SISC
Self-Insured Schools of California
Schools Helping Schools

Health Benefits Manual

2024 – 2025

WHAT'S SPECIAL ABOUT SISC

We're the largest public school pool in the U.S.

That's a huge advantage. Pooling resources provides schools with a more stable long-term insurance solution than purchasing from commercial carriers that may be competitive today and out of reach tomorrow.

Our size and careful analysis of each risk allow us to offer stable, affordable rates. And our fair and predictable rate renewals are major reasons districts join SISC and stay for decades.

This keeps millions of dollars in the classroom that would have otherwise been paid out in premiums.

We've rewritten the rules of insurance coverage

We're not an insurance company. We're a community of public schools structuring coverage to meet the unique needs of our members.

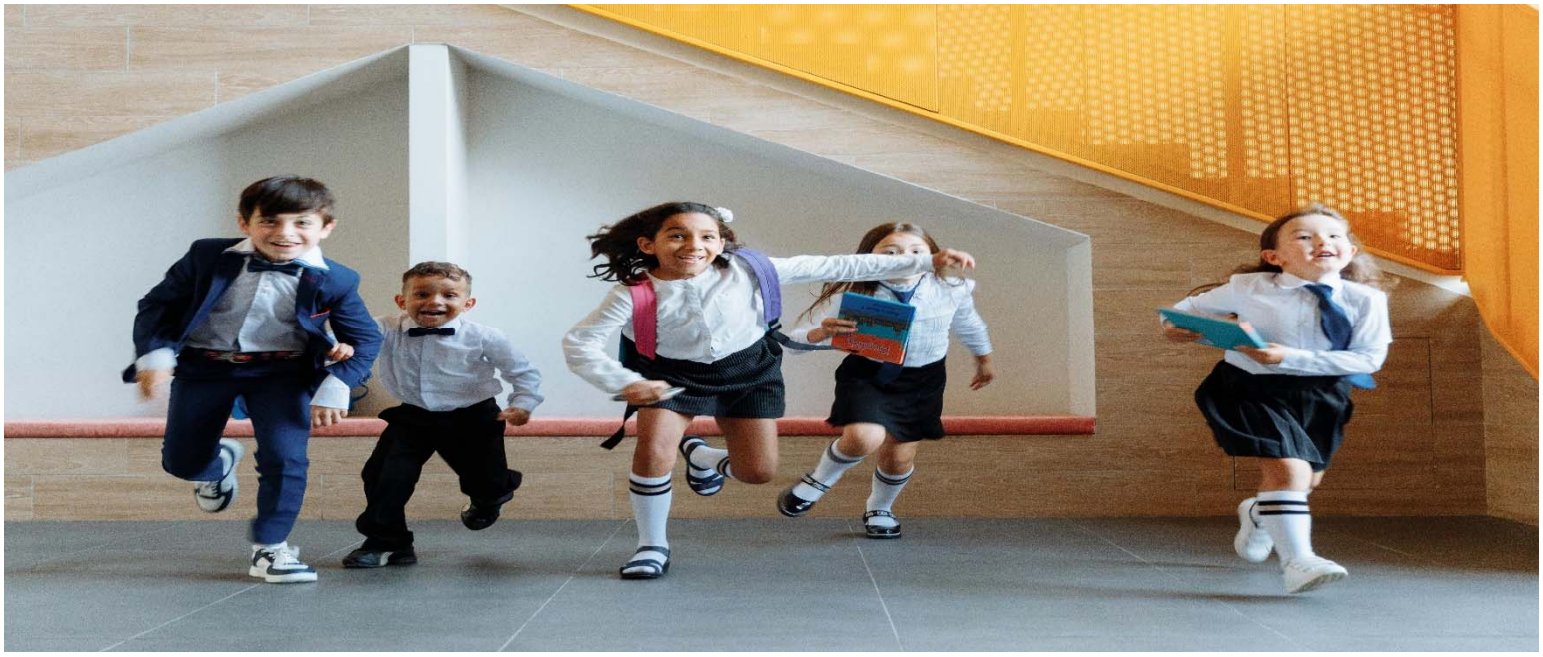
Our position in the market has given us the flexibility to innovate in creative ways. Whether that's collaborating with other pools to deliver a product or influencing negotiations between an insurance company and a provider network – we are all in. And we have been for over 40 years.

All SISC personnel are public school employees

All Board Members are also public school employees and are elected by our membership.

This ensures that SISC policies are in the best interest of schools.

As a public entity, SISC doesn't operate on profit margins. We are relentless about doing what's best for our members.



2024-2025 Changes

- **Effective 10/1/2024** the SISC HSA 3000 plan will be changing to the SISC HSA 3400 plan to comply with IRS HSA regulations.

SISC Renewal Reminders

District Plan Changes: All Open Enrollment plan changes for October 1, 2024, are due to SISC by July 1, 2024. No exceptions. Plan changes outside of Open Enrollment require a minimum notification of 75 calendar days.

Open Enrollment Activity: All activity relating to October 1st Open Enrollment is due in the SISC office by September 1, 2024. Activity received after this date may not be updated in the carrier systems when benefits become effective.

Districts are responsible for reviewing the entire SISC Health Benefits Manual published each year and notifying employees/retirees of changes that may impact them. Not all changes included in the Health Benefits Manual are listed on the Highlights sheet.

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Any reference to "school district" in this document is meant to include any publicly funded educational organization. Educational organizations that are not publicly funded are not eligible to join SISC. In order to participate in SISC, a school district must abide by SISC Underwriting Guidelines.

One hundred percent of the school district or one hundred percent of the employee group of a school district as defined below must enroll in the SISC Medical Plans offered in this manual. Any deviation from SISC Underwriting Guidelines must be requested in writing by the school district and approved in writing by SISC prior to joining. Our contract year is from October 1 through September 30 of each year. A school district may elect the first of any calendar month to join SISC.

The school district will be sent a SISC III Joint Powers Agreement (JPA) and By-Laws. The JPA document along with a letter requesting to join SISC III should be signed by the administrator of the school district. The letter should define the benefits selected by each employee group as well as the effective date.

The signed JPA and letter must be received by SISC at least 90 calendar days prior to the effective date of coverage. The signed and completed Enrollment Forms must be received by SISC 45 calendar days prior to the effective date. The school district is responsible for notifying its current carrier of cancellation according to the agreement in place. Additionally, payment of benefits for claims incurred prior to the effective date of SISC coverage is the responsibility of the school district or its prior carrier.

EMPLOYEE GROUPS

(e.g., Active Certificated, Active Classified or Active Confidential and Management)

School districts meeting size requirements stated below may have three Employee Groups (Bargaining Units) Certificated, Classified and Management. Employees must be enrolled in the bargaining unit for their job classification. If the Confidential Management group does not split out into their own employee group, members of this classification must all enroll in the same benefits as either the certificated or classified employee group that the employee group agrees to follow. Retirees may not participate without their active employee group and must be offered the same benefits as their active employee group.

Districts with 2 through 50 Insured Employees

May have two employee groups; Certificated Employees and Classified Employees

Districts with 51 or more Insured Employees

May have three employee groups; Certificated Employees, Classified Employees and Confidential and Management (Minimum number required. Must have 10 members enrolled in Confidential and Management employee group).

Are Board Members and/or Retirees an Employee Group?

No. Board Members and/or Retirees are not an employee group and must enroll in the same benefits as the corresponding active employee group.

NUMBER OF PLAN OPTIONS PER EMPLOYEE GROUP

1. School district/employee groups with less than **50** insured employees may offer any combination of PPO and HMO plans with a maximum of **four** plans.
2. School district/employee groups with **50** or more insured employees may offer any combination of PPO and HMO plans with a maximum of **six** plans. Districts offering an HSA plan, or a limited network HMO, may offer an additional plan for a total of **seven** plans.
3. Each employee group (bargaining unit) must qualify independently.
4. The Two-Tier HSA plans and the WABE option do not count toward the maximum number of plan options available per employee group.

If you have questions about benefit changes, please consult your SISC Account Management Team.

Only the medical plans shown in this manual may be offered by a SISC school district. School districts/ employee groups offering more than one PPO or HMO must offer the same dental and vision plan for each active and retiree medical plan.

HEALTH MAINTENANCE ORGANIZATION (HMO) PLANS

If your district elects to offer an HMO plan, they must select a plan from one of the HMO plans offered in the Medical Plans section of this manual. Enrollment on an HMO is subject to the carrier guidelines for living in an eligible service area. HMOs are not available in all areas and are not available through SISC outside of California. This includes both active and retiree product offerings. Please contact the SISC office to verify that the HMO is a viable option for your district. To obtain a rate for one of the HMO plans offered in this manual, **please contact your SISC Account Management Team.**

RATE STRUCTURES

What Rate Structures Are Available?
SISC offers a composite rate structure (one rate for all contract types; single, two-party, family) or a three-tier rate structure (a different rate for each contract type; single, two-party, family). Districts must have a uniform rate structure for all medical plans within a bargaining unit/employee group.

When the school district has a three-tier rate for their active employee group, the under-65 retirees will have the same three-tier rate as active employees. When a school district has a composite rate for their active employee group, the under-65 retirees will have a unique three-tier rate structure that corresponds to the composite rate.

75% MEDICAL PREMIUM FOR QUALIFIED COUPLES—COMPOSITE RATES

When married spouses/qualified domestic partners both work for a participating SISC district and are both covered by a composite rated SISC medical plan each district will be billed 75% of the composite rate for the eligible employee. The discount applies to medical products only. Members enrolled on the 75% premium will still be required to participate at 100% of the cost for dental, vision, or life plans through SISC and must continue to participate according to SISC Participation guidelines. The following criteria must be met in order to participate:

Both husband and wife/domestic partners must be:

1. Employees of a participating SISC district; and
2. Both enrolled in each other's SISC medical plan with a composite rate; and
3. Eligible to participate according to SISC Eligibility Guidelines

Not all districts participate in this discount. Employees should verify with both employers as to whether the discount will be applied.

There is no need to report this to SISC. Approved adjustments will be automatically applied to your SISC billing invoice.

OPEN ENROLLMENT PERIOD

Current employees may elect a new plan option only during the designated Open Enrollment period for an effective date of October 1. It is the district's responsibility to notify their members of any changes prior to Open Enrollment and allow enough time for the district to submit the Maintenance Activity Report (MAR) to SISC by September 1 (or the first business day of September). It is highly recommended the district keep the activity due date of September 1 in mind when scheduling the Open Enrollment period. It is suggested districts conduct their Open Enrollment starting in May to be completed before the summer recess period.

BENEFIT OR CONTRIBUTION CHANGES FOR DISTRICTS AND/OR EMPLOYEE GROUPS

How Much Notice Does SISC Require for an October 1 Benefit Change?
For October 1 benefit changes the Notification of Plan Change form is due to SISC by July 1st. When the first falls on a weekend, the form is due the next business day.

How Much Notice Does SISC Require for a Benefit Change Effective Date other than October 1 (Nov.–Sept.)?
Due to the Affordable Care Act (ACA), it is the district's responsibility to notify employees and retirees of any plan changes 60 days prior to the effective date. Therefore, benefit changes for an effective date other than October 1 require a 90-**calendar-day** written notification to SISC.

How Often can a School District/Employee Group Change Benefits?
A school district can change benefits at the first renewal period following the effective date of joining SISC. School districts or employee groups may change benefits once per contract year (October 1 through September 30).

All of the benefits the school district or employee group has elected to change should be changed on the same date. If an employee group changes benefits, the retirees of that employee group will be changed to the same benefits as the active employees. It is the responsibility of the school district to notify employees and retirees of changes.

Will Plan Changes Outside October 1 Create a Special Enrollment Period?
Yes, for the affected employee group and subject to the following conditions:

- When a district offers a new plan(s) employees/ retirees may only move to the new plan(s)
- When a district modifies existing plans employees/retirees may only move to or from the modified plan(s)
- When there is a significant increase or decrease in the district contribution, SISC will allow changes consistent with the contribution change. An increase to the district contribution would allow a member to change to a more expensive plan. Decreasing the contribution will allow a change to a less expensive plan.

Contact your SISC Account Management Team for Details.

How Do We Communicate our Desired Changes to SISC?
School districts must submit the Notification of Plan Change form signed by an administrator identifying the employee group (Classified, Certificated and Confidential Management) changing benefits, new benefits selected and the effective date of the change. You may find these forms on the SISC secure web portal (SISCconnect) at **siscconnect.org.**

Please fax a signed copy of the Notification of Plan Change form to the attention of your SISC Account Management Team at 661-636-4893. You may also scan a signed copy and email it directly to your Account Management Team.

Will the Benefit Changes Create New ID Cards for the Members?
If the change you make creates new medical group numbers, employees enrolled on these new group numbers will receive new ID cards at their home address. Employees who remain on existing group numbers will not receive new ID cards (unless they are modifying their PPO plan to change office visit co-pay). If you change your prescription co-pay, the pharmacy system will be changed to reflect your new co-pay and new ID cards will not be generated.

Because the PPO plan's eligibility and claims system is driven by the ID number (Social Security number or Health Care ID number), when a member's group number changes, claims continue to process using the member's current deductible and co-insurance amounts with no processing problems due to the group number change. However, the prescription drug benefit is driven by both the ID number and the group number. If the member neglects to tell the pharmacist that they have a new group number, the claim will reject as "member not eligible" or "member canceled".

When will a New Rates-at-a-Glance Be Posted to the SISC Secure Web Portal?
The revised Rates-at-a-Glance should be posted to the secure web portal within 15 calendar days of the date SISC receives the change request. The new group numbers and the plans associated with those group numbers will be clearly defined on the Rates-at-a-Glance. Please check the Rates-at-a-Glance to make sure the desired changes and applicable rates are correct.

Our District is Considering a Change to the Contribution Strategy. Does this Affect our Eligibility in the SISC Program?
Contact your SISC Account Manager to discuss details when considering contribution changes.

BILLING AND PREMIUM PAYMENTS

When are the Monthly SISC Invoices Posted to SISCconnect?
SISC invoices are generally posted on the first working day of each month.

What is the SISC Invoice Due Date?
The premium is due upon receipt of the invoice.

Are there Payment Penalties?
Yes. Districts are required to pay their monthly SISC invoice as billed. Payment must be received in the SISC office no later than the 25th of the billed month to avoid a penalty. If the premium is not paid as billed an additional one-half percent (1/2%) will be attached to any unpaid balance.

Example:

Month covered	July
Amount due on July SISC invoice:	$780,000
Amount received from district as of July 25th:	$0
Unpaid balance:	$780,000
Penalty amount due with the August premium (.5% of $780,000):	**$3,900**

How Do I Remit Payment to SISC?
SISC has different options for accepting payments. Payments may be made electronically or by mail. Electronic payments must reference the district name and ID #. When paying by mail, please include only the first page of your SISC invoice along with your payment.

District Initiated ACH Payments or Wire Transfer	
Name and Address of Bank Receiving Payment:	U.S. Bank 603 W. 5th Street Los Angeles, CA 90071
Bank ABA # for ACH or Wires:	122235821
Bank Account Name:	SISC III – Health Benefits
Bank Account Number:	158300179914

Payment by US Postal Service:

SISC III - Health Benefits
Attn: SISC Finance
PO Box 1808
Bakersfield, CA 93303

Payments by Fed Ex or UPS:

SISC III - Health Benefits
Attn: SISC Finance
2000 K Street, 5th Floor
Bakersfield, CA 93301

COBRA/CALCOBRA/HIPAA ADMINISTRATION

COBRA (Consolidated Omnibus Budget Reconciliation Act) and HIPAA (Health Insurance Portability and Accountability Act) are federal laws; CalCOBRA is a state law that offers an additional 18 months of benefits after Federal COBRA has been exhausted.

What is COBRA?
COBRA is temporary group health benefits the employee and his/her family can enroll in after losing coverage through their district. Coverage period is up to 18 months and not to exceed 36 months depending on the qualifying event. Members will be offered the same benefit plan they were enrolled in prior to losing coverage.

What is the Cost of COBRA?
The cost of COBRA is the same premium charged to the district for the plan that the member was enrolled in prior to losing coverage, plus a 2% administration fee for Federal COBRA and 10% administration fee for State Continuation (CalCOBRA). The administrative fee is established according to COBRA Law. The applicable premium is the cost to the plan for a period of coverage for similarly situated beneficiaries with respect to whom a qualifying event has not occurred. (See Code Section 4980B(f)(4)(A), ¶ 1620)

Who Administers COBRA?
SISC will administer COBRA and CalCOBRA for district benefits offered through SISC at no additional cost for SISC III Member Districts.

Districts that Administer Their Own COBRA Benefits

Districts that administer their own COBRA benefits are responsible for all administrative functions associated with COBRA pursuant to federal guidelines.

How Do We Report Activity to SISC if We Administer our own COBRA?
Please refer to the "Reporting" section under "Guidelines and Procedures" in this manual.

District Responsibility Regardless of Who Administers COBRA Benefits

The initial COBRA/Cal COBRA notice must be sent upon commencement of coverage by first class mail and addressed to the employee. If the employee is married, the notice must be addressed to the employee and the employee's spouse/domestic partner. If the covered employee adds the spouse/domestic partner to coverage subsequent to the employee's initial enrollment, the notice must be sent to the spouse/domestic partner upon commencement of the spouse/domestic partner's coverage.

It is also the district's responsibility to send the initial HIPAA notice; this notice must be given to all employees who are eligible for coverage—even employees who may decline coverage (i.e., 50% employee). HIPAA requirements may be satisfied with the Declination of Coverage form. Declination of Coverage forms may be found on the SISC secure web portal (SISCconnect) at **siscconnect.org**.

SISC Responsibility

Once an employee and/or dependent loses coverage, SISC prepares and mails the COBRA 14-day notification to the qualified beneficiary's last known address. The 14-day notification includes information and rates on all of the products the qualified beneficiary is enrolled in through SISC immediately preceding the qualifying event (loss of coverage). SISC will also bill, collect monthly premium and notify members enrolling in COBRA of any benefit changes.

District activity must be reported by the 15th of each month to meet the COBRA notification requirements. If an employee or qualified beneficiary inquires about a product that is not offered through SISC, we will direct them back to the district for rates and enrollment information on that product.

WHO IS ELIGIBLE?

Active Employees (Probationary and Permanent)

Classified permanent or probationary employees who work a minimum of 20 hours per week, Certificated employees currently under contract and who work a minimum of 50% of a Certificated job (even though the hours worked may be less than 20 hours per week), and Adjunct faculty at a college who receive a contribution of at least 50% of what is contributed to a full time employee are eligible to participate in one of the options offered by the district.

School districts may limit this level of participation to probationary and permanent employees who work more than 20 hours per week or more than 50% of the job, but they may not negotiate to allow this level of participation to probationary and permanent employees who work less than this minimum requirement. Active employees (employees who are not on an approved leave of absence) who work less than the number of hours required or do not receive district paid benefits based on a pro rata share of what is contributed towards an eight hour or full-time employee are not eligible.

All probationary and permanent employees who work 90% or more of the full-time equivalent for the applicable job classification are required to participate in one of the options offered by the district. An eligible employee who works less than 90% of the full-time equivalent for the applicable job classification or receives less than 90% of the amount that is contributed towards an eight-hour full-time employee may decline coverage.

However, if an eligible employee declines coverage he/she may not enroll until: 1) Open Enrollment, 2) there is an increase in the number of hours worked, or 3) they have Special Enrollment Opportunity under HIPAA (see Procedures section for details on HIPAA). Employees may not receive any incentives to opt-out of coverage (i.e., cash in lieu of benefits). See the section "Who May Decline Coverage," under "Participation Requirements."

Variable Hour, Temporary, Seasonal and Other Employees

Variable hour, temporary, seasonal and other employees are only eligible to enroll in the Two-Tiered HSA/MEC PPO medical plans. These employees are not eligible for dental, vision, and life insurance. The two tiers are Employee Only and Employee plus Child(ren). Spouses and Domestic Partners are not eligible for this plan. (See the "SISC MEC and 2-Tier MEC Plan Options" page in the "Medical Plans" section for more details.)

A district contribution is not required for participation. Employees in this class must complete an enrollment or declination within two weeks from the date of hire or during Open Enrollment. If an employee in this class declines coverage, they may not enroll until the next Open Enrollment period.

Dependents

In order for SISC to maintain and preserve the integrity of the health plan, it is the district's responsibility to obtain proof of eligibility of the employee's dependents (i.e., spouse/domestic partner, children, etc.) and to submit the documents to SISC when they become eligible for benefits. Failure to submit supporting documentation within 30 calendar days of the qualifying event may result in the employee's dependents being denied coverage. Please refer to the Dependent Eligibility Documentation Chart for required documents.

Who is an Eligible Dependent?

Spouse: The employee's legally wed spouse as defined by state law, regardless of the spouse's residency. A copy of the most recent year's Federal Income Tax return (Form 1040) showing a married filing status must be submitted to SISC in order to add a spouse. All financial information may be blacked out.

Domestic Partner Subject to California Law: SISC eligibility for Domestic Partners is compliant with California law effective 1/1/2020. The law states that if your plan provides benefits for spouses, you must also provide the same benefits for state registered domestic partners (e.g., dependent children, health benefits, COBRA, CalCOBRA, etc.).

It is the district's responsibility to verify domestic partner eligibility and to submit the documentation timely to SISC. Coverage for Domestic Partners when they cannot be claimed on the employee's Federal Income Tax Return is a taxable benefit. If both parties desire that the domestic partnership be terminated, eligibility ends six months following the filing of the Notice of Termination of Domestic Partnership with the Secretary of State.

Special Note for Domestic Partners: SISC medical plans follow CMS guidelines for Domestic Partners concerning enrollment in Medicare A & B when covered on an active medical plan.

Child/Child of Domestic Partner: A natural child or step-child from birth to age 26; a legally adopted child or a child who is in the process of being adopted; a child for whom the member has legal guardianship to age 18. A child who is in the process of being adopted is considered legally adopted when SISC receives legal evidence of (i) the intent to adopt; and (ii) the member has either: (a) the right to control the health care of the child; or (b) assumed a legal obligation for full or partial financial responsibility for the child in anticipation of the child's adoption.

Proof of eligibility will be required when adding a new dependent for an existing employee and at the time of hire for a new employee. Failure to submit supporting documentation within 30 calendar days of the qualifying event may result in the child or child of a domestic partner being denied coverage.

Disabled Dependent: A disabled dependent may be eligible to continue coverage beyond age 26 if unmarried and a dependent for Federal Income Tax purposes; the member must request a Disabled Dependent Certification form within 30 calendar days of the loss of coverage.

What if a Dependent Defined Under the Heading "Who is Eligible" No Longer Meets the Eligibility Requirements?

It is the member's responsibility to notify SISC of dependents who no longer meet eligibility guidelines. SISC reserves the right to terminate ineligible dependents the first of the month following their loss of eligibility. There is a liability for all health care costs incurred from the date of ineligibility. The costs can be significant, so please make sure your enrolled dependents are eligible for coverage.

SURVIVING SPOUSE/DOMESTIC PARTNER PER CALIFORNIA EDUCATION CODE 7000

Are There Benefits for Surviving Spouse/ Domestic Partner of a Certificated Employee?

Yes. Per California Education Code 7000, school districts must offer lifetime benefits to the surviving spouse/domestic partner of a certificated employees. The law does not address vision coverage or coverage for dependent children.

Are There Benefits for a Surviving Spouse or Domestic Partner of a Classified Employee?
There is no law for Classified employees. However, if the district has a Board policy that allows classified staff to continue coverage, they are eligible. SISC must be notified in writing of this policy. If the school district does not have a policy, the surviving spouse/domestic partner may be entitled to COBRA.

Is the District Obligated to Pay for the Coverage?
No. This law does not obligate the school district to pay for coverage, just to offer the same medical and dental benefits provided to active Certificated employees. A copy of this legislation is available at **www.cde.ca.gov**.

How Do I Enroll a Surviving Spouse/ Domestic Partner?
A separate enrollment form must be submitted to enroll a surviving spouse/domestic partner as they become the subscriber. A surviving spouse losing coverage from an active plan will be enrolled on the same plan unless they are over the age of 65. A surviving spouse over age 65 may be enrolled on a retiree plan. Per California Education Code, a surviving spouse or domestic partner may not add a new spouse or domestic partner once they become a subscriber.

APPROVED LEAVE OF ABSENCE

Employees on a Board approved Leave of Absence (LOA) may remain covered the same as an active employee. If they continue coverage while on an approved LOA, they must remain enrolled in all coverage offered through SISC by the district. The monthly premium will continue to be on the district's monthly bill. The district would pay as billed and collect the premiums from the employee if applicable.

Important information regarding coverage limitations is detailed in the Life Plans and Rates Section.

Employees on an approved LOA who do not continue coverage with the district will be offered COBRA. Under COBRA, dental and vision coverage are optional and the member may choose to not pay for these benefits. Life coverage may not be continued through COBRA. Employees returning to work following a Leave of Absence should be re-enrolled the first of the month following their return to work.

BOARD MEMBERS

Board Members may enroll when the district allows participation and contributes at least 50% of the district contribution to benefits. Board Members must elect coverage when first eligible following SISC enrollment guidelines.

- **Board Member Enrollment:** For eligibility purposes, Board Members are treated the same as part time employees. Board Members receiving an annual compensation of $400 or more are considered to have "active employment status" from the district supplying the health coverage. These Board Members should be enrolled as active employees and are subject to the SISC participation guidelines for active, part-time employees. A district offering life insurance may offer coverage to all benefit eligible Board Members, regardless of compensation.

Board Members who are not receiving an annual compensation of at least $400 are not considered to have "active employment status". These Board Members must be enrolled on a retiree/non-active group and be charged the appropriate rates for that group. Board Members enrolled on retiree groups are subject to the SISC retiree guidelines. The policy aligns with Medicare coordination of benefit policies.

- **Terminated or Not Re-elected Board Members:** Board members should be removed from coverage at the end of the month in which they are replaced; or, their term ends. Board Members who have completed one or more terms of office may continue coverage when the district has a policy that allows former Board Members to participate at their own cost. The school district may elect to pay for former Board Members who leave after serving three terms (12 years). See Government Code Section 53201 for further details.

PARTICIPATION REQUIREMENTS

Who Must Enroll in Coverage?
All employees who work 90% or more of the full-time equivalent for the applicable job classification are required to be enrolled as a subscriber in all SISC benefits offered by the district. If the district has a three-tier rate structure, dependent coverage is optional for each product. Each SISC member district is responsible to communicate SISC participation requirements to your employees.

A SISC enrollment form signed by the employee/retiree is required for enrollment into the SISC medical plans. If you are unable to obtain an employee's signature, Waiver of Active Benefit Enrollment (WABE option) is mandatory to meet SISC participation requirements.

Full time employees must enroll in benefits or WABE.

Who May Decline Coverage?

- An eligible employee who works less than 90% of the full-time equivalent for the applicable job classification or receives less than 90% of the amount that is contributed towards an eight-hour full-time employee.
- Active employees who are enrolled in Medi-Cal must show proof of enrollment in Medi-Cal. Documentation must reflect the effective date of enrollment in Medi-Cal.
- Active employees who are enrolled in Medicare Parts A and B may decline when they are first eligible or at Open Enrollment. Evidence of Medicare enrollment is required.
- Active employees who are enrolled in TRICARE must show proof of enrollment. Documentation must reflect the effective date of enrollment in TRICARE. TRICARE rules should be reviewed before a declination is permitted.
- Active employees, who are eligible, enrolled in a Covered California medical plan and receiving a related subsidy must show proof of enrollment and subsidy.

When declining coverage in a SISC Medical plan, an active employee's participation in SISC ancillary products will be dependent upon the collective bargaining agreements in place at each district.

Unless the member will be enrolling in the WABE option, they must complete a Declination of Coverage Form. An example of the Declination of Coverage for Less Than Full-Time Active Employees and HIPAA Notification form can be found on the SISC secure web portal (SISCconnect) at **siscconnect.org**. Employees may not receive any incentives to opt-out of coverage (i.e., cash in lieu of benefits). Please contact your SISC Account Manager for further information.

According to the Health Insurance Portability and Accountability Act (HIPAA) of 1996, an employee who declines coverage for himself/herself and his/her eligible dependents because they are covered elsewhere, must be allowed to enroll immediately upon loss of coverage. He/she must contact you within 30 calendar days of loss of coverage (60 calendar days if the loss of coverage is under a Medicaid plan or Children's Health Insurance Program) and submit evidence of "loss of coverage elsewhere" with the signed and completed enrollment or change form.

Permanent part-time employees, who work less than 90% of the full-time equivalent for the applicable job classification or receives less than 90% of the amount that is contributed towards an eight-hour full-time employee, may terminate coverage on the first of the month following a qualifying event. Please see the Qualifying Event Table for guidelines. Retro terminations will not be allowed. Part-time employees who terminate coverage may not re-enroll until the next Open Enrollment Period, unless they are eligible for a Special Enrollment Opportunity under HIPAA.

Dependents are not eligible if the retiree does not enroll. If the retiree declines or terminates coverage, they must complete a Declination of Coverage for Retirees. An example of the Declination of Coverage for Retirees form can be found on the SISC secure web portal (SISCconnect) at **siscconnect.org**.

Employees on a Board Approved Leave of Absence may decline coverage. If they decline coverage for reasons other than covered elsewhere, they may not re-enroll until they physically return to work from the approved Leave of Absence or during the next Open Enrollment Period.

Waiver of Active Benefit Enrollment (WABE Option)

WABE is an option for a district to comply with the SISC participation requirements. Employees who prefer to decline SISC medical coverage may elect this option in place of a SISC medical plan. Employees who select this option are not enrolled in a medical/Rx plan.

Employees enrolled in WABE will be reported on the monthly billing invoice. The cost of this option is the same as the single rate of the Two-Tier HSA plan for each employee group.

Employees taking this option have access to the following Added Value services:

- 24/7 Physician Line (MDLive)
- Employee Assistance Program—EAP (Anthem Blue Cross)
- Expert Medical Opinions (Teladoc Medical Experts)
- Personal Health Coaching (Vida Health)
- Biometric Screenings (when offered by district)

Districts offering WABE may continue to allow enrollment in dental, vision, and life coverages when offered by the bargaining unit. Alternatively, WABE can be offered in lieu of all coverages (Medical, Rx, Dental, Vision, and Life). However the district chooses to offer the plan, they are required to consistently enroll all members of the bargaining unit in a like manner. Consistent enrollment in WABE is subject to audit.

WABE does not count towards the maximum number of plan options. It is the responsibility of each participating district to understand the implications of offering WABE and properly communicate the details of this election to employees. If your district is interested in making WABE available as an option to your employees, please contact your Account Management Team for details and requirements.

GUIDELINES FOR RETIREES

Are Retirees Enrolled on a Separate Group Number?
Yes. Retirees must be enrolled on their own group number. They cannot be enrolled on the same group suffix with active employees (composite or three-tier rate structures). Retirees must be transferred to a retiree plan the first of the month following their date of retirement. There can be no lapse in SISC coverage. The district must request a group number from SISC to enroll retirees if one is not available on the Rate-at-a-Glance.

Retirees should be enrolled on an over-65 group number the first of the month in which Medicare Parts A and B are effective. If they are enrolled on a two-party contract, they may enroll on an over-65 group the first of the month in which Medicare Parts A and B are effective for both parties.

Is Medicare Required for Retiree Enrollment?
Yes. Retirees and their spouses/domestic partners that are Medicare eligible (65+ years of age, or less than age 65 but Medicare eligible) are required to provide proof of Medicare Parts A and B. A copy of the retiree's and spouse's/domestic partner's Medicare card must be sent to SISC prior to the first of the month in which they turn 65 (or first of the prior month if their birthday is on the 1st). Retirees must have continuous enrollment in Medicare Parts A and B while enrolled in a SISC retiree plan. Failure to maintain continuous coverage in Medicare Part A and B, or enrollment in any Medicare plan outside of SISC may result in permanent loss of coverage. Members cannot assign their Medicare to a health and/or prescription drug plan outside of SISC.

How Will I Know When a Retiree and/or Spouse/Domestic Partner are Turning 65?
SISC will notify districts by securely posting a monthly report to the SISC secure web portal (SISCconnect) approximately three (3) months prior to the member's 65th birthday. This will identify members turning 65.

As a courtesy SISC will notify employees turning age 65 by mailing a letter to them. This letter will explain to them about Medicare and when they must enroll.

It will be the district's responsibility to follow up and contact the member to remind them to submit a copy of their Medicare card and provide SISC with a copy. The premium charged to the district will be surcharged if the Medicare card is not provided timely to SISC.

What if the District does not Provide Proof of Enrollment in Medicare Parts A and B?
If proof of Medicare is not provided to SISC, the following illustrates the non-refundable surcharge that will be applied to the monthly premium of the under-65 groups. The surcharge will be applied the first of the month in which the member turns 65 until the Medicare card is produced.

2024-2025 Surcharge*	
Missing Part A	$650
Missing Part B	$650
Missing Parts A and B	$1,300

*Only members enrolled in Medicare Parts A and B can be moved to an over-65 retiree plan

What if the Retiree and/or Spouse/Domestic Partner is Missing a Part of Medicare?
If the retiree or spouse/domestic partner is under 65 and the other person is over age 65 and is missing one or both parts of Medicare, the above surcharge will be added to the two-party under-65 rate.

If both parties are 65 years of age or older and missing a part of Medicare, the surcharge will be applied for each member to the two-party under-65 rate. **The two-party contract will not be moved to an over-65 group number until all applicable Medicare cards are received.**

If the retiree is single and missing one or both parts of Medicare, the surcharge will be applied to the single under-65 rate until the retiree obtains the missing parts of Medicare and is moved to the appropriate over-65 group.

Who is Responsible for Getting a Copy of the Medicare Card from the Retiree and/or Spouse/Domestic Partner?
It is the district's responsibility to get a copy of the Medicare card from the retiree or spouse/domestic partner and submit a copy to the SISC office. The premium surcharges are non-refundable and are set at a point to help the plan compensate for paying primary on claims when Medicare should pay primary.

What are the Options for Retiree and/or Spouse/Domestic Partner When One is Over Age 65 and One is Under Age 65?
In the case of a retiree two-party contract where one person is over the age of 65 and one is under the age of 65, the following (excluding Kaiser and HMO's) enrollment options are available:

- Both parties remain enrolled on the group suffix for retirees under age 65 (until both parties turn 65); or
- Split the enrollment: the under age 65 person enrolls on an under age 65 group number and the over age 65 person enrolls on an over age 65 group number (different group numbers, same benefits); or
- The age 65 person with both parts of Medicare can enroll on a SISC Retiree Group Medicare Plan (if offered by the district) and the under age 65 person can remain on the under age 65 group suffix.

All of the above scenarios require the person who is age 65 or older to provide proof of Medicare enrollment to SISC. A separate enrollment form completed by the spouse or domestic partner is required if they are enrolling on a separate group number as they then become a subscriber.

Dependent children are not eligible for enrollment as a subscriber and must remain on an under 65 plan with the retiree unless they have been enrolled in Medicare. A dependent child enrolled in Medicare can be moved with the subscriber to an over 65 group

If the spouse/domestic partner is age 65 and does not enroll in Medicare, SISC will assess a monthly surcharge. In certain circumstances a surcharge may be avoided if the spouse/domestic partner can provide proof of ongoing enrollment in another primary group health plan. SISC approval required.

What Options are Available for a Retiree with Dependent Children?
When continuing to cover dependent children, retirees over age 65 must remain on an under-65 retiree group unless the dependent child is enrolled in Parts A and B of Medicare. Only members enrolled in Medicare can be moved to an over-65 retiree plan.

How Do I Handle a Member Enrolled in Kaiser Who is Turning 65?
The district should use the report posted to the SISC Web Portal to determine which members are turning age 65. The retiree and/or spouse/domestic partner of a retiree turning age 65 are required to assign their Medicare to Kaiser the first of the month in which they are turning 65 by completing a Kaiser Election form.

Timely submission of the Election Form is important, if delayed the member may not have the requested effective date for assigning Medicare and Kaiser will surcharge the district a higher premium. This non-refundable surcharge will be added to the district's SISC billing for each month the member's Medicare remains unassigned.

A 45-calendar-day advance notice of the member turning age 65 is recommended to avoid missing the requested effective date. It is the district's responsibility to make sure the impacted member assigns their Medicare to Kaiser.

Is There Dental and/or Vision Coverage for Retirees?
Yes. Retirees may enroll at the time of retirement if the district offers dental and/or vision benefits through SISC. All retirees, regardless of age or district contribution, may have the option of the same dental and/or vision benefit as active employees with a three-tier rate structure.

Can a Retiree Decline District Coverage?
Yes. Retirees who decline a benefit will not be eligible to enroll in that benefit in the future. Dependents of the retiree would not be eligible to continue coverage. COBRA benefits would be offered to retirees and dependents that decline coverage.

If the retiree declines or terminates coverage, they should complete a Declination of Coverage for Retirees. This form is retained at the district as protection from a "no one informed me" scenario. The Declination of Coverage for Retirees form can be found on the SISC website.

ELIGIBLITY FOR RETIREES

How Do I Determine if an Employee Qualifies for Retiree Benefits?
A retiree must qualify for retirement according to the district's requirements AND the requirements of the State Teachers' Retirement System (STRS) or the Public Employees' Retirement System (PERS).

A retiree who does not meet the retirement qualifications of the school district, STRS or PERS is not eligible to continue coverage as a retiree with the district and will be offered COBRA.

Through STRS, a member may be considered an eligible retiree due to a disability. STRS has two types of disability elections and only one of the two types qualifies as a disability retirement.

Disability Allowance (STRS Coverage A): A member who previously elected the Disability Allowance Program is not considered a retiree according to STRS. This member may not continue benefits through the district as a retiree and would only have the option of COBRA. This member would have the option to stay on an Active plan with a Board Approved Leave of Absence.

Disability Retirement Program (STRS Coverage B):
A member who elects the Disability Retirement Program, according to STRS is considered a retiree and may enroll in district retiree benefits.

Are There Benefits for Certificated Retirees and/or a Surviving Spouse/Domestic Partner?
Yes. Per California Education Code 7000, school districts must offer lifetime benefits to certificated retirees and their surviving spouse/domestic partner. The law does not address vision coverage or coverage for dependent children.

Is the District Obligated to Pay for the Coverage?
No. These laws do not obligate the school district to pay for coverage, just to offer the same medical and dental benefits provided to active Certificated employees. A copy of this legislation is available at: **www.cde.ca.gov**

When are Retirees Allowed to Make Plan Changes?
Retirees are allowed the same Open Enrollment period as active employees. At the time of retirement, a retiree may also elect another plan offered by the district.

Other events which would allow a change outside of Open Enrollment include the following:

- A change to the district contribution resulting in an out of pocket increase to the retiree.
- A retiree request to move to a PPO Retiree 65+ (EGWP), CompanionCare Medicare Supplement, or Medicare Advantage Plan. These plans require 45 days advance notice for enrollment per CMS guidelines. Retirees enrolled in Medicare can enroll in these plans without waiting until Open Enrollment.

Retiree Group Medicare Plans require 45-calendar-day advance notice for enrollment and termination.

Are Retirees Allowed to Add Dependents?
Yes. Retirees may add spouse/domestic partner or dependent children at Open Enrollment or as the result of a HIPAA qualifying event. Please refer to the Qualifying Event Table for additional information.

When Can a Retiree Terminate Coverage for a Dependent?
Benefits for a covered dependent may be terminated at Open Enrollment or with any HIPAA qualifying event (see the Qualifying Event Table in this manual).

Can a Dependent Remain Enrolled on a Plan from Which the Retiree is Terminated?
No. An exception is available when the dependent qualifies as a surviving spouse.

When Can a Covered Retiree Terminate Coverage?
A retiree can voluntarily terminate coverage on the first of the month following a written request to terminate benefits. Once retiree benefits are terminated, they cannot be reinstated at a future date.

If a Retiree Fails to Pay Premium to the District, Can the Coverage be Retroactively Terminated?
For under-65 retiree plans, SISC will allow you to terminate the retiree current plus two months retro for failure to pay premium. However, if any claims have been incurred, the retiree may be responsible for reimbursement to the provider(s). Please contact your SISC eligibility technician for further guidance.

What Happens in the Event of a Retiree's Death?
A retiree who passes away while enrolled on a PPO plan, must be terminated from benefits on the last day of the month following passing. SISC will allow a termination back to the date of passing, not to exceed 12 months retro credit. If the aforementioned event pertains to an HMO enrollment, SISC will only allow the current month plus two additional months retro credit.

What Happens to Covered Dependents in the Event of a Retiree's Death?
If the deceased retiree had an enrolled dependent on their plan, termination of the plan can only be allowed within the retro guidelines of current plus two months. (Refer to the "Surviving Spouse/Domestic Partner" section.)

Retiree Group Medicare Plans do not allow retroactive terminations.

MEDICARE PARTS A, B AND D

Members should refer to the "Medicare and You" booklet for complete information www.medicare.gov

What is Medicare Part A?
Hospital Insurance: Medicare Part A helps cover inpatient care in hospitals, including critical access hospitals. It also covers skilled nursing facility, hospice and home health care. You must meet certain conditions to get these benefits.

Is There a Cost to Part A?
You usually don't pay a monthly premium for Part A coverage if you or your spouse paid into Medicare taxes while working. Some members will have a cost if they do not meet the requirements for premium free Part A. If a late enrollment penalty is assessed on the member, that fee would have to be paid by the member. For more information, please contact the Social Security office at 1-800-772-1213.

What is Medicare Part B?
Medical Insurance: Medicare Part B helps cover medical services like doctors' services, outpatient care and other medical services Medicare Part A doesn't cover, if those services are medically necessary. Qualified members must enroll in Part B and pay a monthly premium.

Is There a Cost to Part B or is it Premium-Free?
There is a monthly premium based on your income. For questions regarding Part B premium, members can call Social Security at 1-800-772-1213 or refer to the "Medicare and You" booklet.

Is There a Premium Surcharge for Medicare Part B?
If your modified adjusted gross income as reported on your IRS tax return from two years ago (the most recent tax return information provided to Social Security by the IRS) is above a certain amount, you may pay more. It is the member's responsibility to contact Social Security and/or Medicare to discuss this surcharge.

What is Medicare Part D?
Prescription Drug Coverage through Medicare.

Do I Need to Enroll into Medicare Part D?
Members are automatically enrolled into Medicare Part D on SISC Retiree Plans.

Is There a Premium Surcharge for Medicare Part D?
If your modified adjusted gross income as reported on your IRS tax return from two years ago (the most recent tax return information provided to Social Security by the IRS) is above a certain limit, you may pay a Part D income-related monthly adjustment amount (Part D-IRMAA) in addition to your monthly plan premium. This extra amount is paid directly to Medicare by the member. For questions regarding Part D premium surcharges members can call Social Security at 1-800-772-1213 or refer to the "Medicare and You" booklet.

What Do Members Need to Know About Medicare Part D during the Enrollment Process?
Members are automatically enrolled into Medicare Part D on SISC Retiree Plans. During the enrollment process into Medicare Part D, CMS may send members information and communications that require action on the member's part. The member is responsible for reading the materials and responding to communications from CMS. If a member fails to respond to communications from CMS, their enrollment may not be processed.

SISC cannot advise members regarding Medicare eligibility, premiums, and surcharges. Members are responsible for contacting Medicare and/or Social Security to address their specific concerns.

SISC SECURE WEB PORTAL (SISCCONNECT)

What is the SISC Secure Web Portal?

The SISC Secure Web Portal can be accessed by logging onto **siscconnect.org**. This site is a secure resource center for member districts to access information pertaining to monthly billing, rates, group numbers, benefit documents, forms, SISC memos, Health Benefits Manual, etc.

Each district must designate authorized users by completing a SISCconnect Registration form found on the SISC website. Authorized users will be sent a login ID with a temporary password. When a user logs into SISCconnect for the first time, they will be prompted to create a new password. SISCconnect passwords must not be shared.

What are the Reports and Menu Options?

View Eligibility

Districts can view the eligibility status of members using three search functions:

- **First Name:** search for subscribers by first name.
- **Last Name:** search for subscribers by last name.
- **Social Security Number (SSN):** search for subscribers by full SSN, or by last 4 digits of SSN.

Eligibility Submission

Districts can submit eligibility by uploading enrollment forms and other eligibility documents. The eligibility technician for the district will receive and process these items.

Quick Downloads Menu Items

- **Rates-at-a-Glance (RAAG Reports):** This document is a summary of the district's group numbers, corresponding benefits and rates.
- **Invoices:** The monthly SISC invoice will be posted on the first business day of the month. This report is posted in both a pdf and Excel format so the district can use it for various purposes such as determining the number of single, two party and family contracts.
- **Resources:** Districts can access various employee resources from this menu such as resources, enrollment guides, and product flyers. Districts are encouraged to post these resources to their intranet site so employees and/or retirees can access them easily.
- **Benefit Documents:** SISC works with our benefit carriers to ensure plan documents are provided in a timely manner and posted to SISCconnect in advance of the upcoming plan year. It is the responsibility of the district to make documents available to members on an annual basis. Districts are free to access these documents from SISCconnect and save them to their district's intranet site.
  - Benefit Summaries: District specific benefit summaries are posted under this menu by June 1st of the current plan year.
  - Plan Documents: District specific benefit booklets are posted under this menu prior to the start of the plan year on October 1st.
  - Summary of Benefits and Coverage (SBC): To comply with the requirements as mandated by the Affordable Care Act, SISC posts all current plan year SBCs under this menu by August 1st.
  - SISC Plan Comparison Tool: SISC created this tool to allow districts a way to compare up to seven SISC plans in an easy to use side-by-side format.
- **Reports:** SISC will post reports or documents such as Medicare Reports, Life Insurance Reports, Couple Discount Reports, Domestic Partner Reports, Over Age Dependent Termination Reports, Custom Reports (district specific), and Miscellaneous Reports.
- **Forms:** The most updated SISC forms are available on this menu tab for easy district access.
- **SISC Health Notifications:** Districts can view a list of SISC global communications on a variety of topics.
- **Health Benefits Manual:** The most current copy of the Health Benefits Manual is available on this menu tab for general information on SISC benefits, procedures, and guidelines.

Communication

- **Email:** SISC globally communicates with districts via email from **SISCHealth@siscschools.org**. In order for the district to be aware of important updates and notifications, please make sure the district's IT staff ensures responses are not blocked from **SISCHealth@siscschools.org**.

SISC must have a current email address for the Superintendent, Chief Business Official, HR Director, key contacts, etc. To add or change the district contact information, please complete a SISCconnect Registration Form and email it to: SISCconnect@siscschools.org

REPORTING PROCEDURES

Spouse/domestic partner and children additions and terminations can ONLY be made during Open Enrollment or as a result of a qualifying event. A Qualifying Events table has been added to this section for your reference and clarification of each event scenario and documents required for Open Enrollment and/or mid-year plan changes.

Employee Additions or Changes

When Should I Add a New Employee as a Subscriber to Benefits?
New employees should be added the first of the month following their Date of Hire (DOH). If the DOH is the first working day of the month, the employee may be added the first of that month or the first of the following month. However, your district elects to handle this, make certain that your policy for assigning the effective date of coverage for your employees is consistent; otherwise, you may be leaving the district open for a discrimination suit.

Certificated and Management employees who have a written contract specifying the date coverage begins may be enrolled per the contract effective date. All full-time employees must be added back to the date when they first became eligible.

If a Part-Time Employee Changes to Full-Time Status or has an Increase in Hours, Can I Add Them to the Benefits at that Time?
Yes. If the employee who works less than full-time subsequently becomes full-time they must enroll the first of the month following the date of that event. A part-time employee that has an increase in the number of hours worked may enroll the first of the month following the date of the event. All full-time employees must be added back to the date when they first became eligible.

If a Part-Time Employee Previously Declined Coverage, Can They Enroll in the Benefits Outside of Open Enrollment?
Yes. If a part time employee previously declined coverage because they were covered elsewhere and notifies you within 31 calendar days of loss of eligibility of that coverage (or 60 calendar days if the loss of eligibility is under a Medicaid plan or Children's Health Insurance Program), they can enroll in the benefits at that time.

If they did not decline coverage because they were covered elsewhere or they do not notify you within 31 calendar days of their loss of eligibility elsewhere (or 60 calendar days if loss of eligibility is under a Medicaid plan or Children's Health Insurance Program), they must wait until the next Open Enrollment Period.

What Happens If I Fail to Report a Newly Eligible Employee Timely?
It is the district's responsibility to report activity timely. Late reporting may result in your employee having no benefits or wrong benefits applied to a claim. Members held responsible for an incorrect out-of-pocket amount, due to the district not reporting timely, may be the district's liability.

When Should I Add a Board Member to the Benefits?
When the district has a policy that allows active Board Members to participate, Board Members should be added the first of the following month in which they take office.

Dependent Additions

When Can a Covered Employee or Retiree Add a Spouse to Coverage?
A subscriber can add a spouse to coverage the first of the month following the date of marriage or during any Open Enrollment period with the submission of required documentation.

When Can a Covered Employee or Retiree Add a Domestic Partner to Coverage?
A subscriber can add a domestic partner to coverage at the following times:

- Open Enrollment
- The first of the month following a qualifying event.
- The first of the month following the date they register with the State of California.

Eligible dependent children of the domestic partner must be enrolled at the same time.

When Can a Covered Employee or Retiree Add Dependent Children to Coverage?
A subscriber can add a dependent to coverage during any Open Enrollment period or outside Open Enrollment due to qualifying events:

- See Table of Mid-Year Qualifying Events under "Addition of a Dependent"
- Completed enrollment paperwork and the supporting documentation must be submitted to SISC within 31 calendar days of the qualifying event or Open Enrollment.
- Once the paperwork is complete, add to your batch of activity to be sent to SISC.
- Newborns will be enrolled effective on their date of birth.

The employee must notify the district within 31 calendar days of their qualifying event in order to be eligible for the Special Enrollment (60 calendar days if the qualifying event is loss of eligibility under a Medicaid plan or Children's Health Insurance Program).

What is the SISC Retroactive Enrollment Policy for Dependents?
SISC will enroll dependents during Open Enrollment or due to a qualifying event. The member and/or district must report the addition timely to meet the retro guidelines of current month plus two. SISC must receive the request within those retro guidelines. If the member and/or district fails to report timely, the dependent cannot be added until the next Open Enrollment. New membership change form and supporting documents must be submitted at the district's next Open Enrollment. Requests received beyond the retro guideline, will NOT be processed. **HMOs do not allow retroactiveenrollments.**

Employee Plan Changes

When Can an Employee/Reitree Change Plans?
Currently enrolled employees/retirees may elect a different plan option:

- During the designated Open Enrollment period for an October 1st effective date.
- If the district contribution changes significantly for active employees and/or retirees.
- At the time of retirement. All subsequent plan changes are subject to the rules listed in the "Eligibility for Retirees" section of this manual.

Plan changes must be reported on the MAR Transfer Form found on the SISC website and included in your activity to be uploaded to SISCconnect.

Employee Terminations

When Should I Terminate an Employee's Coverage?
Employees should be removed at the end of the month in which their qualifying event occurs. A district may not bargain to extend benefits beyond this date. Less than 12-month employees, who have completed their contractual obligation to teach/work through a given date, may be terminated at the end of the contract/ agreement. A part-time employee may only opt out of benefits during the next Open Enrollment period or as the result of a qualifying event.

It is the district's responsibility to report activity timely. Late reporting may result in the wrong benefits applied to a claim, which could result in additional liability for the district. Please refer to "Retiree" section for terminations due to retirement.

Terminations of coverage should be processed in SISCconnect with the exception of subscribers who are terminated due to death. These terminations should be reported to SISC on the MAR terminations form available on SISCconnect.

What is the SISC Retroactive Termination Policy?
SISC will terminate during Open Enrollment or due to a qualifying event. If you fail to report the termination timely, we will allow you to terminate the employee/ retiree and /or qualified dependent(s) current plus two months retro from the time the request is received by SISC. However, if any claims have been incurred in the meantime, the employee/retiree or the employee's/ retiree's dependents will be responsible for any amounts paid. **HMOs do not allow retroactive terminations.**

Dependent Terminations

What is the Responsibility of the Employee and District Regarding Termination of a Spouse, Domestic Partner, and/or Dependent Children?
It is the employee's responsibility to notify the district of a loss in eligibility for their spouse/domestic partner or dependent(s). The employee must complete and sign a SISC Membership Change Form and provide appropriate documentation. Terminations due to divorce require a divorce decree be provided. When a domestic partnership is nullified, a copy of the Notice of Termination of Domestic Partnership must be provided. Paid claims on a non-eligible spouse/domestic partner or dependent(s) will be recovered.

The district is required to notify SISC of changes in a timely manner. Completed forms and documentation should be included with district activity and uploaded to SISCconnect.

Dependent children are automatically removed from coverage the first of the month following their 26th birthday. Children enrolled due to guardianship are removed when guardianship ends the first of the month following their 18th birthday.

What Is the Retroactive Termination Policy for Dependents?
SISC will terminate during Open Enrollment or due to a qualifying event. If you fail to report the termination timely, we will allow you to terminate the qualified dependent(s) current plus two months retro from the time request is received by SISC. **HMOs do not allow retroactive terminations.**

Reporting Process

How Do I Enroll a Newly Eligible Employee on Health Benefits?

- The employee completes the Applicant section of the SISC or Kaiser Enrollment Forms, and the district completes the District section. These forms can be found on SISCconnect at **siscconnect.org**.
- If the employee is enrolling on an HMO, (except Kaiser) the Primary Care Provider (PCP) and Medical Group codes are required on the SISC Enrollment Form. If they are missing or incorrect, the Medical carrier will randomly assign a PCP and the member will be responsible for making subsequent changes directly with the carrier.
- If the employee is electing dependent coverage, attach the **required** proof of eligibility (see the "Dependent Eligibility Documentation Chart" in this manual).
- If the employee is enrolling as the result of a qualifying event, attach the required documentation of the event.
- Once the Enrollment Form and supporting documentation are complete, add the enrollment paperwork to the activity that is uploaded to SISCconnect by the 15th of each month.

Adding Dependents

How Do I Add a Dependent to an Employee's Coverage?

- The employee completes and signs a **SISC Membership Change Form** which can be found on the SISC website.
- If the dependent is enrolling on an HMO, (except Kaiser) the Primary Care Provider (PCP) and Medical Group codes are required on the SISC Membership Change Form. If they are missing or incorrect, the member will be randomly assigned a PCP and will be responsible for making subsequent changes directly with the carrier.
- If the employee is adding a dependent during Open Enrollment or outside of Open Enrollment, attach the required documentation of the qualifying event.
- Newborn dependents are enrolled on the date of birth. While hospitalized, newborns who are eligible for benefits may receive services under the coverage of the mother. Once discharged, enrollment of the newborn is necessary to continue receiving services.
- Please refer to the "Dependent Eligibility Documentation Chart" for a list of all **required** documentation when adding a dependent. SISC reserves the right to request additional documentation to substantiate eligibility.
- Once the paperwork is complete, add to your activity to be uploaded to SISCconnect, our secure web portal. The completed enrollment paperwork and required documentation must be uploaded to SISCconnect within 31 days of the qualifying event or Open Enrollment.

Acceptable supporting documentation must identify the dependent to be related to the subscriber as an eligible dependent as defined under the "Who is Eligible?" section of this manual.

ELIGIBILITY DOCUMENTATION CHECKLIST

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

Dependent Type	Required Documentation
Spouse	• Prior year's Federal Tax Form that shows the couple was married (First page only, financial information may be blocked out). • A marriage certificate will be accepted for newly married couples when filing has not yet been required for the current tax year.
Domestic Partner	• A Certificate of Registered Domestic Partnership issued by the State of California or a certified copy of the Declaration of Domestic Partnership that includes the dated, signed Secretary of State Certification Stamp. (Enrolling a Domestic Partner may cause the employer contribution to become taxable.)
Children, Stepchildren, and/or Adopted Children up to age 26	• Legal Birth Certificate or Hospital Birth Certificate (to include full name of child, parent(s) name, and child's DOB) • Legal Adoption Documentation
Legal Guardianship up to age 18	• Legal U.S. Court Documentation establishing Guardianship
Unmarried Disabled Dependents over age 26 (requires enrollment in a SISC medical plan)	**Anthem Blue Cross (All items listed below are required)** • Legal Birth Certificate or Hospital Birth Certificate (to include full name of child, parent(s) name and child's DOB) • Prior year's Federal Tax Form that shows child is claimed as an IRS dependent (First page only, income information may be blocked out.) • Proof of 6 months prior creditable coverage under the employee/retiree's plan. There can be no break in coverage. • Completed Anthem Disabled Dependent Certification Form **Blue Shield (All items listed below are required)** • Legal Birth Certificate or Hospital Birth Certificate (to include full name of child, parent(s) name and child's DOB) • Prior year's Federal Tax Form that shows child is claimed as an IRS dependent (First page only, income information may be blocked out.) • Proof of 6 months prior creditable coverage under the employee/retiree's plan. There can be no break in coverage. • Completed Declaration of Disability for Overage Dependent Child **Kaiser (All items listed below are required)** • Legal Birth Certificate or Hospital Birth Certificate (to include full name of child, parent(s) name and child's DOB) • Prior year's Federal Tax Form that shows child is claimed as an IRS dependent (First page only, income information may be blocked out.) • Proof of 6 months prior creditable coverage under the employee/retiree's plan. There can be no break in coverage.
Retirees and/or Dependents on a Retiree Plan Age 65 or Over	• Proof of enrollment in Medicare Part A & Part B (copy of current Medicare card or Medicare enrollment confirmation letter showing effective dates of Part A and Part B)

QUALIFYING EVENTS OR STATUS CHANGES OUTSIDE OF OPEN ENROLLMENT

Effective date will be determined by the qualifying event date that allows for no lapse in coverage.
This does not apply to Retiree Group Medicare Plans (RGMPs such as EGWP, CompanionCare, KPSA or Blue Shield 65 Plus).
This table is not all inclusive and is subject to SISC approval, retro, and participation guidelines.

Employee/Retiree experiences the following qualifying event	Employee/Retiree MAY make the following change within 31 days of the qualifying event	REQUIRED Documentation: SISC Membership Change Form and applicable documents below
Birth, Adoption, or Legal Guardianship **NOTE:** HIPAA special enrollment rights may apply	• Enroll self, if applicable • Enroll newly eligible child and any other eligible dependents • Change health plans when options are available	• Birth certificate indicating parents' full names; or • Adoption/Guardianship documents issued by a U.S. court
Marriage or Commencement of Domestic Partnership **NOTE:** HIPAA special enrollment rights may apply	• Enroll self, if applicable • Enroll spouse/domestic partner and any newly eligible dependent children • Change health plans when options are available	• Marriage Certificate; or • Declaration of Domestic Partnership filed with the California Secretary of State • Other enrollment forms/documents as applicable
Divorce or Termination of Domestic Partnership **NOTE:** HIPAA special enrollment rights may apply	• Drop spouse/domestic partner • Drop stepchildren gained from marriage or domestic partnership • Enroll self and any newly eligible dependent children who lost eligibility under spouse/domestic partner's plan • Change health plans when options are available	• Final Divorce Decree; or • Dissolution of Domestic Partnership filed with the California Secretary of State • Other enrollment forms/documents as applicable
Death of Dependent (spouse/ domestic partner or child) **NOTE:** HIPAA special enrollment rights may apply	• Remove the dependent from coverage • Change health plans when options are available	• Membership Change Form
Qualified Medical Child Support Order (QMCSO) requiring enrollment of dependent child	• Enroll self, if not already enrolled in coverage • Enroll dependent child named on the QMCSO to employee's health coverage • Change health plans when options are available	• Membership Change Form • Birth certificate indicating parents' full names; and • Qualified Medical Child Support Order (QMCSO) court document
Gain or Loss of Entitlement to Medicare/Medicaid coverage by covered person **NOTE:** HIPAA special enrollment rights may apply	• Enroll self, spouse/domestic partner, and any eligible dependent children, if applicable • Drop coverage for person who became entitled and enrolled in Medicare/Medicaid • Change health plans when options are available	• Proof of enrollment in or loss of coverage in Medicare/Medicaid (whichever applicable) • Other enrollment forms/documents as applicable

(Continued on next page.)

Employee/Retiree experiences the following qualifying event	Employee/Retiree MAY make the following change within 31 days of the qualifying event	REQUIRED Documentation: SISC Membership Change Form and applicable documents below
Change in Employment Status (e.g., Part-time to Full-time, Full-time to Part-time, Active to Retiree, Hourly to Salaried, Unpaid Leave of Absence, Change in Bargaining Unit, etc.)	• Enroll self, spouse/domestic partner, and any eligible dependent children, if applicable • Drop spouse/domestic partner and/or any other dependent children • Change health plans when options are available	• Proof of employment change; and • Other enrollment forms/documents as applicable
Changes to coverage as a result of Open Enrollment under other employer plan/different plan year including enrollment in a Qualified Health Plan (QHP) through a Public Marketplace such as Covered CA	• Enroll self, spouse/domestic partner, and any eligible dependent children, if applicable • Drop spouse/domestic partner and/or any other dependent children • Change health plans when options are available	• Proof of coverage change; and • Other enrollment forms/documents as applicable
Significant increase or decrease in the cost of coverage or an unpaid leave where the district will no longer be making a contribution	• Enroll self, spouse/domestic partner, and any eligible dependent children, if applicable • Drop spouse/domestic partner and/or any other dependent children • Change health plans when options are available	• Proof of increase in cost of coverage (e.g. district submitted plan change); or • Proof of decrease in cost of coverage (e.g. district submitted plan change); and • Other enrollment forms/documents as applicable
Gain or Loss of Coverage Elsewhere, including but not limited to: • Change of home address causing loss of eligibility • Change in employment status of spouse/domestic partner or dependent child (including commencement or termination of employment) • Significant curtailment in employee's spouse's/domestic partner's group coverage **NOTE:** HIPAA special enrollment rights may apply	• Enroll self, spouse/domestic partner, and any eligible dependent children, if applicable • Drop spouse/domestic partner and/or any other dependent children • Change health plans when options are available	• Proof of significant curtailment in spouse's/domestic partner's group coverage; or • Proof of enrollment in other coverage; or • Proof of loss of coverage; and • Other enrollment forms/documents as applicable

DUE DATES AND REPORTING METHODS

When is the District Activity Due to SISC?
District activity is due to SISC by 4 PM the 15th of the month prior to the effective date. If the 15th falls on a weekend or holiday the activity is due to SISC by 4pm the Friday before. The Activity Schedule is posted on the SISC secure web portal (SISCconnect) at **siscconnect.org**. Activity should be uploaded to SISCconnect, complete with all supporting documentation. If submitting different types of activity, activity should be organized by activity type and effective date, and the file name should include the type of activity and effective date. For tracking purposes, separate submissions are preferred. If uploading a batch, include no more than 10 enrollments in a single submission. Following are some file naming examples:

- District Name_Enrollment Forms_September
- District Name_Terminations_July
- District Name_Transfers_July

To ensure proper routing, districts submitting activity through an electronic, third-party vendor should add the extension of _EDI to the end of the file name. Example:

- District Name_Eligibility Documents_EDI

How Do I Send My Activity to SISC?
Districts must submit activity through the SISC secure web portal at **siscconnect.org.** This address is reserved for district activity only. Instructions for SISCconnect may be found on the SISC website at **sisc.kern.org**.

Upload activity from the "Eligibility Submission" tab. Please note: Activity containing Protected Health Information (PHI) which is sent in a non-secure manner violates the HIPAA Privacy & Security law. Any revisions to previously submitted activity must be clearly marked as **REVISED** to ensure that the revision is noticed and processed.

Should I Send Activity to SISC while Awaiting Supporting Documentation?
No. Incomplete activity should not be sent to SISC. Activity is considered incomplete when it does not include all necessary forms and all supporting documentation. It is the district's responsibility to review all forms for accuracy and completeness before sending to SISC.

**It is the district's responsibility to review their SISC invoice on a monthly basis and verify activity received by the designated due date was processed.*

What if I Don't Provide Supporting Documentation with Enrollments?
Failure to submit supporting documentation within 31 calendar days of the qualifying event may result in coverage being denied for dependents.

How Do I Submit Missing Documents?
Submit to SISC via SISCconnect. Supporting eligibility documents MUST be accompanied by a copy of the original Enrollment Form or SISC Membership Change form. Documents received without the original Enrollment Form or Membership Change Form cannot be processed.

Should I Mail the Original Once I Have Chosen One of these Two Delivery Methods?
No. There is no need to mail originals.

How Do I Know if SISC Received My Activity?
Activity received in the SISC office by the scheduled due date should appear on the district's next bill. It is the district's responsibility to review the SISC monthly invoice to ensure that all activity received by the due date was processed. If the district chooses to send activity using SISCconnect, the upload will show whether it was successful or had errors on the upload page.

When Will Employees Receive Their ID Cards?
Once SISC has processed the district's activity this information is transmitted to our vendors (Anthem, Blue Shield and Kaiser). Once the vendor completes the enrollment, members receive their ID Cards in approximately 7–10 business days. During Open Enrollment, it may take slightly longer to process due to heavy volume.

Where Can I Find the Required SISC Forms?
All SISC forms are available on the SISC secure web portal (SISCconnect) at siscconnect.org.

Life Insurance Reporting

Refer to the "Life Plans and Rates" section of this manual.

ADDED VALUE SERVICES OFFERED BY SISC 2024-2025

SISC
Self-Insured Schools of California
Schools Helping Schools

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

BENEFIT HIGHLIGHTS	AVAILABILITY AND HOW TO GET STARTED
24/7 Help with Personal Concerns *SISC Employee Assistance Program* Access free, confidential resources for help with emotional, marital, financial, addiction, legal, or stress issues.	All employees at member districts **Call** 800-999-7222 **Visit** anthemEAP.com/SISC
24/7 Virtual Primary Care Doctor *Eden Health* Virtually connect with a primary care physician to manage all your physical and mental healthcare needs. Eden providers diagnose conditions, manage prescriptions, refer to specialists, and answer follow up questions using video visits or live chat.	Anthem and Blue Shield PPO members **Scan the QR code to download the Eden Health app, and register for your Eden Health membership.**
Personal Health Coaching *Vida Health* Get one-on-one health coaching, therapy, chronic condition management, health trackers and other tools and resources online or via phone.	Anthem and Blue Shield members **Call** 855-442-5885 **Visit** vida.com/sisc
24/7 Physician Access—Anytime, Anywhere *MDLive* Access to virtual visits with psychiatrists and therapists for members age 10 and up. Virtual urgent care services are available to all members. Physicians can prescribe medication when appropriate. *copays may apply	Anthem and Blue Shield members **Call 800-657-6169** **Visit** mdlive.com/sisc
Free Generic Medications *Costco* Access most generic medications at no cost through Costco retail and mail order pharmacies. You don't need to be a Costco member.	Anthem and Blue Shield members **Call** 800-774-2678 (press 1) **Visit** costco.com

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

Continued → 1

BENEFIT HIGHLIGHTS	AVAILABILITY AND HOW TO GET STARTED
Expert Medical Opinions *Teladoc Medical Experts* Get answers to health care questions and second opinions from world-leading experts.	Anthem, Blue Shield, and Kaiser Permanente members **Call** 855-380-7828 **Visit** teladoc.com/SISC
Physical Therapy for Back or Joint Pain *Hinge Health* Get access to free wearable sensors and monitoring devices, unlimited one-on-one coaching and personalized exercise therapy.	Anthem and Blue Shield PPO members **Call** 855-902-2777 **Visit** hingehealth.com/sisc
24/7 Access to Virtual Maternity and Postpartum Support *Maven* Consult with a care advocate who connects you with trustworthy content delivered by doctors, specialists coaches and other maternity providers to help deal with pregnancy and postpartum concerns.	Anthem and Blue Shield PPO members **Visit** mavenclinic.com/join/SISC
Hip, Knee, and Spine Surgical Benefit *Carrum Health* Consult top-quality surgeons on hip and knee replacements and certain spine surgeries. Benefit covers all related travel and medical bills.	Anthem and Blue Shield PPO members **Call** 888-855-7806 **Visit** info.carrumhealth.com/sisc
Enhanced Cancer Benefit *Contigo Health* Consult experts on initial diagnosis and development of a care plan. Benefit includes care coordination services with at home provider, transportation, and more.	Anthem and Blue Shield PPO members **Call** 877-220-3556 **Visit** sisc.contigohealth.com

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

Additional Added Value Services Offered by SISC

COBRA/CalCOBRA Administration

COBRA (Consolidated Omnibus Budget Reconciliation Act) is a federal law; CalCOBRA is a state law that attaches itself to COBRA. SISC will administer COBRA and CalCOBRA at no additional cost for SISC III Member Districts when the district offers a medical plan through SISC. This service includes providing members with notification letters and collection of monthly premiums. For more information please refer to the "COBRA" Administration section of this book.

Direct Billing Self-Pay Retirees

Districts have the option of allowing SISC to manage the monthly billing and collection of premium for their self-pay retirees on qualified products. A 90 day advance notice is required for set up of Direct Bill groups. SISC will administer this program for our member districts at no additional cost. For more information please refer to the "Retiree" section of this book.

Section 125 Plan "SISC Flex"

The SISC Flex Plan allows active employees to use pre-tax dollars to pay for eligible medical and dependent care expenses. The plan is divided into four parts:

1. **Premium Only Plan (POP):** Employee paid medical, dental and vision group premiums can be made on a pre-tax basis;
2. **Dependent Care Expense Account:** Payments for daycare, home care, or child-care for care of a dependent child under age 13, a disabled child of any age, a disabled spouse or a disabled dependent parent can be made on a pre-tax basis through this account; and
3. **Health Care Expense Account:** Payments for co-pays, deductibles and many medical, dental and vision expenses that are not covered by insurance can be made on a pre-tax basis through this account.
4. **Limited Purpose Expense Account:** Payments for dental, orthodontia, vision, and preventive care expenses for Health Savings Account (HSA) participants. Additional information is available at: http://sisc.kern.org/flex or contact the SISC Finance department at 661-636-4416, or siscflex@siscschools.org.

Quest Health Screening Program

SISC has partnered with Quest Diagnostics to provide biometric health screenings to covered employees and their eligible dependents over the age of 18. The screening provides an opportunity for members to learn their total cholesterol, HDL, blood pressure, pulse, blood glucose, BMI, and other key biometrics.

Employees also have the option to have their screening done at a Quest Patient Service Center (PSC) if unable to attend the district's onsite event, or if no event is offered by the district.

Program information is available in December and events may be scheduled January through June.

Participation is a voluntary and confidential benefit offered at no cost to our members.

Please visit My.QuestForHealth.com/Home/FAQ or My.QuestForHealth.com/ContactUs for more information, or call 1-855-623-9355.

Onsite Biometric Health Screening

SISC offers free onsite health screening events for Member Districts.

The Districts that have hosted onsite health screening events report that employees have enjoyed the process and learned a lot about their health.

To host an onsite health screening event, please contact your Account Management Team at 661-636-4410.

Onsite Flu Shot Clinics

SISC has partnered with Costco to sponsor free flu shot clinics for districts and bargaining units who participate in the SISC Health Smarts program. Working in schools is a major risk factor for the flu so flu vaccines are especially important for you and your employees. Program information is available in August and the clinics may be scheduled in the fall.

Condition Management

Condition management is a confidential, voluntary program designed to help people with specific conditions stay as healthy as possible for as long as possible. Health management nurses work over the telephone with PPO plan participants who are living with one of the following conditions:

- Diabetes
- Coronary artery disease (CAD)

Please visit the Health Smarts web page at **www.sischealth.com** for additional information.

BLUECARD OUT OF STATE

Protection When Traveling or Living Outside Your Home State

You and your enrolled dependents may access PPO benefits when you're traveling or temporarily living outside your home state with the BlueCard program. The BlueCard also covers enrolled dependents, including students and family members, who temporarily reside outside your home state. To locate BlueCard providers, call BlueCard Access® at 1-800-810-BLUE (2583).

BlueCard is not applicable to HMO plans or Medicare Supplement plans.

Blue Cross Blue Shield (BCBS) Global Core—How Do I Access Medical Care in a Foreign Country?

- Before you leave, contact BCBS Global Care for coverage details. Coverage outside the United States may be different.
- Always carry your current member ID card.
- In an emergency, go directly to the nearest hospital.
- If you need to locate a doctor or hospital or need medical assistance services, call the Service Center for BCBS Global Core at 1-800-810-BLUE (2583) or call collect 1-804-673-1177, 24 hours a day, seven days a week. An assistance coordinator, in conjunction with a medical professional, will arrange a physician appointment or hospitalization, if necessary.
- If you need to be hospitalized, call the Service Center at the numbers listed above and the BCBS Company for pre-certification or pre-authorization. Refer to the phone number on the back of your member ID card to reach the BCBS Company.
- Call the Service Center at 1-800-810-2583 or collect at 1-804-673-1177 when you need inpatient care. In most cases, you should not need to pay upfront for inpatient care at participating BCBS Global Core hospitals except for the out-of-pocket expenses (non-covered services, deductible, co-payment and co-insurance) you normally pay. The hospital should submit your claim on your behalf.
- You will need to pay upfront for care received from a doctor and/or non-participating hospital. Then complete a Blue Cross Blue Shield Global Core international claim form and send it with the bills(s) to the Service Center (the address is on the form). International claim forms are available from, **www.bcbsglobalcore.com**, or the BCBS Global Core Service Center at 1-800-810-2583 or collect at 1-804-673-1177.

Claim Filing Information

- If Blue Cross Blue Shield Global Core arranged your hospitalization, the hospital will file the claim for you; you will need to pay the hospital for the out-of-pocket expenses you normally pay.
- For outpatient and doctor care or inpatient care not arranged through the Blue Cross Blue Shield Global Core center you will need to pay the healthcare provider and submit an international claim form with original bills to the Service Center.
- International claim forms are available from the Service Center or on-line at **www.bcbsglobalcore.com**.

To Learn More about Blue Cross Blue Shield Global Core:

- Call your Blue Cross Blue Shield Plan.
- Visit **www.bcbsglobalcore.com**
- Call the Blue Cross Blue Shield Global Core Service Center at 1-800-810-2583 or call collect at 1-804-673-1177.

Important:
Call the Blue Cross Blue Shield Global Core Center at 1-800-810-BLUE (2583) or call collect at 1-804-673-1177 to locate doctors and hospitals or obtain medical assistance services when outside the United States.

HEALTH SAVINGS ACCOUNT (HSA)

SISC provides qualified HSA compliant health plans. **SISC does not set-up or administer the savings account component of the plan.**

Health Savings Accounts enable tax-free savings for the qualified medical expenses of "eligible individuals" and their dependents.

An "eligible individual" or HSA owner is an individual:

- covered by an HSA-compatible High Deductible Health Plan (HDHP); and
- not covered by a non-HSA compliant plan or Medicare; and
- not claimed as a dependent on another individual's tax return

Qualified medical expenses are defined in Internal Revenue Code Section 213 [d]. In general they include specified deductibles, co-payments and other medical expenses not covered under the HDHP or in any other manner. All HSA-compatible HDHP benefits, including added value programs, are subject to the deductible.

All HSA enrollees will be subject to the plan design and any mid-year changes based on Federal/Legislative guidelines.

HSA Advantages

- HSA contributions are tax-deductible.
- Interest on an HSA is tax-deferred.
- HSAs are portable and owned by the individual; contributions cannot be taken away.
- Unspent balances roll over to the following year and can accumulate over a lifetime to help pay for uncovered Medicare expenses after retirement.
- In the event of the account holder's death, HSA balances pass to their designated beneficiaries.

Frequently Asked Questions

Q: Who can contribute to an HSA?
A: The HSA is funded by contributions from an eligible employee, employer or both.

Q: What is the calendar year maximum amount that can be contributed to an HSA?
A: $4,150 per individual and $8,300 per family (2024)

Q: How does the HSA plan work?
A: Money in the HSA can be used to pay for covered medical expenses and prescriptions not paid by the qualified health plan. The HSA dollars used apply towards the plan's annual deductible. If all of the dollars are not spent, the money remaining in the account will roll over to the following year.

Q: Who do I contact to set up an HSA (Health Savings Account)?
A: Any bank, credit union or other entity that currently meets the IRS standards can be an HSA trustee or custodian. Districts and/or employees may choose a financial institution to administer the savings account.

For additional resources on HSA plans, visit **www.irs.gov**.

Please contact your SISC Account Manager regarding plan design details.

SISC *MEC $9000 and 2-Tier *MEC $9000 PLAN COMPARISON

The objective of the MEC $9000 Plan is to provide a lower cost plan that will assist districts in complying with employer requirements under the Affordable Care Act. Eligibility and plan design of the two-tiered MEC $9000 replaces the previous Anchor Bronze plan. *Minimum Essential Coverage

Frequently Asked Questions	MEC $9000 PPO Plan	2-Tier MEC $9000 PPO Plan
How are MEC and 2-Tier MEC plans different?	There is no difference in the plan design. Please note other differences below.	There is no difference in the plan design. Please note other differences below.
How may this plan be offered?	This plan may be added to current plan options and will count toward the maximum number of plans SISC allows a district/employee group to offer.	This plan will be added to current plan options. This plan will typically be assigned one group number per district and will be shared by all bargaining units. It will NOT count against the maximum number of plans SISC allows a district/employee group to offer. Districts may choose to offer it to all employees.
What is the rate structure?	This plan will follow the same rate structure as the current plan options for the district/employee group.	This plan will only have a two-tier rate structure: Employee OR Employee and Child(ren)
Who is eligible?	Only probationary and permanent district employees, retirees and their eligible dependents may enroll in this plan if offered by their employee group.	If allowed by the district, all district employees and their eligible dependent children may enroll in this plan. This includes variable hour, substitutes, temporary and seasonal employees. Spouses/domestic partners/retirees are not eligible for this plan.
Is participation permitted in the district's dental, vision, and/or life plans through SISC?	When the district/employee group offers dental, vision, and/or life plans through SISC, employees enrolled in this plan MUST participate in dental, vision, and/or life plans.	Non-permanent and part-time employees not eligible for a district contribution CANNOT be enrolled in SISC dental, vision, and/or life plans. SISC dental, vision, and/or life plans may be offered to employees who receive the district cap if the district has provided a signed request on district letterhead. Proof of collective bargaining agreement language is required.
How is this plan different than other SISC PPO Plans?	The pharmacy benefit is subject to the deductible. See benefit overview in the Medical Plans section of this manual.	The pharmacy benefit is subject to the deductible. See benefit overview in the Medical Plans section of this manual. This plan only has a two-tier rate structure: Employee OR Employee and Child(ren).
What is the process to add this plan to the district/employee groups menu of options?	The process is the same as the notification process for any other district plan changes. **Contact your SISC Account Management Team.**	This plan will typically be included as an available plan option. Contact your Account Management team for the setup of dental, vision, or life insurance options for full time or part time benefit eligible employees.
Is the provider network restricted?	No, this plan uses the same network providers as the current PPO plans offered in the manual.	No, this plan uses the same network providers as the current PPO plans offered in this manual.

SECTION 125 PLAN "SISC FLEX"

What is the SISC Flex Plan?

The SISC Flex Plan is an added value service for all SISC III Member districts. The plan allows participants to set aside funds pre-tax to pay for out-of-pocket medical, dental, vision and dependent care expenses. The SISC Flex Plan includes the following options for employees:

- **Premium Only Plan (POP) or Automatic Pre-tax Salary Reduction Option.**
- **Health Care Expense Account:** $3,050 maximum annual election for the 2024 calendar year.
- **Limited Purpose Expense Account:** $3,050 maximum annual election for the 2024 calendar year.
- **Dependent Care Expense Account:** $5,000 maximum annual election for the 2024 calendar year.

Employer Advantages

- **No Fees:** There is no cost to offer the SISC Flex Plan to your employees. 100% of the cost is covered by SISC.
- **Custom Enrollment Materials:** All participant facing communications and enrollment materials are provided by SISC.
- **Easy Administration:** Online enrollment may be available for the SISC Flex Plan. SISC Finance will assist member districts with all aspects of participant administration.

Participant Advantages

- **Excellent Service:** Participants will have access to Navia's refreshing approach to customer service; no phone trees, live representatives with individual phone numbers and email addresses. Navia's customer service team is available Monday–Friday, 5:00am–5:00pm.
- **Available to All:** The SISC Flex Plan is available to ALL active employees of the district. Full-time and part-time employees may participate including those who are not eligible for SISC Health benefits.
- **Online Tools:** Visit Navia's comprehensive website **www.naviabenefits.com** for more information about eligible expenses, merchant lists, and over-the-counter items.

  Once registered employees may view their account balance(s), claims status, and update personal information. Employees have access to FlexConnect an auto-claim substantiation prep tool, Dependent Care, and Orthodontia recurring claim features.

Questions

If you have any additional questions about the available options, please contact:

Carmen Gonzales
SISC—Finance
661-636-4416
cagonzales@siscschools.org

PPO PLANS

	PPO 100%	PPO 90%	PPO 80%
Calendar Year Out-of-Pocket (OOP) Maximums	**Member Pays**	**Member Pays**	**Member Pays**
Individual/Family Deductibles	See PPO Options page		
Individual/Family Out-of-Pocket Maximums (includes deductibles and co-pays)	See PPO Options page		
Professional Services			
Office Visit/Urgent Care Co-pay	See PPO Options page		
Specialists/Consultants Co-pay	See PPO Options page		
Prenatal, Postnatal Office Visit Co-pay	See PPO Options page		
Scans: CT, CAT, MRI, PET, etc.	0%	10%	20%
Diagnostic X-ray and Laboratory Procedures	0%	10%	20%
Infertility Services (see benefit booklet for details)	Not covered		
Preventive Care Services (includes physical exams and screenings)	0%, Deductible Waived		
Hospital and Skilled Nursing Facility Services			
Emergency Room Visit (co-pay waived if admitted)	$100 co-pay	$100 co-pay + 10%	$100 co-pay + 20%
Inpatient Hospital Co-pay (preauthorization required)	0%	10%	20%
Outpatient Hospital Co-pay	0%	10%	20%
Surgery, Outpatient (performed in an ambulatory surgery center)	0%	10%	20%
Surgery, Outpatient (performed in a hospital)	0%	10%	20%
Mental Health Services and Substance Abuse Treatment			
Inpatient Care—Facility-based care (preauthorization required)	0%	10%	20%
Outpatient Care—Facility-based care (preauthorization required)	Deductible waived; office visit co-pay applies		
Other Services			
Acupuncture—Limits apply	0%	10%	20%
Ambulance (ground or air)	$100 co-pay	$100 co-pay + 10%	$100 co-pay + 20%
Chiropractic—Limits apply	0%	10%	20%
Durable Medical Equipment (DME)	0%	10%	20%
Hearing Aids ($700 benefit allowance per 24-month period)	Cost in excess of allowance		
Physical and Occupational Therapy—Limits apply	0%	10%	20%
Prescription Drug Plans			
Generic Co-pay/Days Supply	See Prescription Drug Plan Chart		
Brand Co-pay/Days Supply	See Prescription Drug Plan Chart		
Mail Order (generic-brand co-pay/days supply)	See Prescription Drug Plan Chart		

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

PPO PLAN OPTIONS

Calendar Year Deductibles, Out-of-Pocket (OOP) Maximums and Co-pays

100% Plans	Individual/Family Deductible	Individual/Family OOP Maximums	Office Visit Co-pay
100-A $10	$0/$0	$1,000/$3,000	$10
100-A $20	$0/$0	$1,000/$3,000	$20
100-B $20	$100/$300	$1,000/$3,000	$20
100-C $20	$200/$400	$1,000/$3,000	$20
100-D $20	$300/$600	$1,000/$3,000	$20
100-G $20	$500/$1,000	$1,000/$3,000	$20

90% Plans	Individual/Family Deductible	Individual/Family OOP Maximums	Office Visit Co-pay
90-A $20	$100/$300	$1,000/$3,000	$20
90-C $20	$200/$500	$1,000/$3,000	$20
90-G $20	$500/$1,000	$1,000/$3,000	$20

80% Plans	Individual/Family Deductible	Individual/Family OOP Maximums	Office Visit Co-pay
80-C $20	$200/$500	$1,000/$3,000	$20
80-E $20	$300/$600	$1,000/$3,000	$20
80-G $20	$500/$1,000	$2,000/$4,000	$20
80-G $30	$500/$1,000	$2,000/$4,000	$30
80-J $30	$750/$1,500	$3,000/$6,000	$30
80-K $30	$1,000/$2,000	$3,000/$6,000	$30
80-L $30	$2,000/$4,000	$4,000/$8,000	$30
80-M $40	$3,000/$6,000	$4,000/$8,000	$40

Calendar-year Out-of-Pocket Maximums include plan co-pays, deductible and co-insurance for in-network and emergency services.

Medical Out-of-Pocket Maximums shown are for medical plans only. See Prescription Drug Page for applicable Pharmacy Out-of-Pocket Maximums.

Plans shown on this page are non-HSA compliant.

HSA PLANS

Unless otherwise stated, member responsibility below is after the deductible has been met.

	HSA $1700 Single Coverage	HSA $1700 Family Coverage	HSA $3400	HSA $5000 (formerly Minimum Value Plan)
Calendar Year Out-of-Pocket (OOP) Maximums	**Member Pays**	**Member Pays**	**Member Pays**	**Member Pays**
Individual/Family Deductibles (unless otherwise noted, all services are subject to deductible)	$1700	$3,400*/$3,400	$3,400/$6,800	$5,000/$10,000
Individual/Family Out-of-Pocket Maximums (includes deductibles and co-pays)	$3,400	$3,400/$6,800	$6,000/$12,000	$6,350/$12,700
Professional Services	**After Deductible**		**After Deductible**	**After Deductible**
Office Visit/Urgent Care Co-pay	10%		10%	30%
Specialists/Consultants Co-pay	10%		10%	30%
Prenatal, Postnatal Office Visit Co-pay	10%		10%	30%
Scans: CT, CAT, MRI, PET, etc.	10%		10%	30%
Diagnostic X-ray & Laboratory Procedures	10%		10%	30%
Infertility Svcs (see benefit booklet for details)	Not covered		Not covered	Not covered
Preventive Care Services (includes physical exams and screenings)	0%, ded waived		0%, ded waived	0%, ded waived
Hospital and Skilled Nursing Facility Services	**After Deductible**		**After Deductible**	**After Deductible**
Emergency Room Visit (co-pay waived if admitted)	10% $100 co-pay		10% $100 co-pay	30% $100 co-pay
Inpatient Hospital Co-pay (preauthorization required)	10%		10%	30%
Outpatient Hospital Co-pay	10%		10%	30%
Surgery, Outpatient (performed in an ambulatory surgery center)	10%		10%	30%
Surgery, Outpatient (performed in a hospital, limits apply)	10%		10%	30%
Mental Health Services and Substance Abuse Treatment	**After Deductible**		**After Deductible**	**After Deductible**
Inpatient Care—Facility-based care (preauthorization required)	10%		10%	30%
Outpatient Care—Facility-based care (preauthorization required)	10%		10%	30%
Other Services	**After Deductible**		**After Deductible**	**After Deductible**
Acupuncture—Limits apply	10%		10%	30%
Ambulance (ground or air)	10% $100 co-pay		10% $100 co-pay	30% $100 co-pay
Chiropractic—Limits apply	10%		10%	30%
Durable Medical Equipment (DME)	10%		10%	30%
Hearing Aids ($700 benefit allowance per 24-month period)	Cost in excess of allowance		Cost in excess of allowance	30% plus cost in excess of allowance
Physical/Occupational Therapy - Limits apply	10%		10%	30%
Prescription Drug Plans	**After Deductible**			
Generic Co-pay/Day Supply	$9/30 day supply			
Brand Co-pay/Day Supply	$35/30 day supply			
Mail Order (generic-brand co-pay/day supply)	$0-90/90 day supply			

*See the Kaiser HSA $1700 Plan for Individual Deductible on Family Coverage This is only a brief summary of benefits that reflects In-Network benefits. Please review the benefit summaries or plan booklets for details, limitations and exclusions. Benefits may be subject to change due to mid-year legislative changes.

MEC $9000 and 2-Tier WABE Match option

Unless otherwise stated, member responsibility below is after the deductible has been met.

	MEC $9000	2-Tier MEC $9000 (WABE Match)
Calendar Year Out-of-Pocket (OOP) Maximums	**Member Pays**	
Individual/Family Deductibles	$9,000/$18,000	
Individual/Family Out-of-Pocket Maximums (includes deductibles and co-pays)	$9,000/$18,000	
Professional Services	**After Deductible**	
Office Visit/Urgent Care Co-pay	0%	
Specialists/Consultants Co-pay	0%	
Prenatal, Postnatal Office Visit Co-Pay	0%	
Scans: CT, CAT, MRI, PET, etc.	0%	
Diagnostic X-ray and Laboratory Procedures	0%	
Infertility (see benefit booklet for details)	Not covered	
Preventive Care Services (includes physical exams and screenings)	0%, deductible waived	
Hospital and Skilled Nursing Facility Services	**After Deductible**	
Emergency Room Visit Co-pay	0%	
Inpatient Hospital Co-pay (preauthorization required)	0%	
Outpatient Hospital Co-pay	0%	
Surgery, Outpatient (performed in an ambulatory surgery center)	0%	
Surgery, Outpatient (performed in a hospital, limits apply)	0%	
Mental Health Services and Substance Abuse Treatment	**After Deductible**	
Inpatient Care Facility-based care (preauthorization required)	0%	
Outpatient Care Facility-based care (preauthorization required)	0%	
Other Services	**After Deductible**	
Acupuncture—Limits apply	0%	
Ambulance (ground or air)	0%	
Chiropractic—Limits apply	0%	
Durable Medical Equipment (DME)	0%	
Hearing Aids ($700 benefit allowance per 24-month period)	Cost in excess of allowance	
Physical and Occupational Therapy—Limits apply	0%	
Prescription Drug Plans	**After Deductible**	
Generic Co-pay/Days Supply	$0	
Brand Co-pay/Days Supply	$0	
Mail Order (generic-brand co-pay/days supply)	$0	

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ANTHEM BLUE CROSS HMO PLANS

	Anthem Premier HMO 10	Anthem Premier HMO 20	Anthem Classic HMO 20/40/250 Admit	Anthem Value HMO 30/40/500/ 3 day
Calendar Year Out-of-Pocket (OOP) Maximums	**Member Pays**	**Member Pays**	**Member Pays**	**Member Pays**
Individual/Family Deductibles	$0/$0			
Individual/Family Out-of-Pocket Maximums (includes deductibles and co-pays)	$1,000/$2,000	$1,500/$3,000	$2,000/$4,000	$2,500/$5,000
Professional Services				
Office Visit/Urgent Care Co-pay	$10	$20	$20	$30
Specialists/Consultants Co-pay	$10	$20	$40	$40
Prenatal, Postnatal Office Visit Co-pay	$10	$20	$20	$30
Scans: CT, CAT, MRI, PET, etc.	$100 per test			
Diagnostic X-ray and Laboratory Procedures	$0			
Infertility (see benefit booklet for details)	50%			
Preventive Care Services (includes physical exams and screenings)	$0			
Hospital and Skilled Nursing Facility Services				
Emergency Room Visit (co-pay waived if admitted)	$100	$100	$100	$150
Inpatient Hospital Co-pay (preauthorization required)	$0	$200	$250	$500/day 3-day max
Outpatient Hospital Co-pay	$0	$100	$125	$250
Surgery, Outpatient (performed in an ambulatory surgery center)	$0	$100	$125	$250
Surgery, Outpatient (performed in a hospital)	$0	$100	$125	$250
Mental Health Services and Substance Abuse Treatment				
Inpatient Care Facility-based care (preauthorization required)	$0	$200	$250	$500/day 3-day max
Outpatient Care Facility-based care (preauthorization required)	$0			
Other Services				
Acupuncture • Via HMO Plan—PCP-referred (limits apply) • Via Plan Rider—Self-referred (limits apply)	• Office visit co-pay • $10/30 visits combined with chiropractic			
Ambulance (ground or air)	$100			
Chiropractic • Via HMO Plan—PCP-referred (limits apply) • Via Plan Rider—Self-referred (limits apply)	• Office visit co-pay • $10/30 visits combined with acupuncture			
Durable Medical Equipment (DME)	0%	20%	20%	50%
Hearing Aids (50% benefit allowance/1 device/36 months)	Cost in excess of allowance			
Physical and Occupational Therapy—Limits apply	$10	$20	$40	$40

	Anthem Premier HMO 10	Anthem Premier HMO 20	Anthem Classic HMO 20/40/250 Admit	Anthem Value HMO 30/40/500/ 3 day
Prescription Drug Plans				
Generic Co-pay/Day Supply	See Prescription Drug Plan Chart			
Brand Co-pay/Day Supply	See Prescription Drug Plan Chart			
Mail Order (generic-brand co-pay/day supply)	See Prescription Drug Plan Chart			

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BLUE SHIELD HMO PLANS

	Blue Shield HMO 10-0	Blue Shield HMO 20-250	Blue Shield HMO 25-500	Blue Shield HMO 30-20% Zero Facility
Calendar Year Out-of-Pocket (OOP) Maximums	**Member Pays**	**Member Pays**	**Member Pays**	**Member Pays**
Individual/Family Deductibles	$0/$0			
Individual/Family Out-of-Pocket Maximums (includes deductibles and co-pays)	$1,000/$2,000	$1,500/$3,000	$2,000/$4,000	$1,500/$3,000
Professional Services				
Office Visit/Urgent Care Co-pay	$10	$20	$25	$30
Specialists/Consultants Co-pay	$10	$20	$25	$30
Prenatal, Postnatal Office Visit Co-pay	$0	$0	$0	$30
Scans: CT, CAT, MRI, PET etc.	$0			
Diagnostic X-ray and Laboratory Procedures	$0			
Infertility (see benefit booklet for details)	50%			
Preventive Care Services (includes physical exams and screenings)	$0			
Hospital and Skilled Nursing Facility Services				
Emergency Room Visit (co-pay waived if admitted)	$100	$100	$100	$150
Inpatient Hospital Co-pay (preauthorization required)	$0	$250	$500	20%
Outpatient Hospital Co-pay	$0	$250	$500	$0
Surgery, Outpatient (performed in an ambulatory surgery center)	$0	$100	$150	$0
Surgery, Outpatient (performed in a hospital)	$0	$150	$300	$0
Mental Health Services and Substance Abuse Treatment				
Inpatient Care Facility-based care (preauthorization required)	$0	$250	$500	20%
Outpatient Care Facility-based care (preauthorization required)	$10	$20	$25	$30
Other Services				
Acupuncture—Limits apply	$10/30 visits combined with chiropractic			
Ambulance (ground or air)	$100			
Chiropractic—Limits apply	$10/30 visits combined with acupuncture			
Durable Medical Equipment (DME)	0%	20%	20%	20%
Hearing Aids (50% benefit allowance/1 device/24 months)	Cost in excess of allowance			
Physical and Occupational Therapy—Limits apply	$10	$20	$25	$30
Prescription Drug Plans				
Generic Co-pay/Days Supply	See Prescription Drug Plan Chart			
Brand Co-pay/Days Supply	See Prescription Drug Plan Chart			
Mail Order (generic-brand co-pay/days supply)	See Prescription Drug Plan Chart			

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KAISER HMO PLANS

	Kaiser Traditional HMO $10/$10	Kaiser Traditional HMO $20/$10-$20	Kaiser Traditional HMO $30/$10-$30	Kaiser Deductible HMO $500 Hospital ONLY	Kaiser Deductible HMO $1,000 Hospital ONLY
Calendar Year Out-of-Pocket (OOP) Maximums	**Member Pays**	**Member Pays**	**Member Pays**	**Member Pays**	**Member Pays**
Individual/Family Deductibles	$0	$0	$0	$500/$1,000	$1,000/$2,000
Individual/Family Out-of-Pocket Maximums (includes deductibles and co-pays)	$1,500/$3,000	$1,500/$3,000	$1,500/$3,000	$3,000/$6,000	$3,000/$6,000
Professional Services					
Office Visit/Urgent Care Co-pay	$10	$20	$30	$20	$20
Specialists/Consultants Co-pay	$10	$20	$30	$20	$20
Prenatal, Postnatal Office Visit Co-pay			$0		
Scans: CT, CAT, MRI, PET, etc.	$0	$0	$0	10% up to $50	10% up to $50
Diagnostic X-ray and Laboratory Procedures	$0	$0	$0	$10	$10
Infertility (see benefit booklet for details)			Office visit co-pay or hospitalization co-pay applies		
Preventive Care Services (includes physical exams and screenings)	$0	$0	$0	$0, ded waived	$0, ded waived
Hospital and Skilled Nursing Facility Services					
Emergency Room Visit (co-pay waived if admitted)	$100	$100	$100	10% (after ded)	20% (after ded)
Inpatient Hospital Co-pay (preauthorization required)	$0	$0	$0	10% (after ded)	20% (after ded)
Outpatient Hospital Co-pay	$10	$20	$30	10% (after ded)	20% (after ded)
Surgery, Outpatient (performed in an ambulatory surgery center)	$10	$20	$30	10% (after ded)	20% (after ded)
Surgery, Outpatient (performed in a hospital)	$10	$20	$30	10% (after ded)	20% (after ded)
Mental Health Services and Substance Abuse Treatment					
Inpatient Care—Facility-based care (preauthorization required)	$0	$0	$0	10% (after ded)	20% (after ded)
Outpatient Care—Facility-based care (preauthorization required)	$10	$20	$30	10% (after ded)	20% (after ded)
Other Services					
Acupuncture—Limits apply			$10/30 visits		
Ambulance (ground or air)	$50	$50	$50	$150	$150
Chiropractic—Limits apply			$10/30 visits		
Durable Medical Equipment (DME)	$0	$0	$0	20% (after ded)	20% (after ded)

	Kaiser Traditional HMO $10/$10	Kaiser Traditional HMO $20/$10-$20	Kaiser Traditional HMO $30/$10-$30	Kaiser Deductible HMO $500 Hospital ONLY	Kaiser Deductible HMO $1,000 Hospital ONLY
Hearing Aids ($500 benefit allowance/device—1 device/ear—2 devices/36-month period)	Cost in excess of allowance				
Physical and Occupational Therapy—Limits apply	$10	$20	$30	$20	$20
Prescription Drug Plans					
Generic Co-pay/Day Supply	$10/100-day	$10/100-day	$10/100-day	$10/30-day	$10/30-day
Brand Co-pay/Day Supply	$10/100-day	$20/100-day	$30/100-day	$30/30-day	$30/30-day
Mail Order (generic-brand co-pay/day supply)	$10/100-day	$10-20/ 100-day	$10-30/ 100-day	$20-60/ 100-day	$20-60/ 100-day

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

KAISER HSA PLANS

	HSA-$1700 Kaiser—Single Coverage	HSA-$1700 Kaiser—Family Coverage	HSA-$3400 Kaiser
Calendar Year Out-of-Pocket (OOP) Maximums	**Member Pays**	**Member Pays**	**Member Pays**
Individual/Family Deductibles	$1,700/$3,400	$3,200/$3,400	$3,400/$6,800
Individual/Family Out-of-Pocket Maximums (includes deductibles and co-pays)	$3,400/$6,800	$3,400/$6,800	$6,000/$12,000
Professional Services			
Office Visit/Urgent Care Co-pay	10%		20%
Specialists/Consultants Co-pay	10%		20%
Prenatal, Postnatal Office Visit Co-pay	$0		$0
Scans: CT, CAT, MRI, PET, etc.	10%		20%
Diagnostic X-ray and Laboratory Procedures	10%		20%
Infertility (see benefit booklet for details)	Office visit co-pay or hospitalization co-pay applies		Office visit co-pay or hospitalization co-pay applies
Preventive Care Services (includes physical exams and screenings)	0%, ded waived		0%, ded waived
Hospital and Skilled Nursing Facility Services			
Emergency Room Visit (co-pay waived if admitted)	10%		20%
Inpatient Hospital Co-pay (preauthorization required)	10%		20%
Outpatient Hospital Co-pay	10%		20%
Surgery, Outpatient (performed in an ambulatory surgery center)	10%		20%
Surgery, Outpatient (performed in a hospital)	10%		20%
Mental Health Services and Substance Abuse Treatment			
Inpatient Care—Facility-based care (preauthorization required)	10% after deductible		20% (after ded)
Outpatient Care—Facility-based care (preauthorization required)	10% after deductible		20% (after ded)
Other Services			
Acupuncture—Limits apply	Limited coverage, if authorized		Limited coverage, if authorized
Ambulance (ground or air)	10%		20%
Chiropractic—Limits apply	Not covered		Not covered
Durable Medical Equipment (DME)	10%		20%
Hearing Aids	Not covered		Not covered
Physical and Occupational Therapy—Limits apply	10%		20%
Prescription Drug Plans			
Generic Co-pay/Day Supply	$10/30-day (after ded)		$10/30-day (after ded)
Brand Co-pay/Day Supply	$30/30-day (after ded)		$30/30-day (after ded)
Mail Order (generic-brand co-pay/day supply)	$20–60/100-day (after ded)		$20–60/100-day (after ded)

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

ADDITIONAL MEDICAL PLAN NOTATIONS

- Prescription drug copays do not apply to the Out-of-Pocket (OOP) maximums with the exception of Health Savings Accounts and Kaiser plans.
- Deductibles and Out-of-pocket maximums accrue on a calendar year (Jan-Dec) basis.
- The SISC PPO medical and Rx plans have 4th quarter deductible carryover. This plan feature allows amounts credited toward the deductible in the 4th quarter of the calendar year (Oct–Dec) to carry over and apply to the deductible for the following calendar year. The 4th quarter carryover does not apply to copays, coinsurance, or HSA plans.
- The district may not partially pay, reimburse, or otherwise reduce the member's OOP responsibility unless they contribute to a Health Savings Account (HSA) for the employee. Plan rates are based on members making benefit decisions based on their OOP responsibilities and being a thoughtful consumer of health care.
- Unless otherwise noted, co-insurance applies after the deductible has been met.
- Narrow network plans may be available in certain regions. Contact your account management team for details.

This sheet is only a brief summary of benefits that reflects In-Network benefits.

Please review the benefit summaries and benefit booklets for details, limitations and exclusions. Benefits may be subject to change due to mid-year legislative changes.

PHARMACY BENEFIT INFORMATION

Generic Substitution

If a brand name medication has a generic equivalent available, the pharmacy or mail order facility will automatically fill the prescription with a generic when the brand name is not medically necessary. If the physician or member requests to have a brand name medication dispensed when it is not medically necessary, the member will pay the difference in the cost of the brand and generic medication plus the generic co-pay.

There is a Clinical Review Process through which it is possible to have a determination made as to whether or not a brand name drug is medically necessary. The member's physician may contact customer service to initiate the review process*. If approved as medically necessary, the member will pay the brand co-pay.

**Some restrictions apply.*

Mail Order Pharmacy Service

Members may use the mail order pharmacy for their maintenance medications. A member can order a 90-day supply and have the convenience of having the medications shipped directly to their home (or alternate address) by paying the co-pays shown on the next page. Everything a member needs to place an order should be available at the district office or by calling Navitus' customer service. **Please note:** Not all prescriptions can be filled by mail order.

What is a Specialty Medication?

Specialty medications are high-cost injectable, infused, oral, or inhaled medications that generally require special handling and may be subject to special rules such as quantity limits, prior authorization and/or step therapy. These medications have become a vital part of the treatment for chronic illnesses and complex diseases such as multiple sclerosis, rheumatoid arthritis and cancer.

Some medications may involve special delivery and instructions that not all pharmacies can easily provide. These medications require personalized coordination between the member, the prescriber and pharmacy. Navitus Specialty helps patients stay on track with treatment while offering the highest standard of compassionate care through personalized support, free delivery and refill reminders. Most medications classified as Specialty can be found on the SISC Drug List located on Navitus' secure member website Navi-Gate for Members at **www.navitus.com**.

Deductible Plans (on brand name drugs only)

Deductible plans create consumer awareness by requiring the member to share in more of the cost of brand name medications. Since generics are not subject to the brand name only deductible, these plans encourage members to consider lower cost generic alternatives.

These plans help to keep the cost of the monthly premium down. The deductible works the same way as a medical deductible. It is based on a calendar year. Like most SISC pharmacy plans, members enrolled in the deductible plans still have access to zero or reduced co-pays on most generic drugs at Costco. See next page for details on the Costco program for generic drugs.

Please refer to the Pharmacy Benefit Booklet or the Evidence of Coverage for additional information regarding plan benefits.

PRESCRIPTION DRUG PLANS 2024-2025

Free Generic Drugs at Costco as well as through Mail Order (80% of prescriptions are filled with Generic Drugs)

Costco Pharmacies are open to non-Costco members.

		WALK-IN			MAIL	
	DAYS SUPPLY	NETWORK 30	COSTCO 30	COSTCO 90	COSTCO 90	NAVITUS 30
Plan 5-20	Generic	$5	FREE	FREE	FREE	
	Brand	$20	$20	$50	$50	
	Specialty*					$20
	Out-of-Pocket Maximum	$1,500 Individual/$2,500 Family				
Plan 7-25	Generic	$7	FREE	FREE	FREE	
	Brand	$25	$25	$60	$60	
	Specialty*					$25
	Out-of-Pocket Maximum	$1,500 Individual/$2,500 Family				
Plan 9-35	Generic	$9	FREE	FREE	FREE	
	Brand	$35	$35	$90	$90	
	Specialty*					$35
	Out-of-Pocket Maximum	$2,500 Individual/$3,500 Family				
Plan 200 10-35	Brand/Specialty Deductible**	$200 Individual/$500 Family				
	Generic	$10	FREE	FREE	FREE	
	Brand	$35	$35	$90	$90	
	Specialty*					$35
	Out-of-Pocket Maximum	$2,500 Individual/$3,500 Family				

** Drugs designated as Specialty Drugs are only available in 30-day supplies through the mail from Navitus.*
*** Rx plans on this page with a deductible include fourth quarter carryover. Once the deductible has been satisfied, the member will be responsible for the brand name co-pay.*

Free Generic Drugs at Costco as well as through Mail Order

- **Some narcotic pain and cough medications are not included in the Costco Free Generic or 90-day supply programs.**
- **Due to Medicare Part D restrictions, this program does not apply to the CompanionCare pharmacy benefit.**

Generic Co-Pays for Lancets and Syringes

Generic Co-Pays for Test Strips manufactured by Abbott (Freestyle) and Lifescan (One Touch)

- **Diabetic supplies are only available as brand prescriptions and not generic. However, the SISC pharmacy plans charge the generic co-pay for Lancets and Syringes. In addition, SISC pharmacy plans charge the generic co-pay on Test Strips manufactured by Abbott (Freestyle) and Lifescan (One touch). The brand co-pay is charged for all test strips from other manufacturers.**

The group plan benefits must be communicated without modification to the members. A district may not partially pay, reimburse or otherwise reduce the member's responsibility for deductibles, co-pays, coinsurance, etc.

RETIREE GROUP MEDICARE PLANS (RGMP)

In addition to district retiree plans SISC offers three Retiree Group Medicare Plan (RGMP) options. These are available to retirees turning age 65 enrolled in Medicare Parts A and B when offered by the district.

Members are required to maintain continuous coverage of Medicare Parts A and B while enrolled in an over-65 retiree plan. Members are automatically enrolled into Medicare Part D on SISC Retiree Group Medicare Plans.

- **Blue Shield 65 Plus HMO Medicare Advantage Plan (BSMA):** Must reside in California service area
- **CompanionCare Medicare Supplement Plan (COC):** Must reside within the United States
- **Kaiser Medicare Senior Advantage Plan (KPSA):** Must reside in California service area
- **PPO 100-A $0 Plan (EGWP):** Must reside within the United States

All forms will be available on the SISC secure web portal (SISCconnect) at siscconnect.org.

When Can a Retiree Enroll?

A retiree with Medicare Parts A and B may enroll at any time. They do not need to wait for Open Enrollment. A signed and completed application must be received 45 days prior to the effective date.

Why is a 45-Calendar-Day Advance Notice Required for Enrollments and Disenrollments?

Centers for Medicare and Medicaid Services (CMS) require advance notice for enrollments and disenrollments in order to set up the account.

If the enrollment and/or disenrollment form is not submitted in advance the retiree may not get the effective and/or termination date that was requested. Members may not have their Medicare restored with the requested effective date due to an untimely submission of the disenrollment form.

How do I Submit Activity for the Retiree Group Medicare Plans?

Drop off activity to SISC using the SISCconnect secure web portal at **siscconnect.org**. It needs to be sent separately from the district activity and should include "RGMP documents" as part of the file name.

This process will help SISC sort through the volume of activity and identify these time-sensitive items more quickly. These plans are regulated by Centers for Medicare and Medicaid Services (CMS) which requires a different process and are not easily identified when batched with other activity and/or forms.

The following documents that will be affected are the CompanionCare Application, Kaiser Senior Advantage Election form and the Blue Shield Medicare Advantage enrollment form along with a copy of the retiree's Medicare card.

Can Retirees Enroll in Dental and/or Vision?

Yes. Retirees on a Retiree Group Medicare Plan have the option to retain their district vision and/or dental coverage but they must pay the appropriate **retiree rate** for the dental and/or vision coverage. The spouse/domestic partner of a retiree is only eligible for the products in which the retiree is currently enrolled.

If Kaiser Senior Advantage retirees enroll in dental, vision or hearing aid benefit directly through Kaiser this will trigger a termination of their SISC medical coverage.

Are Retro Enrollments and Disenrollments Allowed?

No. Retro enrollments and disenrollments are not allowed on the Medicare Advantage Plan or CompanionCare.

Are Retirees Allowed to go Back to a District Plan Once They Have Enrolled in an RGMP?

Yes. Upon district approval a retiree may return to a district medical plan at open enrollment as long as there is no break in SISC coverage

How Should I Keep Track of Our Retirees?

Send out an annual letter requesting confirmation of contact information that you have on file.

BLUE SHIELD 65 PLUS HMO MEDICARE ADVANTAGE PLAN

What is Blue Shield 65 Plus HMO Medicare Advantage?

Blue Shield 65 **Plus** HMO is a Medicare Advantage Plan that is offered through a Health Maintenance Organization (HMO) in lieu of Medicare benefits. The HMO contracts with Centers for Medicare and Medicaid Services (CMS) to provide a wide variety of benefits. Retirees cannot use their Medicare benefits while enrolled in this plan.

Who Can Enroll?
This plan may be offered to retirees over the age of 65 with Medicare Parts A and B (see **www.medicare.gov** for information on Medicare).

Is There Dependent Coverage?
No. Blue Shield 65 Plus HMO Medicare Advantage Plan is an individual enrollment. If a spouse/domestic partner qualifies for enrollment in Blue Shield 65 Plus HMO Medicare Advantage they would enroll on their own contract.

How Does a Member Enroll?
A Blue Shield 65 Plus HMO Medicare Advantage enrollment form *must* be completed and submitted to SISC along with a copy of the member's Medicare card. A 45-calendar day advance notice and proof of enrollment in both Medicare Parts A and B is required.

What if the Member is Missing a Part of Medicare or Does Not Assign Their Medicare to Blue Shield?
The member would not be eligible. Members enrolled in this plan must have continuous Medicare Parts A and B coverage.

How Does a Member Disenroll?
A SISC disenrollment form is required to cancel Blue Shield 65 Plus HMO Medicare Advantage. By disenrolling, the member will have their Medicare benefits restored. Until the cancellation process is complete, the retiree cannot use their Medicare benefits.

Does the Member Need to Enroll in Medicare Part D?
No. Retirees enrolling in Medicare Advantage Plans will be automatically enrolled in Medicare Part D for prescription drug coverage. This automatic enrollment in Medicare Part D through the Medicare Advantage Plan will cause the retiree to be automatically disenrolled from Medicare Part D coverage through other plans.

Where Does a Member Find a Provider?
Members can contact customer service.

How Do I Find out if I Live in a Blue Shield 65 Plus HMO Medicare Advantage (GMA-PD) Service Area?
Although the HMO coverage for Active employees may be offered in the city/county and ZIP Code of the retiree's permanent residence, the Medicare Advantage Plan may not be available in that ZIP Code area. Members must live in an approved ZIP Code of the Blue Shield of California GMA-PD service area. Please contact the SISC office to make certain that this benefit is offered in the ZIP Code where the retiree resides. Medicare Advantage Plans are not available through SISC outside the State of California.

COMPANIONCARE MEDICARE SUPPLEMENT PLAN

What is CompanionCare?
CompanionCare Plan is a supplement to Medicare. The plan is "claim free" only when a provider accepts assignment of Medicare Benefits. When the member uses a provider who does not accept assignment of Medicare Benefits, the provider of service or member must file the claim twice; once for the Medicare payment and then again for the plan payment.

How Does CompanionCare Coordinate with Medicare?
The provider will need to submit claims to Medicare for payment and to Anthem Blue Cross for CompanionCare to pay. Medicare pays 80% of allowable charges and CompanionCare will pay for the other 20% of allowable charges. "In-network" Medicare providers may choose to charge up to 15% more than the Medicare Allowed Amount. The CompanionCare plan will not pay the excess charges over the allowed amount.

Who Can Enroll?
This plan may be offered to retirees over 65 with Medicare Parts A and B (see **www.medicare.gov** for information on Medicare) and retirees **under age 65 with Medicare for the disabled**. In order to be eligible, the member must be retired and enrolled in both Medicare Parts A and B. No Exceptions.

Is There Dependent Coverage?
No. CompanionCare is an individual enrollment. If a spouse/domestic partner qualifies for enrollment in CompanionCare they would enroll on their own contract.

How Does a Member Enroll?
A CompanionCare enrollment form must be completed and submitted to SISC with a copy of the member's Medicare card. If the card is not available, enrollment in CompanionCare will be delayed until the card is received.

How Does a Member Disenroll?
A member must complete a SISC disenrollment form to terminate coverage in CompanionCare. This termination will cancel both the medical and prescription drug benefits.

Does The Member Need to Enroll in Medicare Part D?
No. SISC will automatically enroll CompanionCare members in Medicare Part D for prescription medications. CompanionCare members already enrolled in non-SISC Medicare Part D plan will be automatically disenrolled from those plans.

What Happens if Member Enrolls in a Medicare Part D Plan Outside of SISC?
The Centers for Medicare and Medicaid Services (CMS) does not allow a member to be enrolled in two Medicare Part D plans. The SISC medical and prescription drug benefits will be terminated.

Where Does a Member Find a Provider for CompanionCare?
Any provider that accepts Medicare will accept CompanionCare.

Are There Benefits Outside of California with CompanionCare?
Yes. Medicare is the primary insurance and as long as the provider accepts Medicare, CompanionCare will pay on allowed charges.

PPO EGWP PLAN

What is the PPO EGWP Plan?
The PPO EGWP Plan (Employer Group Waiver Plan) is a PPO plan that coordinates with Original Medicare for both medical and Part D prescription drugs.

How Does PPO EGWP Coordinate with Medicare?
The plan requires the member use a provider that accepts Medicare assignment in order to receive the greatest benefit. When the member uses a provider who does not accept assignment of Medicare Benefits the member may incur additional costs. The provider will need to submit claims to Medicare for payment and to the medical carrier for secondary payment. The EGWP plan will not pay the excess charges over the PPO contracted amount.

Who Can Enroll?
This plan may be offered to retirees over 65 with Medicare Parts A and B (see **www.medicare.gov** for information on Medicare) and retirees **under age 65 with Medicare for the disabled**. In order to be eligible, the member must be retired and maintain continuous enrollment in both Medicare Parts A and B. No Exceptions.

Is There Dependent Coverage?
Yes. Dependents who are enrolled in Part A and Part B of Medicare may be enrolled on the same plan with the subscriber.

How Does a Member Enroll?
An EGWP enrollment form must be completed and submitted to SISC with a copy of the member's Medicare card. If the card is not available, enrollment will be delayed until the card is received.

How Does a Member Disenroll?
A member must complete a SISC disenrollment form to terminate coverage . This termination will cancel both the medical and prescription drug benefits.

Does The Member Need to Enroll in Medicare Part D?
No. SISC will automatically enroll EGWP members in Medicare Part D for prescription medications. Members already enrolled in a non-SISC Medicare Part D plan will be automatically disenrolled from those plans.

What Happens if Member Enrolls in a Medicare Part D Plan Outside of SISC?
The Centers for Medicare and Medicaid Services (CMS) does not allow a member to be enrolled in two Medicare Part D plans. The SISC EGWP medical and prescription drug benefits will be terminated and the member moved temporarily to a non-Medicare plan at a higher monthly premium.

Where Does a Member Find a Provider for EGWP?
Any provider that accepts Medicare and is contracted in the carrier's PPO network.

Are There Benefits Outside of California with EGWP?
Yes. Medicare is the primary insurance and as long as the provider accepts Medicare. Outside of California, the carrier network is the Blue Cross/Blue Shield association.

KAISER SENIOR ADVANTAGE (KPSA) MEDICARE ADVANTAGE PLAN

What is Kaiser Senior Advantage?
Kaiser Senior Advantage is a Medicare Advantage Plan that is offered through a Health Maintenance Organization (HMO) in lieu of Medicare benefits. The HMO contracts with Centers for Medicare and Medicaid Services (CMS) to provide a wide variety of benefits. Retirees are required to assign their Medicare Parts A and B over to Kaiser while enrolled in this plan and cannot use their Medicare benefits while enrolled.

Who Can Enroll?
This plan may be offered to retirees over the age of 65 with Medicare Parts A and B (see **www.medicare.gov** for information on Medicare).

Is Dependent Coverage Different?
Yes. If the retiree has a dependent under the age of 65, their dependent may continue to participate in the same HMO plan that they are currently enrolled. However, the retiree's coverage will be the Senior Advantage benefits which could be different from the district's benefit (see the "Retiree" section of this manual).

How Does a Member Enroll?
A Kaiser Senior Advantage Election Form **must** be completed and submitted to SISC along with a copy of the member's Medicare card showing proof of enrollment in Medicare Parts A and B.

It is now **required** that the Kaiser Election form be date stamped (top of page one on the form) by the district when the completed and signed form is received from the member. A District could incur a surcharge if the form is not date stamped when received. This provides proof of receipt by the district in a timely manner (45- calendar days' advance notice).

What if the Member is Missing a Part of Medicare or Does Not Assign Their Medicare to Kaiser?
The member would not be eligible. If a member is missing a part of Medicare or does not assign their Medicare a surcharge will be assessed and added to the district's next monthly SISC invoice. Members enrolled in this plan must have continuous Medicare Parts A and B coverage.

How Does a Member Disenroll?
A SISC disenrollment form is required to cancel Kaiser Medicare Senior Advantage. By disenrolling, the member will have their Medicare benefits restored. Until the cancellation process is complete, the retiree cannot use their Medicare benefits.

Does the Member Need to Enroll in Medicare Part D?
No. Retirees enrolling in Medicare Advantage Plans will be automatically enrolled in Medicare Part D for prescription drug coverage. This automatic enrollment in Medicare Part D through the Medicare Advantage Plan will cause the retiree to be automatically disenrolled from Medicare Part D coverage through other plans. There is no donut hole on the SISC KPSA pharmacy plans.

Where Does a Member Find a Provider?
Members can contact customer service.

How Do I Find out if I Live in a Kaiser Service Area?
Although the HMO coverage for Active employees may be offered in the city/county and ZIP Code of the retiree's permanent residence, the Medicare Advantage Plan may not be available in that ZIP Code area. Please contact the SISC office to make certain that this benefit is offered in the ZIP Code where the retiree resides.

Medicare Advantage Plans are not available through SISC outside the State of California.

DIRECT BILLING SELF-PAY RETIREES

SISC offers this added value service to our member districts at no cost to the retiree or the district. This service allows member districts the option of SISC managing the monthly billing and collection of medical, dental, and/or vision premiums for eligible retirees.

In order to be eligible for this service the retiree must meet the following guidelines:

- The retiree must pay 100% of their medical, dental and vision coverage (if offered by SISC)
- The retiree and eligible spouse/domestic partner must maintain continuous enrollment in Medicare Parts A and B

SISC Direct Billing is available only for the following retiree plans:

  - Blue Shield 65 Plus HMO Medicare Advantage
  - CompanionCare Medicare Supplement
  - Kaiser Permanente Senior Advantage
  - PPO 100-A $0 Retiree Plan with SISC Medicare Part D Drug Coverage (EGWP)
- The retiree will have the option of the following dental and/or vision plan:
  - Delta Dental Premier Plan $1,500*
  - VSP C $20*

Dental and vision are optional products. However, the retiree must be currently participating in the dental and/or vision product in order to purchase them from SISC.

**If your district offers dental and vision through SISC, dental and vision plans listed above are the only choices offered under this program. If the retiree currently has a different dental or vision plan with the school district and they wish to continue with one or both of these products, they will have to change to the plans listed above in order to participate in this program.*

Orthodontic coverage is not included on the Direct Bill dental plan. This dental plan does not include an incentive level.

Acceptable Payment Methods:

Retirees may set up either a one-time or recurring online (ACH) payment, or they can mail a check or money order to the SISC office. Payments are past due by the 20th of the month for which they are billed.

District Responsibility:

- Determine member eligibility as a Direct Bill Retiree.
- Provide the eligible member with Direct Bill Retiree plan options, benefit summaries, and enrollment forms as applicable.
- Submit the completed and signed enrollment form, a MAR Transfer form, and a copy of the member's Medicare Card confirming enrollment in Part A & B of Medicare.
- *Documents should be submitted via SISCconnect at least 45 days prior to the requested effective date.*

SISC Responsibility:

- Process the MAR Transfer Form.
- Send welcome packet with payment options.
- Manage premium payments.
- Communicate any future plan/rate changes.

Member Responsibility:

- Maintain continuous enrollment in Part A & B of Medicare
- Maintains monthly payments to SISC
- Responsible for payment of non-refundable monthly surcharges if the member fails to maintain Medicare parts A & B

IMPORTANT! The following will result in termination of benefits and/or non-refundable premium surcharges:

- **Disenrollment from Medicare Part A or B**
- **Enrollment in a Medicare Part D Drug Plan outside of SISC**
- **Assigning Medicare to a non-SISC Medical Plan**
- Retirees who lose Medicare while enrolled on the self pay program may need to be re-enrolled on district benefits until the Medicare enrollment is resolved.

If you are interested in this program and would like additional information, please contact the SISC office at 661-636-4410. SISC will need a 90-calendar-day advance notice to implement this program.

BLUE SHIELD OF CALIFORNIA, NORTHERN REGION—65 PLUS HMO MEDICARE ADVANTAGE PLAN

Benefit Summary 2024-2025

Services	Benefits
Ambulance	• $0 co-pay per trip
Annual Physical Examination	• $0 co-pay, although office visit co-pay may apply
Durable Medical Equipment (DME)—Medicare Covered Services	• $0 co-pay
Hospitalization • Inpatient • Outpatient hospital services • Emergency room	 • $0 co-pay per admission • $0 co-pay • $50 co-pay/waived if admitted within 24 hours for the same condition
Immunizations • Includes flu injections and all Medicare-approved immunizations	 • $0 co-pay, although office visit co-pay may apply
Laboratory Services	• No charge
Manual Manipulation of the Spine	• $20 co-pay per visit (subject to medical necessity)
Mental Health—Inpatient	• No charge for day 1–150 • Member pays 100% from day 151 and over
Mental Health—Outpatient Unlimited Visits	• $20 co-pay
Physician Services/Basic Health Services • Office visits • Consultation, diagnosis and treatment by a specialist	 • $20 co-pay • $20 co-pay
Prescription Drugs (10/30/50 three-tiered plan) • Generic • Preferred brand • Non-preferred brand • Injectables **Specialty** • 30-day supply at retail, 90-day supply through mail	 • $10 retail, $20 mail order • $30 retail, $60 mail order • $50 retail, $100 mail order • 20% up to $100 per prescription retail, $300 mail order • 20% up to $100 per prescription retail, $300 mail order
Skilled Nursing Facility	• Covered in full for 100 days per benefit period
Hospice	• Covered in full from a Medicare-certified hospice
X-ray Services	• $0 co-pay, although office visit co-pay may apply

Rate Effective October 1, 2023	Total Cost Per Person
	Northern Region: $507.00

A school district's geographic location will determine the applicable rate. Northern Region includes Monterey, Kings, Tulare, Inyo and counties to the north with the exception of Fresno, Madera, and Sacramento counties.

Requires continuous enrollment in Medicare Parts A and B

Members *must* live in an approved zip code of the Blue Shield of California GMA-PD Service Area. Please refer to the Group Benefit Summary or Evidence of Coverage for details www.blueshieldca.com/SISC

BLUE SHIELD OF CALIFORNIA, SOUTHERN REGION—65 PLUS HMO MEDICARE ADVANTAGE PLAN

Benefits Summary 2024-2025

Services	Benefits
Ambulance	• $0 co-pay per trip
Annual Physical Examination	• $0 co-pay, although office visit co-pay may apply
Durable Medical Equipment (DME)—Medicare Covered Services	• $0 co-pay
Hospitalization • Inpatient • Outpatient hospital services • Emergency room	 • $0 co-pay per admission • $0 co-pay • $50 co-pay/waived if admitted within 24 hrs for the same condition
Immunizations • Includes flu injections and all Medicare-approved immunizations	• $0 co-pay, although office visit co-pay may apply
Laboratory Services	• No charge
Manual Manipulation of the Spine	• $20 co-pay per visit (subject to medical necessity)
Mental Health—Inpatient	• No charge for day 1–150 • Member pays 100% from day 151 and over
Mental Health—Outpatient Unlimited Visits	• $20 co-pay
Physician Services/Basic Health Services • Office visits • Consultation, diagnosis and treatment by a specialist	 • $20 co-pay • $20 co-pay
Prescription Drugs (10/30/50 three-tiered plan) • Generic • Preferred brand • Non-preferred brand • Injectables **Specialty** • 30-day supply at retail, 90-day supply through mail	 • $10 retail, $20 mail order • $30 retail, $60 mail order • $50 retail, $100 mail order • 20% up to $100 per prescription retail, $300 mail order • 20% up to $100 per prescription retail, $300 mail order
Skilled Nursing Facility	• Covered in full for 100 days per benefit period
X-ray Services	• $0 co-pay, although office visit co-pay may apply

Rate Effective October 1, 2023	Total Cost Per Person
	Southern Region: $335.00

A school district's geographic location will determine the applicable rate. Southern Region includes San Luis Obispo, Kern, San Bernardino and counties to the south with the exception of Ventura County.

Members *must* live in an approved zip code of the Blue Shield of California GMA-PD Service Area. Please refer to the Group Benefit Summary or Evidence of Coverage for details www.blueshieldca.com/SISC

COMPANIONCARE MEDICARE SUPPLEMENT PLAN

Benefit Summary

(As of 1/1/2024—Medicare benefits based on Calendar Year)

Services	Medicare 2024 Benefits	CompanionCare Based on 2024 Medicare Benefits
Inpatient Hospital (Part A)	• Pays all but first $1,632 for 1st 60 days • Pays all but $408 a day for the 61st–90th day • Pays all but $816 a day Lifetime Reserve for 91st to 150th day • Pays nothing after Lifetime Reserve is used (refer to Evidence of Coverage)	• Pays $1,632 • Pays $408 a day • Pays $816 a day • Pays 100% after Medicare and Lifetime Reserve are exhausted, up to 365 days per lifetime
Skilled Nursing Facilities (must be approved by Medicare)	• Pays 100% for 1st 20 days • Pays all but $204 a day for 21st to 100th day • Pays nothing after 100th day	• Pays nothing • Pays $204 a day for 21st to 100th day • Pays nothing after 100th day
Deductible (Part B)	• $240 Part B deductible per year	• Pays $240
Basis of Payment (Part B)	• 80% Medicare-approved (MA) charges after Part B deductible	• Pays 20% MA charges Including 100% of Medicare Part B deductible
Medical Services (Part B) • Doctor, X-Ray, Appliances, and Ambulance • Lab	• 80% MA charges • 100% MA charges	• Pays 20% MA charges • Pays nothing
Physical/Speech Therapy (Part B)	• 80% MA charges up to the Medicare annual benefit amount	• Pays 20% MA charges up to the Medicare annual benefit amount (PT and ST combined)
Blood (Part B)	• 80% MA charges after 3 pints	• Pays 1st 3 pints unreplaced blood and 20% MA charges
Travel Coverage (when outside the US for less than 6 consecutive months)	• Not covered	• Pays 80% inpatient hospital, surgery, anesthetist and in-hospital visits for medically necessary services for 90 days of treatment per hospital stay. For details call Anthem customer service at 1-800-825-5541.

Outpatient Prescription Drugs	Medicare Part D Prescription Drug Plan Through Navitus Health Solutions
Retail Pharmacy **Mail Order**	• 30-day supply $9 Generic co-pay, $35 Brand co-pay • 90-day supply $18 Generic co-pay, $90 Brand co-pay
Due to Medicare restrictions the following programs are not available with CompanionCare: • $0 generic co-pay at Costco • Diabetic supplies for generic co-pay	• Pharmacy benefits are administered through Navitus Health Solutions Medicare Rx using a Medicare D formulary. Some exclusions and prior authorizations may apply. Members that have questions regarding their medication coverage can call Navitus Health Solutions Medicare Rx at 1-866-270-3877 or TYY users please call 711.

CompanionCare is a Medicare Supplement plan that pays for medically necessary services and procedures that are considered a Medicare Approved Expense. SISC will automatically enroll CompanionCare Members into Medicare Part D. No additional premium required. SISC plans are NOT subject to the "doughnut hole"

Eligibility: Member must be retired and enrolled in Medicare Part A (hospital) and Medicare Part B (medical) coverage. Retirees under age 65 with Medicare for the disabled (Parts A and B) may enroll in CompanionCare.

Enrollment: Enrollment forms and a copy of the Medicare card must be received by SISC 45 calendar days in advance of requested effective date—NO exceptions. SISC will automatically enroll members in Medicare Part D for outpatient prescription medications. Members already enrolled in non-SISC Medicare Part D plans will be automatically disenrolled from those plans.

Disenrollment: Disenrollment throughout the year requires submission of a disenrollment form to SISC with a 45-calendar day advance notice of requested effective date. During the annual Medicare D Open Enrollment members can enroll into Medicare Part D plans outside of SISC with a January 1 effective date. Enrollment in a Medicare D plan outside of SISC will terminate the SISC medical and Rx benefits.

Provider Network: Physicians who accept Medicare Assignment. The plan does not cover excess Medicare Part B charges. Excess charges may occur when receiving services from a provider who does not accept the Medicare Assignment amount.

For additional Medicare benefit information, please go to www.medicare.gov or call 1-800-medicare (1-800-633-4227) For additional Navitus Medicare Rx prescription drug information, please go to www.navitus.com or call 1-866-270-3877.

Statewide Rate Effective October 1, 2024	Total Cost Per Person
Retirees with Medicare Parts A and B (SISC will enroll members in Part D)	$419.00

KAISER, NORTHERN REGION—SENIOR ADVANTAGE HMO MEDICARE PLAN

Benefit Summary 2024-2025

Services	Benefits
Ambulance	• $50 per trip
Annual Physical Examination	• No Charge
Acupuncture/Chiropractic	• $10 co-pay, 30 combined visits
Dental Care (Delta Care)	• Not Covered
Durable Medical Equipment (DME) (Kaiser DME formulary guidelines apply)	• 100%
Hearing Examination	• $10 co-pay per visit
Hospitalization • Inpatient • Emergency Room	 • $0/Admit • $50 co-pay/waived if admitted
Immunizations (includes flu injections and all Medicare-approved immunizations)	• No charge • Office visit co-pay may apply if administered as part of a physician office visit
Laboratory Services	• No charge
Manual Manipulation of the Spine	• $10 co-pay per visit (subject to medical necessity)
Mental Health—Inpatient	• No charge
Mental Health—Outpatient unlimited visits	• $10 co-pay per individual visit • $5 co-pay per group visit
Physician Services/Basic Health Services • Office visits • Consultation, diagnosis and treatment by a specialist	 • $10 co-pay per visit • $10 co-pay per visit
Prescription Drugs • Using Kaiser pharmacies • Not subject to doughnut hole	 • Generic: $10 co-pay for up to a 100-day supply • Brand: $20 co-pay for up to a 100-day supply
Skilled Nursing Facility	• Covered in full for 100 days per benefit period
Hospice	• Covered in full from a Medicare certified hospice
Vision Care • Examination for eyeglasses • Glaucoma testing • Standard frame/lenses every 24 months	 • $10 per visit • $10 co-pay per visit • $150 frame and lens allowance every 24 months
X-ray Services	• No charge

Rate Effective October 1, 2024	Total Cost Per Person
Retirees with Medicare Parts A and B	Northern Region: $329.00

A school district's geographic location will determine the applicable rate. Northern Region includes Monterey, Kings, Tulare, Inyo and all other counties to the north.

Requires continuous enrollment in Medicare Parts A and B

Members *must* live in an approved zip code of the Kaiser California Service Area. www.kp.org

KAISER, SOUTHERN REGION—SENIOR ADVANTAGE HMO MEDICARE PLAN

Benefit Summary 2024-2025

Services	Benefits
Ambulance	• $50 per trip
Annual Physical Examination	• No charge
Acupuncture/Chiropractic	• $10 co-pay, 30 combined visits
Dental Care (Delta Care)	• Not covered
Durable Medical Equipment (DME) (Kaiser DME formulary guidelines apply)	• 100%
Hearing Examination	• $10 co-pay per visit
Hospitalization • Inpatient • Emergency Room	 • $0/Admit • $50 co-pay/waived if admitted
Immunizations (includes flu injections and all Medicare-approved immunizations)	• No charge • Office visit co-pay may apply if administered as part of a physician office visit
Laboratory Services	• No charge
Manual Manipulation of the Spine	• $10 co-pay per visit (subject to medical necessity)
Mental Health—Inpatient	• No charge
Mental Health—Outpatient unlimited visits	• $10 co-pay per individual visit • $5 co-pay per group visit
Physician Services/Basic Health Services • Office visits • Consultation, diagnosis and treatment by a specialist	 • $10 co-pay per visit • $10 co-pay per visit
Prescription Drugs • Using Kaiser pharmacies • Not subject to doughnut hole	 • Generic: $10 co-pay for up to a 100 day supply • Brand: $20 co-pay for up to a 100 day supply
Skilled Nursing Facility	• Covered in full for 100 days per benefit period
Hospice	• Covered in full from a Medicare certified hospice
Vision Care • Examination for eyeglasses • Glaucoma testing • Standard frame/lenses every 24 months	 • $10 per visit • $10 co-pay per visit • $150 frame and lens allowance every 24 months
X-Ray Services	• No Charge

Rate Effective October 1, 2024	Total Cost Per Person
Retirees with Medicare Parts A and B	Southern Region: $215.00

A school district's geographic location will determine the applicable rate. Southern Region includes San Luis Obispo, Kern, San Bernardino and all other counties to the south.

Requires continuous enrollment in Medicare Parts A and B

Members *must* live in an approved zip code of the Kaiser California Service Area. www.kp.org

DIRECT BILL RETIREE DENTAL

Dental Benefit Summary 2024-2025

Annual Benefit Maximum
• The maximum benefit paid per calendar year is $1,700* per person in-network (this amount includes the additional $200 for using a Delta PPO dentist. • The maximum benefit paid per calendar year is $1,500 per person out-of-network

Services	Delta Dental Dentists**	Non-Delta Dental Dentists**
Diagnostic and Preventive — Exams, 2 cleanings per calendar year, x-rays	100% covered	100% covered
Fillings and Other Basic Services Fillings, simple tooth extractions, sealants	100% covered	100% covered
Endodontics (root canals) — Covered Under Basic Services	100% covered	100% covered
Periodontics (gum treatment) — Covered Under Basic Services	100% covered	100% covered
Oral Surgery— Covered Under Basic Services	100% covered	100% covered
Major Restorative Services— Crowns, inlays, onlays, and cast restorations	100% covered	100% covered
Dentures, Bridges and Dental Implants	50% covered	50% covered
Dental Accident Benefits	100% (separate $1,000 maximum per person per calendar year)	

**Limitations or waiting periods may apply for some benefits; some services may be excluded from your plan. Reimbursement is based on Delta Dental contract allowances and not necessarily each dentist's actual fees.*
*** Reimbursement is based on PPO contracted fees for PPO dentists, Premier contracted fees for Premier dentists and program allowance for out-of-networkdentists.*

Rates	
Single	$58.00
Two-party	$116.00
Family	$153.00

DIRECT BILL RETIREE VISION

Vision Benefit Summary 2024-2025

VSP Signature Plan C (Exam, lenses and frames every 12 months)	
Services	**Benefits**
Eligibility	Spouse/domestic partner, and dependent children to age 26.
Benefits Renew	January 1 of each year or every other year depending on the plan frequency.
Standard Lenses	Covered in full up to 60mm.
Diabetic Eyecare Plus Program	Supplemental Eyecare for patients with Type I and II diabetes. See your vision provider for extended services beyond the initial eye exam. $20 co-pay per visit.
Laser Vision Care (Lasik)	Benefits provided at a discount through VSP approved center. Visit www.vsp.com or contact VSP's Customer Service for additional information. NOTE: Your health plan does not provide benefits for eye surgery solely for the purpose of correcting refractive defects of the eye.
Photochromic Lenses (transition)	Covered up to schedule of allowances under Plan C only
Elective Contact Lenses (in lieu of frames and lenses)	$150 paid towards the cost of the contact fitting and evaluation and contact lenses when a member doctor is used.
Medically Necessary Contact Lenses	Covered in full with pre-certification (applies to certain medical conditions).
Warranty	No specified warranty. If the member is unsatisfied with the services rendered, please contact VSP's Customer Service Department at 1-800-877-7195.

Co-pay and Rates	
Exam and Materials Co-pay	**$20**
Single	$12.10
Two-party	$24.20
Family	$36.30

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DELTA DENTAL—PPO INCENTIVE PLAN

Benefit Summary and 2024–2025 Monthly Rates

Services	In-Network		Out-Of-Network
Provider Network	**PPO Dentists**	**Premier Network Dentists**	**Non-Delta Dentists**
	When using a PPO contracted dentist, the annual maximum will be **increased by $500**.	When using a Delta Premier contracted dentist, Delta will pay up to the Annual Maximum elected by the district or bargaining unit.	When using a non-Delta Dentist, Delta will pay based on a plan allowance that meets the majority of Premier reimbursements for a defined geographic region.
Diagnostic and Preventive Exams, X-rays, Cleanings	70% 1st year 80% 2nd year 90% 3rd year 100% 4th year and after	70% 1st year 80% 2nd year 90% 3rd year 100% 4th year and after	70% 1st year 80% 2nd year 90% 3rd year 100% 4th year and after
Other Basic Services Oral Surgery, Fillings, Periodontic Procedures, Root Canals and Sealants	70% 1st year 80% 2nd year 90% 3rd year 100% 4th year and after	70% 1st year 80% 2nd year 90% 3rd year 100% 4th year and after	70% 1st year 80% 2nd year 90% 3rd year 100% 4th year and after
Crowns Crowns, Jackets and Cast Restorations	70% 1st year 80% 2nd year 90% 3rd year 100% 4th year and after	70% 1st year 80% 2nd year 90% 3rd year 100% 4th year and after	70% 1st year 80% 2nd year 90% 3rd year 100% 4th year and after
Prosthodontics Dentures, Bridges, and Implants**	50%	50%	50%

***If the plan has an unlimited annual maximum, members will receive 60% coverage for Prosthodontics when using a PPO dentist and 50% for a Non-PPO dentist.*

Annual Plan Maximum	$1,000	$1,500	$2,000	Unlimited**
Rates for Active Employees Only				
Single	$40.00	$47.00	$52.00	$62.00
Two-party	$82.00	$97.00	$107.00	$128.00
Family	$114.00	$133.00	$148.00	$176.00
Composite	$79.00	$93.00	$103.00	$124.00
Rates for All Retirees				
Single	$49.00	$58.00	$64.00	$78.00
Two-party	$98.00	$116.00	$128.00	$156.00
Family	$129.00	$153.00	$168.00	$205.00

All SISC Incentive Plans were enhanced to include a PPO advantage. As a result, when the member or dentist accesses benefit information from Delta Dental the subscriber will show active on a PPO plan. This does not mean that their benefits are being reduced in any way. The title of the plan has been changed to include the PPO indicator for dental network purposes.

The PPO Incentive plan can be offered as a dual choice with one of the Delta Dental PPO Plans. You may not have two PPO Incentive plans or two PPO plans.

Members must maintain uninterrupted coverage in the PPO incentive plan to continue at their incentive level. Any interruption to coverage will cause the incentive level to reset at 70%.

The Unlimited Plan choice has an annual $2,000 in-network maximum for dental implants.

The group plan benefits must be communicated without modification to the members. The district may not partially pay, reimburse or otherwise reduce the member's responsibility for deductibles, co-pays, coinsurance, etc.

Locate a provider at: www.deltadentalins.com

DELTA DENTAL PPO PLANS

Benefit Summary and 2024–2025 Monthly Rates

Services	In-Network		Out-of-Network
Provider Network	**PPO Dentists**	**Premier Network Dentists**	**Non-Delta Dentists**
Annual Deductible	No deductible	$25 per member $75 per family	$25 per member $75 per family
Annual Maximum	Plan maximum selected by district	Limited to $1,000 regardless of plan maximum	Limited to $1,000 regardless of plan maximum
Basis of Payment	Participating Fee Allowance	Participating Fee Allowance	Plan Allowance
Diagnostic and Preventive Exams, X-rays, Cleanings	100%	50%	50%
Other Basic Services Oral Surgery, Fillings, Periodontic Procedures, Root Canals and Sealants	100%	50%	50%
Crowns Crowns, Jackets and Cast Restorations	100%	50%	50%
Prosthodontics Dentures, Bridges, and Implants**	50%	50%	50%

*** The Unlimited Plan choice has an annual $2,000 in-network maximum for dental implants. Out-of-network coverage on implants is limited to 50% up to $1,000.*

Annual Plan Maximum	$1,500	$2,000	$3,000	Unlimited**
Rates for Active Employees Only				
Single	$43.00	$46.00	$48.00	$55.00
Two-party	$89.00	$95.00	$99.00	$113.00
Family	$122.00	$131.00	$136.00	$156.00
Composite	$85.00	$91.00	$95.00	$110.00
Rates for All Retirees				
Single	$53.00	$57.00	$59.00	$69.00
Two-party	$106.00	$114.00	$118.00	$138.00
Family	$139.00	$150.00	$155.00	$181.00

The PPO Plan can be offered as a dual choice with one of the Delta Dental PPO Incentive Plans. You may not have two PPO Plans or two PPO Incentive Plans.

Members may change from the PPO to the PPO Incentive Plan during Open Enrollment. If they make this change, their incentive level will start at 70% for the employee and all dependents.

PPO subscribers can use ANY Delta Specialist (i.e., orthodontist, periodontist, endodontist, oral surgeon).

The group plan benefits must be communicated without modification to the members. The district may not partially pay, reimburse or otherwise reduce the member's responsibility for deductibles, copays, coinsurance, etc.

Locate a provider at: www.deltadentalins.com

ORTHODONTIC BENEFITS (NON-VOLUNTARY) FOR ALL DELTA DENTAL PLANS—100% DISTRICT-PAID PARTICIPATION

2024–2025 Monthly Rates

Maximum*	$500	$1,000	$1,500	$2,000	$3,000
Coverage for Dependent Children Only					
Single	N/A	N/A	N/A	N/A	N/A
Two-party	$0.40	$0.80	$1.20	$1.60	$2.40
Family	$3.80	$7.60	$11.40	$15.20	$22.80
Composite	$3.50	$7.00	$10.50	$14.00	$21.00
Coverage for Adults and Dependent Children					
Single	$0.40	$0.80	$1.20	$1.60	$2.40
Two-party	$1.00	$2.00	$3.00	$4.00	$6.00
Family	$4.80	$9.60	$14.40	$19.20	$28.80
Composite	$4.10	$8.20	$12.30	$16.40	$24.60

** Coverage is 100% of the lifetime maximum per covered individual. Restrictions apply.*

Third Cleaning Option	
Single	$1.30
Two-party	$2.60
Family	$3.90
Composite	$2.60

Prosthodontic Rider	PPO Plans	PPO Incentive Plans
Single	$3.00	$4.40
Two-party	$5.50	$8.80
Family	$9.00	$13.20
Composite	$5.50	$8.80

Dental benefit includes two cleanings per calendar year.

Districts can offer more by adding the third cleaning benefit or the prosthodontic rider listed above for an additional cost.

Rates for orthodontic, third cleaning option, and the prosthodontic rider apply to active employees and retirees. District retiree benefits must mirror active employee benefits.

Pro-rated orthodontia payments are not made after the coverage termination date. Delta pays 50% when patient is banded and 50% 12 months later. If member terminates coverage before 12 months of initial banding, no further payments will be made.

The group plan benefits must be communicated without modification to the members. The district may not partially pay, reimburse or otherwise reduce the member's responsibility for deductibles, co-pays, coinsurance, etc.

SISC DENTAL HEALTH NETWORK PLAN powered by Anthem Dental

Benefit Summary 2024–2025

Key Features	
Annual Benefit Maximum	$4,000
Annual Deductible	$0
Annual Dental Implant Maximum	$2,000
Lifetime Orthodontic Maximum*	$2,000
Office Visit Co-pay	$0

Services	In-Network**	Out-of-Network
Diagnostic and Preventive—Exams, cleanings, x-rays	100% covered	Not covered
Fillings and Other Basic Services Fillings, simple tooth extractions, sealants	100% covered	Not covered
Root Canals and Retreatments— Surgical and non-surgical	100% covered	Not covered
Gum Maintenance— Gum maintenance, scaling, root planing, gum surgery	100% covered	Not covered
Oral Surgery—Simple and surgical extraction	100% covered	Not covered
Major Restorative Services—Crowns, onlays, veneers	100% covered	Not covered
Dentures, Bridges and Dental Implants	50% covered	Not covered
Repairs and Adjustments— Crown, denture and bridge repair; denture and bridge adjustments	50% covered	Not covered
Orthodontics (braces)	100% up to $2,000	100% up to $2,000

** Orthodontic coverage is included automatically at no extra charge.*
*** Anthem Dental Essential Choice is offered through Anthem Blue Cross as an in-network benefit only, on the SISC Dental Health Network. To find a dentist in the network, go to **www.anthem.com/ca** or call member services at (844) 729-1565.*

This limited network plan is available only in select counties: Fresno County, Kern County, Kings County, Madera County, Merced County, Riverside County, San Luis Obispo County, Santa Barbara County, and Tulare County.

The SISC Dental Health Network plan can be offered as an additional choice alongside the Delta Dental plan options. This is not an incentive plan design. If a member chooses to disenroll from an incentive plan, their incentive level will start at 70% upon re-enrollment.

Members *must* use specialists in the Anthem Dental Essential Choice Network (i.e., periodontist, endodontist, oral surgeon).

Annual Plan Maximum	$4,000
Rates for Active Employees Only	
Single	$48.00
Two-party	$99.00
Family	$136.00
Composite	$95.00
Rates for All Retirees	
Single	$59.00
Two-party	$118.00
Family	$155.00

EYEMED PLANS

Benefit Summary 2024-2025

Services	Benefits
Eligibility	Spouse/domestic partner, and dependent children to age 26
Benefits Renew	January 1 of each year or every other year depending on the plan
Standard Lenses	Covered in full
Progressive Lenses	Covered with tiered copay (Register at **eyemed.com/member** for more information)
Laser Vision Care (Lasik)	As an EyeMed member, you are entitled to a 15% discount through providers in the US Laser Network. For more information on Lasik, the providers and discounts call 800.988.4221
Polycarbonate Lenses	Covered for dependent children up to age 18
Sunglasses	See discount details below
Tinted Lenses	Additional discount available for Solid or Gradient
Photosensitive Lenses (transition)	Covered with a $75 copay under Plan C only
Elective Contact Lenses (in lieu of frames and lenses)	$150 Cosmetic Contact Lens allowance. Covers conventional or disposable. Standard Contact fit/follow up fee capped at $40 copay.
Medically Necessary Contact Lenses	Paid in full at in-network provider locations.
Warranty	No specific warranty; it varies at each location.
Choice of Frames	Coverage up to $150 allowance, plus 20% off the balance at participating provider locations. Visit **eyemed.com/member** to confirm the wholesale allowance for Costco.
Provider Network	Largest vision network in California. Panel includes independent providers, national retail locations like LensCrafters, TargetOptical, Costco and Wal-Mart Vision, as well as online in-network providers like glasses.com, ContactsDirect.com and RayBan.com.

Member Options

In order to protect members, EyeMed has negotiated limits on the amount of out-of-pocket amounts in-network providers can charge members for lens options such as progressives, polycarbonates, photochromic and other lens options. Details are included in the applicable benefit brochure for each plan. Members should visit eyemed.com/member to locate Participating Providers nearest to them. Refer to plan documents for plan exclusions and limitations.

Discount Details

Member receives a 20% discount on items not covered by the plan at EyeMed In-Network locations. Discount does not apply to EyeMed 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 are subject to change at any time.

*Discounts are not insured benefits.

Plan	Examination	Lenses	Frames
A	Every calendar year	Every other calendar year	Every other calendar year
B	Every calendar year	Every calendar year	Every other calendar year
C	Every calendar year	Every calendar year	Every calendar year

Plan A provides lenses every 24 months, with new lenses available at a 12-month interval if there is a change in prescription.

Districts/Employee Group may offer only one SISC vision plan option and cannot be offered as a dual choice with VSP.

Locate a provider at: eyemed.com/member

EYEMED PLAN—ACTIVE EMPLOYEES ONLY

2024-2025 Monthly Rates

Single Co-pay Plans*			
Exam and Materials Co-pay	$0	$10	$20
PLAN A (Exam every 12 months, lenses and frames every 24 months)			
Single	$5.10	$4.70	$4.30
Two-party	$10.20	$9.40	$8.60
Family	$15.30	$14.10	$12.90
Composite	$11.40	$10.50	$9.60
PLAN B (Exam and lenses every 12 months, frames every 24 months)			
Single	$6.10	$5.60	$5.10
Two-party	$12.20	$11.20	$10.20
Family	$18.30	$16.80	$15.30
Composite	$13.50	$12.50	$11.40
PLAN C (Exam, lenses and frames every 12 months)			
Single	$8.30	$7.70	$7.00
Two-party	$16.60	$15.40	$14.00
Family	$24.90	$23.10	$21.00
Composite	$18.40	$17.00	$15.50

Dual Co-pay Plans*			
Exam Co-pay	$0	$10	$20
Materials Co-pay	$25	$25	$25
PLAN A (Exam every 12 months, lenses and frames every 24 months)			
Single	$4.30	$4.00	$3.60
Two-party	$8.60	$8.00	$7.20
Family	$12.90	$12.00	$10.80
Composite	$9.60	$8.90	$8.10
PLAN B (Exam and lenses every 12 months, frames every 24 months)			
Single	$5.10	$4.70	$4.30
Two-party	$10.20	$9.40	$8.60
Family	$15.30	$14.10	$12.90
Composite	$11.40	$10.50	$9.60
PLAN C (Exam, lenses and frames every 12 months)			
Single	$7.00	$6.40	$5.90
Two-party	$14.00	$12.80	$11.80
Family	$21.00	$19.20	$17.70
Composite	$15.50	$14.30	$13.10

** Your benefit and co-pay amounts renew on January 1.*

Supplemental Benefits (Available with Plan C only)	**2nd Pair of Glasses w/ $20 Deductible** **(subject to annual frame allowance)** **OR** **$150 Annual contact lens allowance**
Single	$1.20
Two-party	$2.40
Family	$3.60
Composite	$2.70

EYEMED PLAN—ALL RETIREES, UNDER AND OVER AGE 65

2024-2025 Monthly Rates

Single Co-pay Plans*			
Exam and Materials Co-pay	$0	$10	$20
PLAN A (Exam every 12 months, lenses and frames every 24 months)			
Single	$6.40	$5.90	$5.40
Two-party	$12.80	$11.80	$10.80
Family	$19.20	$17.70	$16.20
PLAN B (Exam and lenses every 12 months, frames every 24 months)			
Single	$7.60	$7.00	$6.40
Two-party	$15.20	$14.00	$12.80
Family	$22.80	$21.00	$19.20
PLAN C (Exam, lenses and frames every 12 months)			
Single	$10.30	$9.60	$8.70
Two-party	$20.60	$19.20	$17.40
Family	$30.90	$28.80	$26.10

Dual Co-pay Plans*			
Exam Co-pay	$0	$10	$20
Materials Co-pay	$25	$25	$25
PLAN A (Exam every 12 months, lenses and frames every 24 months)			
Single	$5.40	$5.00	$4.60
Two-party	$10.80	$10.00	$9.20
Family	$16.20	$15.00	$13.80
PLAN B (Exam and lenses every 12 months, frames every 24 months)			
Single	$6.40	$5.90	$5.40
Two-party	$12.80	$11.80	$10.80
Family	$19.20	$17.70	$16.20
PLAN C (Exam, lenses and frames every 12 months)			
Single	$8.70	$8.00	$7.40
Two-party	$17.40	$16.00	$14.80
Family	$26.10	$24.00	$22.20

** Your benefit and co-pay amounts renew on January 1.*

Supplemental Benefits (Available with Plan C only)	2nd Pair of Glasses w/ $20 Deductible (subject to annual frame allowance) OR $150 Annual contact lens allowance
Single Two-party Family	$1.50 $3.00 $4.50

VISION SERVICE PLAN (VSP) SIGNATURE PLAN

Benefit Summary 2024-2025

Services	Benefits
Eligibility	Spouse/domestic partner, and dependent children to age 26.
Benefits Renew	January 1 of each year or every other year depending on the plan frequency.
Standard Lenses	Covered in full up to 60mm.
Progressive Lenses	Standard progressives covered in full. See Patient Options below for premium progressive lenses and custom progressive lenses.
Diabetic Eyecare Plus Program	Supplemental Eyecare for patients with Type I and II diabetes. See your vision provider for extended services beyond the initial eye exam. $20 co-pay per visit.
Laser Vision Care (Lasik)	Benefits provided at a discount through VSP approved center. Visit **www.vsp.com** or contact VSP's Customer Service for additional information. **NOTE:** Your health plan does not provide benefits for eye surgery solely for the purpose of correcting refractive defects of the eye.
Polycarbonate Lenses	Covered for dependent children up to age 18
Sunglasses	See Added Value Discounts below
Tinted Lenses	See Patient Options below
Photochromic Lenses (transition)	Covered up to schedule of allowances under Plan C only
Elective Contact Lenses (in lieu of frames and lenses)	$150 paid towards the cost of the contact fitting and evaluation and contact lenses when a member doctor is used.
Medically Necessary Contact Lenses	Covered in full with pre-certification (applies to certain medical conditions).
Warranty	No specified warranty. If the member is unsatisfied with the services rendered, please contact VSP's Customer Service Department at 1-800-877-7195.
Choice of Frames	You will receive a $150 allowance toward any frame of your choice plus 20% off any amount over the allowance.
Provider Network	VSP Signature network includes independent contracted providers nationwide. Member's may also choose to go outside of the network and use the out of network reimbursement. To find a provider, visit **www.vsp.com** and register or search as a guest.
Participating Retail Locations	Participating Retail Locations includes Costco, Visionworks and RxOptical. To find Participating Retail Locations visit **www.vsp.com** or call VSP customer service at 1-800-877-7195.
Added Value Discounts	30% off unlimited additional pairs of prescription glasses and/or non-prescription sunglasses, including lens options (same day as the members eye exam and from the same doctor). Or get 20% off unlimited additional pairs of glasses 12 months from the covered eye exam with any VSP doctor.

Patient Options

Patients who choose to purchase lens options may do so with a **35–40% savings on all non covered lens options**. The patient should check with a VSP participating doctor to verify whether items are covered or are considered options. These cosmetic options are not covered in full by VSP; however, due to our agreements with VSP participating doctors and laboratories, these services are provided at a controlled cost, available only to VSP subscriber.
Examples of options patients may choose include:

- Premium & Custom Progressive lenses
- Blended (seamless) bifocals
- Contact lenses (except as noted)
- Oversize lenses (61mm or greater)
- Fashion and gradient tinting
- Scratch coating
- Laminating of lenses
- A frame that costs more than the plan allowance
- Cosmetic lenses
- Ultra-violet coating
- Polycarbonate lenses for adults age 18 and older
- Tinted lenses

Plan	Examination	Lenses	Frames
A*	Every calendar year	Every other calendar year	Every other calendar year
B*	Every calendar year	Every calendar year	Every other calendar year
C**	Every calendar year	Every calendar year	Every calendar year

** Plans A and B cover tinted pink #1 and #2 only. Basic benefits are the same on Plans A and B with the exception of frequency on lenses.*
*** Plan C covers all tints and photochromic lenses (transition lenses).*

Plan A provides lenses every 24 months, with new lenses available at a 12-month interval if there is a change in prescription.
Districts/Employee Group may offer only one SISC vision plan option and cannot be offered as a dual choice with EyeMed.
Locate a provider at: www.vsp.com

VISION SERVICE PLAN (VSP)—SIGNATURE PLAN—ACTIVE EMPLOYEES ONLY

2024-2025 Monthly Rates

Single Co-pay Plans*			
Exam and Materials Co-pay	$0	$10	$20
PLAN A (Exam every 12 months, lenses and frames every 24 months)			
Single	$7.10	$6.60	$6.00
Two-party	$14.20	$13.20	$12.00
Family	$21.30	$19.80	$18.00
Composite	$15.80	$14.60	$13.30
PLAN B (Exam and lenses every 12 months, frames every 24 months)			
Single	$8.40	$7.80	$7.10
Two-party	$16.80	$15.60	$14.20
Family	$25.20	$23.40	$21.30
Composite	$18.70	$17.30	$15.80
PLAN C (Exam, lenses and frames every 12 months)			
Single	$11.50	$10.60	$9.70
Two-party	$23.00	$21.20	$19.40
Family	$34.50	$31.80	$29.10
Composite	$25.50	$23.60	$21.50

Dual Co-pay Plans*			
Exam Co-pay	$0	$10	$20
Materials Co-pay	$25	$25	$25
PLAN A (Exam every 12 months, lenses and frames every 24 months)			
Single	$6.00	$5.50	$5.00
Two-party	$12.00	$11.00	$10.00
Family	$18.00	$16.50	$15.00
Composite	$13.30	$12.30	$11.20
PLAN B (Exam and lenses every 12 months, frames every 24 months)			
Single	$7.10	$6.60	$6.00
Two-party	$14.20	$13.20	$12.00
Family	$21.30	$19.80	$18.00
Composite	$15.80	$14.60	$13.30
PLAN C (Exam, lenses and frames every 12 months)			
Single	$9.70	$9.00	$8.20
Two-party	$19.40	$18.00	$16.40
Family	$29.10	$27.00	$24.60
Composite	$21.50	$19.90	$18.10

** Your benefit and co-pay amounts renew on January 1.*

Supplemental Benefits (Available with Plan C only)	**2nd Pair of Glasses w/ $20 Deductible** **(subject to annual frame allowance)** **OR** **$150 Annual contact lens allowance**
Single	$1.70
Two-party	$3.40
Family	$5.10
Composite	$3.70

VISION SERVICE PLAN (VSP)—SIGNATURE PLAN—ALL RETIREES UNDER AND OVER AGE 65

2024-2025 Monthly Rates

Single Co-pay Plans*			
Exam and Materials Co-pay	$0	$10	$20
PLAN A (Exam every 12 months, lenses and frames every 24 months)			
Single	$8.90	$8.20	$7.50
Two-party	$17.80	$16.40	$15.00
Family	$26.70	$24.60	$22.50
PLAN B (Exam and lenses every 12 months, frames every 24 months)			
Single	$10.50	$9.70	$8.90
Two-party	$21.00	$19.40	$17.80
Family	$31.50	$29.10	$26.70
PLAN C (Exam, lenses and frames every 12 months)			
Single	$14.30	$13.30	$12.10
Two-party	$28.60	$26.60	$24.20
Family	$42.90	$39.90	$36.30

Dual Co-pay Plans*			
Exam Co-pay	$0	$10	$20
Materials Co-pay	$25	$25	$25
PLAN A (Exam every 12 months, lenses and frames every 24 months)			
Single	$7.50	$6.90	$6.30
Two-party	$15.00	$13.80	$12.60
Family	$22.50	$20.70	$18.90
PLAN B (Exam and lenses every 12 months, frames every 24 months)			
Single	$8.90	$8.20	$7.50
Two-party	$17.80	$16.40	$15.00
Family	$26.70	$24.60	$22.50
PLAN C (Exam, lenses and frames every 12 months)			
Single	$12.10	$11.20	$10.20
Two-party	$24.20	$22.40	$20.40
Family	$36.30	$33.60	$30.60

** Your benefit and co-pay amounts renew on January 1.*

Supplemental Benefits (Available with Plan C only)	**2nd Pair of Glasses w/ $20 Deductible (subject to annual frame allowance) OR** $150 Annual contact lens allowance
Single Two-party Family	$2.10 $4.20 $6.30

VISION SERVICE PLAN (VSP) CHOICE PLAN

Benefit Summary 2024-2025

Services	Benefits
Eligibility	Spouse/domestic partner, and dependent children to age 26
Benefits Renew	January 1 of each year or every other year depending on the plan frequency
Standard Lenses	Covered in full up to 60mm.
Progressive Lenses	Standard progressives covered in full. See Patient Options below for premium progressive lenses and custom progressive lenses.
Diabetic Eyecare Plus Program	Supplemental Eyecare for patients with Type I and II diabetes. See your vision provider for extended services beyond the initial eye exam. $20 co-pay per visit.
Laser Vision Care (Lasik)	Benefits provided at a discount through VSP approved center. Visit **www.vsp.com** or contact VSP's Customer Service for additional information. **NOTE:** Your health plan does not provide benefits for eye surgery solely for the purpose of correcting refractive defects of the eye.
Polycarbonate Lenses	Covered for dependent children up to age 18
Sunglasses	See Added Value Discounts below
Tinted Lenses	See Patient Options below
Photochromic Lenses (transition)	Covered up to schedule of allowances under Plan C only
Elective Contact Lenses (in lieu of frames and lenses)	$150 paid towards the cost of the contact fitting and evaluation and contact lenses when using an in-network provider.
Medically Necessary Contact Lenses	Covered in full with pre-certification (applies to certain medical conditions).
Warranty	No specified warranty. If the member is unsatisfied with the services rendered, please contact VSP's Customer Service Department at 1-800-877-7195.
Choice of Frames	You will receive a $150 allowance toward any frame of your choice when using an in-network provider plus 20% off any amount over the allowance.
Provider Network	VSP Choice Network is a subset of the Signature network that includes independently contracted providers nationwide. Member's may also choose to go outside of the network and use the out of network reimbursement. To find a provider visit **www.vsp.com** and register or search as a guest.
Participating Retail Locations	Participating Retail Locations includes Costco, Visionworks and RxOptical. To find Participating Retail Locations visit **www.vsp.com** or call VSP customer service at 1-800-877-7195. Contact VSP customer service to confirm wholesale allowance with Wholesale participating providers.
Added Value Discounts	20% off unlimited additional pairs of prescription glasses and/or non-prescription sunglasses, including lens options, from any VSP doctor 12 months from the covered eye exam.

Patient Options

Patients who choose to purchase options may do so with a 20–25% savings on all non-covered lens options. The patient should check with a VSP participating doctor to verify whether items are covered or are considered options. These cosmetic options are not covered in full by VSP; however, due to our agreements with VSP participating doctors and laboratories, these services are provided at a controlled cost, available only to VSP subscribers.
Examples of options patients may choose include:

- Premium & Custom Progressive lenses
- Blended (seamless) bifocals
- Contact lenses (except as noted)
- Oversize lenses (61mm or greater)
- Fashion and gradient tinting
- Scratch coating
- Laminating of lenses
- A frame that costs more than the plan allowance
- Cosmetic lenses
- Ultra-violet coating
- Polycarbonate lenses for adults age 18 and older
- Tinted lenses

Plan	Examination	Lenses	Frames
A*	Every calendar year	Every other calendar year	Every other calendar year
B*	Every calendar year	Every calendar year	Every other calendar year
C**	Every calendar year	Every calendar year	Every calendar year

** Plans A and B cover tinted pink #1 and #2 only. Basic benefits are the same on Plans A and B with the exception of frequency on lenses.*
*** Plan C covers photochromic lenses (transition lenses).*

Districts/Employee Group may offer only one SISC vision plan option and cannot be offered as a dual choice with EyeMed.

Locate a provider at: www.vsp.com

VISION SERVICE PLAN (VSP)—CHOICE PLAN RATES

2024-2025 Monthly Rates

Active Employees Only			
Exam and Materials Co-pay	$0	$10	$20
PLAN A (Exam every 12 months, lenses and frames every 24 months)			
Single	$5.90	$5.50	$5.00
Two-party	$11.80	$11.00	$10.00
Family	$17.70	$16.50	$15.00
Composite	$13.20	$12.20	$11.10
PLAN B (Exam and lenses every 12 months, frames every 24 months)			
Single	$7.00	$6.50	$5.90
Two-party	$14.00	$13.00	$11.80
Family	$21.00	$19.50	$17.70
Composite	$15.60	$14.40	$13.20
PLAN C (Exam, lenses and frames every 12 months)			
Single	$9.60	$8.90	$8.10
Two-party	$19.20	$17.80	$16.20
Family	$28.80	$26.70	$24.30
Composite	$21.30	$19.70	$17.90

All Retirees Under and Over Age 65			
Exam and Materials Co-pay	$0	$10	$20
PLAN A (Exam every 12 months, lenses and frames every 24 months)			
Single	$7.40	$6.90	$6.20
Two-party	$14.80	$13.80	$12.40
Family	$22.20	$20.70	$18.60
PLAN B (Exam and lenses every 12 months, frames every 24 months)			
Single	$8.80	$8.10	$7.40
Two-party	$17.60	$16.20	$14.80
Family	$26.40	$24.30	$22.20
PLAN C (Exam, lenses and frames every 12 months)			
Single	$12.00	$11.10	$10.10
Two-party	$24.00	$22.20	$20.20
Family	$36.00	$33.30	$30.30

BASIC LIFE INSURANCE

What is Basic Group Life Insurance?
Basic Group Life Insurance is an employer sponsored life insurance coverage for active employees and board members that includes Accidental Death and Dismemberment (AD&D) benefits.

How Much Coverage Can Be Offered?
Coverage can be offered in increments of $5,000 to a maximum of $100,000. Each employee group can have only one offering of coverage. Board Members are not an employee group and can only participate in the group life program with the employee group they agreed to follow.

What are the Monthly Rates for the Basic Group Life Insurance?
Basic Group Life rates are tiered and determined upon a district's participation in Voluntary Life. To qualify for the lower rate, Voluntary Life participation levels should be at least 25% of the eligible population. Districts with Voluntary Life Participation falling below this threshold become subject to the higher premium tier. Districts offering other life products outside of SISC may have difficulty maintaining the minimum participation guidelines.

Monthly Rates per $1,000 of Benefit	
Districts offering only Basic Life benefits or who do not meet participation levels for Voluntary Life.	$0.145
Districts offering Basic Life with Voluntary Life	$0.095

Is Dependent Coverage Available?
Yes. Each employee group can elect to add the following dependent coverage for an additional $0.36 per subscriber.

Dependent	Benefit
Spouse/Domestic Partner	$1,500
Each child age 6 months to 26 years	$1,500
Each child from live birth to 6 months	$500

What are the Eligibility Guidelines?
One hundred percent participation of full time employees, participating part time employees, and participating board members enrolled in health benefits is required. Former Board Members and retirees are not eligible (see Board Members section in Guidelines and Procedures).

Can an Employee Remain Covered While on a Board Approved Leave of Absence?
Yes, up to a maximum leave of 1 year. If the Leave of Absence exceeds 1 year the member must be offered the option of converting coverage.

Will the Benefit Ever Reduce?
Yes. The benefit is reduced by 50% when an employee reaches age 70 and continues to reduce by 50% every five years with a final reduction at age 80. The benefit reduction will occur in the event of a claim. The benefit is reduced according to the Age Discrimination in Employment Act (ADEA) chart (see the Schedule of Insurance section of the "Basic Group Life" policy). Benefits will terminate when the insured person retires.

When is Coverage Terminated?
Coverage is automatically terminated on the first of the month following the employee's last day of active work.

Can Basic Group Life Coverage Continue for an Employee Who Leaves The District?
Yes. The Basic Group Life Insurance policy allows for conversion to an individual policy with the insurance carrier upon loss of coverage. An employee who loses coverage through the district has 31 calendar days from the loss of coverage date to convert the plan.

The employee/spouse/domestic partner will be subject to rates based on the industry standard. **It is the district's responsibility to notify the employee of this option immediately upon loss of coverage.** The Basic Life Conversion form can be found at **siscconnect.org**.

Where Can I Get More Detailed Information about the Basic Group Life Insurance?
Plan Documents are available on SISCconnect and should be referenced for additional information. The Basic Group Life insurance document should be provided to employees upon enrollment. and can be posted to the district's intranet site so employees can access it if needed.

Contact your SISC Account Management team if you are considering changes to your life insurance offering.

VOLUNTARY TERM LIFE INSURANCE

What Is Voluntary Term Life Insurance?
Voluntary Term Life Insurance is an optional life insurance coverage available to employees of districts who are participating in the Basic Group Life Insurance. The policy does not include an AD&D provision.

Who Can Enroll on The Voluntary Term Life Insurance Coverage through SISC?
Employees receiving Basic Life Insurance from their district may enroll in coverage within the first 31 calendar days of hire or of becoming newly eligible **without** having to provide evidence of good health (Guarantee Issue). During the Guarantee Issue period, Employees can purchase up to $250,000 (increments of $10,000) for themselves, up to $50,000 (increments of $5,000) for a spouse/domestic partner, and $10,000 for each dependent child. If an employee requests higher amounts of coverage, evidence of insurability will be required.

Is There an Open Enrollment Period for Voluntary Term Life Insurance?

At the time a district initially offers voluntary life insurance they may offer a **one-time** only open enrollment for all eligible employees without Evidence of Insurability required. Please contact your Account Management team if you would like to know more about this opportunity.

What are the Monthly Rates?

Employee Age	Rate per $1,000 of Benefit—Effective 10/1/2016
Under 25	$0.05
25–29	$0.06
30–34	$0.07
35–39	$0.08
40–44	$0.10
45–49	$0.16
50–54	$0.24
55–59	$0.49
60–64	$0.67
65–69	$1.14
70–74 (active employees only)	$2.16
75 and over (active employees only)	$3.02

How Much Coverage Can Be Purchased Through SISC?
Employees can purchase up to $500,000 for themselves (increments of $10,000) and their spouse/domestic partner (increments of $5,000), and $10,000 for each dependent child. Employees requesting coverage amounts in excess of Guarantee Issue, or outside the Guarantee Issue period, will be subject to approval from the life insurance carrier through an Evidence of Insurability application.

Can a Spouse/Domestic Partner or Dependent Child's Coverage Exceed the Employee's Coverage?
No. Coverage for a spouse/domestic partner is limited to 100% of the employee benefit. Coverage for dependent children is limited to $10,000 per child.

How are the Premiums Calculated for Spouse/Domestic Partners?
The rates for a spouse/domestic partner are based upon the age of the employee (see monthly rate table).

What is the Monthly Premium for Dependent Children?
All dependent children are allowed $10,000 of coverage for a total monthly premium of $1 regardless of the number of children covered. Dependent children are only covered under this policy through their 26th birthday.

Does an Employee's Premium Increase as They Age?
Yes. The premium will increase the January following an employee's transition into the next age band. A report of these increases will be available on SISCconnect each December. It is the district's responsibility to notify the employee of any premium changes.

Does the Voluntary Term Life Benefit Ever Reduce?
Yes. The benefit and corresponding premium are reduced by 50% when an employee reaches age 70 and continues to reduce by 50% every five years until the employee reaches age 80. The benefit is reduced according to the Age Discrimination in Employment Act (ADEA) chart (see the schedule of benefits section of the "Voluntary Term Life" policy).

Is There a Cash Value to this Policy?
No.

Can Voluntary Term Life Coverage Continue for an Employee Who Leaves the District?
Yes. The Voluntary Term Life Insurance policy has the added value of being portable. This means that an employee who loses district coverage can continue their policy directly with the insurance carrier for the same group rates charged to SISC members up to age 70.

Employees must apply for continuation within 31 calendar days from the loss of coverage date. **It is the district's responsibility to notify the employee of this option immediately upon loss of coverage.** Forms to continue Voluntary Life Insurance can be found on the SISC secure web portal (SISCconnect) at **siscconnect.org**. Employees over age 70 who lose district coverage may contact the insurance carrier directly for other continuation options.

Who Does an Employee Contact If He or She Would Like to Apply for the Voluntary Term Life Insurance after the Initial Enrollment Period?
Late entrants are subject to evidence of insurability requirements and a medical evaluation. Evidence of Insurability is completed online directly with Lincoln Financial through a district specific web portal. Access to the district's web portal and instructions for completing the EOI are available on SISCconnect. SISC will notify the district of an approved enrollment and subsequent premium changes when a decision is received from Lincoln Financial. There may be an application fee which is the responsibility of the employee and does not guarantee coverage will be approved.

Where Can I Get More Detailed Information about the Voluntary Term Life Insurance?
Plan documents should be referenced for additional information and should be provided to employees upon enrollment. You may download the documents from the "Life Insurance" option on the "Reports" tab in SISCconnect. The document and summary can be posted to the district's intranet site so employees can access it if needed.

Additional Life Insurance Provisions

Is Extended Coverage Available for Disabled Employees?
Yes. If an insured employee becomes totally and permanently disabled prior to reaching age 65 and meets other qualifying conditions, he or she may qualify for extended life insurance coverage without premium if approved by the insurance carrier. SISC encourages employees to apply for this extended coverage as soon as he or she may be eligible. For more information on this provision, the plan document should be referenced.

Is a Living Benefit Available?
Yes. In the event a covered employee is diagnosed with a terminal illness which is expected to result in death within 12 months, the insured person may elect to withdraw an Accelerated Death Benefit which will reduce the benefit payable at death. For more information on this provision, the plan document should be referenced.

Life Insurance Reporting

How Do I Enroll a Newly Eligible Employee on the Basic Group Life Insurance?
There are two forms to complete. The employee must complete a SISC Enrollment Form and a Basic Group Life Enrollment Form. The correct Basic Life Group Number from the Rates-at-a-Glance should be indicated on the SISC Enrollment Form and submitted with the district's activity.

Do I Need to Submit the Basic Life Enrollment Form to SISC?
No. It is the district's responsibility to keep a copy in the employee's personnel file. In the event of a claim, the district will be responsible for providing the form with the claim.

If a Newly Eligible Employee is Enrolling on Voluntary Term Life Insurance, Do I Need to Submit a Voluntary Term Life Enrollment Form to SISC?
Yes. If a newly eligible employee would like to enroll in the Voluntary Term Life Insurance, the employee must complete the Voluntary Term Life Insurance Enrollment Form within the first 31 calendar days of hire or of becoming newly eligible. It is the district's responsibility to keep the original enrollment form in the employee's personnel file and provide a copy to SISC via **siscconnect.org**.

How Do I Report Voluntary Term Life Terminations to SISC?
Voluntary Term Life terminations should be submitted in writing through SISCconnect. It is the district's responsibility to keep a copy of the employee's requested termination in the employee's personnel file.

How Do I Report Voluntary Term Life Decreases of Coverage to SISC?
Requests for decreases of coverage should be submitted in writing through SISCconnect. It is the district's responsibility to keep a copy of the employee's requested changes in the employee's personnel file.

Beneficiaries and How to File a Life Insurance Claim

How Does an Employee Change a Beneficiary?
An employee can complete a Beneficiary Designation form at any time. This form can be found on SISCconnect. It is the district's responsibility to keep this in the employee's personnel file. Do not forward to SISC unless a claim is being filed.

Do I Need to Send Life Insurance Beneficiary Change Forms to SISC?
No. It is the district's responsibility to keep any beneficiary change forms in the employee's personnel file.

What is a Primary Beneficiary?
A Primary Beneficiary is a person named to receive an employee's life insurance benefit in the event of a claim. If an employee wishes to designate more than one primary beneficiary, then percentages totaling 100% should be indicated.

What is a Secondary Beneficiary?
A Secondary Beneficiary is a person named to receive an employee's benefit in the event that no primary beneficiaries are alive when a claim is filed. If an employee wishes to designate more than one secondary beneficiary, then percentages totaling 100% should be indicated.

Can a Minor Child be a Beneficiary?
Yes. Minor children can be beneficiaries. In the event of a claim, the benefit may be released to a legally appointed guardian or held in a trust with the insurance carrier until the child reaches age 18.

What Happens If No Beneficiaries are Named?
If an employee does not name a beneficiary or if no beneficiary survives the employee, benefits will be paid in the following order:

1. to a surviving spouse/domestic partner; if none, then
2. to surviving natural and/or adopted children; if none, then
3. to a surviving parent(s); if none, then
4. to surviving brothers and sisters in equal share, if note, then
4. to an estate

Benefits will be paid equally among surviving children or surviving parents.

How Do I File a Claim?
In the event of a claim, it is the district's responsibility to provide the appropriate forms to the claimant. Life Claim form can be found on SISCconnect. Completed claims should consist of the Life Claim form, Basic life and Voluntary Term life enrollment form(s), Certificate of Death, and any Funeral Assignment forms if applicable. The forms should be submitted through SISCconnect and the district should keep a copy of all forms.

How Long Does a Claim Take to Process?
It takes the insurance carrier about 31 days to fully review each claim submitted. If additional information is required by the carrier, this may further delay the processing time.

FORMS AND RESOURCES

Most of the forms listed below can be found on the SISC secure web portal (SISCconnect) at **siscconnect.org** which you may access and print as needed. Some forms will be interactive and all forms related to activity must be returned to SISC for processing. Forms noted as 'District Use Only' are to be kept at the district as SISC does not need a copy.

- Address Change Form (SISC use to notify District of returned mail)
- Blue Shield 65 Plus HMO Medicare Advantage Enrollment
- Declination of Coverage: Less Than Full-Time Active Employees and HIPAA Notification (for district use only)
- Declination of Coverage for Dependents of Active Employees and HIPAA Notification (for district use only)
- Declination of Coverage for Retirees: (for district use only)
- Delta Dental Designation Form: (for district use only)
- RGMP Disenrollment Form
- Kaiser Permanente Enrollment Form
- Maintenance Activity Report (MAR) Transfers
- Maintenance Activity Report (MAR) Terminations
- Membership Change Form (change member address, name, add/delete dependents etc.)
- Notification of Plan Changes: District's making changes
- PPO Retiree 65+ EGWP or Companion Care Enrollment Form
- SISCconnect Registration Form
- Universal Enrollment Form (excluding Kaiser)
- Notices sent by SISC to members (subject to change without notice)
  - CMS Notice of Rx Creditable Coverage Disclosure
  - HIPAA Notice of Privacy Practices
  - Women's Health (included with HIPAA Notice of Privacy Practices)
  - Medicare Eligible Notification Letter (turning-65 letter)
- Annual Notices sent to district's via SISC Health email (subject to change without notice)
  - Benefits Provided to Domestic Partners as Taxable Income
  - Flu Vaccine Clinic: Sponsored by SISC
  - Open Enrollment Reminder
  - SISC Activity Schedule
- Affordable Care Act (ACA) resources contact your SISC Account Management Team

TELEPHONE NUMBERS—WHO TO CONTACT

Please furnish employees with one of the following phone numbers when they need a new ID card or have questions regarding benefits or claims (phone numbers beginning with 800, 844, 855, and 866 are toll-free):

Claims and Customer Service		
Anthem Blue Cross	www.anthem.com/ca/sisc	See ID Card
Blue Shield of California	www.blueshieldca.com/sisc	855-599-2657
COBRA	SISCCOBRA@siscschools.org	661-636-4410
Delta Dental of California	www.deltadentalins.com	866-499-3001
Employee Assistance Program (EAP) • Anthem Blue Cross (EAP)	www.anthemeap.com	800-999-7222
Teladoc Medical Experts	www.teladoc.com/sisc	800-835-2362
Health Maintenance Organization (HMO) Plans • Anthem Blue Cross HMO • Blue Shield HMO • Kaiser Permanente	www.anthem.com/ca/sisc www.blueshieldca.com/sisc www.kp.org/sisc	800-825-5541 855-599-2657 800-464-4000
I.D. Cards	See Vendor Website	
Life Insurance	SISCLIFE@siscschools.org	661-636-4410
MDLive (SISC PPO and HMO Members)	www.mdlive.com/sisc	800-657-6169
EyeMed	www.eyemed.com	866-800-5457
Navitus—Customer Service and Mail Order Service	www.navitus.com	866-333-2757
Retiree Group Medicare Plans/ Medicare Advantage Plans • Blue Shield 65 Plus HMO Medicare Advantage • CompanionCare • Kaiser Senior Advantage		800-776-4466 800-825-5541 800-443-0815
SISC Dental Health Network Plan powered by Anthem Dental	www.anthem.com/ca/sisc	844-729-1565
SISC Direct Bill Retirees	SISCRetirees@siscschools.org	661-636-4410
SISC FLEX Plan	cagonzales@siscschools.org	661-636-4416
Vision Service Plan	www.vsp.com	800-877-7195

SISC Main Telephone Number 661-636-4410

Secure document upload for activity only—**siscconnect.org**

Supervisor - Health Benefits

Shawna Smith	shsmith@siscschools.org	661-636-4669

SISC Eligibility Technicians

Jasmin Cazares	jacazares@siscschools.org	661-636-4508
Jennifer De La Torre Catano	jecatano@siscschools.org	661-636-4576
Denise Faz	defaz@siscschools.org	661-636-4869
Christina Lele'a	chlelea@siscschools.org	661-636-4394
Eleanor Maldonado	elmaldonado@siscschools.org	661-636-4307
Holly Polk	hopolk@siscschools.org	661-636-4397

SISC Account Management Teams

Fax 661-636-4893

Manager - Health Benefits

Lola Nickell	lonickell@siscschools.org	661-636-4533

Contact Name	E-mail address	Phone Number	Counties of Service
Armando Cabrera	arcabrerra@siscschools.org	(661) 636-4608	Imperial, Kern, Los Angeles, Orange, Riverside, San Diego*
Isabel Sanchez	issanchez@siscschols.org	(661) 636-4574	
Frank Impastato	frimpastato@siscschools.org	(661) 636-4304	Alameda, Antelope Valley, Contra Costa, Kern, Merced, San Bernardino, Santa Barbara, Santa Cruz, San Luis Obispo, Ventura*
Bobbette Wellwood	bowellwood@siscschools.org	(661) 636-4221	
Frank Impastato (temporarily assigned)	frimpastato@siscschools.org	(661) 636-4304	Butte, Kern, Kings, Lake, Lassen, Marin, Mendocino, Napa, Placer, Plumas, Sacramento, San Joaquin, Solano, Sonoma, Stanislaus, Sutter, Tulare*
Karen Morovich	kamorovich@siscschools.org	(661) 636-4622	
Lauri Phillips	laphillips@siscschools.org	(661) 636-4711	El Dorado, Fresno, Humboldt, Kern, Madera, Mariposa, Mono, Monterey, San Benito, San Mateo, Santa Clara, Shasta, Siskiyou, Tehama, Trinity, Tuolumne*
Kimberly Winn	kiwinn@siscschools.org	(661) 636-4790	

*If you have an inquiry about a county not listed, please call our office at (661) 636-4410 for more information.

CUSTOMER SERVICE PHONE NUMBERS AND ADDRESSES FOR CLAIMS INFORMATION AND PROCESSING

The SISC III office **does not process medical claims**. Our medical claims are processed by one of the offices listed below. Physicians or subscribers should forward their claim to the address on the member's ID card.

All claims sent to our office will be returned directly to the doctor or the subscriber who sent it to the SISC office.

Provider	Address	Phone Number
Anthem Blue Cross PPO Plans	**Foundation for Medical Care of Kern County** PO Box 12020 Bakersfield, CA 93389-2020 5701 Truxtun Avenue # 100 Bakersfield, CA 93309	661-327-7581 800-322-5709
	Foundation for Medical Care of Tulare & Kings Counties, Inc. 3335 South Fairway Visalia, CA 93277	559-734-1321 888-720-4725
Anthem Blue Cross PPO or HMO Plans	**Anthem Blue Cross of California Woodland Hills** PO Box 60007 Los Angeles, CA 90060	800-825-5541
Blue Shield PPO or HMO Plans	**Blue Shield of California** PO Box 272540 Chico, CA 95927	855-599-2657
Blue Shield 65 Plus Medicare Advantage Plan	**Blue Shield 65 Plus** PO Box 927 Woodland Hills, CA 91365	800-776-4466
Kaiser Permanente HMO Plans	**Northern California** Kaiser Foundation Health Plan, Inc. Claims Department PO Box 12923 Oakland, CA 94604	800-390-3510
	Southern California Kaiser Foundation Health Plan, Inc. Claims Department PO Box 7004 Downey, CA 90242	800-390-3510