additional eyecare services specifically for members with diabetic eye disease, glaucoma or age-related macular degeneration (AMD). Eligible members can receive both routine and follow-up medical eyecare from their VSP doctor—the doctor who already knows their eyes best.

The program also provides supplemental coverage for non-surgical medical eye conditions such as diabetic retinopathy, abnormal blood vessel growth on the eye (rubeosis), and diabetic macular edema. Members can self-refer, visit their VSP Provider as often as needed, and pay only a copay for services.

Access To Over $3,000 In Exclusive Member Savings

Visit vsp.com/offers to learn more about these resources and other VSP exclusive member extras.



Wellbeing & Balance

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

A Happier, Healthier You

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

	What you need to know
Employee Assistance Program (EAP)	Access resources to manage stress, chemical dependency, mental health and family issues.
Mental Health Resources	Mental health coverage provided by your medical carrier.
Wellness Program	Maximize your physical well-being.
Time Away From Work	Take time to spend with family and friends, take care of personal business, or just have a little extra "me time".

Important

For immediate assistance in a mental health crisis please call 911. Or call the National Suicide Prevention Lifeline at 988 for a national network of local crisis centers that provides free and confidential emotional support.

Employee Assistance Program (EAP)

Help for you and your household members

There are times when everyone needs a little help or advice, or assistance with a serious concern. The EAP through Anthem can help you handle a wide variety of personal issues such as emotional health and substance abuse; parenting and childcare needs; financial coaching; legal consultation; and eldercare resources.

Best of all, contacting the EAP is completely confidential, free and available to any member of your immediate household.

No cost EAP resources

The EAP is available around the clock to ensure you get access to the resources you need:

- Unlimited phone access 24/7
- In-person or video counseling for short-term issues; access up to 6 visits per person, per issues
- Unlimited web access to helpful articles, resources, and self-assessment tools

Available Resources

Counseling Benefits

- Difficulty with relationships
- Emotional distress
- Job stress
- Communication/ conflict issues
- Alcohol or drug problems
- Loss and death

Parenting & Childcare

- Referrals to quality providers
- Family day care homes
- Infant centers and preschools
- Before/after school care
- 24-hour care

Financial Coaching

- Money management
- Debt management
- Identity theft resolution
- Tax issues

Legal Consultation

- Referral to a local attorney
- Family issues (marital, child custody, adoption)
- Estate planning
- Landlord/tenant
- Immigration
- Personal Injury
- Consumer protection
- Real estate
- Bankruptcy

Eldercare Resources

- Help with finding appropriate resources to care for an elderly or disabled relative

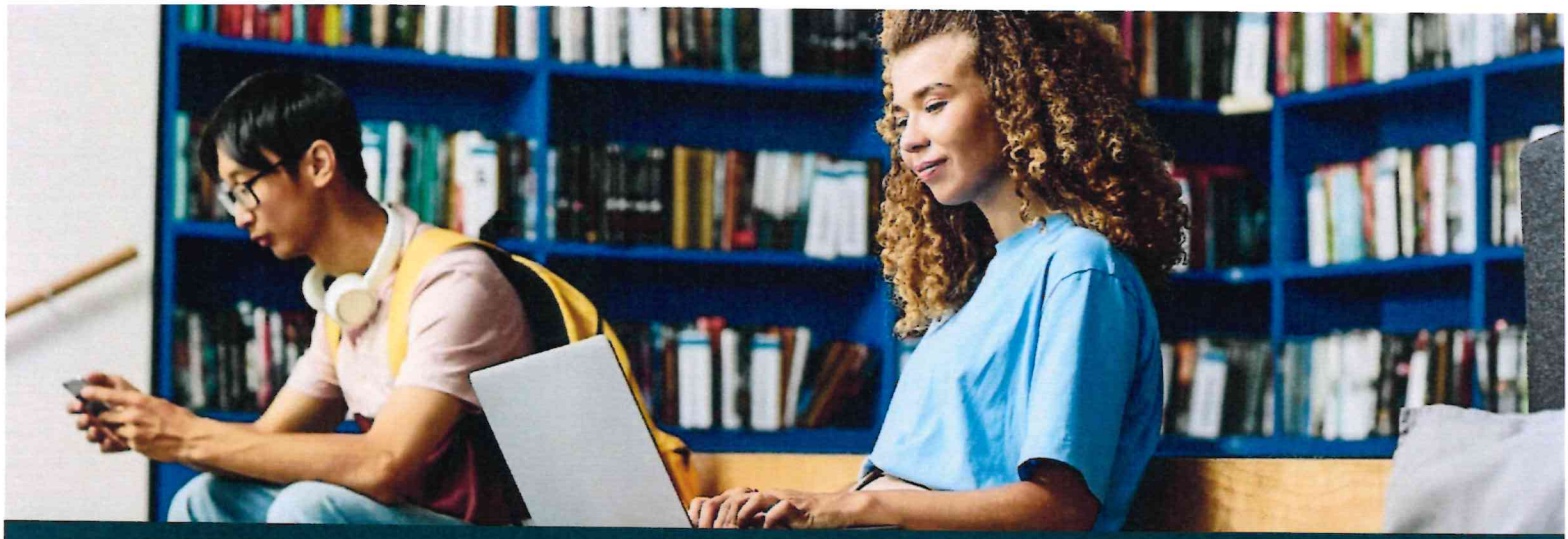
Online Resources

- Self-help tools to enhance resilience and well-being
- Useful information and links to various services and topics

Contact the EAP

Phone
800-999-7222

Website
AnthemEAP.com and enter SISC



Important Plan Information

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

	What you need to know
Your Benefit Costs	An overview of your healthcare costs.
Important Contacts	Contact information for our benefit carriers and vendors.
Benefits Glossary	A Benefits Glossary to help you understand important insurance terms.
Important Notices	A summary of the health plan notices you are entitled to receive annually, and where to find them.

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

Plan Contacts

If you need to reach our plan providers, here is their contact information:

Plan Type	Provider	Phone Number	Website/Email
Medical	Blue Shield of CA	(855) 599-2657	blueshieldca.com/sisc
Medical	Kaiser Permanente	(800) 464-4000	kp.org/sisc
Medical	Anthem	(800) 888-8288	www.anthem.com/ca
Dental	Delta Dental	(866) 499-3001	deltadentalins.com
Vision	VSP	(800) 877-7195	vsp.com
Prescription Drugs and Mail Order Service	Navitus	(866) 333-2757	navitus.com
Employee Assistance Program	Anthem	(800) 999-7222	anthemEAP.com Code: SISC

Glossary

-A-

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

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

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

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

-B-

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

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

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

-C-

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

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

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

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

-D-

Deductible
The amount of healthcare expenses you have to pay for with your own money before your health plan will pay. The deductible does not apply to preventive care and certain other services.
Family coverage may have an ***aggregate*** or ***embedded*** deductible. Aggregate means your family must meet the entire family deductible before any individual expenses are covered. Embedded means the plan begins to make payments for an individual member as soon as they reach their individual deductible.

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

Dental Diagnostic & Preventive Generally includes routine cleanings, oral exams, x-rays, and fluoride treatments.

Glossary

-I-

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

-L-

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

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

-M-

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

-O-

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

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

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

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

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

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

-P-

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

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

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

IMPORTANT PLAN INFORMATION

HEALTH PLAN NOTICES

These notices must be provided to plan participants on an annual basis and are available in the Annual Notices document, located at the end of this guide:

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

COBRA CONTINUATION COVERAGE

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

PLAN DOCUMENTS

Important documents for our health plan and retirement plan are available at the end of this guide. Paper copies of these documents and notices are available if requested. If you would like a paper copy, please contact the Plan Administrator.

Medicare Part D Notice

Important Notice from Redwood Empire School's Insurance Group (RESIG) 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 RESIG and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

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

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. RESIG has determined that the prescription drug coverage offered by SISC 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 RESIG coverage will not be affected. See below for more information about what happens to your current coverage if you join a Medicare drug plan.

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

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

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

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

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

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

Contact the 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 RESIG changes. You also may request a copy of this notice at any time.

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

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

For more information about Medicare prescription drug coverage:

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

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

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

Date: May 1, 2025
Name of Entity/Sender: Redwood Empire Schools' Insurance Group (RESIG)
Contact-Position/Office: Elizabeth Matheny – Employee Benefits Supervisor
Address: 5760 Skylane Blvd., Ste 100, Windsor, CA 95492
Phone Number: (707) 836-0779, ext. 120

Women's Health and Cancer Rights Act

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

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Therefore, the following deductibles and coinsurance apply. If you would like more information on WHCRA benefits, call your plan administrator at 707-836-0779, ext. 124.

Newborns' and Mothers' Health Protection Act

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). If you would like more information on maternity benefits, call your plan administrator at (707) 836-0779, ext. 120.

HIPAA Notice of Special Enrollment Rights

If you decline enrollment in RESIG's health plan for you or your dependents (including your spouse) because of other health insurance or group health plan coverage, you or your dependents may be able to enroll in RESIG's health plan without waiting for the next open enrollment period if you:

- Lose other health insurance or group health plan coverage. You must request enrollment within 31 days after the loss of other coverage.
- Gain a new dependent as a result of marriage, birth, adoption, or placement for adoption. You must request health plan enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.
- Lose Medicaid or Children's Health Insurance Program (CHIP) coverage because you are no longer eligible. You must request medical plan enrollment within 60 days after the loss of such coverage.

If you request a change due to a special enrollment event within the 31 day timeframe, coverage will be effective the date of birth, adoption or placement for adoption. For all other events, coverage will be effective the first of the month following your request for enrollment. In addition, you may enroll in RESIG's health plan if you become eligible for a state premium assistance program under Medicaid or CHIP. You must request enrollment within 60 days after you gain eligibility for medical plan coverage. If you request this change, coverage will be effective the first of the month following your request for enrollment. Specific restrictions may apply, depending on federal and state law.

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

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

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

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

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

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

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

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

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

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

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

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

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

Notice of Choice of Providers

Kaiser Permanente and Blue Shield plans generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the number on the back of your ID card.

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

You do not need prior authorization from Kaiser Permanente, Blue Shield or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the number on the back of your ID card.

Michelle's Law

The RESIG plan may extend medical coverage for dependent children if they lose eligibility for coverage because of a medically necessary leave of absence from school. Coverage may continue for up to a year, unless your child's eligibility would end earlier for another reason.

Extended coverage is available if a child's leave of absence from school — or change in school enrollment status (for example, switching from full-time to part-time status) — starts while the child has a serious illness or injury, is medically necessary and otherwise causes eligibility for student coverage under the plan to end. Written certification from the child's physician stating that the child suffers from a serious illness or injury and the leave of absence is medically necessary may be required.

If your child will lose eligibility for coverage because of a medically necessary leave of absence from school and you want his or her coverage to be extended, RESIG in writing as soon as the need for the leave is recognized. In addition, contact your child's health plan to see if any state laws requiring extended coverage may apply to his or her benefits.

Availability of Privacy Practices Notice

We maintain the HIPAA Notice of Privacy Practices for RESIG describing how health information about you may be used and disclosed. You may obtain a copy of the Notice of Privacy Practices by contacting Elizabeth Matheny, at 707-836-0779, ext. 124.

ACA Disclaimer

This offer of coverage may disqualify you from receiving government subsidies for an Exchange plan even if you choose not to enroll. To be subsidy eligible you would have to establish that this offer is unaffordable for you, meaning that the required contribution for employee only coverage under our base plan exceeds 9.02% in 2025 of your modified adjusted household income.

Continuation Coverage Rights Under COBRA

Introduction

You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by 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."

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to your district, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

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;
- Commencement of a proceeding in bankruptcy with respect to the employer; 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: All qualified beneficiaries and provide the required documents to the Plan Administrator.

How is COBRA continuation coverage provided?
Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation 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. Notice needs to be given to the Plan Administrator by the qualified beneficiary within 30 days of the notice by Social Security.

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 Administrator 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 legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or 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

Please contact your RESIG Benefits Specialist II at 5760 Skylane Blvd., Ste. 100, Windsor, CA 95492 or (707) 836-0779.