



reepforbenefits.org

EMPLOYEE BENEFITS *Guide*



**2026
2027**

C^{INSURANCE}CCS

CONTROLLING INSURANCE COSTS
IN CALIFORNIA SCHOOLS



COLTON REDLANDS YUCAIPA
REGIONAL OCCUPATIONAL PROGRAM
Inspiring Possibilities

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The information in this brochure is a general outline of the benefits offered under CRY-ROP's benefits program. Specific details and plan limitations are provided in the Summary Plan Descriptions (SPD), which is based on the official Plan Documents that may include policies, contracts and plan procedures. The SPD and Plan Documents contain all the specific provisions of the plans. In the event the information in this brochure differs from the Plan Documents, the Plan Documents will prevail.

Colton Redlands Yucaipa ROP strives to provide our employees a comprehensive benefits program designed to protect you and your family from costs associated with illness, injury or accident. We are pleased to continue to provide a suite of quality benefit plans to all benefit eligible employees for the 2026-2027 plan year. This booklet is designed to provide information about the benefits available through Colton Redlands Yucaipa ROP.

Colton Redlands Yucaipa ROP offers medical, dental, vision and life coverage along with other voluntary plans and tax-favored flexible spending accounts. Whether you're enrolling for the first time or adjusting your existing coverage, this guide is designed to help you understand your choices and make informed decisions for the upcoming year.

How to Use This Guide

Please take time to review this guide carefully. It includes important plan details, helpful tips, and resources to support your decision-making. We encourage you to keep it on hand as a reference throughout the year.

Open Enrollment Overview

Our benefit plans renew each year on July 1. In the weeks leading up to this date, we hold an annual Open Enrollment period that gives you the opportunity to review your benefit options and make any updates to your current elections.

General Enrollment Information

When First Eligible – New Hires

If you are eligible for benefits, the District Benefits Office will direct you to BenefitBridge to make your benefit plan selections and enroll. If your hire date is between the 1st through the 15th of the month, your benefits will become effective on the 1st of the following month. If your hire date is between the 16th and the end of the month, your benefits will become effective on the 1st of the month proceeding the following month.

The effective date for voluntary plans will vary by plan.

Annual Enrollment

During Open Enrollment, you may change your current benefit elections with new coverage effective July 1 each year.



What You Can Do During Annual Open Enrollment

- Enroll in or make changes to your medical, dental, vision, and other voluntary plans
- Add or remove dependents
- Update your beneficiary information

Key Dates

Open Enrollment Period: May 11 – May 24, 2026

Effective Date for New Elections/Changes: July 1, 2026

All elections must be submitted online through **BenefitBridge**. Step-by-step instructions for logging in and navigating the system are included in this guide. Enrollment information submitted that is not complete or is missing documents will cause a delay in access to benefits effective July 1, 2026.

Once you make your benefit elections, coverage will remain in effect for the full plan year, July 1, 2026 through June 30, 2027.

Changes Outside of Open Enrollment

Changes to your benefits outside of the Open Enrollment window are only permitted if you experience a **Qualifying Life Event** such as marriage, divorce, birth or adoption of a child, or loss of other coverage. If you believe you've experienced a qualifying event, please contact the Benefits Department for guidance.

You cannot change plans until the next Open Enrollment period unless you (or a family member) experience an IRS approved qualifying event in family status such as losing health coverage under another plan, marriage, divorce or legal separation, death, birth, adoption (or placement of adoption), entitlement to Medi-Cal, or loss of entitlement to Medi-Cal.

You must notify the Benefits Department within 30 days of a qualified status change in order to make a benefit change or wait until the next Open Enrollment period to make a change. Any benefit change must be consistent with the status change (for example, you may add dependent coverage after the birth of a child).

Employee Benefit Questions

If you have questions, please contact the Benefits Office at [909-793-3115](tel:909-793-3115) or Alma_orozco@cry-rop.org

You can also visit BenefitBridge at www.benefitbridge.com/cryrop for additional information.

Who Can Enroll?



The District provides medical, dental, vision and life insurance benefits to all benefit eligible employees. You can enroll the following family members in the medical, dental and vision plans.

- **Your spouse** – a legally married spouse under state law, including a same-sex spouse.
- **Your domestic partner** – is eligible once you complete a Domestic Partner Affidavit. The affidavit outlines important rules for adding a partner, ending coverage and making changes to partner eligibility.
- **Your children (including your domestic partner's children)**
 - **Under age 26**
 - They do *not* need to live with you.
 - They do *not* need to be in school.
 - They may be married, employed, or living independently.
 - They remain eligible **as long as they do not have other coverage.**
 - **Age 26 or older – eligible only if**
 - They are incapacitated due to a disability, **and**
 - They are primarily dependent on you for support.
 - **Children covered by a Qualified Medical Child Support Order (QMCSO)**
 - A QMCSO is a federal legal order requiring coverage for a child.

Required Documentation

If you are adding an eligible dependent, the following documents are required:

Spouse, Domestic Partner (AB205) or Domestic Partner (Non-AB205):

In addition to the documentation listed below, a copy of last year's tax return(s) will be required. Please redact financial information and the first five digits of your Social Security Number. If taxes were filed separately, a copy of both returns is required.

- **Spouse** – Photocopy of the legal Certificate of Marriage or officiate-issued certificate
- **Domestic Partner (AB205)** – Photocopy of a certified copy of the Declaration of Domestic Partnership that was filed with California Secretary of State (once filed, the form is stamped by the state)
- **Domestic Partner (Non-AB205)** – Photocopy of a notarized copy of the Declaration of Domestic Partnership form
- **Dependent Child** – Photocopy of the legal birth certificate, hospital certificate, adoption paperwork, or legal guardianship paperwork issued by a court (documentation must include both child and parents' names and the dependent relationship to the employee). Grandchildren are only eligible if they are the employee/retiree's dependent through adoption or legal guardianship, with the exception of Kaiser. Kaiser will allow a covered dependent child under your plan to include their dependent child(ren).



CRY-ROP Online Benefits Enrollment is easy with BenefitBridge!

Need Help?

For all questions related to your benefits, please contact your employer's benefits administrator. For BenefitBridge technical assistance **only**, please contact BenefitBridge Customer Care at 800.814.1862; Mon – Fri, 8:00 a.m. – 5:00 p.m., PST or email benefitbridge@keenan.com.

Here's what you can do on BenefitBridge:

- View Current Plan Year Benefits
- Compare Plan Options
- Enroll in Benefits
- Resource Center: Health Insurance Basics, Medicare, Glossary, Media Resources
- Add or Remove Dependents/Beneficiaries
- Message Center
- Update My Account Info
- Available 24/7 via the Internet

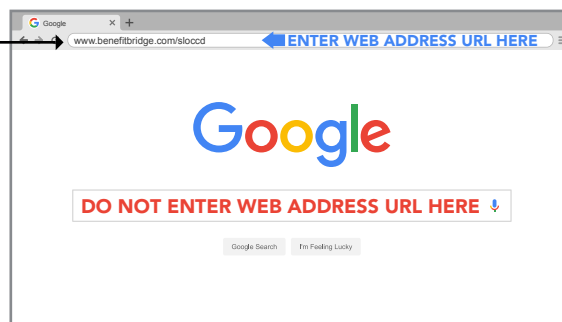
Registration and Login

Already have login credentials?

1. Login to **BenefitBridge** at www.benefitbridge.com/cryrop
2. Forgot your Username or Password? Click on **"Forgot Username/Password?"**
3. Please add or update your email address to receive an email confirmation of your enrollment approval.

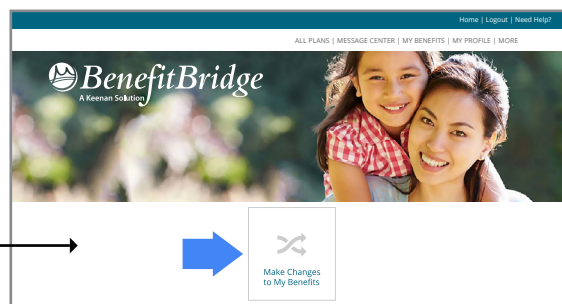
Need to create login credentials?

1. In the **address bar**, type www.benefitbridge.com/cryrop (Not in the Google, Yahoo, Bing, etc. search engine field)
2. Click the **Enter** key, then follow the instructions below to register:
 - **STEP 1:**
Select **"Register"** to **Create an Account**
 - You will need to create an account using your first and last names as they appear on your payroll statement.
 - **STEP 2:**
Create a **Username** and **Password**
 - **STEP 3:**
Select a picture, as instructed
 - **STEP 4:**
Select **"Continue"** to access **BenefitBridge**



Enrolling in Benefits

Access your enrollment via the **"Make Changes to My Benefits"** button



For BenefitBridge technical assistance only, please contact BenefitBridge Customer Care at

800.814.1862

Monday – Friday, 8:00 AM - 5:00 PM, PST or email benefitbridge@keenan.com.

Once again, the REEP JPA has been hard at work, acting to implement plans and benefit enhancements designed to provide the REEP member districts with more options and reduce overall costs. Below is an overview of the updates and policy changes for the 2026-2027 plan year.



NEW! Wondering which plan to choose this year?

Feeling stressed about the benefits selection process? Good news: you have access to your very own benefits pro, ALEX. All you have to do is answer a few short questions about your anticipated health insurance needs, and ALEX will help you find the best plan for your needs and budget. - <https://start.myalex.com/cryrop>

REEP Health Center for Anthem PPO, HPN EPO, HSA and MVP Members

As part of your benefits through REEP, you and your eligible family members now have access to Marathon Health virtual care.

Available for REEP members on Anthem PPO/HSA/MVP/HPN health plans!

Virtual care at no cost with Marathon Health:

- Little to no cost
- See a provider virtually through our secure portal
- Same-and next-day visits for immediate care needs
- 24/7 virtual access to manage your care
- More time with your provider
- Annual wellness review
- Condition management
- Diet and nutrition review and counseling
- Lab test recommendations
- Medication management
- Sick and immediate care

Our Health Center has updated its hours to better accommodate our members' schedules. Additionally, we have welcomed a new provider to our team, enhancing the quality of care available to our members. See the flyer on the Marathon Health Center on page 50 for additional information.

The Marathon Health Center covers up to 90% of your comprehensive and primary care needs with virtually no out-of-pocket costs (\$0 copay for all preventive services for PPO and HSA plan participants. \$0 copay for non-preventive services for PPO members and only a \$10 copay for HSA plan participants). REEP participating school district/college employees and dependents on **PPO, HPN EPO, HSA or MVP** plans can access Marathon Health services including virtual care and 24/7 access to your provider for emergencies.

Marathon Health Center services include, but are not limited to the following:

- Annual physical exams
- Chronic condition management
- Full-scope family medicine
- Men's and women's health
- Mental health screenings
- No cost onsite lab work
- School and sports physicals
- Select onsite medications at little to no cost
- Sick and urgent care
- Same and next day appointments
- 24/7 phone access to your care team for urgent needs

To learn more, visit <https://marathon.health/>

2026-2027 Benefit Updates & Policy Changes (continued)



Plan Updates for 2026:

Anthem and Kaiser Medical Changes

In compliance with federal mandates, we have updated the deductibles for our HSA plans. The HSA 1650 plan will now be known as HSA 1.

Kaiser Treatment for infertility and fertility services

For plans renewed on or after July 1, 2025, Kaiser Permanente will cover:

- Services required to diagnose infertility, including laboratory and imaging services
- Services to treat infertility, including medications, artificial insemination, and in vitro fertilization

Members will have the same cost share for fertility services (such as imaging or lab tests) as they do when they receive those services for other conditions. Deductibles, copayments, and coinsurance for fertility services will be applied to any out-of-pocket maximums for their benefit plan.

SB 729: Infertility & Fertility Coverage

Kaiser Permanente is committed to continuing to provide our members with high-quality care to help them start or grow a family.

We will comply with all applicable requirements of California's SB 729, which imposes new coverage requirements for infertility and fertility services for fully insured large group plans, effective upon the plan's renewal date on or after January 1, 2026.

SB 729 includes coverage for the diagnosis and treatment of infertility and fertility services, including artificial insemination, IVF, and fertility drugs as medically indicated. Cost sharing for fertility services will match the plan's cost sharing for non-fertility medical services. Once we receive final guidance from the California regulator on what SB 729 coverage entails, we will share more details.

AB 904 Doula Services

What is a doula? A doula is a nonmedical, trained professional who supports people during pregnancy, labor and postpartum.

As of January 1, 2026, members must select a Kaiser Permanente contracted doula to receive covered services. However, members who began working with a non-contracted doula prior to January 1, 2026, can continue to receive covered services from that doula until they exhaust their doula benefit for their pregnancy.

SB 40: Insulin Cost Share Requirements

Prohibits health plans and health insurers from imposing a copayment, coinsurance, deductible (including High Deductible Health Plans (HDHP), or any other cost sharing on self-administered outpatient insulin prescription drugs that exceeds \$35 for a 30-day supply.

New Home Medical Equipment Vendor

Starting December 1, 2025, Kaiser Permanente switched from Apria Healthcare to AdaptHealth

- The transition to Kaiser Permanente's new Home Medical Equipment vendor, AdaptHealth, continues to roll out across all KP regions
- On February 1, members in the Southern California, Colorado, and Northwest regions transitioned to AdaptHealth.

2026-2027 Benefit Updates & Policy Changes (continued)



Anthem IVF Legislation

Executive Summary

Infertility and fertility services coverages will be effective July 1, 2026. This bill requires large group health care plans to cover infertility and fertility services, removing the ban on in-vitro fertilization, and revises the definition of "infertility."

Key Requirements

1. Large Group Plans:

- Cover infertility and fertility services, effective July 1, 2026.
- Include up to three oocyte retrievals with unlimited embryo transfers.
- Excludes specialized contracts.

2. Notices:

- All group plans must inform members of fertility coverage in their evidence of coverage.

3. Infertility Definition:

- Based on medical history, inability to reproduce, or unsuccessful conception after set periods depending on age.

4. Coverage Prohibitions:

- No exclusions or restrictions on fertility medications differing from other prescriptions.
- No denial of coverage due to participation by a third party (e.g., donor, surrogate).
- Standardized cost-sharing with other services.

5. Rights Preservation:

- Does not remove existing rights or benefits for infertility coverage.

6. Non-Discrimination:

- Coverage must be irrespective of various personal characteristics except as per clinical judgment.

7. Religious Employer Exemption:

- Excludes religious employers, defined under current codes.

8. Applicability:

- Applies to all policies for California residents, regardless of the contract location.

Feedback from Compliance

- **Financial Impact:** The financial impact on FI rates and ASO claims is still being evaluated. Under the mandate, Large Group plans must cover infertility diagnosis and treatment for plans issued, amended, or renewed on or after July 1, 2025. Small Groups must offer the same coverage, potentially as a rider instead of a benefit expansion.
- **Benefits Changes:** The mandate removes the exclusion of in vitro fertilization from coverage and redefines "infertility." Additional guidance from the CA regulator, DMHC, will be provided in an upcoming All Plan Letter. (expected in the next few weeks)
- **CA Plan Implementation Status:** The statutory effective date is July 1, 2025. However, the Governor has shown interest in delaying it to January 1, 2026, which would require legislative action. The Government Relations team is seeking further clarity.

Express Scripts

Move to National Preferred formulary Prescription Coverage Changes

Your current medication may no longer be covered under the prescription plan or may have new limitations. Covered alternative medications are available, and your doctor can prescribe one of these options instead. If there is a clinical reason you need to remain on your current medication, your doctor may request a coverage review after the change takes effect, but any existing approvals may expire.

2026-2027 Benefit Updates & Policy Changes (continued)



Transcarent

Understanding Your Surgical Benefit with Anthem and Transcarent

REEP has partnered with Transcarent to help members make confident, informed decisions when planning a surgical procedure.

Every year, unnecessary or misaligned surgeries can lead to higher costs, avoidable complications, and additional follow-up care. Transcarent is here to help you better understand your options and connect with high-quality surgical care that delivers excellent outcomes — often at low or no out-of-pocket cost to you.

Transcarent works alongside Anthem to:

- Connect you with top-tier facilities that specialize in your procedure
- Help you understand how your surgical benefits work
- Provide concierge support for scheduling, billing, and questions

This support is designed to complement your Anthem medical coverage and make the surgical experience easier to navigate.

How Transcarent Can Support You

If you're planning an elective surgery, you're encouraged to speak with a Transcarent Care Coordinator. This conversation is optional but can be a helpful step in understanding your benefits and care choices.

What You Can Expect

During a consultation, a Transcarent Care Coordinator can:

- Learn more about your planned procedure
- Review your Anthem surgical benefits
- Share high-quality, cost-effective care options
- Answer questions and help you feel confident about next steps

Many members find this support valuable as they prepare for surgery and explore their options.

Your Choice, Your Care

After speaking with Transcarent, you decide how to move forward:

- You may choose a Transcarent Surgical Center of Excellence, which can offer high-quality care and potential cost savings, **or**
- You can continue with your traditional Anthem provider and network options

Using Transcarent is entirely your choice and does not limit your access to Anthem benefits.

How to Connect with Transcarent

Getting started is easy and on your schedule:

- Download the Transcarent app
- Visit member.transcarent.com
- Call [844-643-0606](tel:844-643-0606)

Transcarent is available to support you whenever questions come up — whether you're early in the decision-making process or already planning your surgery.



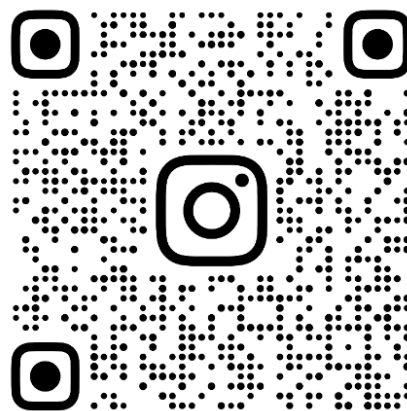


REEP has a new Instagram Page! Follow to stay up to date on REEP Employee Benefits!

Click the URL: https://www.instagram.com/reep_benefits/, scan the QR code, or look us up on the app @reep_benefits to follow.

Bi-weekly random follower drawings for \$100!

*Must fill out form in bio to enter



REEP_BENEFITS

Medical: Plan Options

Whether you have a common cold or will be undergoing surgery, medical benefits cover a range of services and can provide peace of mind to help you offset health care costs.

You have several health plans options to choose from under the REEP umbrella. The main difference between the plans are network of providers and copays for services. There is Kaiser plan options and Anthem HMO plan options to choose from.

Kaiser Medical Plans	
• HMO 30	• Virtual Complete 2500
• DHMO 500	• MVP 4500

Anthem Medical Plans		
• Anthem HMO 20	• Anthem PPO 1250	• Anthem EPO 1250
• Anthem HMO 30	• Anthem HSA 1 (1700)	• Anthem EPO HSA 4500
• Anthem DHMO 500	• Anthem PPO MVP 5900	

NEW! Wondering which plan to choose this year?

Feeling stressed about the benefits selection process? Good news: you have access to your very own benefits pro, ALEX. All you have to do is answer a few short questions about your anticipated health insurance needs, and ALEX will help you find the best plan for your needs and budget. - <https://start.myalex.com/crypop>

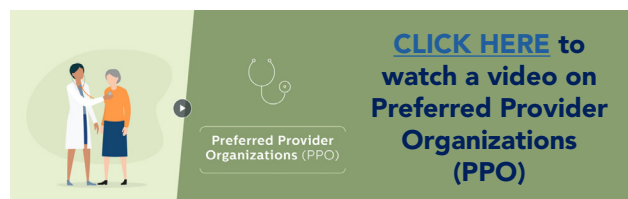
Selecting a Plan that's Right for You

When choosing a health plan, it's important to consider several key factors:

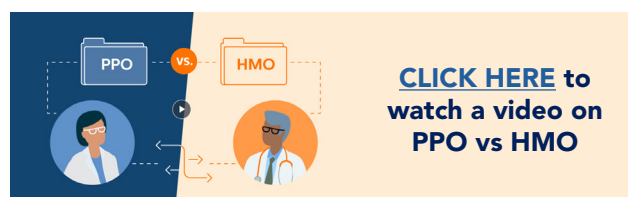
- **Choice:** If you have preferred doctors, specialists, or medical facilities, ensure that the plan you select covers services from these providers. Some health plans limit your choice of providers, while others offer more flexibility.
- **Cost:** Cost is often a significant factor in selecting a plan. Be sure to look at various cost components such as deductibles, copayments, and coinsurance, as well as the amount deducted from your payroll for the plan.



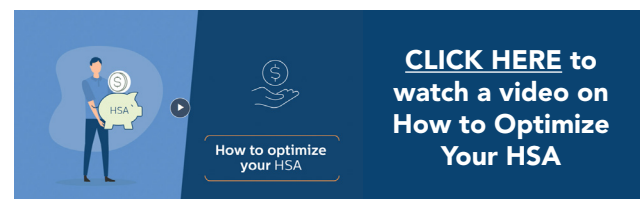
CLICK HERE to watch a video on Health Maintenance Organizations (HMO)



CLICK HERE to watch a video on Preferred Provider Organizations (PPO)



CLICK HERE to watch a video on PPO vs HMO



CLICK HERE to watch a video on How to Optimize Your HSA



CLICK HERE to watch a video on Health Savings Accounts (HSA)

ANTHEM & KAISER MEDICAL PLANS

Anthem & Kaiser Medical Plan Comparisons



Anthem HMO and DHMO Plan Comparison

Below are all the REEP HMO/DHMO plan options. All REEP HMO/DHMO plans can add chiropractic coverage at a \$10 copay which includes 30 visits/calendar year; provided through American Specialty Health.

	Anthem Blue Cross		
	HMO 20 w/Chiro - \$15/40/80 Rx	HMO 30 - \$19/50/75 Rx	DHMO 500 Select w/Chiro - \$15/40/80 Rx
General Plan Information			
• Annual Deductible/Individual	\$0	\$0	\$500
• Annual Deductible/Family	\$0	\$0	\$1,000
• Coinsurance	100%	100%	100%
• Office Visit/Exam	\$20 copay	\$30 copay	\$40 copay
• Outpatient Specialist Visit	\$20 copay	\$30 copay	\$40 copay
• Annual Out-of-Pocket Limit/Individual	\$500 Rx not included	\$500 Rx not included	\$1,500 Rx not included
• Annual Out-of-Pocket Limit/Family	\$1,500 Rx not included	\$1,500 Rx not included	\$4,500 Rx not included
• Deductible Included in Out-of-Pocket Limits	N/A	N/A	
• Lifetime Plan Maximum	Unlimited	Unlimited	Unlimited
• Primary Care Physician Election Required	Yes	Yes	Yes
Outpatient Services			
Preventive Services			
• Well-Child Care	100%	100%	100% deductible waived
• Immunizations	100%	100%	100% deductible waived
• Well Woman Exams	100%	100%	100% deductible waived
• Mammograms	100%	100%	100% deductible waived
• Adult Periodic Exams with Preventive Tests	100%	100%	100% deductible waived
• Diagnostic X-Ray and Lab Tests	100% \$20 copay for CT/SPECT/PET/MRA/MRI	100% \$30 copay for CT/SPECT/PET/MRA/MRI	100% \$40 copay for CT or CAT scan/PET/MRI

The information described on this page is only intended to be a summary of benefits. It does not describe or include all benefit provisions, limitations, exclusions, or qualifications for coverage. Please review plan documents for full details. If there are any conflicts with information provided on this page, the plan documents will prevail.

Anthem & Kaiser Medical Plan Comparisons (continued)



	Anthem Blue Cross		
	HMO 20 w/Chiro - \$15/40/80 Rx	HMO 30 - \$19/50/75 Rx	DHMO 500 Select w/Chiro - \$15/40/80 Rx
Maternity Care			
• Pregnancy and Maternity Care (<i>Pre-Natal Care</i>)	\$20 copay	\$30 copay	\$40 copay
Inpatient Hospital Services			
• Inpatient Hospitalization	100%	100%	100% after deductible has been met, then \$250 per admit
• Pre-Authorization of Services Required	Yes	Yes	Yes
• Semi-Private Room & Board; Including Services and Supplies	100%	100%	100%
Surgical Services			
• Outpatient Facility Charge	100%	100%	100% after deductible has been met, then \$250 copay
Emergency Services			
• Emergency Room	\$100 copay waived if admitted	\$100 copay waived if admitted	\$100 copay waived if admitted
Urgent Care			
• Urgent Care Facility	\$20 copay	\$30 copay	\$40 copay
Mental Health Benefits			
• Inpatient Care	100% (subject to utilization review; waived for emergency admissions)	100% (subject to utilization review; waived for emergency admissions)	100% (subject to utilization review; waived for emergency admissions)
• Outpatient Care	100% (Behavioral Health treatment for autism or pervasive development disorders require pre-service review.)	100% (Behavioral Health treatment for autism or pervasive development disorders require pre-service review.)	100% (Behavioral Health treatment for autism or pervasive development disorders require pre-service review.)

The information described on this page is only intended to be a summary of benefits. It does not describe or include all benefit provisions, limitations, exclusions, or qualifications for coverage. Please review plan documents for full details. If there are any conflicts with information provided on this page, the plan documents will prevail.

Anthem & Kaiser Medical Plan Comparisons (continued)



	Anthem Blue Cross		
	HMO 20 w/Chiro - \$15/40/80 Rx	HMO 30 - \$19/50/75 Rx	DHMO 500 Select w/Chiro - \$15/40/80 Rx
Prescription Drug Benefits			
• Prescription Drug Deductible			
• Prescription Drug Annual Out-of-Pocket Limit/Individual	\$1,000	\$1,000	\$1,000
• Prescription Drug Annual Out-of-Pocket Limit/Family	\$3,000	\$3,000	\$3,000
• Generic	\$15 copay/Tier 1 Pharmacy; \$15 copay + \$15/Tier 2 Pharmacy provided by ESI	\$19 copay/Tier 1 Pharmacy \$19 copay + \$15/Tier 2 Pharmacy provided by ESI	\$15 copay/Tier 1 Pharmacy; \$15 copay + \$15/Tier 2 Pharmacy provided by ESI
	(see www.express-scripts.com for a list of pharmacies)		
• Brand (Formulary/Preferred)	\$40 copay/Tier 1 Pharmacy \$40 copay + \$15/Tier 2 Pharmacy provided by ESI	\$50 copay/Tier 1 Pharmacy \$50 copay + \$15/Tier 2 Pharmacy provided by ESI	\$40 copay/Tier 1 Pharmacy; \$40 copay + \$15/Tier 2 Pharmacy provided by ESI
	(see www.express-scripts.com for a list of pharmacies)		
• Brand (Non-Formulary/Non-preferred)	\$80 copay/Tier 1 Pharmacy; \$80 copay + \$15/Tier 2 Pharmacy provided by ESI	\$75 copay/Tier 1 Pharmacy \$75 copay + \$15/Tier 2 Pharmacy provided by ESI	\$80 copay/Tier 1 Pharmacy; \$80 copay + \$15/Tier 2 Pharmacy provided by ESI
	(see www.express-scripts.com for a list of pharmacies)		
• Number of Days Supply			
Mail Order			
• Mail Order Mandatory			
• Generic			
• Brand (Formulary/Preferred)	\$30 copay provided by Express Scripts	\$38 copay provided by Express Scripts	\$30 copay provided by Express Scripts
• Brand (Non-Formulary/Non-preferred)			
• Number of Days Supply for Mail Order	\$80 copay provided by Express Scripts	\$100 copay provided by Express Scripts	\$80 copay provided by Express Scripts

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Anthem & Kaiser Medical Plan Comparisons (continued)



Anthem PPO

Below are all the REEP PPO plan options. All REEP PPO plans can add chiropractic coverage at a \$10 copay which includes 30 visits/calendar year; provided through American Specialty Health.

	Anthem Blue Cross			
	PPO Essentials - \$15/50/15 Rx + Cost		PPO MVP 5900 - \$19/50/75 Rx + Cost	
	In-Network	Out-of-Network	In-Network	Out-of-Network
General Plan Information				
• Annual Deductible/Individual	\$1,250	\$1,250	\$5,900	\$11,800
• Annual Deductible/Family	\$3,750	\$3,750	\$11,800	\$23,600
• Coinsurance	70% after deductible	50% after deductible	100% after the deductible has been satisfied	50%
• Office Visit/Exam	\$40 copay; deductible waived	50%	\$35 copay; deductible waived first 3 visits/combined services	50%
• Outpatient Specialist Visit	\$40 copay; deductible waived	50%	\$35 copay; deductible waived first 3 visits/combined services	50%
• Annual Out-of-Pocket Limit/Individual	\$3,000 Rx not included	\$6,000 Rx not included	\$6,100 Rx not included	\$12,700 Rx not included
• Annual Out-of-Pocket Limit/Family	\$9,000 Rx not included	\$18,000 Rx not included	\$12,200 Rx not included	\$25,400 Rx not included
• Lifetime Plan Maximum	Unlimited	Unlimited	Unlimited	Unlimited
Inpatient Hospital Services				
• Inpatient Hospitalization	70%	50% plus \$500 admission fee after the deductible has been satisfied (waived for emergency)	100% after the deductible has been satisfied	50% plus \$500 admission fee after the deductible has been satisfied (waived for emergency)
• Semi-Private Room & Board; Including Services and Supplies	70%	50% plus \$500 admission fee after the deductible has been satisfied (waived for emergency)	100% after the deductible has been satisfied	50% plus \$500 admission fee after the deductible has been satisfied (waived for emergency)

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Anthem & Kaiser Medical Plan Comparisons (continued)



	Anthem Blue Cross			
	PPO Essentials - \$15/50/15 Rx + Cost		PPO MVP 5900 - \$19/50/75 Rx + Cost	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Emergency Services				
• Emergency Room	70%	70%	100%	100%
Mental Health Benefits				
• Inpatient Care	70% (subject to utilization review; waived for emergency admissions)	50% (subject to utilization review; waived for emergency admissions)	100% (subject to utilization review; waived for emergency admissions)	50% (subject to utilization review; waived for emergency admissions)
• Outpatient Care	\$40 copay; deductible waived (Behavioral Health treatment for Autism or Pervasive Development disorders require pre-service review)	50%	\$35 copay/visit with deductible waived for the first 3 visits (Behavioral Health treatment for Autism or Pervasive Development disorders require pre-service review)	50%
Alcohol Abuse				
Inpatient Care				
• Inpatient Hospitalization	70% (subject to utilization review; waived for emergency admissions)	50% (subject to utilization review; waived for emergency admissions)	100% (subject to utilization review; waived for emergency admissions)	50% plus \$500 admission fee after the deductible has been satisfied (waived for emergency).
• Inpatient Detoxification Services	70% (subject to utilization review; waived for emergency admissions)	50% (subject to utilization review; waived for emergency admissions)	100% (subject to utilization review; waived for emergency admissions)	50% plus \$500 admission fee after the deductible has been satisfied (waived for emergency).
Outpatient Care				
• Outpatient Services	\$40 copay; deductible waived (Behavioral Health treatment for Autism or Pervasive Development disorders require pre-service review)	50%	\$35 copay/visit with deductible waived for the first 3 visits	50%
• Outpatient Detoxification Services	\$40 copay; deductible waived (Behavioral Health treatment for Autism or Pervasive Development disorders require pre-service review)	50%	\$35 copay/visit with deductible waived for the first 3 visits	50%

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Anthem & Kaiser Medical Plan Comparisons (continued)



	Anthem Blue Cross			
	PPO Essentials - \$15/50/15 Rx + Cost		PPO MVP 5900 - \$19/50/75 Rx + Cost	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Substance Abuse				
Inpatient Care				
• Inpatient Hospitalization	70% (subject to utilization review; waived for emergency admissions)	50% (subject to utilization review; waived for emergency admissions)	100% (subject to utilization review; waived for emergency admissions)	50% (subject to utilization review; waived for emergency admissions)
• Inpatient Detoxification Services	70% (subject to utilization review; waived for emergency admissions)	50% (subject to utilization review; waived for emergency admissions)	100% (subject to utilization review; waived for emergency admissions)	50% (subject to utilization review; waived for emergency admissions)
Outpatient Care				
• Outpatient Services	\$40 copay; deductible waived (Behavioral Health treatment for Autism or Pervasive Development disorders require pre-service review)	50%	\$35 copay/visit with deductible waived for the first 3 visits	50%
• Outpatient Detoxification Services	\$40 copay; deductible waived (Behavioral Health treatment for Autism or Pervasive Development disorders require pre-service review)	50%	\$35 copay/visit with deductible waived for the first 3 visits	50%

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Anthem & Kaiser Medical Plan Comparisons (continued)



	Anthem Blue Cross			
	PPO Essentials - \$15/50/15 Rx + Cost		PPO MVP 5900 - \$19/50/75 Rx + Cost	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Prescription Drug Benefits				
• Generic	\$15 copay/Tier Pharmacy; \$15 copay + \$15/Tier 2 Pharmacy provided by ESI	50% + an additional \$15 fee applies per prescription for a Tier 2 Pharmacy; provided by ESI	\$19 copay/Tier 1 Pharmacy; \$19 copay + \$15/Tier 2 Pharmacy provided by ESI	50% + an additional \$15 fee applies per prescription for a Tier 2 Pharmacy; provided by ESI
	(see www.express-scripts.com for a list of pharmacies)			
• Brand (Formulary/Preferred)	\$50 copay/Tier 1 Pharmacy; \$50 copay + \$15/Tier 2 Pharmacy provided by ESI	50% + an additional \$15 fee applies per prescription for a Tier 2 Pharmacy; provided by ESI	\$50 copay/Tier 1 Pharmacy; \$50 copay + \$15/Tier 2 Pharmacy provided by ESI	50% + an additional \$15 fee applies per prescription for a Tier 2 Pharmacy; provided by ESI
	(see www.express-scripts.com for a list of pharmacies)			
• Brand (Non-Formulary/Non-preferred)	\$15 copay/Tier 1 Pharmacy; \$15 copay + \$15/Tier 2 Pharmacy + cost difference between generic and brand when generic equivalent is available;	50% + an additional \$15 fee applies per prescription for a Tier 2 Pharmacy + cost difference between generic and brand when generic equivalent is available;	\$75 copay/Tier 1 Pharmacy; \$75 copay + \$15/Tier 2 Pharmacy provided by ESI	50% + an additional \$15 fee applies per prescription for a Tier 2 Pharmacy; provided by ESI
	(see www.express-scripts.com for a list of pharmacies)			
• Number of Days Supply	30 days	30 days	30 days	30 days
Mail Order				
• Generic	\$30 copay provided by Express Scripts	Not covered	\$38 copay provided by Express Scripts	Not covered
• Brand (Formulary/Preferred)	\$100 copay provided by Express Scripts	Not covered	\$100 copay provided by Express Scripts	Not covered
• Brand (Non-Formulary/Non-preferred)	\$30 copay plus cost difference between generic and brand when generic equivalent is available; provided by Express Scripts	Not covered	\$150 copay provided by Express Scripts	Not covered
• Number of Days Supply for Mail Order	90 days	N/A	90 days	N/A

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Anthem & Kaiser Medical Plan Comparisons (continued)



Anthem HSA Plan Comparison

Below is the REEP HSA plan option. All REEP HSA plans can add chiropractic coverage at a \$10 copay which includes 30 visits/calendar year; provided through American Specialty Health.

	Anthem Blue Cross	
	HSA 1 (1700) - \$19/50/75 Rx	
	In-Network	Out-of-Network
General Plan Information		
• Annual Deductible/Individual	\$1,700 medical/prescription/MH-SA in/out of network combined	\$1,700 medical/prescription/MH-SA in/out of network combined
• Annual Deductible/Family	\$3,400 medical/prescription/MH-SA in/out of network combined	\$3,400 medical/prescription/MH-SA in/out of network combined
• Coinsurance	90%	70%
• Office Visit/Exam	90%	70%
• Outpatient Specialist Visit	90%	70%
• Annual Out-of-Pocket Limit/Individual	\$3,000	\$9,000
• Annual Out-of-Pocket Limit/Family	\$6,000	\$18,000
• Deductible Included in Out-of-Pocket Limits	Yes	Yes
• Lifetime Plan Maximum	Unlimited	Unlimited
• High Deductible Health Plan		
Outpatient Services		
Preventive Services		
• Well-Child Care	100% deductible waived	Not covered
• Immunizations	100% deductible waived	Not covered
• Well Woman Exams	100% deductible waived	Not covered
• Mammograms	100% deductible waived	Not covered
• Adult Periodic Exams with Preventive Tests	100% deductible waived	Not covered
• Diagnostic X-Ray and Lab Tests	90%	70%

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Anthem & Kaiser Medical Plan Comparisons (continued)



	Anthem Blue Cross	
	HSA 1 (1700) - \$19/50/75 Rx	
	In-Network	Out-of-Network
Maternity Care		
<ul style="list-style-type: none"> Pregnancy and Maternity Care (<i>Pre-Natal Care</i>) 	90%	70%
Inpatient Hospital Services		
<ul style="list-style-type: none"> Inpatient Hospitalization 	90%	70% plus \$500 admission fee after the deductible has been satisfied (waived for emergency)
<ul style="list-style-type: none"> Pre-Authorization of Services Required 	Yes	Yes. If not pre-certified, penalty is \$500 per admission (waived for emergency)
<ul style="list-style-type: none"> Semi-Private Room & Board; Including Services and Supplies 	90%	70%
Surgical Services		
<ul style="list-style-type: none"> Outpatient Facility Charge 	90%	70% limited to \$350/admit
Emergency Services		
<ul style="list-style-type: none"> Emergency Room 	90%	90%
Urgent Care		
<ul style="list-style-type: none"> Urgent Care Facility 	90%	70%
Mental Health Benefits		
<ul style="list-style-type: none"> Inpatient Care 	90% (subject to utilization review; waived for emergency admissions)	70% plus \$500 copay per admission (waived for emergency); there is an additional \$250 copay if a utilization review is not obtained.
<ul style="list-style-type: none"> Outpatient Care 	90%	70% facility care. Physician visits behavioral health treatment for autism or pervasive development disorders requires pre-service review.

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Anthem & Kaiser Medical Plan Comparisons (continued)



	Anthem Blue Cross	
	HSA 1 (1700) - \$19/50/75 Rx	
	In-Network	Out-of-Network
Prescription Drug Benefits		
• Prescription Drug Deductible	\$1,700 ind/\$3,400 fam medical/prescription/MH-SA in/out of network combined	\$1,700 ind/\$3,400 fam medical/prescription/MH-SA in/out of network combined
• Prescription Drug Annual Out-of-Pocket Limit/Individual		
• Prescription Drug Annual Out-of-Pocket Limit/Family		
• Generic	\$19 after deductible/ Tier 1 Pharmacy \$19 copay after deductible + \$15/Tier 2 Pharmacy provided by ESI	50% after deductible + an additional \$15 fee applies per prescription for a Tier 2 Pharmacy; provided by ESI
	(see www.express-scripts.com for a list of pharmacies)	
• Brand (Formulary/Preferred)	\$50 after deductible/ Tier 1 Pharmacy \$50 copay after deductible + \$15/Tier 2 Pharmacy provided by ESI	50% after deductible + an additional \$15 fee applies per prescription for a Tier 2 Pharmacy; provided by ESI
	(see www.express-scripts.com for a list of pharmacies)	
• Brand (Non-Formulary/Non-preferred)	\$75 after deductible/ Tier 1 Pharmacy \$75 copay after deductible + \$15/Tier 2 Pharmacy provided by ESI	50% after deductible + an additional \$15 fee applies per prescription for a Tier 2 Pharmacy; provided by ESI
	(see www.express-scripts.com for a list of pharmacies)	
• Number of Days Supply	30 days	30 days
Mail Order		
• Mail Order Mandatory		
• Generic		
• Brand (Formulary/Preferred)	\$38 copay after deductible; provided by Express Scripts	Not covered
• Brand (Non-Formulary/Non-preferred)		
• Number of Days Supply for Mail Order	\$100 copay after deductible; provided by Express Scripts	Not covered

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Anthem & Kaiser Medical Plan Comparisons (continued)



Anthem High Performance EPO 1250 & EPO 4500

Below are all the REEP EPO plan options. All REEP EPO plans can add chiropractic coverage at a \$10 copay which includes 30 visits/calendar year; provided through American Specialty Health.

	Anthem Blue Cross	
	Anthem High Performance Network EPO 1250 - \$15/50/15 Rx + cost difference	Anthem High Performance Network EPO HSA 4500 - \$15/\$40/\$80
General Plan Information		
• Annual Deductible/Individual	\$1,250	\$4,500
• Annual Deductible/Family	\$3,750	\$9,000
• Coinsurance	70% after deductible is met	90% after deductible is met
• Office Visit/Exam	\$40 copay; deductible waived	90% after deductible is met
• Outpatient Specialist Visit	\$40 copay; deductible waived	90% after deductible is met
• Annual Out-of-Pocket Limit/Individual	\$3,000	\$5,000
• Annual Out-of-Pocket Limit/Family	\$9,000	\$10,000
• Deductible Included in Out-of-Pocket Limits	Yes	Yes
• Lifetime Plan Maximum	Unlimited	Unlimited
• Primary Care Physician Election Required	No	No
Outpatient Services		
Preventive Services		
• Well-Child Care	100%	100%
• Immunizations	100%	100%
• Well Woman Exams	100%	100%
• Mammograms	100%	100%
• Adult Periodic Exams with Preventive Tests	100%	100%
• Diagnostic X-Ray and Lab Tests	70% after deductible is met	90% after deductible is met

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Anthem & Kaiser Medical Plan Comparisons (continued)



	Anthem Blue Cross	
	Anthem High Performance Network EPO 1250 - \$15/50/15 Rx + cost difference	Anthem High Performance Network EPO HSA 4500 - \$15/\$40/\$80
Maternity Care		
• Pregnancy and Maternity Care (<i>Pre-Natal Care</i>)	\$40 copay: deductible waived	90% after deductible is met
Inpatient Hospital Services		
• Inpatient Hospitalization	70% after deductible is met	90% after deductible is met
• Pre-Authorization of Services Required	Yes	Yes
• Semi-Private Room & Board; Including Services and Supplies	70% after deductible is met	90% after deductible is met
Surgical Services		
• Outpatient Facility Charge	70% after deductible is met	90% after deductible is met
Emergency Services		
• Emergency Room	70% after deductible is met, in and out of network	90% after deductible is met; in and out of network
Urgent Care		
• Urgent Care Facility	\$40 copay; deductible waived in and out of network	90% after deductible is met; in and out of network
Mental Health Benefits		
• Inpatient Care	70% after deductible is met	90% after deductible is met
• Outpatient Care	70% after deductible is met	90% after deductible is met

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Anthem & Kaiser Medical Plan Comparisons (continued)



	Anthem Blue Cross	
	Anthem High Performance Network EPO 1250 - \$15/50/15 Rx + cost difference	Anthem High Performance Network EPO HSA 4500 - \$15/\$40/\$80
Prescription Drug Benefits		
• Prescription Drug Deductible		
• Prescription Drug Annual Out-of-Pocket Limit/Individual	\$1,000	\$1,000
• Prescription Drug Annual Out-of-Pocket Limit/Family	\$3,000	\$3,000
• Generic	\$15 copay/Tier 1 Pharmacy; \$15 copay + \$15/Tier 2 Pharmacy provided by ESI (see www.express-scripts.com for a list of pharmacies)	\$15 copay/Tier 1 Pharmacy; \$15 copay + \$15/Tier 2 after deductible, Pharmacy provided by ESI
• Brand (Formulary/Preferred)		
• Brand (Non-Formulary/Non-preferred)	\$50 copay/Tier 1 Pharmacy \$50 copay + \$15/Tier 2 Pharmacy provided by ESI (see www.express-scripts.com for a list of pharmacies)	\$40 copay/Tier 1 Pharmacy \$40 copay + \$15/Tier 2 after deductible, Pharmacy provided by ESI
• Number of Days Supply	\$15 copay/Tier 1 Pharmacy; \$15 copay + \$15/Tier 2 Pharmacy + cost difference between generic & brand when generic equivalent is available provided by ESI (see www.express-scripts.com for a list of pharmacies)	\$80 copay/Tier 1 Pharmacy \$80 copay + \$15/Tier 2 Pharmacy after deductible. (see www.express-scripts.com for a list of pharmacies)
Mail Order		
• Mail Order Mandatory		
• Generic		
• Brand (Formulary/Preferred)	\$30 copay provided by Express Scripts	\$30 copay after deductible, provided by Express Scripts
• Brand (Non-Formulary/Non-preferred)		
• Number of Days Supply for Mail Order	\$100 copay provided by Express Scripts	\$80 copay after deductible, provided by Express Scripts

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Anthem & Kaiser Medical Plan Comparisons (continued)

Kaiser HMO 30 Plan Comparison

Below is the REEP HMO plan option. All REEP HMO plans can add chiropractic coverage at a \$10 copay which includes 30 visits/calendar year; provided through American Specialty Health.

	Kaiser HMO 30
General Plan Information	
• Annual Deductible/Individual	\$0
• Annual Deductible/Family	\$0
• Coinsurance	100%
• Office Visit/Exam	\$30 copay
• Outpatient Specialist Visit	\$30 copay
• Annual Out-of-Pocket Limit/Individual	\$1,500
• Annual Out-of-Pocket Limit/Family	\$3,000
• Deductible Included in Out-of-Pocket Limits	N/A
• Lifetime Plan Maximum	Unlimited
• Primary Care Physician Election Required	Yes
Outpatient Services	
Preventive Services	
• Well-Child Care	100% through age 23 months
• Immunizations	100%
• Well Woman Exams	100%
• Mammograms	100%
• Adult Periodic Exams with Preventive Tests	100%
• Diagnostic X-Ray and Lab Tests	100% \$30 copay for MRI/CT/PET

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Anthem & Kaiser Medical Plan Comparisons (continued)



	Kaiser HMO 30
Maternity Care	
• Pregnancy and Maternity Care (<i>Pre-Natal Care</i>)	100%
Inpatient Hospital Services	
• Inpatient Hospitalization	100%
• Pre-Authorization of Services Required	Yes
• Semi-Private Room & Board; Including Services and Supplies	100%
Surgical Services	
• Outpatient Facility Charge	\$30 copay per procedure
Emergency Services	
• Emergency Room	\$100 copay waived if admitted
Ambulance	
• Air	100%
• Ground	100%
Urgent Care	
• Urgent Care Facility	\$30 copay
Mental Health Benefits	
• Inpatient Care	100%
• Outpatient Care	\$30 copay

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Anthem & Kaiser Medical Plan Comparisons (continued)



	Kaiser HMO 30
Substance Abuse	
Inpatient Care	
• Inpatient Hospitalization	100%
• Inpatient Detoxification Services	100%
Outpatient Care	
• Outpatient Services	\$30 copay
Prescription Drug Benefits	
• Generic	\$15 copay
• Brand (Formulary/Preferred)	\$35 copay
• Number of Days Supply	30 days
Mail Order	
• Generic	\$30 copay
• Brand (Formulary/Preferred)	\$70 copay
• Number of Days Supply for Mail Order	100 days
Other Services and Supplies	
• Durable Medical Equipment & Prosthetic Devices	100%
• Home Health Care	100% limited to 100 visits/calendar year
• Skilled Nursing or Extended Care Facility	100% limited to 100 days/benefit period
• Hospice Care	100%
• Acupuncture	Not covered

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Anthem & Kaiser Medical Plan Comparisons (continued)

Kaiser DHMO 500

Below is the REEP DHMO 500 plan option. All REEP DHMO plans can add chiropractic coverage at a \$10 copay which includes 30 visits/calendar year; provided through American Specialty Health.

	Kaiser DHMO 500
General Plan Information	
• Annual Deductible/Individual	\$500
• Annual Deductible/Family	\$1,000
• Coinsurance	80%
• Office Visit/Exam	\$20 copay
• Outpatient Specialist Visit	\$20 copay
• Annual Out-of-Pocket Limit/Individual	\$3,000
• Annual Out-of-Pocket Limit/Family	\$6,000
• Deductible Included in Out-of-Pocket Limits	Yes
• Lifetime Plan Maximum	Unlimited
• Primary Care Physician Election Required	No
Outpatient Services	
Preventive Services	
• Well-Child Care	100% through age 23 months
• Immunizations	100%
• Well Woman Exams	100%
• Mammograms	100% for preventive
• Adult Periodic Exams with Preventive Tests	100%
• Diagnostic X-Ray and Lab Tests	\$10 copay per encounter after deductible; \$50 copay per procedure for MRI/CT/PET after deductible

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Anthem & Kaiser Medical Plan Comparisons (continued)



	Kaiser DHMO 500
Maternity Care	
• Pregnancy and Maternity Care (<i>Pre-Natal Care</i>)	100%
Inpatient Hospital Services	
• Inpatient Hospitalization	80% after deductible
• Pre-Authorization of Services Required	Yes
• Semi-Private Room & Board; Including Services and Supplies	80% after deductible
Surgical Services	
• Outpatient Facility Charge	80% after deductible
Emergency Services	
• Emergency Room	80% after deductible
Ambulance	
• Air	\$150 copay per trip; after deductible
• Ground	\$150 copay per trip; after deductible
Urgent Care	
• Urgent Care Facility	\$20 copay; deductible waived
Mental Health Benefits	
• Inpatient Care	80% after deductible
• Outpatient Care	\$20 copay; deductible waived

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Anthem & Kaiser Medical Plan Comparisons (continued)



	Kaiser DHMO 500
Substance Abuse	
Inpatient Care	
• Inpatient Hospitalization	80% after deductible
• Inpatient Detoxification Services	80% after deductible
Outpatient Care	
• Outpatient Services	\$20 copay; deductible waived
Prescription Drug Benefits	
• Prescription Drug Deductible	\$100 per Member/calendar year
• Generic	\$10 copay; deductible waived
• Brand (Formulary/Preferred)	\$30 copay; after \$100 prescription deductible
• Number of Days Supply	30 days
Mail Order	
• Generic	\$20 copay; deductible waived
• Brand (Formulary/Preferred)	\$60 copay; after \$100 prescription deductible
• Number of Days Supply for Mail Order	100 days

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Anthem & Kaiser Medical Plan Comparisons (continued)

Kaiser HMO MVP 4500

Below is the REEP HMO MVP plan option. All REEP HMO MVP plans can add chiropractic coverage at a \$10 copay which includes 30 visits/calendar year; provided through American Specialty Health.

	Kaiser HMO MVP 4500
General Plan Information	
• Annual Deductible/Individual	\$4,500
• Annual Deductible/Family	\$9,000
• Coinsurance	60%
• Office Visit/Exam	\$50 copay; after deductible
• Outpatient Specialist Visit	\$50 copay; after deductible
• Annual Out-of-Pocket Limit/Individual	\$6,000
• Annual Out-of-Pocket Limit/Family	\$12,000
• Deductible Included in Out-of-Pocket Limits	Yes (except prescription drugs)
• Lifetime Plan Maximum	Unlimited
• Primary Care Physician Election Required	No
Outpatient Services	
Preventive Services	
• Well-Child Care	100% through age 23 months
• Immunizations	100%
• Well Woman Exams	100%
• Mammograms	100% for preventive
• Adult Periodic Exams with Preventive Tests	100%
• Diagnostic X-Ray and Lab Tests	60% after deductible

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Anthem & Kaiser Medical Plan Comparisons (continued)



	Kaiser HMO MVP 4500
Maternity Care	
• Pregnancy and Maternity Care (<i>Pre-Natal Care</i>)	100%
Inpatient Hospital Services	
• Inpatient Hospitalization	60% after deductible
• Pre-Authorization of Services Required	Yes
• Semi-Private Room & Board; Including Services and Supplies	60% after deductible
Surgical Services	
• Outpatient Facility Charge	60% after deductible
Emergency Services	
• Emergency Room	\$250 copay; after deductible
Ambulance	
• Air	60% after deductible
• Ground	60% after deductible
Urgent Care	
• Urgent Care Facility	\$50 copay; after deductible
Mental Health Benefits	
• Inpatient Care	60% after deductible
• Outpatient Care	\$50 copay; after deductible

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Anthem & Kaiser Medical Plan Comparisons (continued)



	Kaiser HMO MVP 4500
Substance Abuse	
Inpatient Care	
• Inpatient Hospitalization	60% after deductible
• Inpatient Detoxification Services	60% after deductible
Outpatient Care	
• Outpatient Services	\$50 copay; after deductible
Prescription Drug Benefits	
• Prescription Drug Deductible	
• Generic	\$15 copay; deductible waived
• Brand (Formulary/Preferred)	\$35 copay; after prescription deductible
• Number of Days Supply	30 days
Mail Order	
• Generic	\$30 copay; deductible waived
• Brand (Formulary/Preferred)	\$70 copay; after prescription deductible
• Number of Days Supply for Mail Order	100 days
Other Services and Supplies	
• Durable Medical Equipment & Prosthetic Devices	60% deductible waived
• Home Health Care	100% limited to 100 visits/calendar year
• Skilled Nursing or Extended Care Facility	60% after deductible; limited to 100 days/benefit period
• Hospice Care	100%
• Acupuncture	Not covered

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2. Click on Find Care
3. Click on [BASIC SEARCH AS A GUEST](#)
4. Under [SELECT THE TYPE OF PLAN OR NETWORK](#), select MEDICAL PLAN OR NETWORK
5. Under [SELECT THE STATE WHERE THE PLAN OR NETWORK IS OFFERED](#), select CALIFORNIA
6. Under [SELECT HOW YOU GET HEALTH INSURANCE](#), select MEDICAL - EMPLOYER-SPONSORED
 - A. **California Members** - Under [SELECT A PLAN OR NETWORK](#):
 - 1) **HMO Full Network**: Select [Blue Cross HMO \(CACARE\) – Large Group](#)
 - 2) **Select or Priority Select HMO Network**: Select [Select HMO or Priority Select HMO](#)
 - 3) **PPO and Anthem PPO HSA-California**: Select [Blue Cross PPO \(Prudent Buyer\) – Large Group](#)
 - B. **Non-California Members** – Select a Non-California State.
 - 1) **PPO/Anthem PPO HSA/Lumenos HSA-Non-California**: Select [National PPO \(Blue Card PPO\)](#)
7. Click [CONTINUE](#)
8. Next, [Enter the CITY, COUNTY or ZIP](#)
9. Next, choose who you like to see. You can search for a doctor nearby or use the doctors name
10. Next, select a provider to see more details

*****Primary Medical Group/Primary Care Physician code is located under PCP ID/ENROLLMENT ID. Code is either a 3 or 6 digit code**

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Activate Your Transcarent Surgery Benefit

Planning for surgery, now or in the future, can be overwhelming. But it doesn't have to be. With Transcarent, you get the support and resources you need to make informed decisions and access high-quality surgical care at little to no cost—all as part of your benefits.



It's Quick

Registration only takes a minute



Expert Guidance

Get answers to all your surgery-related questions from a Care Coordinator and/or medical expert.



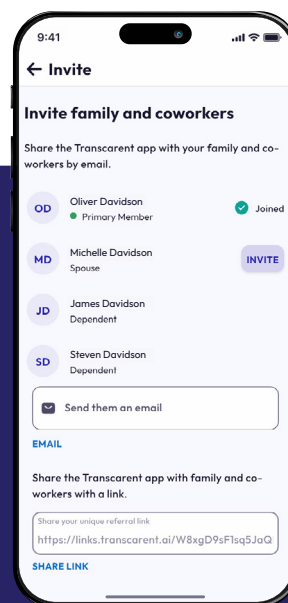
Peace of Mind

Be prepared for any future health needs with easy access to support, expert second opinion and care options.

Get Started



Download the Transcarent app or visit member.transcarent.com to activate your account in minutes. A dedicated Care Coordinator is ready to assist you!



Share with covered family members

Don't forget to share Transcarent with your covered dependents! Once you sign up, go to your profile and click **"Invite others"** to give your family members access to these great benefits.

Common covered surgeries include:



Bariatric



Cardiac



General



Neurological



Orthopedic



Spine



Vascular



Women's Health

Express Scripts By EVERNORTH

Go digital

For fast, simple and
secure access to your
prescription benefits



Resources right within reach

At Express Scripts by Evernorth®, we help you get the right medication for the lowest possible price. Get anywhere, anytime access to your pharmacy benefits with an online account. **Create your account today by registering online – in just 5 clicks and 2 minutes – or through our mobile app.** Then use both to manage your medications 24/7.

Express Scripts' brand evolution

We are refreshing our branding to more closely link to Evernorth Health Services® — a health services organization designed to make the system and people better.¹ Express Scripts is Evernorth's pharmacy benefit service and will continue to help you stress less and save more on your prescription medications.

New look, same trusted service

The brand changes update our look and feel, including our logo and colors. While our branding is evolving, our commitment to serving you never wavers. These changes will not impact the exceptional care or service that you receive now or in the future. We will continue to deliver access to the very best care at the very best value to those we serve.

Express Scripts
By EVERNORTH

Ready to create your online account with Express Scripts?

Visit express-scripts.com
or scan the QR code to
learn more about
pharmacy benefits you
can depend on, for
everyone who depends
on you.



+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+
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Our pharmacy benefit capabilities



SAVE ON MEDICATIONS

Check the price of a medication before and during a doctor’s visit.



FIND A PHARMACY

Locate the most convenient network pharmacy for your needs.



COVERAGE REVIEW

Before a doctor prescribes a medication, check to see if it needs a coverage review.



SET REMINDERS

Set reminders to take your medication and sign up for text alerts.

Get started now

Visit express-scripts.com to learn more about our pharmacy benefit service, so you can stress less and save more.



Download our mobile app

Use this QR code or search Express Scripts® in your app store.



Download the app for free, then tap Register Now to get started.



Express Scripts
By EVERNORTH



Marathon Health is part of your benefits package

REEP members enrolled in Anthem PPO, HSA, MVP, or HPN plans are automatically eligible to use the Marathon Health Center for primary care services, including many labs and medications provided onsite at no copays and no insurance deductibles.

Exception: HSA plan members have a \$10 copay for in-person, non-preventative visits until the deductible is met. Virtual visits are always \$0 for all plans.

Who is Marathon Health

Marathon Health is a low to no cost healthcare benefit available to you. With same-day or next-day appointments for immediate care needs, you'll have little to no wait times and not be rushed.

REEP with Marathon Health Center

25395 Hancock Ave, Suite 200
Murrieta, CA 92562
951-229-0708 | my.marathon.health

Hours of Operation

Mon. 7am - 3:30pm
Tues. 10am - 7pm
Wed. 10am - 7pm
Thur. 7am - 3:30pm
Fri. 7am - 2pm

Services you can count on

- In-person or virtual appointments
- Annual physical exams, back to school & sports physicals
- Sick and immediate care
- Preventive screenings
- Mental health screening and support
- Chronic condition management
- Family care ages 3+
- Men's and women's health
- Onsite labs, vaccines, & pharmacy at no extra cost

<https://clients.marathon.health/reep>

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Next steps:

1. Enroll in an eligible Anthem plan during Open Enrollment
2. Activate your Marathon Health account (instructions sent after enrollment)
3. Schedule your first visit—same or next day availability

Meet Your Provider-

Abigail Kent PA-C





Get reimbursed with REEP CompleteCare®



What is CompleteCare?

CompleteCare reimburses you (the employee) and your dependents for eligible health care expenses and premium expenses incurred under alternate group health coverage.

\$100/single, \$200/2-party and \$300/family. If the cost of alternate coverage is less than you would have paid for the REEP medical plan, the premium contribution reimbursement is \$0.

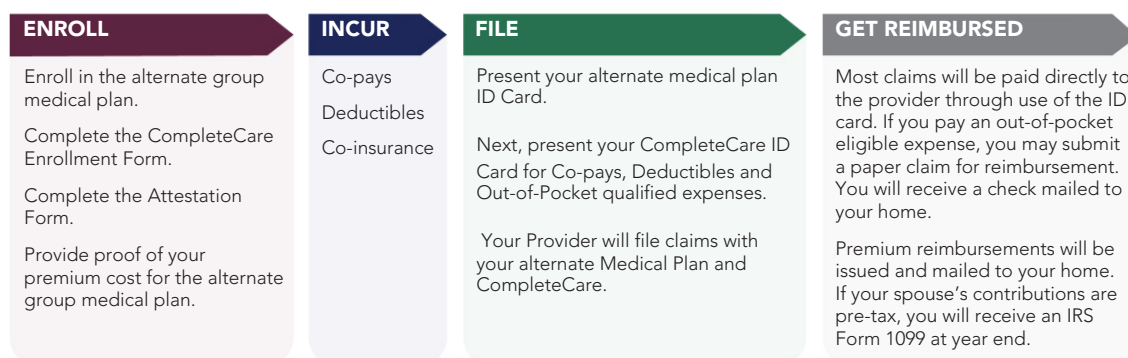
CompleteCare Benefits

- Co-pays, deductibles and co-insurance reimbursed by CompleteCare up to \$10,600/single and \$21,200/family per year.
- No premium contribution deducted from your paycheck.
- You will be reimbursed for the premium contribution paid for the alternate coverage if it exceeds the premium contribution that you would have paid to remain on the REEP medical plan up to a monthly maximum of

IRS Rules

- You may be enrolled in an HRA or FSA. You CANNOT be reimbursed from both CompleteCare and your HRA or FSA.
- You are NOT eligible for CompleteCare if your alternate coverage is:
 - a high deductible health plan (HDHP) with active contributions to a Health Savings Account (HSA);
 - Medicare, Medicaid, Tricare or an Individual Policy.

How Does CompleteCare Work?



(continued on back)

REEP CompleteCare (continued)

Are you eligible for CompleteCare?



*Your alternate plan's open enrollment is considered a qualifying event. If at any point an employee loses access to their alternate group health plan – a Qualifying Event – you will be able to enroll in REEP's group health plan



For more information, scan the QR code to access the Resource Center, contact Catilize Health at 877-872-4232 or email us at completecure@catilizehealth.com.

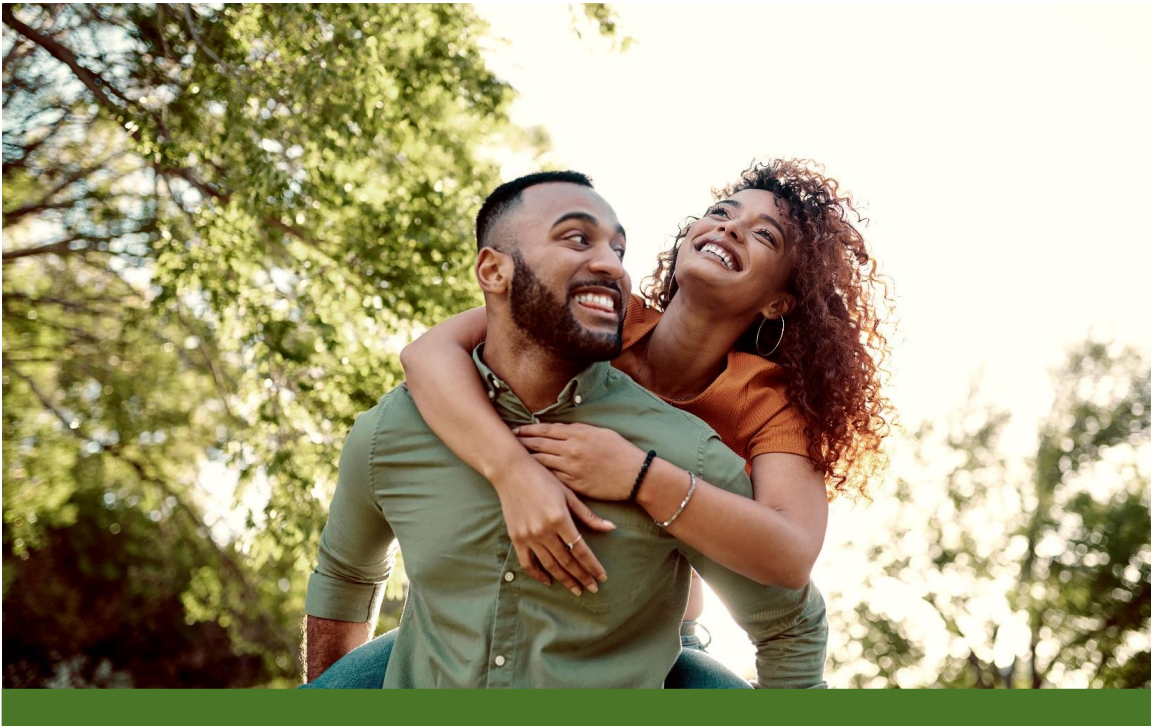


Keenan®

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KAISER PERMANENTE MICROSITE



Rediscover Kaiser Permanente on a website just for **REEP for Benefits Members**

Whether you are a current member or considering Kaiser Permanente for the first time, you can get all the information you need at choose.kaiserpermanente.org/reep.

- View detailed information about your health plan benefits
- Wellness Tools and Resources
- Personal telephonic wellness coaching
- See how easy it is to stay on top of your health online
- Fitness program discount
- On-demand videos



More care options while you're away from home

No matter where life takes you, Kaiser Permanente has you covered. If something unexpected happens while you're away from home, it's easier than ever to get care.



Nonurgent care

Use your **kp.org** account or the Kaiser Permanente app across the U.S. to:

- Get 24/7 care and advice from Kaiser Permanente clinicians by phone or online
- Access care by phone,¹ video,¹ or e-visit – usually at no cost²
- Email nonurgent questions to your doctor's office



Urgent care³

You can get urgent care anywhere in the world. At many locations outside Kaiser Permanente states, you'll only pay your copay or coinsurance for care or prescriptions⁴ related to your urgent care visit – no need to file a claim later:

- Cigna PPO Network⁵
- MinuteClinic, including pharmacies⁶
- Concentra Urgent Care⁶
- The Little Clinic, including pharmacies⁶

At all other locations, you must pay the full cost of care upfront and file a claim for reimbursement later.



Emergency care⁷

No matter where you are, you can simply go to the nearest hospital emergency room. If it's a Kaiser Permanente location or Cigna PPO provider, you'll only pay your normal copay or coinsurance.

Support while you're away



Need help finding care or learning what's covered while you're away? Call the Away from Home Travel Line at **951-268-3900 (TTY 711)**⁸ or visit **kp.org/travel**.

Learn more at kp.org/travel

 **KAISER PERMANENTE®**

DENTAL PLANS

Dental - CICC'S Delta Dental

Summary of Dental PPO Incentive Plans (Includes Implant/ Diagnostic & Preventive Waiver Rider)

	Delta Dental	
	PPO (CSDC)	
	In-Network	Out-of-Network
General Plan Information		
• Annual Deductible/Individual	\$25	\$25
• Annual Deductible/Family	\$75	\$75
• Annual Plan Maximum	\$2,200 in network	\$2,000 out of network
• Lifetime Orthodontia Plan Maximum	\$4,000 in/out of network combined	\$4,000 in/out of network combined
Covered Services		
Diagnostic and Preventive Services		
• Diagnostic and Preventive	70-100%	70-100%
Basic Services		
• Basic	70-100%	70-100%
• Endodontic Treatment	70-100%	70-100%
• Periodontic Treatment	70-100%	70-100%
• Cleaning and Scaling	100% Cleaning; 4 per cal year; 90% Scaling, teeth whitening	100% Cleaning; 4 per cal year; 80% Scaling; teeth whitening
Major Services		
• Major - Crowns, onlays and cast restorations	70-100%	70-100%
• Occlusal guard	50%; \$500 lifetime max in/out of network combined	50%; \$500 lifetime max in/out of network combined
• Implants	Included	Included
Orthodontia Services		
• Orthodontia	50%	50%
• Dependent Children	\$4,000 lifetime maximum in/out of network combined	\$4,000 lifetime maximum in/out of network combined
• Adults (and Covered Full-Time Students, if Eligible)	\$4,000 lifetime maximum in/out of network combined	\$4,000 lifetime maximum in/out of network combined

The information described on this page is only intended to be a summary of benefits. It does not describe or include all benefit provisions, limitations, exclusions, or qualifications for coverage. Please review plan documents for full details. If there are any conflicts with information provided on this page, the plan documents will prevail.



Resources at your fingertips

Go online to manage your plan



Whether you need to check your benefits or select a new dentist, you can do it all with Delta Dental's online tools.

Create an account

What you can do:

- Check your plan details and eligibility.
- Browse claim history.
- Download plan documents.
- Find an in-network dentist.
- View your member ID card or print a paper copy.
- Update your settings to go paperless.



Try it out: Go to deltadentalins.com and choose **Log in** to create an account or log in to your existing account.

Tip: Access your benefits info on mobile, tablet or desktop!

Find an in-network dentist

What you can do:

- Search by distance, specialty, language spoken, extended office hours, wheelchair accessibility and more.
- Browse Yelp ratings and reviews from real patients, and check out DentaQual scores for an objective quality metric based on actual claims data.



Try it out: Go to deltadentalins.com, enter your address or ZIP code and select your network. Not sure which network to choose? Log in to your account first and follow the prompts to find a dentist.



deltadentalins.com/members

Understand your plan

What you can do:

- Browse answers to frequently asked questions.
- Get tips on planning for a dental visit.
- Find claim forms.
- Learn how to go paperless, sign up for a virtual dental visit and coordinate coverage with two or more plans.



Try it out: Visit deltadentalins.com/members for useful resources and tips.

Explore dental wellness

What you can do:

- Browse articles on everything from acid reflux to xylitol.
- Find delicious recipes for healthy meals.
- Check out videos on preventive care and common procedures.



Try it out: Visit deltadentalins.com/wellness to start learning.

Download the app

What you can do:

- Check your plan details and eligibility.
- Browse claim history.
- View your member ID card.
- Get a cost estimate.
- Find an in-network dentist.



Try it out: Search for Delta Dental in the App Store or Google Play.

Tip: Don't need another app? Just visit deltadentalins.com on your smartphone or tablet and log in to your account.

Our Delta Dental enterprise includes these companies in these states: Delta Dental of California — CA, Delta Dental of the District of Columbia — DC, Delta Dental of Pennsylvania — PA & MD, Delta Dental of West Virginia, Inc. — WV, Delta Dental of Delaware, Inc. — DE, Delta Dental of New York, Inc. — NY, Delta Dental Insurance Company — AL, DC, FL, GA, LA, MS, MT, NV, TX and UT.

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EF30 #135842.07 (rev. 03/23)

New! DeltaCare DHMO

DeltaCare Plan 12I Plan Comparison Comparison

	Delta Dental of California
	DeltaCare DHMO Plan 12I
	All Employees
General Plan Information	
• Annual Deductible/Individual	\$0
• Annual Deductible/Family	\$0
• Annual Plan Maximum	N/A
• Lifetime Orthodontia Plan Maximum	N/A
Covered Services	
Diagnostic and Preventive Services	
• Diagnostic and Preventive	Various copays apply
• Oral Exams	Various copays apply
• Bitewing X-Rays	\$0 1 every 6 months
• Full Mouth X-Rays	\$0 1 every 24 months
• Cleaning and Scaling	Various copays apply
• Prophylaxis Treatments	\$0 1 every 6 months
• Fluoride Treatments	\$0 1 every 6 months
• Space Maintainers	\$35 Copay
• Sealants	\$10 per tooth Limited to permanent molars through age 15
Basic Services	
• Basic	
• Oral Surgery: Extractions and Other Surgical Procedures	Various copays apply
• Restorative: Amalgam, Synthetic Porcelain and Plastic Restorations (<i>Fillings</i>)	Various copays apply
• Endodontic Treatment	Various copays apply
• Periodontic Treatment	Various copays apply
• Re-linings and Re-basings of Existing Removable Dentures	Various copays apply
• Repair or Re-cementing of Crowns, Inlays, Onlays, Dentures or Bridgework	Various copays apply
Major Services	
• Major	Various copays apply
• Crowns, Jackets and Cast Restoration Benefits	Various copays apply
• TMJ	Not covered
• Prosthodontic Benefits (<i>Fixed Bridges, Partial / Complete Dentures</i>)	Various copays apply
• Implants	Included
Orthodontia Services	
• Orthodontia	
• Dependent Children	\$1,700

The information described on this page is only intended to be a summary of benefits. It does not describe or include all benefit provisions, limitations, exclusions, or qualifications for coverage. Please review plan documents for full details. If there are any conflicts with information provided on this page, the plan documents will prevail.

VISION PLAN

Vision - CICC'S EyeMed (continued)



CICC'S Health and Welfare Trust

(Insight CA Network)

SUMMARY OF BENEFITS			
VISION CARE SERVICES	IN-NETWORK MEMBER COST AT PLUS PROVIDERS	IN-NETWORK MEMBER COST	OUT-OF-NETWORK MEMBER REIMBURSEMENT
EXAM SERVICES			
Exam	\$0 copay	\$0 copay	Up to \$40
Retinal Imaging	Up to \$39	Up to \$39	Not covered
CONTACT LENS FIT AND FOLLOW-UP			
Fit and Follow-up - Standard	Up to \$40	Up to \$40	Not covered
Fit and Follow-up - Premium	10% off retail price	10% off retail price	Not covered
FRAME			
Frame - Retail	\$0 copay; 20% off balance over \$175 allowance	\$0 copay; 20% off balance over \$125 allowance	Up to \$88
Frame - Wholesale*	Not covered	\$0 copay; 100% of balance over \$88 allowance	Up to \$88
LENSES			
Single Vision	\$0 copay	\$0 copay	Up to \$30
Bifocal	\$0 copay	\$0 copay	Up to \$50
Trifocal	\$0 copay	\$0 copay	Up to \$70
Lenticular	\$0 copay	\$0 copay	Up to \$70
Progressive - Standard	\$0 copay	\$0 copay	Up to \$50
Progressive - Premium Tier 1 - 4	\$85 - 175 copay	\$85 - 175 copay	Up to \$50
LENS OPTIONS			
Anti Reflective Coating - Standard	\$0 copay	\$0 copay	Up to \$23
Anti Reflective Coating - Premium Tier 1 - 3	\$12 - 85 copay	\$12 - 85 copay	Up to \$23
Photochromic - Non-Glass	\$75	\$75	Not covered
Polycarbonate - Standard	\$40	\$40	Not covered
Polycarbonate - Standard < 19 years of age	\$0 copay	\$0 copay	Up to \$20
Scratch Coating - Standard Plastic	\$15	\$15	Not covered
Tint - Solid and Gradient	\$15	\$15	Not covered
UV Treatment	\$15	\$15	Not covered
All Other Lens Options	20% off retail price	20% off retail price	Not covered
CONTACT LENSES			
Contacts - Conventional	\$0 copay; 15% off balance over \$125 allowance	\$0 copay; 15% off balance over \$125 allowance	Up to \$88
Contacts - Disposable	\$0 copay; 100% of balance over \$125 allowance	\$0 copay; 100% of balance over \$125 allowance	Up to \$88
Contacts - Medically Necessary	\$0 copay	\$0 copay	Up to \$300
OTHER			
Hearing Care from Amplifon Network	Up to 66% off hearing aids; call 1-877-203-0675	Up to 66% off hearing aids; call 1-877-203-0675	Not covered
LASIK or PRK from U.S. Laser Network	15% off retail or 5% off promo price; call 1.800.988.4221	15% off retail or 5% off promo price; call 1.800.988.4221	Not covered
FREQUENCY		ALLOWED FREQUENCY - ADULTS	ALLOWED FREQUENCY - KIDS
Exam		Once every 12 months from the date of service	Once every 12 months from the date of service
Lenses		Once every 12 months from the date of service	Once every 12 months from the date of service
Frame		Once every 24 months from the date of service	Once every 24 months from the date of service
Contact Lenses		Once every 12 months from the date of service	Once every 12 months from the date of service

(Plan allows the member to receive either contacts and frame, or frame and lens services.)

*Available at wholesale providers, such as Costco Optical; discounts do not apply. View the provider locator to find wholesale providers. Fees charged by a Provider for services other than a covered benefit and any local, state or Federal taxes must be paid in full by the Insured Person to the Provider. Such fees, taxes or materials are not covered under the Policy. Allowances provide no remaining balance for future use within the same Benefit Frequency. Some provisions, benefits, exclusions or limitations listed herein may vary by state. No benefits will be paid for services or materials connected with or charges arising from: medical or surgical treatment, services or supplies for the treatment of the eye, eyes or supporting structures; Refraction, when not provided as part of a Comprehensive Eye Examination; services provided as a result of any Workers' Compensation law, or similar legislation, or required by any governmental agency or program whether federal, state or subdivisions thereof; orthoptic or vision training, subnormal vision aids and any associated supplemental testing; Aniseikonic lenses; any Vision Examination or any corrective Vision Materials required by a Policyholder as a condition of employment; safety eyewear; solutions, cleaning products or frame cases; non-prescription sunglasses; plano (non-prescription) lenses; plano (non-prescription) contact lenses; two pair of glasses in lieu of bifocals; electronic vision devices; services rendered after the date on Insured Person ceases to be covered under the Policy, except when Vision Materials ordered before coverage ended are delivered, and the services rendered to the Insured Person are within 31 days from the date of such order; lost or broken lenses, frames, glasses, or contact lenses that are replaced before the next Benefit Frequency when Vision Materials would next become available. Member receives a 20% discount on items not covered by the plan at In-Network locations. Discount does not apply to Provider's professional services or contact lenses. Plan discounts cannot be combined with any other discounts or promotional offers. In certain states members may be required to pay the full retail rate and not the negotiated discount rate with certain participating providers. Please see the online provider locator to determine which participating providers have agreed to the discounted rate. Discounts on vision materials may not be applicable to certain manufacturers' products. The Plan reserves the right to make changes to the products on each tier and to the member out-of-pocket costs. Fixed tier pricing is reflective of brands at the listed product level. All providers are not required to carry all brands at all levels. Services and amounts listed above are subject to change at any time. Discounts are not insured benefits.

Savings plus convenience plus choice

PLUS Providers add another layer of
coverage

\$175

Frame - Retail allowance

Staying in-network helps you save money on eye exams, frames and lenses. Visiting a PLUS Provider is designed to help you save even more.

And since PLUS Providers are already in our network, the additional perks are built right into your vision benefits. No promo codes, no coupons, no paperwork. The same vision benefits, plus a little more savings.



This information is available broadly and
is not plan or state specific.

PDF-2303-M-1084

The choice is yours

Find plenty of in-network eye doctors – including PLUS Providers – on our Provider Locator. Just look for the PLUS.

Need extra assistance? Contact us at 866.804.0982 or visit eyemed.com.

**INDEPENDENT
PROVIDER
NETWORK**



LENSCRAFTERS®

**PEARLE
VISION**

OPTICAL®

EXPERIENCE MORE: MOBILE ACCESS

HOW TO: mobilize your vision plan

EYEMED MEMBERS APP

Our member app was the first of its kind. But innovation – like your life – never stops. The EyeMed Members App is packed with ahead-of-the-game resources wherever you are. Before, during and after your eye appointment.

Get the latest EyeMed Members App:

- 1. DOWNLOAD** – Search “EyeMed Members” in your App store, iTunes or Google Play.
- 2. OPEN** – You can use some features right away; others unlock once you register.
- 3. REGISTER** – You’ll need your member ID or the last four digits of your social security number.
- 4. LOG IN** – If you’ve already registered on eyemed.com, you can log onto the app the same way.

	Ready when you download	Unlocked when you register
Find nearby network providers	◆	
On-the-fly appointment scheduling	◆	
Turn by turn directions and map	◆	
Eye exam and contact lens reminders		◆
Electronic ID card for office visits		◆
Save vision prescriptions*		◆
Benefit plan details		◆
Answers to common questions	◆	
Special offers and discounts		◆
Direct line to EyeMed support	◆	

SEE THE GOOD STUFF

Register on eyemed.com or grab the member app (App Store or Google Play) now.

* Take a picture of your prescription and store it in your app.
No need to type in the numbers.

**INDEPENDENT
PROVIDER
NETWORK**



LENSCRAFTERS
♥ 👁

**PEARLE
VISION**

OPTICAL

**sears
OPTICAL**

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EMPLOYEE ASSISTANCE PROGRAM

for employees

What is the Employee Assistance Program?

Provided through ComPsych® GuidanceResources®, the Employee Assistance Program (EAP) offers counseling, legal and financial consultation, work-life assistance, and other health and well-being resources.

The EAP is available at no cost to you and your household members to help with emotional, financial, legal or other concerns, whether at work or at home, anytime of the day or night. Just call your designated number or log on to the the EAP website, GuidanceResources® Online, for immediate assistance.

Why would someone use the EAP?

There are many reasons. **Among the most common are:**

1 Feeling overwhelmed by the demands of balancing work and family.

4 Having concerns about **substance misuse** for yourself or a dependent.

2 Experiencing **stress, anxiety or depression.**

5 Needing assistance with **child or elder care** concerns.

3 Dealing with **grief and loss or separation.**

6 Struggling with **legal or financial** issues.

❓ Can my children use the EAP?

Yes. The EAP is a benefit for employees and each of their household family members, including children.

What happens when I call?

When you call, you will speak with a GuidanceConsultantSM, a trained intake counselor who will collect some general information about you and discuss your needs. They will then work with you to develop a plan of action and help you schedule appointments or access other services.

What counseling services are provided?

The EAP provides free short-term counseling in person, over the phone or via video call with local providers who can help you with your concerns.

Many issues can be resolved with short-term counseling provided through the EAP. If you need longer-term treatment beyond what the EAP provides, you will be referred to a specialist and given help arranging services.

Strict EAP confidentiality.

No personal information about your participation in the EAP will be provided to your employer without your permission.



Live Assistance

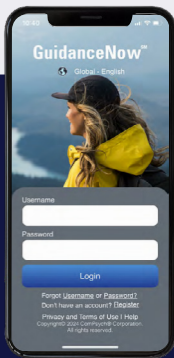
Call: 855-459-6512
App: GuidanceNow®
Web ID: REEPEAP
Online: guidanceresources.com

TRS: Dial 711

→
Scan for more resources



Online *support*



Download the free GuidanceNow app for anytime access

Register as a new user on guidanceresources.com using your organization's Web ID.

Download the app from either the App Store or Google Play.

Log in using your username and password.



App Store



Google Play

What you want. When and how you want it.

The GuidanceResources® portal and app ensure you have the right support, at the right time, and in the right way. Whether you are looking for immediate access to tools and services, would like individualized resources suggested to you, or want a more holistic experience with highly-personalized care recommendations, you will find it on the guidanceresources.com platform and the GuidanceNowSM app.

Log on today for information on the issues that matter most to you: mental health, relationships, work, school, parenting, wellness, legal, financial, free time, and much more. With 24/7 access online and on the app, you can get the info you need when and where you need it.

Log on:



Schedule counseling, Work-Life, Legal, and Financial guidance



Take the Assess Me journey to create your personalized Well-Being plan



Browse an extensive library of videos, articles, podcasts, and slideshows



And much more



Live Assistance

Call: 855-459-6512
App: GuidanceNowSM
Online: guidanceresources.com

TRS: Dial 711
Web ID: REEPEAP



Scan for more resources



VALUE ADDED & VOLUNTARY PLANS



REEP Wellness Program Overview 2026-2027



Invest in Your Health – Get Rewarded.

Free digital wellness programs + cash rewards

REEP continues to offer a streamlined program with wellness offerings for both Anthem Blue Cross and Kaiser Permanente medical plan members.

Omada Health Digital Programs

Personalized Support for:

- Diabetes & Pre-Diabetes
- Hypertension & Pre-Hypertension
- Joint & Muscle Pain



Scan the QR code to learn more and apply today

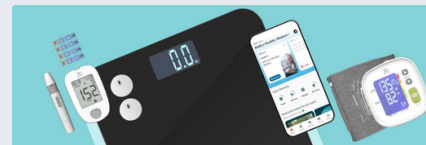
Perks of Participating:

FREE Smart Devices

Eligible participants receive devices such as:

- Smart scale
- Blood pressure monitor
- Glucose monitor
- Joint & muscle support kit

Provided based on program eligibility



Earn Rewards

- **\$150 e-Gift Card** - For eligible member employees who enroll in an Omada condition management program
- **\$100 e-Gift Card Monthly Drawings** - 3 eligible member employee winners selected every month who apply to an Omada Health program

Wellness Challenges

- Two online wellness challenges each year
- Fun, inclusive activities
- District-wide friendly competition
- Incentives for participation



Want to Get More Involved?

Join the REEP Wellness District Coordinators Group

Help shape future wellness offerings.

Contact vtorres@keenan.com



Access a health program built just for you

REEP is offering Omada® to help people manage diabetes, lower blood pressure or lose weight with one-on-one health coaching and the tools needed to build healthy habits that stick.

The best part: the program is **no cost to you** if you're clinically eligible to enroll.

With Omada, you'll get

- ✓ One-on-one support from a health coach, and a specialist for diabetes and blood pressure program members
- ✓ OmadaSpark AI—get answers to your food related questions and ideas for healthier meals and snacks
- ✓ Easy food tracking—just snap a picture, scan a barcode, use your voice or type in your meals

REEP will cover the entire cost of the program if you or your spouse, domestic partner, or adult dependent aged 18 and older are enrolled in a REEP Anthem Blue Cross or Kaiser Permanente medical plan, and apply, qualify, and meet the eligibility requirements.



Get a welcome kit at no extra cost once you enroll*

It includes easy-to-use smart devices, based on your needs, shipped to your door, yours to keep.

- Two continuous glucose monitor (CGM) sensors†
- Blood glucose meter (BGM) with an ongoing supply of test strips and lancets, as needed
- Blood pressure monitor
- Smart scale



Claim My Benefit:
omadahealth.com/reep

*Certain features and smart devices are only available for certain programs and if you meet program and clinical eligibility requirements.

†The no cost CGM excludes Medicare, Medicaid, and other government payers. The Abbott FreeStyle Libre 14 day system is available to eligible participants with a valid prescription and compatible smartphone. Setup is required for continuous glucose monitoring. The circular shape of the sensor housing, FreeStyle, Libre, and related brand marks are marks of Abbott. FreeStyle Libre 14 day system: Failure to use FreeStyle Libre 14 day system as instructed in labeling may result in missing a severe low or high glucose event and/or making a treatment decision, resulting in injury. If readings do not match symptoms or expectations, use a finger stick value from a blood glucose meter for treatment decisions. Seek medical attention when appropriate or contact Abbott at 855-632-8658 or FreeStyleLibre.us for safety info.

Images, including apps, do not reflect real members or information about a specific person.



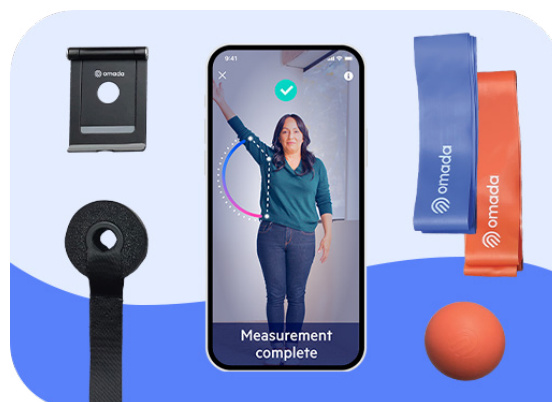
Move easier and feel better with Omada®

You may have access to a virtual physical therapy program as it's provided by REEP.

From sprains to chronic pain, Omada for Joint & Muscle Health® can support your unique needs.

Specialized programs

- Chronic Pain
- Women's Health
- Ergonomics
- Surgery Navigation
- Work Conditioning



What's included in your benefit:*

- Dedicated licensed physical therapist
- Unlimited video visits
- Customized care plan
- App-based tools like virtual form detection
- Exercise kit with resistance bands

81% of members improved function in their area of concern.[†]



Claim My Benefit:
msk.omadahealth.com/reep

If you, your spouse, domestic partner, or adult dependent (age 18 or older) are enrolled in a REEP Anthem Blue Cross or Kaiser Permanente medical plan, you may qualify to participate in the Omada program at no cost. To be eligible, you must apply, meet the program's qualifications, and satisfy all eligibility requirements.

*The program features described are specific to the Recovery Omada for Joint & Muscle Health® program, which includes a physical therapist. Women's Health is a version of the Recovery program. Members not experiencing a relevant injury or musculoskeletal condition may instead receive a preventive version of Omada for Joint & Muscle Health®, which includes different features and does not include a physical therapist.

Virtual physical therapy is only available where it is allowed by law.

[†]Omada internal analysis, member population data, 2024-2025.

Images, including apps, do not reflect real members or information about a specific person.



Your employees get exclusive access to:

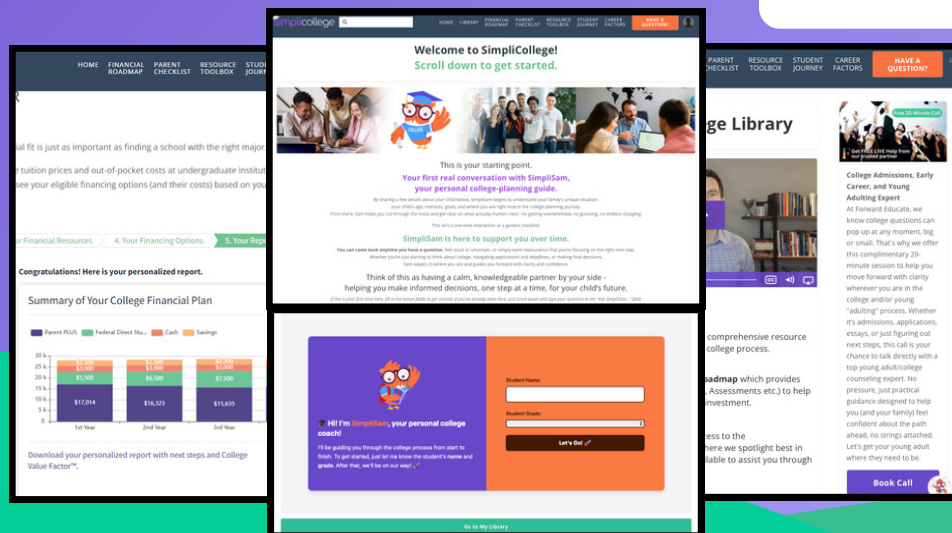
- ✓ **On-demand coaching** with our AI-powered CoachBot!
- ✓ **The Financial Roadmap:** SimpliCollege's proprietary approach to get the biggest return on investment for college.
- ✓ **Help with every part of the college process:** Choosing a career, finding a college, paying for school, getting in, and getting the most from the college experience.
- ✓ **Exclusive access** to the College Budget Calculator, The College Checkup, and The Career Factors for Students.

SimpliCollege is a benefit now available to all of your employees

Scan the QR code above to learn more!

Bonus for schools:

When you provide this to your employees, you can give it to your parents at no additional cost!



What can SimpliCollege do for your employees?

- ➔ Reduce stress and anxiety
- ➔ Provide strategies for lowering the cost of college
- ➔ Help make confident decisions
- ➔ Help prevent costly mistakes
- ➔ Help find grants & scholarships
- ➔ Teach how to appeal for additional financial aid

There are a variety of benefits you can purchase through payroll deductions (no contributions are provided by the District). See the District Benefits Office or BenefitBridge for more information.

TruHearing Discount Program

All REEP members have access to hearing aids at a far reduced price through the TruHearing Discount Program. REEP members can shop state of the art hearing aid technology at a savings between 30% to 60% off. Call TruHearing at [\(844\) 524-3976](tel:8445243976) Monday through Friday, 8am – 8pm, For TTY, dial 711.



Take the first step to better hearing

EPIC Hearing Healthcare is here to make it easier

Treat hearing loss and protect your hearing health with a hearing exam and consultation covered by your plan.



Contact EPIC to request an initial hearing exam and consultation

Call **1-866-956-5400** to start treating any hearing loss and to protect your hearing health.

Have your plan name on hand when you call: **CICCS Trust**



Find the solution for your lifestyle

At your appointment, your hearing care professional will assess your hearing, answer questions and provide a personalized recommendation based on your goals and activities.

Hearing plan name: **CICCS Trust**

Hearing aid benefit:

\$1,000 per ear, once every 60 months (adults)
\$1,000 per ear, once every 24 months (children)

Be sure to have your plan name available when you call to request your appointment.



Learn more about your hearing health

Scan using your smartphone's camera or visit
epichearing.com/2025

Continued on the back.



EPIC
HEARING HEALTHCARE™

C^{INSURANCE}CCCS
CONTROLLING INSURANCE COSTS
IN CALIFORNIA SCHOOLS

Hear better, live better

Your overall wellness is affected by your hearing — now and into the future. Your EPIC benefits are here to help you safeguard your health, simply by catching and addressing hearing loss as soon as possible. Learn more about the connections between hearing and overall wellness at epichearing.com/connect.



Nearly **8 in 10**

hearing aid users say that their quality of life was better since wearing aids¹

Good-to-know details

- ✓ You have 60 days to try out hearing aids purchased from a hearing care professional
- ✓ Receive a no-cost hearing exam and consultation with a hearing care professional in EPIC's national network
- ✓ Your plan includes a 3-year extended warranty for repairs and a one-time loss or damage replacement²
- ✓ Schedule up to 3 follow-up visits at no cost,³ with additional support available
- ✓ Save on a broad array of high-quality hearing aids from major brands

What to expect from prescription hearing aids

Innovative new hearing aids help you stay connected and engaged, thanks to the cutting-edge technology of today's prescription hearing aids. They include:



Expert care with
in-person support



Personalized hearing aid
recommendations



Holistic follow-up for
comfort and adjusting to use

Ready to get started?

1-866-956-5400, TTY 711

Call 6 a.m. - 6 p.m. PT, Monday through Friday.
Be sure to have your plan name available.

Hearing plan name: C^{INSURANCE}CCCS Trust

¹American Speech-Language-Hearing Association. "Attitudes and actions towards hearing health." <https://www.asha.org/siteassets/bhsm/2021/asha-bhsm-2021-report.pdf>. Accessed June 2025.

²One-time professional fee may apply.

³Hearing aids purchased in the Silver technology level will receive 1 follow-up visit.

All trademarks property of respective owners.

Hearing aids must be ordered through the EPIC Hearing Healthcare provider network. Price per hearing aid, based on suggested manufacturer pricing. Hearing aids ordered through providers outside of the EPIC Hearing Healthcare provider network will not be covered. Home delivery may not be available on all plans. EPIC Hearing Healthcare complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex.

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EPIC
HEARING HEALTHCARE™

C^{INSURANCE}CCCS
CONTROLLING INSURANCE COSTS
IN CALIFORNIA SCHOOLS



How Do I Enroll?

A Colonial Life Advisor will assist you via a screen share enrollment which requires access to a computer and Internet.

Prepare for your appointment:

Be sure to bring social security numbers and dates of birth for any dependents that will be covered.

Click or Scan the QR code to schedule an appointment.

SCAN HERE



Powered by qrtly for monday.com

Click the icon to the right to watch a short video on the claims process. The URL at the bottom of the page takes you to the Policy Holder website.



ACCIDENT

For a covered accident, policyholders receive cash benefits for use as they see fit.



CANCER

A plan designed to pay cash benefits that can be used to help offset cancer-related expenses.



CRITICAL ILLNESS

For a covered critical illness, policyholders receive a lump sum cash benefit to use as they see fit.



GROUP MEDICAL BRIDGE

Pays cash amounts to help with the non-covered expenses of a hospital stay.



LIFE INSURANCE

Helps you get the peace of mind knowing your family is taken care of.



www.ColonialLife.com/individuals

The district provides life insurance from Madison National Life. Employees also have the opportunity to elect additional voluntary life and AD&D. The following pages provide details of coverage as well as rates for the available plans. Enrollment can be done in **BenefitBridge**.

In the event of your death, Life Insurance will provide your family members or other beneficiaries with financial protection and security. Additionally, if your death is a result of an accident or if you become dismembered, your Accidental Death & Dismemberment (AD&D) coverage may apply.

Basic Life & Accidental Death & Dismemberment (AD&D)

District paid benefit to cover each eligible employee with this term group life and AD&D insurance. Madison National Life underwrites this insurance policy.

The Accidental Death & Dismemberment (AD&D), included in the Basic Life plan, is available to you even if you already have accident insurance. It provides benefits beyond your disability or life insurance for losses due to covered accidents — while commuting, traveling by public or private transportation and during business trips.

Voluntary Life & Voluntary Accidental Death & Dismemberment

If you would like to supplement your employer paid insurance, additional Life coverage for you and/or your dependents is available for purchase through Madison National Life. Premiums will be deducted from employee's paycheck. Enrollments can be made using the BenefitBridge platform. Evidence of Insurability may be required for newly elected amounts of coverage.

Select Your Beneficiary

Beneficiaries are individuals or entities that you select to receive benefits from your policy.

- **You can change your beneficiary designation at any time.**
- **You may designate a sole beneficiary or multiple beneficiaries to receive payment in the amount you specify.**
- **Make any changes via BenefitBridge.**



Accidental Death and Dismemberment Insurance



Colton-Redlands-Yucaipa Regional Occupational Program

All Eligible Employees

How much Accidental Death & Dismemberment (AD&D) insurance is available?

For You:

Basic AD&D	\$2,000
Voluntary AD&D (if elected)	Options of \$10,000; \$25,000; \$50,000; \$100,000; \$250,000; or \$500,000 - not to exceed 10 times your Annual Salary or \$500,000, whichever is lesser.

For Your Dependents: (if Family Plan is elected)

Spouse Only (if elected)	60% of Employee's Voluntary AD&D Benefit
Child(ren) Only (if elected)	25% of Employee's Voluntary AD&D Benefit – not to exceed \$50,000.
Spouse and Child(ren) (if elected)	60% of Employee's Voluntary AD&D Benefit for your Spouse; and 25% of Employee's Voluntary AD&D Benefit for each of your children, not to exceed \$50,000.

Who is eligible for this insurance?

Employees working at least 30 hours per week. This does not include temporary or seasonal Employees.

Dependent AD&D Insurance: No person may be considered a Dependent of more than one Eligible Employee. No person can be insured as an Employee and as a Dependent.

Will the insurance benefit ever reduce?

For You: Your Employee Basic and Voluntary AD&D will not reduce and will terminate at retirement and/or separation of employment.

For Your Spouse: Your Spouse's Dependent Voluntary AD&D will not reduce and will terminate at the Employee's retirement and/or separation of employment.

For Your Child(ren): Your Child/ren's Dependent Voluntary AD&D will not reduce and will terminate at the earlier of Your child's marriage or attainment of age 26 unless legally incapacitated and unable to be self-supporting because of a medically ascertainable mental or physical handicap, the Employee's retirement and/or separation of employment.

How much is my premium?

Your Employee Basic AD&D is of no cost to you.

For the Employee Voluntary AD&D and Dependent Voluntary AD&D, please reference the Premium Table below.

Benefit Amount	Tenthly			
	Employee Only	Employee and Spouse	Employee and Child(ren)	Employee and Family
\$10,000	\$0.42	\$0.67	\$0.47	\$0.72
\$25,000	\$1.06	\$1.69	\$1.16	\$1.80
\$50,000	\$2.10	\$3.36	\$2.33	\$3.59
\$100,000	\$4.20	\$6.72	\$4.66	\$7.18
\$250,000	\$10.50	\$16.80	\$11.40	\$17.70
\$500,000	\$21.00	\$33.60	\$21.90	\$34.50

Who do I contact with questions?

Questions may be directed to National Insurance Services at 1-800-627-3660

Administered by:



Corporate Headquarters:
300 N Corporate Drive, Suite 300
Brookfield, WI 53045
Offices Nationwide
800.627.3660



Corporate Headquarters:
2355 Crenshaw Blvd., Suite 200
Torrance, CA 90501
310-212-3344
800-654-8102

Underwritten by:



PO Box 5008, Madison, WI 53705

This brochure is not the insurance contract. It is a brief description of your insurance underwritten by Madison National Life Insurance Company, Inc.

Founded in 1961, Madison National Life is headquartered in Madison, the rapidly growing capital city of Wisconsin. Madison National Life is licensed in 49 states and specializes in group life, disability, and specialty health insurance. The company is a wholly owned subsidiary of Horace Mann Educators Corporation (NYSE:HMN), the largest financial services company focused on providing America's educators and school employees with insurance and retirement solutions.



Colton-Redlands-Yucaipa Regional Occupational Program

All Eligible Management, Certificated and Classified Employees

How much Basic Life and Accidental Death and Dismemberment (AD&D), and Supplemental Life Insurance is available?

For You:	
Basic Life and AD&D	\$40,000
Supplemental Life (if elected)	Increments of \$10,000 - up to a maximum of \$500,000.
For Your Spouse:	
Dependent Basic Life (if elected)	\$10,000
Dependent Supplemental Life (if elected)	Increments of \$10,000 - up to a maximum of \$500,000 - not to exceed 100% of your Employee Supplemental Life.
For Your Child(ren):	
Dependent Basic Life (if elected)	\$1,000
Dependent Supplemental Life (if elected)	Options of \$2,500, \$5,000, and \$10,000
The AD&D benefit pays a benefit to you or your beneficiary equal to the Basic Life amount in the event of a Covered Loss.	

Are there any medical questions or tests needed to qualify for this insurance?

Depending on your eligibility, this is the maximum amount of coverage you may apply for during initial enrollment without answering medical questions.

For You:	
Basic Life and AD&D	\$40,000
Supplemental Life (if elected)	\$100,000
For Your Spouse:	
Dependent Basic Life (if elected)	\$10,000
Dependent Supplemental Life (if elected)	\$20,000

Madison National Life (continued)



For Your Child(ren):

Dependent Basic Life (if elected)	\$1,000
Dependent Supplemental Life (if elected)	\$10,000

Please note: To elect Dependent Spouse Supplemental Life and/or Dependent Child Supplemental Life coverage, you must elect Employee Supplemental Life Insurance coverage.

Who is eligible for this insurance?

Employees working at least 30 hours a week.

Dependent Life Insurance: No person may be considered a Dependent of more than one Eligible Employee. No person can be insured as an Employee and as a Dependent.

How much is my premium?

Your Dependent Basic Life tenthly premium is at \$ 4.14 .

Your Dependent Child Supplemental Life Premium is per dependent unit. Please see the table below:

Coverage Amount	Tenthly Premium
\$2,500	\$0.60
\$5,000	\$1.20
\$10,000	\$2.40

Your monthly premiums for Employee Supplemental Life and Dependent Spouse Supplemental Life are based on the Employee's age (please see the attached Premium Table to get the Premium).

Who do I contact with questions?

Questions may be directed to National Insurance Services at 1-800-627-3660

Administered by:



Corporate Headquarters:
250 South Executive Drive, Suite 300
Brookfield, WI 53005
Offices Nationwide
800.627.3660



Corporate Headquarters:
2355 Crenshaw Blvd., Suite 200
Torrance, CA 90501
310-212-3344
800-654-8102

Underwritten by:



PO Box 5008, Madison, WI 53705

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Madison National Life (continued)



Employee Supplemental Life and Dependent Spouse Supplemental Life Tenthly Premiums

Benefit Amount	Under 35	35 - 39	40 - 44	45 - 49	50 - 54	55 - 59	60 - 64	65 - 69	70 - 99
\$10,000	\$0.50	\$0.70	\$1.10	\$1.90	\$2.90	\$4.70	\$7.80	\$13.10	\$22.20
\$20,000	\$1.00	\$1.40	\$2.20	\$3.80	\$5.80	\$9.40	\$15.60	\$26.20	\$44.40
\$30,000	\$1.50	\$2.10	\$3.30	\$5.70	\$8.70	\$14.10	\$23.40	\$39.30	\$66.60
\$40,000	\$2.00	\$2.80	\$4.40	\$7.60	\$11.60	\$18.80	\$31.20	\$52.40	\$88.80
\$50,000	\$2.50	\$3.50	\$5.50	\$9.50	\$14.50	\$23.50	\$39.00	\$65.50	\$111.00
\$60,000	\$3.00	\$4.20	\$6.60	\$11.40	\$17.40	\$28.20	\$46.80	\$78.60	\$133.20
\$70,000	\$3.50	\$4.90	\$7.70	\$13.30	\$20.30	\$32.90	\$54.60	\$91.70	\$155.40
\$80,000	\$4.00	\$5.60	\$8.80	\$15.20	\$23.20	\$37.60	\$62.40	\$104.80	\$177.60
\$90,000	\$4.50	\$6.30	\$9.90	\$17.10	\$26.10	\$42.30	\$70.20	\$117.90	\$199.80
\$100,000	\$5.00	\$7.00	\$11.00	\$19.00	\$29.00	\$47.00	\$78.00	\$131.00	\$222.00
\$110,000	\$5.50	\$7.70	\$12.10	\$20.90	\$31.90	\$51.70	\$85.80	\$144.10	\$244.20
\$120,000	\$6.00	\$8.40	\$13.20	\$22.80	\$34.80	\$56.40	\$93.60	\$157.20	\$266.40
\$130,000	\$6.50	\$9.10	\$14.30	\$24.70	\$37.70	\$61.10	\$101.40	\$170.30	\$288.60
\$140,000	\$7.00	\$9.80	\$15.40	\$26.60	\$40.60	\$65.80	\$109.20	\$183.40	\$310.80
\$150,000	\$7.50	\$10.50	\$16.50	\$28.50	\$43.50	\$70.50	\$117.00	\$196.50	\$333.00
\$160,000	\$8.00	\$11.20	\$17.60	\$30.40	\$46.40	\$75.20	\$124.80	\$209.60	\$355.20
\$170,000	\$8.50	\$11.90	\$18.70	\$32.30	\$49.30	\$79.90	\$132.60	\$222.70	\$377.40
\$180,000	\$9.00	\$12.60	\$19.80	\$34.20	\$52.20	\$84.60	\$140.40	\$235.80	\$399.60
\$190,000	\$9.50	\$13.30	\$20.90	\$36.10	\$55.10	\$89.30	\$148.20	\$248.90	\$421.80
\$200,000	\$10.00	\$14.00	\$22.00	\$38.00	\$58.00	\$94.00	\$156.00	\$262.00	\$444.00
\$210,000	\$10.50	\$14.70	\$23.10	\$39.90	\$60.90	\$98.70	\$163.80	\$275.10	\$466.20
\$220,000	\$11.00	\$15.40	\$24.20	\$41.80	\$63.80	\$103.40	\$171.60	\$288.20	\$488.40
\$230,000	\$11.50	\$16.10	\$25.30	\$43.70	\$66.70	\$108.10	\$179.40	\$301.30	\$510.60
\$240,000	\$12.00	\$16.80	\$26.40	\$45.60	\$69.60	\$112.80	\$187.20	\$314.40	\$532.80
\$250,000	\$12.50	\$17.50	\$27.50	\$47.50	\$72.50	\$117.50	\$195.00	\$327.50	\$555.00
\$260,000	\$13.00	\$18.20	\$28.60	\$49.40	\$75.40	\$122.20	\$202.80	\$340.60	\$577.20
\$270,000	\$13.50	\$18.90	\$29.70	\$51.30	\$78.30	\$126.90	\$210.60	\$353.70	\$599.40
\$280,000	\$14.00	\$19.60	\$30.80	\$53.20	\$81.20	\$131.60	\$218.40	\$366.80	\$621.60
\$290,000	\$14.50	\$20.30	\$31.90	\$55.10	\$84.10	\$136.30	\$226.20	\$379.90	\$643.80
\$300,000	\$15.00	\$21.00	\$33.00	\$57.00	\$87.00	\$141.00	\$234.00	\$393.00	\$666.00
\$310,000	\$15.50	\$21.70	\$34.10	\$58.90	\$89.90	\$145.70	\$241.80	\$406.10	\$688.20
\$320,000	\$16.00	\$22.40	\$35.20	\$60.80	\$92.80	\$150.40	\$249.60	\$419.20	\$710.40
\$330,000	\$16.50	\$23.10	\$36.30	\$62.70	\$95.70	\$155.10	\$257.40	\$432.30	\$732.60
\$340,000	\$17.00	\$23.80	\$37.40	\$64.60	\$98.60	\$159.80	\$265.20	\$445.40	\$754.80
\$350,000	\$17.50	\$24.50	\$38.50	\$66.50	\$101.50	\$164.50	\$273.00	\$458.50	\$777.00
\$360,000	\$18.00	\$25.20	\$39.60	\$68.40	\$104.40	\$169.20	\$280.80	\$471.60	\$799.20
\$370,000	\$18.50	\$25.90	\$40.70	\$70.30	\$107.30	\$173.90	\$288.60	\$484.70	\$821.40
\$380,000	\$19.00	\$26.60	\$41.80	\$72.20	\$110.20	\$178.60	\$296.40	\$497.80	\$843.60
\$390,000	\$19.50	\$27.30	\$42.90	\$74.10	\$113.10	\$183.30	\$304.20	\$510.90	\$865.80
\$400,000	\$20.00	\$28.00	\$44.00	\$76.00	\$116.00	\$188.00	\$312.00	\$524.00	\$888.00
\$410,000	\$20.50	\$28.70	\$45.10	\$77.90	\$118.90	\$192.70	\$319.80	\$537.10	\$910.20
\$420,000	\$21.00	\$29.40	\$46.20	\$79.80	\$121.80	\$197.40	\$327.60	\$550.20	\$932.40
\$430,000	\$21.50	\$30.10	\$47.30	\$81.70	\$124.70	\$202.10	\$335.40	\$563.30	\$954.60
\$440,000	\$22.00	\$30.80	\$48.40	\$83.60	\$127.60	\$206.80	\$343.20	\$576.40	\$976.80
\$450,000	\$22.50	\$31.50	\$49.50	\$85.50	\$130.50	\$211.50	\$351.00	\$589.50	\$999.00
\$460,000	\$23.00	\$32.20	\$50.60	\$87.40	\$133.40	\$216.20	\$358.80	\$602.60	\$1,021.20
\$470,000	\$23.50	\$32.90	\$51.70	\$89.30	\$136.30	\$220.90	\$366.60	\$615.70	\$1,043.40
\$480,000	\$24.00	\$33.60	\$52.80	\$91.20	\$139.20	\$225.60	\$374.40	\$628.80	\$1,065.60
\$490,000	\$24.50	\$34.30	\$53.90	\$93.10	\$142.10	\$230.30	\$382.20	\$641.90	\$1,087.80
\$500,000	\$25.00	\$35.00	\$55.00	\$95.00	\$145.00	\$235.00	\$390.00	\$655.00	\$1,110.00

Nationwide Pet Insurance



Pet insurance



Pet-loving employees can fetch the best health coverage for their pets with My Pet Protection ChoiceSM, available only through workplace benefit programs.

Nationwide offers two ready-made employee plans, plus the ability to customize a coverage plan for individual pets and their specific care needs.¹

Pet protection when it matters most

Nationwide's pet insurance plans cover:

- Accidents and injuries
- Common illnesses
- Serious illnesses
- Chronic illnesses
- Hereditary conditions
- Testing and diagnostics
- Procedures
- Holistic and alternative care
- And more!

Coverage includes emergency care and specialists. No networks, no pre-approval, no problem.

What's the difference between accident, illness and wellness coverage?



Accident coverage

Support for unexpected injuries



Illness coverage

Support for when pets get sick



Wellness coverage

Support for proactive care

Easy to use, easy to understand

Using a Nationwide pet insurance plan is easy:

- Visit any vet, anywhere
- Submit a claim from any device
- Get reimbursed for eligible expenses once the deductible is met



Did you know? Nationwide is the industry's first provider of coverage for birds and exotic pets.

<http://www.petinsurance.com/ciccs> | Call: 877-738-7874



Don't
let thieves break your bank!

Enroll today for just \$12 tenthly!

24/7 Peace of Mind

ID Theft Protector offers unlimited identity theft restoration services for you and your family to help easily recover from identity theft.

24/7 "real time" access to credit bureau records allow specially trained and certified fraud resolution specialists to identify the crime, respond quickly to stop additional damage, remove fraudulent activity from the victim's name and regain control of your credit history.

With ID Theft Protector, resolution services happen much more quickly than with competitive programs. Whenever and wherever a victim's identity is stolen, ID Theft Protector begins to make it better right away - with only one call to our 24/7 emergency assistance center.

Backed by Industry Leaders

ID Theft Protector is backed by industry leaders to help 24/7 at home or when you are traveling. The product is backed by two of the largest and most experienced companies of their type in the identity protection business: CLC, Incorporated, who provides Legal, Financial and Identity Theft protection services to over 27 million households and over 25,000 corporations, and Trans Union/True Credit, a leading provider of business intelligence, consumer information and Web-based services helping consumers prevent and resolve credit fraud and identity theft issues, supported by more than 3,600 employees in 25 countries worldwide.

\$1,000,000 Cash Asset and Expense Reimbursement

Unlimited restoration and up to \$1,000,000 in identity theft insurance with a zero deductible for unauthorized electronic funds transfers from personal checking and savings accounts as well as certain fraud-related expenses, such as lost wages, reasonable attorney's fees (appointed by the insurance company) along with other out-of-pocket expenses that are related to the recovery of your identity. To establish eligibility you must enroll in Identity Theft Monitoring.

Key Service Features

-  **Instant Alerts**
Get immediate alerts of questionable activity
-  **Quick Response**
Experts will work to assess any situation 24/7
-  **Quick Restore**
Your identity is restored in record time
-  **Quick Relief**
Get life back to normal as soon as possible



For any product-related questions, please contact your Account Executive or Benefits Administrator!

If you are already a member of ID Theft Protector powered by ID Theft Assist and have any activation questions or suspect your identity is compromised in any way, immediately call 1-866-262-5844.



Keenan

Keenan & Associates
CA License No. 0451271

Medical FSA and Dependent Care FSA will require you to complete your enrollment for the new plan year – **even if you are electing the same dollar amount, you must re-enroll in the FSA each year.** To do this, you will need to schedule an in-person or virtual meetings by calling American Fidelity [800-365-9180](tel:800-365-9180).



Important Reminders

1. Governmental regulations require all employees carry medical insurance. Therefore, any employee who declines group medical insurance **MUST** denote on **BenefitBridge** that you are waiving medical insurance, electing not to enroll in the plan(s) offered by the district.
2. Once you make your plan elections, you cannot change to a different plan until the next open enrollment period without a qualifying event. A loss or change of provider is not considered a qualifying event. If your physician is no longer an eligible provider for the plan you have chosen, you must choose a new participating provider, or the carrier will select one on your behalf.
3. Eligible dependents include your spouse, registered domestic partner, and your children up to their 26th birthday (or your dependent child(ren) of any age who is totally disabled prior to age 26). This includes natural children, step-children, adopted children and children for whom you are a court appointed guardian. This also includes any child for whom you are required to provide coverage under a Qualified Medical Child Support Order (QMCSO).

No Surprises Act Notice

Our medical plans are subject to the No Surprises Act, which limits the amount covered persons may have to pay for some out-of-network surprise medical bills. More information about surprise billing requirements included under the No Surprises Act and similar state laws can be found on the medical insurance company's website or the Plan Sponsor's website. Additional information may be found in your Explanation of Benefits for any affected claims.

Discrimination is Against the Law

Colton Redlands Yucaipa ROP complies with the applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin (including limited English proficiency and primary language), age, disability, or sex (including pregnancy, sexual orientation, gender identity, and sex characteristics) Colton Redlands Yucaipa ROP does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Newborns' and Mothers' Health Protection Act (NMHPA)

Benefits for a pregnancy hospital stay (for delivery) for a mother and her newborn may not be restricted to less than 48 hours following a vaginal delivery or 96 hours following a cesarean section. Also, any utilization review requirements for inpatient hospital admissions will not apply to this minimum length of stay. Early discharge is permitted only if the attending health care provider, in consultation with the mother, decides an earlier discharge is appropriate.

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

Your plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services, including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema. For more information, you should review the Summary Plan Description or call your Plan Administrator at (909) 793-3115.

Patient Protections

The medical plan requires the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. Until you make this designation, the plan will designate one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, please contact Alma Orozco at (909) 793-3115 x105.

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

You do not need prior authorization from the plan or any other person (including a primary care provider) 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, please contact Alma Orozco at (909) 793-3115 x105.

Networks/Claims/Appeals

The major medical plans described in this booklet have provider networks with Anthem and Kaiser Permanente. The listing of provider networks will be available to you automatically and free of charge. A list of network providers can be accessed immediately by using the Internet address found in the Summary of Benefits and Coverage that relates to the Plan. You have a right to appeal denials of claims and a right to a response within a reasonable amount of time. Claims that are not submitted within a reasonable time may be denied. Please review your Summary Plan Description or contact the Plan Administrator for more details.

Notice of Extended Coverage to Children Covered as Students

Michelle's Law generally extends eligibility for group health benefit plan coverage to a dependent child over age 26, who, as a condition of coverage, is enrolled in an institution of higher education. Please review the following information with respect to your dependent child's rights in the event student status is lost.

Michelle's Law requires the Plan to allow extended eligibility in some cases for a covered child over age 26, who would lose eligibility for Plan coverage due to loss of full-time student status.

There are two definitions that are important for purposes of determining whether the Michelle's Law extension of eligibility applies to a particular child:

- *Dependent child means a child over age 26 who is a dependent of a plan participant and who is eligible under the terms of the Plan based on their student status and enrollment at a post-secondary educational institution immediately before the first day of a medically necessary leave of absence.*
- *Medically necessary leave of absence means a leave of absence or any other change in enrollment:*
 - of a dependent child from a post-secondary educational institution that begins while the child is suffering from a serious illness or injury;
 - Which is medically necessary; and,
 - Which causes the dependent child to lose student status under the terms of the Plan.

The dependent child's treating physician must provide written certification of medical necessity (i.e., a certification that the dependent child suffers from a serious illness or injury that necessitates a leave of absence or other enrollment change that would otherwise cause loss of eligibility).

If a dependent child qualifies for the Michelle's Law extension of eligibility, the Plan will treat the dependent child as eligible for coverage until the earlier of:

- *One year after the first day of the leave of absence; or*
- *The date that Plan coverage would otherwise terminate (for reasons other than failure to be a full-time student).*

A dependent child on a medically necessary leave of absence is entitled to receive the same Plan benefits as other dependent children covered under the Plan. Further, any change to Plan coverage that occurs during the Michelle's Law extension of eligibility will apply to the dependent child to the same extent as it applies to other dependent children covered under the Plan.

COBRA Continuation Coverage

This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under covered medical, dental, and vision plans (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 receive 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 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 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 does not 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 are an employee, you will become a Qualified Beneficiary if you lose 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 are the spouse of an employee, you will 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 their 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.

Important Notices (continued)



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

WHEN IS COBRA CONTINUATION COVERAGE AVAILABLE?

The Plan will offer COBRA continuation coverage to Qualified Beneficiaries only after the Plan Administrator has been notified of a Qualifying Event:

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

For all other Qualifying Events (e.g., divorce or legal separation of the employee and spouse, or a dependent child losing eligibility for coverage as a dependent child, etc.), you must notify the Plan Administrator within 60 days after the Qualifying Event occurs. You must provide this notice to your employer.

Life insurance, accidental death and dismemberment benefits, and weekly income or long-term disability benefits (if part of the employer's plan), are not eligible for continuation under COBRA.

NOTICE AND ELECTION PROCEDURES

Each type of notice or election to be provided by a covered employee or a Qualified Beneficiary under this COBRA Continuation Coverage Section must be in writing, must be signed and dated, and must be mailed or hand-delivered to the Plan Administrator, properly addressed, or as otherwise permitted by the COBRA administrator, no later than the date specified in the election form, and properly submitted to the Plan Administrator.

Each notice must include all of the following items: the covered employee's full name, address, phone number, and Social Security Number; the full name, address, phone number, and Social Security Number of each affected dependent, as well as each dependent's relationship to the covered employee; a description of the Qualifying Event or disability determination that has occurred; the date the Qualifying Event or disability determination occurred; a copy of the Social Security Administration's written disability determination, if applicable; and the name of the Plan. The Plan Administrator may establish specific forms that must be used to provide a notice or election.

ELECTION AND ELECTION PERIOD

COBRA continuation coverage may be elected during the period beginning on the date Plan coverage would otherwise terminate due to a Qualifying Event and ending on the later of the following: (1) 60 days after coverage ends due to a Qualifying Event, or (2) 60 days after the notice of the COBRA continuation coverage rights is provided to the Qualified Beneficiary.

If, during the election period, a Qualified Beneficiary waives COBRA continuation coverage rights, the waiver can be revoked at any time before the end of the election period. Revocation of the waiver will be an election of COBRA continuation coverage. However, if a waiver is revoked, coverage need not be provided retroactively (that is, from the date of the loss of coverage until the waiver is revoked). Waivers and revocations of waivers are considered to be made on the date they are sent to the employer or 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 on behalf of their dependent 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.

DISABILITY EXTENSION OF THE 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. This disability would have to have started 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. (See Notice and Election Procedures.)

SECOND QUALIFYING EVENT EXTENSION OF 18-MONTH PERIOD OF COBRA CONTINUATION COVERAGE

If your family experiences another Qualifying Event during the 18 months of COBRA continuation of coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation of coverage, for a maximum of 36 months, if the Plan is properly notified about the second Qualifying Event. This extension may be available to the spouse and any dependent children receiving COBRA continuation of coverage if the employee or former employee dies; becomes entitled to Medicare (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 the dependent child to lose coverage under the Plan had the first Qualifying Event not occurred. (See Notice and Election Procedures.)

OTHER OPTIONS BESIDES COBRA CONTINUATION COVERAGE

Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, Children's Health Insurance Program (CHIP), 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.

ENROLLMENT IN MEDICARE INSTEAD OF COBRA

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an eight-month special enrollment period¹ to sign up for Medicare Part A or B, beginning on the earlier of:

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer), and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information, visit <https://www.medicare.gov/medicare-and-you>.

IF YOU HAVE QUESTIONS

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 subject to ERISA, 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. (Address 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.

¹ <http://www.socialsecurity.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.

EFFECTIVE DATE OF COVERAGE

COBRA continuation coverage, if elected within the period allowed for such election, is effective retroactively to the date coverage would otherwise have terminated due to the Qualifying Event, and the Qualified Beneficiary will be charged for coverage in this retroactive period.

COST OF CONTINUATION COVERAGE

The cost of COBRA continuation coverage will not exceed 102% of the Plan's full cost of coverage during the same period for similarly situated non-COBRA beneficiaries to whom a Qualifying Event has not occurred. The "full cost" includes any part of the cost which is paid by the employer for non-COBRA beneficiaries.

The initial payment must be made within 45 days after the date of the COBRA election by the Qualified Beneficiary. Payment must cover the period of coverage from the date of the COBRA election retroactive to the date of loss of coverage due to the Qualifying Event (or the date a COBRA waiver was revoked, if applicable). The first and subsequent payments must be submitted and made payable to the Plan Administrator or COBRA Administrator. Payments for successive periods of coverage are due on the first of each month thereafter, with a 30-day grace period allowed for payment. Where an employee, organization or any other entity that provides Plan benefits on behalf of the Plan Administrator permits a billing grace period greater than the 30 days stated above, such period shall apply in lieu of the 30 days. Payment is to be made on the date it is sent to the Plan or Plan Administrator.

The Plan will allow the payment for COBRA continuation coverage to be made in monthly installments, but the Plan can also allow for payment at other intervals. The Plan is not obligated to send monthly premium notices.

The Plan will notify the Qualified Beneficiary, in writing, of any termination of COBRA coverage based on the criteria stated in this Section that occurs prior to the end of the Qualified Beneficiary's applicable maximum coverage period. Notice will be given within 30 days of the Plan's decision to terminate.

Such notice shall include the reason that continuation coverage has terminated earlier than the end of the maximum coverage period for such Qualifying Event and the date of termination of continuation coverage.

See the Summary Plan Description or contact the Plan Administrator for more information.

Uniformed Services Employment and Reemployment Rights Act (USERRA)

If you leave your job to perform military service, you have the right to elect to continue your existing employer-based health plan coverage for you and your dependents (including your spouse) for up to 24 months while in the military. Even if you do not elect to continue coverage during your military service, you have the right to be reinstated in your employer's health plan when you are reemployed, generally without any waiting periods or exclusions for pre-existing conditions except for service-connected injuries or illnesses.

Flexible Spending Accounts (FSAs) – Termination and Claims Submission Deadlines

Note: If you lose eligibility for any reason during the Plan Year, your contributions to your Health and/or Dependent Care FSAs will end as of the date your eligibility terminates. You may submit claims for reimbursement from your FSAs for expenses incurred during the Plan Year prior to your eligibility termination. You must submit claims for reimbursement from your Health and/or Dependent Care FSAs no later than 90 days after the date your eligibility terminates. Any balance remaining in your FSAs will be forfeited after claims submitted prior to this date have been processed.

Special Enrollment Rights Notice

CHANGES TO YOUR HEALTH PLAN ELECTIONS

Once you make your benefits elections, they cannot be changed until the next Open Enrollment. Open Enrollment is held once a year.

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if there is a loss of other coverage. However, you must request enrollment no later than 30 days after that other coverage ends.

If you declined coverage while Medicaid or the Children's Health Insurance Program (CHIP) is in effect, you may be able to enroll yourself and/or your dependents in this plan if you or your dependents lose eligibility for that other coverage. However, you must request enrollment no later than 60 days after Medicaid or CHIP coverage ends.

If you or your dependents become eligible for Medicaid or CHIP premium assistance, you may be able to enroll yourself and/or your dependents into this plan. However, you must request enrollment no later than 60 days after the determination to remain eligible for such assistance.

If you have a change in family status such as a new dependent resulting from marriage, birth, adoption or placement for adoption, divorce (including legal separation and annulment), death, or a Qualified Medical Child Support Order, you may be able to enroll yourself and/or your dependents. However, you must request enrollment no later than 30 days after the marriage, birth, adoption, or placement for adoption or divorce (including legal separation and annulment).

For information about Special Enrollment Rights, please contact:

Alma Orozco
Director of Human Resources
(909) 793-3115 x105

Availability of Health Insurance Portability and Accountability Act (HIPAA) Notice of Privacy Practices

Colton Redlands Yucaipa ROP Group Health Plan (Plan) maintains a Notice of Privacy Practices that provides information to individuals whose protected health information (PHI) will be used or maintained by the Plan. If you would like a copy of the Plan's Notice of Privacy Practices, please contact (909) 793-3115.

Important Notice Regarding Wellness Information

REEP Omada is a voluntary program available to all employees who participate in Anthem or Kaiser Permanente medical plans and is subject to federal law including the Americans with Disabilities Act and the Genetic Information Nondiscrimination Act.

If you choose to participate, you may be asked to complete a voluntary health risk assessment that asks questions about your health-related activities and behaviors and whether you have or have had certain medical conditions. You may also be asked to complete a voluntary biometric screening which includes certain tests.

The information gathered from your health risk assessment and/or biometric screening will be used to provide you with information to help you understand your current health, potential risks, and may also be used to offer you services through the wellness program. You are also encouraged to share your results or concerns with your own doctor.

The law requires us to maintain the privacy and security of your personally identifiable health information. Although the wellness program and Colton Redlands Yucaipa ROP may use aggregate, non-employee-specific information to design a program to address health risks in the workplace, your personally identifiable information will never be disclosed publicly or to your employer. Medical information that personally identifies you in connection with the wellness program will not be disclosed to your supervisors or managers and will never be used to make decisions regarding your employment. Anyone (e.g., a registered nurse, a doctor, a health coach, etc.) who receives information about you for the purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements.

All medical information obtained through the wellness program will be maintained by Omada.

If you have any questions or concerns, please contact Alma Orozco at (909) 793-3115 x105.

Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: GENERAL INFORMATION

This notice provides you with information about Colton Redlands Yucaipa ROP in the event you wish to apply for coverage on the Health Insurance Marketplace. All the information you need from Human Resources is listed in this notice. If you wish to have someone assist you in the application process or have questions about subsidies that you may be eligible to receive, (for California residents only) you can contact KeenanDirect at 855-653-3626 or at www.KeenanDirect.com, or (for everyone) contact the Health Insurance Marketplace directly at www.Healthcare.gov.

WHAT IS THE HEALTH INSURANCE MARKETPLACE?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget by offering “one-stop shopping” to find and compare private health insurance options. You may also be eligible for a tax credit that lowers your monthly premium right away.

Open Enrollment for health insurance coverage through Covered California begins on November 1 of each year and ends on January 31 of each year. For more information on Open Enrollment and other opportunities to enroll, visit www.coveredca.com, KeenanDirect at 855-653-3626 or www.KeenanDirect.com.

Open Enrollment for most other states begins on November 1 and closes on January 15 of each year. For more information on Open Enrollment and other opportunities to enroll, visit www.healthcare.gov.

CAN I SAVE MONEY ON MY HEALTH INSURANCE PREMIUMS IN THE MARKETPLACE?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer you coverage, offers medical coverage that is not “Affordable,” or does not provide “Minimum Value.” If the lowest cost plan from your employer that would cover you (and not any other members of your family) is more than 9.96% (for 2026) of your household income for the year, then that coverage for you is not Affordable. Affordability for dependent family members is determined separately and is based on the total cost of family coverage. Moreover, if the medical coverage offered covers less than 60% of the benefits costs, then the plan does not provide Minimum Value.

DOES EMPLOYER HEALTH COVERAGE AFFECT ELIGIBILITY FOR PREMIUM SAVINGS THROUGH THE MARKETPLACE?

Yes. If you have an offer of medical coverage from your employer that is both Affordable and provides Minimum Value, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer’s medical plan. If you receive premium savings for Marketplace coverage, the IRS may seek reimbursement of those funds.

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered medical coverage. Also, this employer contribution, as well as your employee contribution to employer-offered coverage, is often excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

STATES WITH INDIVIDUAL MANDATE

Taxpayers in CA, DC, MA, NJ, RI, and VT (this list is neither complete nor exhaustive) are reminded that your state imposes an individual mandate penalty (tax) should you, your spouse, and children choose to not have (and keep) medical/Rx coverage for each tax year. Please consult your tax advisor for how a non-election for health coverage may affect your tax situation.

Important Notices (continued)



PART B: INFORMATION ABOUT HEALTH COVERAGE OFFERED BY YOUR EMPLOYER

In the event you wish to apply for coverage on the Exchange, all the information you need from Human Resources is listed below. If you are located in California and wish to have someone assist you in the application process or have questions about subsidies that you may be eligible to receive, you can contact KeenanDirect at 855-653-3626 or at www.KeenanDirect.com. The information is numbered to correspond to the Marketplace application.

3. Employer name Colton Redlands Yucaipa ROP	4. Employer Identification Number (EIN) 95-2748022	
5. Employer address 1214 Indiana Court	6. Employer phone number (909) 793-3115	
7. City Redlands	8. State CA	9. ZIP code 92405
10. Who can we contact about employee health coverage at this job? Alma Orozco, Director of Human Resources		
11. Phone number (if different from above) (909) 793-3115 x105	12. Email address HumanResources@cry-rop.org	

As your employer, we offer coverage that meets the minimum value standard to the employees as described in this Guide. The coverage offered to you meets the minimum value standard and the cost of this coverage to you is intended to be affordable based on employee wages.

Notice of Creditable Coverage: Information About Medicare Part D and Your Prescription Drug Coverage

Colton Redlands Yucaipa ROP has determined that the prescription drug coverage offered by the Colton Redlands Yucaipa ROP is, on average for all plan participants, expected to pay out the same or more than what the standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage.

Please read this notice carefully and keep it where you can find it. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice. NOTE: You are responsible for providing this notice to all Medicare eligible family members (or those about to become Medicare eligible).

WHEN CAN YOU JOIN A MEDICARE DRUG PLAN?

When someone first becomes eligible to enroll in a government-sponsored Medicare "Part D" prescription drug plan, enrollment is considered timely if completed by the end of his or her "Initial Enrollment Period" which ends three months after the month in which he or she turned 65.

Unfortunately, if you choose not to enroll in Medicare Part D during your Initial Enrollment Period, when you finally do enroll, you may be subject to a late enrollment penalty added to your monthly Medicare Part D premium. Specifically, the extra cost, if any, increases based on the number of full, uncovered months during which you went without either Medicare Part D or without "Creditable" prescription drug coverage from another plan, such as our plan.

Eligible individuals can enroll in a Medicare Part D prescription drug plan during Medicare's "Annual Coordinated Election Period" (a.k.a. "Open Enrollment Period") running from October 15 through December 7 of each year, as well as during what is known as a "Medicare Special Enrollment Period" which is triggered by certain qualifying events, including the loss of creditable group prescription drug coverage. Those who miss these opportunities are generally unable to enroll in a Medicare Part D plan until another enrollment period becomes available. Finally, please be cautioned that even if you elect our coverage, you could be subject to a payment of higher Part D premiums if you subsequently experience a break in coverage of 63 continuous days or longer before you enroll in the Medicare Part D plan. Carefully coordinating your transition between plans is therefore essential.

WHAT HAPPENS TO YOUR CURRENT COVERAGE IF YOU DECIDE TO JOIN A MEDICARE DRUG PLAN?

If you decide to join a Medicare drug plan, your current Colton Redlands Yucaipa ROP coverage will not be affected. If you keep this coverage and elect Medicare, the Colton Redlands Yucaipa ROP coverage will coordinate with Part D coverage. If you do decide to join a Medicare drug plan and drop your current Colton Redlands Yucaipa ROP coverage, be aware that you and your dependents may be unable to get this coverage back.

It is important for those eligible for both Medicare and our group health plan to look ahead and weigh the costs and benefits of the various options on a regular, if not annual, basis. Based on individual facts and circumstances, some choose to elect Medicare only, some choose to elect coverage under the group health plan only, while some choose to enroll in both coverages. When both are elected, please note that benefits coordinate according to the Medicare Secondary Payer Rules. That is, one plan or the other would reduce their payment to prevent you from being reimbursed the full amount from both sources. Your age, the reason for your Medicare eligibility and other factors determine which plan is primary (pays first, generally without reductions) versus secondary (pays second, generally with reductions).

WHEN WILL YOU PAY A HIGHER PREMIUM (PENALTY) TO JOIN A MEDICARE DRUG PLAN?

If you are Medicare eligible and 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 creditable coverage. For example, if you go 19 months without creditable coverage, your premium may be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) the entire time you have Medicare prescription drug coverage.

FOR MORE INFORMATION ABOUT YOUR OPTIONS UNDER MEDICARE PRESCRIPTION DRUG COVERAGE

If you have questions about your Medicare eligibility or how you can get help to pay for it, you can call the Social Security Administration at 1-800-772-1213 or visit www.socialsecurity.gov.

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, dial 1-877-KIDS-NOW, or visit 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 with paying your employer health plan premiums. The following list of states is current as of July 31, 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@MyAKHIPPA.com
Medicaid Eligibility:
<https://health.alaska.gov/dpa/Pages/default.aspx>

ARKANSAS - Medicaid

Website: <http://myarhipp.com/>
Phone: 1-855-MyARHIPP (1-855-692-7447)

CALIFORNIA - Medicaid

Health Insurance Premium Payment (HIPP) Program Website:
<http://dhcs.ca.gov/hipp>
Phone: 1-916-445-8322
Fax: 1-916-440-5676
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/chp>
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.flmedicaidtprecovery.com/flmedicaidtprecovery.com/hipp/index.html>
Phone: 1-877-357-3268

GEORGIA - Medicaid

GA HIPP Website: <https://medicaid.georgia.gov/programs/third-party-liability/health-insurance-premium-payment-program-hipp>
Phone: 1-678-564-1162, Press 1
GA CHIPRA Website:
<https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra>
Phone: 1-678-564-1162, Press 2

INDIANA - Medicaid

Website: <https://www.in.gov/medicaid/> or
<http://www.in.gov/fssa/dfr/>
Family and Social Services Administration
Phone: 1-800-403-0864
Member Services Phone: 1-800-457-4584

IOWA – Medicaid & CHIP (Hawki)

Medicaid Website: <https://hhs.iowa.gov/medicaid>
Medicaid Phone: 1-800-338-8366
Hawki Website: <https://hhs.iowa.gov/programs/welcome-iowa-medicaid/iowa-health-link/hawki>
Hawki Phone: 1-800-257-8563
HIPP Website: <https://hhs.iowa.gov/medicaid/plans-programs/fee-service/health-insurance-premium-payment-program>
HIPP Phone: 1-888-346-9562

Important Notices (continued)



KANSAS - Medicaid

Website: <https://www.kancare.ks.gov/>
Phone: 1-800-792-4884
HIPAA Phone: 1-800-967-4660

KENTUCKY - Medicaid

Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website:
<https://www.chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx>
Phone: 1-855-459-6328
Email: KIHIPPProgram@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/la hipp
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: 1-800-977-6740 | TTY: Maine relay 711

MASSACHUSETTS - Medicaid & 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: 1-573-751-2005

MONTANA - Medicaid

Website: <http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP>
Phone: 1-800-694-3084
Email: HHSHIPPPProgram@mt.gov

NEBRASKA - Medicaid

Website: <http://www.accessnebraska.ne.gov/>
Phone: 1-855-632-7633
Lincoln: 1-402-473-7000
Omaha: 1-402-595-1178

NEVADA - Medicaid

Medicaid Website: <https://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: 1-603-271-5218
Toll free number for the HIPP program: 1-800-852-3345, ext. 15218
Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov

NEW JERSEY - Medicaid & CHIP

Medicaid Website:
<https://www.nj.gov/humanservices/dmahs/clients/medicaid/>
Phone: 1-800-356-1561
CHIP Premium Assistance Phone: 1-609-631-2392
CHIP Website: <https://njfamilycare.dhs.state.nj.us/>
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: 1-919-855-4100

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

Website: <http://healthcare.oregon.gov/Pages/index.aspx>
Phone: 1-800-699-9075

PENNSYLVANIA - Medicaid & CHIP

Website: <https://www.pa.gov/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp>
Phone: 1-800-692-7462
CHIP Website: <https://www.dhs.pa.gov/CHIP/Pages/CHIP.aspx>
CHIP Phone: 1-800-986-KIDS (5437)

RHODE ISLAND - Medicaid and CHIP

Website: <http://www.eohhs.ri.gov/>
Phone: 1-855-697-4347, or 1-401-462-0311 (Direct Rltte 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

Important Notices (continued)



TEXAS - Medicaid

Website: <https://www.hhs.texas.gov/services/financial/health-insurance-premium-payment-hipp-program>
Phone: 1-800-440-0493

UTAH - Medicaid & 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: <https://dvha.vermont.gov/members/medicaid/hipp-program>
Phone: 1-800-250-8427

VIRGINIA - Medicaid & CHIP

Website: <https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select>
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/http://mywvhipp.com/>
Medicaid Phone: 1-304-558-1700
CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)

WISCONSIN - Medicaid & 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 July 31, 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

HIPAA NOTICE OF PRIVACY PRACTICES

Colton-Redlands-Yucaipa Regional Occupational Program	1214 Indiana Court, Redlands, CA 92374 https://www.cryrop.edu/
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YOUR INFORMATION. YOUR RIGHTS. OUR RESPONSIBILITIES.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information.

Please review it carefully.

YOUR RIGHTS

When it comes to your health information, you have certain rights under the Health Insurance Portability and Accountability Act (HIPAA). This Section explains your rights and some of our responsibilities to help you.

Get a copy of your health and claims records	<ul style="list-style-type: none">You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.We will provide a copy of a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
Ask us to correct health and claims records	<ul style="list-style-type: none">You can ask us to correct your health and claims records if you think we are incorrect or incomplete. Ask us how to do this.We may say “no” to your request, but we’ll tell you why in writing within 60 days.
Request confidential communications	<ul style="list-style-type: none">You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.We will consider all reasonable requests, and must say “yes” if you tell us you would be in danger if we do not.
Ask us to limit what we use or share	<ul style="list-style-type: none">You can ask us not to use or share certain health information for treatment, payment, or our operations.We are not required to agree to your request, and we may say “no,” for example, if it would affect your care. If we agree to your request, we may still share this information in the event that you need emergency treatment.
Get a list of those with whom we’ve shared information	<ul style="list-style-type: none">You can ask for a list (accounting) of the times we’ve shared your health information for six years prior to the date you ask, who we shared it with, and why.We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We will provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

YOUR RIGHTS *CONTINUED*

- | | |
|--|--|
| Get a copy of this privacy notice | <ul style="list-style-type: none">You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly. |
| Choose someone to act for you | <ul style="list-style-type: none">If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.We will make sure the person has this authority and can act for you before we take action. |
| File a complaint if you feel your rights are violated | <ul style="list-style-type: none">You can complain if you feel we have violated your rights by contacting us using the information on page 1.You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting https://www.hhs.gov/hipaa/filing-a-complaint/index.htmlWe will not retaliate against you for filing a complaint. |

YOUR CHOICES

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

- | | |
|---|---|
| In these cases, you have both the right and choice to tell us to: | <ul style="list-style-type: none">Share information with your family, close friends, or others involved in payment for your careShare information in a disaster relief situationIf you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety. |
| In these cases, we never share your information unless you give us written permission: | <ul style="list-style-type: none">Marketing purposesSale of your information |

OUR USES AND DISCLOSURES

How do we typically use or share your health information? We typically use or share your health information in the following ways.

Help manage the health care treatment you receive	<ul style="list-style-type: none"> We can use your health information and share it with professionals who are treating you. 	Example: A doctor sends us information about your diagnosis and treatment plan, so we can arrange additional services.
Run our organization	<ul style="list-style-type: none"> We can use and disclose your information to run our organization and contact you when necessary. We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long term care plans. 	Example: We use health information about you to develop better services for you.
Pay for your health services	<ul style="list-style-type: none"> We can use and disclose your health information as we pay for your health services. 	Example: We share information about you with your dental plan to coordinate payment for your dental work.
Administer your plan	<ul style="list-style-type: none"> We may disclose your health information to your health plan sponsor for plan administration. 	Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.

How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. And in all cases, if we have substance use disorder patient records about you, subject to 42 CFR Part 2, we cannot use or share information in those records in civil, criminal, administrative, or legislative investigations or proceedings against you without (1) your consent or (2) a court order and a subpoena.

Help with public health and safety issues	<ul style="list-style-type: none"> We can share health information about you for certain situations such as: <ul style="list-style-type: none"> Preventing disease Helping with product recalls Reporting adverse reactions to medications Reporting suspected abuse neglect, or domestic violence Preventing or reducing a serious threat to anyone's health or safety
Do research	<ul style="list-style-type: none"> We can use or share your information for health research.

HIPAA Notice Of Privacy Practices (continued)



OUR USES AND DISCLOSURES *CONTINUED*

Comply with the law	<ul style="list-style-type: none">▪ We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
Respond to organ and tissue donation requests and work with a medical examiner or funeral director	<ul style="list-style-type: none">▪ We can share health information about you with organ procurement organizations.▪ We can share health information with a coroner, medical examiner, or funeral director when an individual dies.
Address workers' compensation, law enforcement, and other government requests	<ul style="list-style-type: none">▪ We can use or share health information about you:<ul style="list-style-type: none">▪ For workers' compensation claims▪ For law enforcement purposes or with a law enforcement official▪ With health oversight agencies for activities authorized by law▪ For special government functions such as military, national security, and presidential protective services
Respond to lawsuits and legal actions	<ul style="list-style-type: none">▪ We can share health information about you in response to a court or administrative order, or in response to a subpoena.

To the extent that we have your substance use disorder patient records, subject to 42 CFR part 2, we will not share that information for investigations or legal proceedings against you without (1) your written consent or (2) a court order and a subpoena.

OUR RESPONSIBILITIES

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see:

www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html

Changes to the Terms of This Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site, and we will mail a copy to you.

Effective Date of Notice: February 13, 2026

Alma Orozco, Director of Human Resources

Alma_Orozco@cry-rop.org

(909) 793-3115 ext. 108

Coordination of Benefits (COB)



What is COB?

Coordination of Benefits (COB) applies to District members who are covered by more than one health care plan. COB helps ensure that you receive the benefits you are entitled to with more than one plan while avoiding overpayment by either plan. This avoids delay in processing your claim payments.

How COB Works

When you are covered by more than one health plan (for example, when you are covered under the District's plan as well as your spouse's health plan), one plan is considered to be the primary carrier and the other is considered to be the secondary carrier. The primary carrier covers the major portion of the bill according to plan allowances, and the secondary carrier covers any remaining allowable expenses.

The COB provisions of your plan determine which plan is primary. That plan's benefits are applied to the claim first. The unpaid balance is usually paid by the secondary plan to the limit of its responsibility. Benefits are thus "coordinated" among all of the health plans, and payments do not exceed 100% of charges for the covered services.

Primary vs. Secondary Carrier

The following rules apply when determining which plan will be the primary payer:

- Any plan without a COB provision always pays first.
- If the person receiving benefits is the participant under the contract, that plan will be primary. The spouse's plan will become secondary.
- If a dependent child is covered under two or more plans, the plan of the member covering the child whose birthday occurs earlier in the calendar year will be primary (known as the birthday rule). If both have the same birthday, the policy that has been in effect longer will be primary. The birthday rule is superseded when a court order or custody rule applies.

Dependent Coverage When Parents Are Divorced

If the dependent is a child of divorced or separated parents, primary payer status is determined according to the following:

- If the divorce decree places responsibility on one parent, that parent's plan is primary.
- Otherwise, the custodial parent's plan is primary and the other parent's plan becomes secondary.
- If there is joint custody, the birthday rule applies and the plan of the parent whose birthday occurs earlier in the calendar year is primary.

Other COB Issues

Often, some or all of the costs of medical care are the responsibility of your health plan carrier except for:

- Members who are injured or become ill as a result of work-related accidents or environment are eligible for benefits under the Workers' Compensation Law.
- Injuries as a result of car accidents. Auto insurance companies will pay for medical expenses.
- In certain situations, Medicare may be a participant's primary or secondary coverage. Your plan carrier will coordinate benefits with Medicare according to the Medicare Secondary Payer rules.

It is your responsibility to inform your plan carriers if you have another medical, dental or vision group plan coverage.

Make sure to respond promptly to requests for Coordination of Benefits/Other Health Information that you receive in the mail from your carriers to ensure timely claim payments.

Affordable Care Act and Patient Protection (ACA)

Also called Health Care Reform, the ACA requires health plans to comply with certain requirements. The ACA became law in March 2010. Since then, the ACA has required some changes to medical coverage—like covering dependent children to age 26, no lifetime limits on medical benefits, covering preventive care without cost-sharing, etc, among other requirements.

Allowed Amount

Maximum amount on which payment is based for covered health care services. This may be called “eligible expense,” “payment allowance” or “negotiated rate.” If your provider charges more than the allowed amount, you may have to pay the difference. (See Balance Billing.)

Balance Billing

When a provider bills you for the difference between the provider’s charge and the allowed amount. For example, if the provider’s charge is \$100 and the allowed amount is \$70, the provider may bill you for the remaining \$30. A preferred provider may not balance bill you.

Brand Name Drug

The original manufacturer’s version of a particular drug. Because the research and development costs that went into developing these drugs are reflected in the price, brand name drugs cost more than generic drugs.

COBRA (Consolidated Omnibus Budget Reconciliation Act)

The Consolidated Omnibus Budget Reconciliation Act allows people who lose their jobs to continue their employer-sponsored insurance coverage for up to 18 months.

Children’s Health Insurance Program (CHIP)

The government program that provides free or low-cost health coverage for children up to age 19 in families whose income is too high to qualify for Medicaid but too low to afford private insurance. CHIP covers U.S. citizens and eligible immigrants. In some states, CHIP covers pregnant people. CHIP goes by different names in some states.

Claim

A request for payment that you or your health care provider submits to your health insurer to be paid or reimbursed for items or services you have received. Most often, you will not be responsible for making claim requests. Usually, billing and claims specialists employed by the health care provider (e.g. primary care office, hospital) will make the claim on your behalf.

Coinsurance

A percentage of costs you pay “out-of-pocket” for covered expenses after you meet the deductible.

Copayment (Copay)

A fee you have to pay “out-of-pocket” for certain services, such as a doctor’s office visit or prescription drug.

Comprehensive Coverage

A health insurance plan that covers the full range of care that you may need. This may include preventive services (like flu shots), physical exams, prescription drugs, and doctor or hospital care.

Deductible

The amount you pay “out-of-pocket” before the health plan will start to pay its share of covered expenses.

Formulary

A list of prescription drugs covered by the health plan, often structured in tiers that subsidize low-cost generics at a higher percentage than more expensive brand-name or specialty drugs.

Generic Drug

Lower-cost alternative to a brand name drug that has the same active ingredients and works the same way.

High-Deductible Health Plan (HDHP)

High-deductible health plans (HDHPs) are health insurance plans with lower premiums and higher deductibles than traditional health plans. Only those enrolled in an HDHP are eligible to open and contribute tax-free to a health savings account (HSA).

Health Savings Account (HSA)

A health savings account (HSA) is a portable savings account that allows you to set aside money for health care expenses on a tax-free basis. State taxes may apply. You must be enrolled in a high-deductible health plan in order to open an HSA. An HSA rolls over from year to year, pays interest, can be invested, and is owned by you—even if you leave the company.

Health Reimbursement Arrangements (HRAs)

Unlike HSAs, only an employer may fund an HRA and the funds revert back to the employer when the employee leaves the organization. HRAs are not subject to the same contribution limits as HSAs, and they may be paired with either high-deductible plans or traditional health plans.

In-Network

Doctors, clinics, hospitals and other providers with whom the health plan has an agreement to care for its members. Health plans cover a greater share of the cost for in-network health providers than for providers who are out-of-network.

Non-Preferred Provider

A provider who doesn't have a contract with your health insurer or plan to provide services to you. You'll pay more to see a non-preferred provider.

Out-of-Pocket Maximum

The most you pay each year "out-of-pocket" for covered expenses. Once you've reached the out-of-pocket maximum, the health plan pays 100% for covered expenses.

Out-Of-Network

A health plan may not cover treatment for doctors, clinics, hospitals and other providers who are out-of-network, but covered employees will pay more out-of-pocket to use out-of-network providers than for in-network providers.

Out-Of-Pocket Limit

The most an employee could pay during a coverage period (usually one year) for his or her share of the costs of covered services, including co-payments and co-insurance.

Plan Year

The year for which the benefits you choose during Annual Enrollment remain in effect. If you're a new employee, your benefits remain in effect for the remainder of the plan year in which you enroll, and you enroll for the next plan year during the next Annual Enrollment.

Preferred Provider

A provider who has a contract with your health insurer or plan to provide services to you at a discount.

Premium

The amount that must be paid for a health insurance plan by covered employees, by their employer, or shared by both. A covered employee's share of the annual premium is generally paid periodically, such as monthly, and deducted from his or her paycheck.

Preventive Care

Health care services you receive when you are not sick or injured— so that you will stay healthy. These include annual checkups, gender- and age-appropriate health screenings, well-baby care, and immunizations recommended by the American Medical Association.

Qualifying Life Event

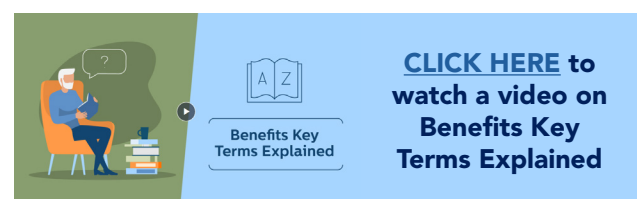
A change in your life that can make you eligible for a Special Enrollment Period to enroll in health coverage. Examples of qualifying life events include moving to a new state, certain changes in your income, and changes in your family size.

Skilled Nursing Care

Services from licensed nurses in your own home or in a nursing home. Skilled care services are from technicians and therapists in your own home or in a nursing home.

Urgent Care

Care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room care.



Contact Information



Below is a listing of the telephone numbers you can call with questions about the plans available to you. You can also use the website (if available) to access information from providers for the various plans.

Carrier	Phone Number	Website
REEP General		www.reepforbenefits.org
Medical		
• Kaiser	800-464-4000	choose.kaiserpermanente.org/reep
• Anthem	800-331-1476	www.anthem.com/ca
• Marathon	951-229-0708	https://marathon.health/
• Express Scripts	888-806-4969	www.express-scripts.com
• ComPsych EAP	800-557-1005	www.compsych.com/services
Dental		
• Delta Dental	800-448-3815	deltadentalins.com/members
Vision		
• EyeMed	866-939-3633	member.eyemedvisioncare.com
Basic Life AD&D		
• Madison National	800-356-9601	
Ancillary		
• CHUBB	855-241-9891	https://www.chubb.com/content/chubb-sites/chubb-com/na/cica-cwb/reep.html
• Simplicollege		https://www.simplicollege.com/
• Colonial	800-325-4368	ColonialLife.com
• Transcarent	844-643-0606	member.transcarent.com
• CompleteCare	877-872-4232	https://britehr.app/REEP
• Omada Wellness	888-987-8337	www.omadahealth.com/reep
• Nationwide Pet	877-738-7874	www.petinsurance.com/ciccs

