Employee Health Benefits
Guide for Plan Year 2022-2023

Plan Year: October 1, 2022- September 30, 2023

This guide provides information about health benefits with State Center Community College District (SCCCD). Employees and new hires should use this guide as your go-to source for health benefits for plan year 2022-2023.
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Introduction

Welcome! State Center Community College District ("District") strives to provide you and your family with a comprehensive and valuable health benefits package. We want to make sure you are getting the most out of our benefits—which is why we have put together this guide. This guide will summarize your employee health benefits and should be your go-to guide when you have benefit-related questions.

This guide is not intended to be a contract (expressed or implied), nor is it intended to otherwise create any legally enforceable obligation on the part of the District, its agents, or its employees.

Open Enrollment
Open Enrollment is held from August 9th – September 9th this year. Open Enrollment is the one time each year you can make changes to your benefits without a qualifying event.

All open enrollment notices are sent to employees District e-mail addresses.

During the open enrollment period, it is the employee’s responsibility to review current plan elections and plan changes for the new plan year. During the open enrollment period, employees may make changes to their health plan elections, flexible spending account elections, and add/remove eligible dependents.

Plan Year
Our health insurance plan year is October 1 through September 30. Any changes to the plans made during the annual open enrollment period take effect October 1 of that year.

Health plan deductibles, out of pocket maximums, and dental plan maximums, all run calendar year, beginning January 1.

Frequently Asked Questions
You can find answers to frequently asked questions on page 43. If you have a question that is not answered by this guide, please reach out to us.

Email: District Benefits

Phone:
Reina Kemble, Benefits Technician, (559) 243-7134
Frances Garza, Benefits Coordinator, (559) 243-7133
District Human Resources Office, (559) 243-7100
Eligibility

Employees
The District offers medical, dental, vision, and group life/accidental death and dismemberment insurances along with an employee assistance program to full-time employees and their eligible dependents.

Full-time benefit eligible employees and health plan effective dates are defined in the bargaining unit agreements, Board Policies, and Administrative Regulations.

Eligible Dependents
When enrolling eligible dependents, appropriate supporting documentation and/or proof of dependent status is required. Dependent children can be enrolled on the health plans up to the age of 26.

<table>
<thead>
<tr>
<th>Eligible Dependent</th>
<th>Supporting Documents Needed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Legally Married Spouse</td>
<td>Copies of the original, certified marriage certificate and spouse’s social security card.</td>
</tr>
<tr>
<td>Registered Domestic Partner (RDP)</td>
<td>Copies of Declaration of Domestic Partnership with the California Secretary of State and RDP’s social security card.</td>
</tr>
<tr>
<td>Biological Child(ren)</td>
<td>Copies of original certified birth certificate(s) naming the employee as child’s biological parent and a copy of the child’s social security card.</td>
</tr>
<tr>
<td>Stepchild(ren)</td>
<td>Copies of original, certified birth certificate(s) naming current legally, married spouse as the child’s biological parent and the child’s social security card.</td>
</tr>
<tr>
<td>Foster child, legal guardianship, or grandchildren</td>
<td>Copies of original certified birth certificate(s), along with court papers showing legal responsibility and/or guardianship of the child(ren) and the child’s social security card.</td>
</tr>
</tbody>
</table>
New Hire Enrollment
Newly hired employees have 31 days from their date of hire, including their date of hire, to enroll in the health insurance plans.

Newly hired employees must complete their benefit enrollment on their new hire onboarding portal, either NeoEd or TalentEd/PeopleAdmin.

New employees who do not make an election within 31-days from date of hire, including the date of hire, will automatically be enrolled for employee only coverage under the lowest cost health plans for the plan year.

Change in Dependent Eligibility/Qualifying Event
Employees have 31-days from a qualifying event date, including the event date, to make changes to dependents on the health plans.

Employees who experience a dependent eligibility change/qualifying event are responsible to notify the District Human Resources – benefits staff via e-mail or by calling (559) 243-7134 and submit the required enrollment change form(s) and supporting document(s) within 31-days from the qualifying event date, including the event date. Failure to submit notification in a timely manner may impact dependent eligibility for health insurance, health care continuation under COBRA, and may result in you incurring liability for health care expenses.

Qualifying events include, but are not limited to:
- Change in legal marital status, including marriage, divorce, legal separation, annulment, registration or dissolution of domestic partnership, and death of a spouse.
- Birth, adoption, placement for adoption, or death of a dependent child.
- Change in employment status, including the start or termination of employment by you, your spouse, or your dependent child.
- Permanent change in work schedule, including a significant increase or decrease in hours of employment by you, your spouse, or your dependent child, including a switch between part-time and full-time employment that affects eligibility for benefits.
- Change in an individual's eligibility for Medicare or Medicaid.
- A court order resulting from a divorce, legal separation, annulment, or change in legal custody (including a Qualified Medical Child Support Order) requiring coverage for your child or dependent foster child.
**Health Benefit Offerings**

The District’s health benefit package includes medical, dental, vision, and life and accidental death & dismemberment insurances, along with an employee assistance program. The District also offers a voluntary long-term disability insurance plan, at employee cost.

The District and employees share in the cost of the health insurance coverage. The District Contribution toward the health insurance plans monthly premiums is specified in the bargaining unit agreements, board policy, and/or administrative regulation. The employee portion of the premium is automatically deducted from your paycheck on a monthly basis. *Employees can elect to have the employee payroll deduction taken out on a pre-tax basis. This election can occur at initial time of hire or during the annual open enrollment period.*

### Medical Insurance Plans

<table>
<thead>
<tr>
<th>Plan</th>
<th>Monthly Employee Payroll Deduction</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bronze PPO Medical Insurance Plan</td>
<td>$217</td>
</tr>
<tr>
<td>Modern Care PPO Medical Insurance Plan</td>
<td>$420</td>
</tr>
<tr>
<td>Kaiser Low Deductible HMO Medical Insurance Plan</td>
<td>$0</td>
</tr>
<tr>
<td>Kaiser High HMO Medical Insurance Plan</td>
<td>$204.73</td>
</tr>
</tbody>
</table>

### Dental Insurance Plan

<table>
<thead>
<tr>
<th>Plan</th>
<th>Monthly Employee Payroll Deduction</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ameritas PPO Dental Insurance Plan</td>
<td>$0, fully paid for by the district.</td>
</tr>
</tbody>
</table>

### Vision Insurance Plan

<table>
<thead>
<tr>
<th>Plan</th>
<th>Monthly Employee Payroll Deduction</th>
</tr>
</thead>
<tbody>
<tr>
<td>VSP Vision Insurance Plan</td>
<td>$0, fully paid for by the district.</td>
</tr>
</tbody>
</table>

### Life and Accidental Death and Dismemberment (AD&D) Insurance Plan

<table>
<thead>
<tr>
<th>Plan</th>
<th>Monthly Employee Payroll Deduction</th>
</tr>
</thead>
<tbody>
<tr>
<td>VOYA Life and Accidental Death &amp; Dismemberment (AD&amp;D) Insurance Plan</td>
<td>$0, fully paid for by the district.</td>
</tr>
</tbody>
</table>

### Voluntary Long-Term Disability (LTD) Insurance Plan

<table>
<thead>
<tr>
<th>Plan</th>
<th>Monthly Employee Payroll Deduction</th>
</tr>
</thead>
<tbody>
<tr>
<td>Voya Voluntary Long-Term Disability Insurance Plan</td>
<td>Premium rate varies. Fully paid for by the employee.</td>
</tr>
</tbody>
</table>
What is New in 2022?

**BenefitBridge – our new online benefits administration system**
- BenefitBridge is a web-based portal that is available at open enrollment and year round to capture enrollments and life event changes. BenefitBridge is available 24/7 via the internet and includes a resource center for quick access to benefits information.

**Modern Care and Bronze PPO Medical Plans – Effective October 1, 2022**
- **Buzz Rx**: This plan offers an added benefit of a prescription discount card that can be utilized on any and all pharmacy claims for those prescriptions excluded from the PPO medical plan benefits. This is provided to all plan members at no additional cost, and pharmacies will receive all the information they need directly from IPM to get this discount for members anytime a pharmacy claim comes up for an excluded prescription.

  - **Site-of-Care Program**: This is a new optional benefit, as our PPO plans want to ensure members have adequate access to care through most appropriate places of service. Select medications and services associated with infusions are available via the plan's pharmacy benefits, in addition to the current medical plans. Members should seek out coverage for eligible medications via the pharmacy benefit whenever possible to ensure adequate access to care. Members and their providers are able to contact IPM for assistance with initiating infusion services and navigation of necessary steps to receive care.

- EdCare has enhanced the team member benefit offering for our PPO plans to include personalized prescription(s). Members and their physicians will be guided to targeted therapies through appropriate testing that improves outcomes and care. The first two therapeutic categories for this benefit enhancement are Rheumatoid Arthritis and Mental Health. While any current treatments will be unimpacted, for any members that would be impacted in the future, both you and your physician will receive communication from IPM on how to utilize this benefit, the IPM team will assist with the process.

- New ID cards will follow directly to your homes the beginning of October.

**Dental Plan – Effective October 1, 2022**
- The professional consultations and office visits will be covered separately from routine examinations. Coverage would remain limited to 2 procedures in a 12-month period for each consultation’s and exams.
BenefitBridge Online Benefits System

State Center Community College District Online Benefits Enrollment is easy with BenefitBridge!

Need Help?
For all questions related to your benefits, please contact your employer’s benefits administrator. For BenefitBridge technical assistance only, please contact BenefitBridge Customer Care at 800-814-1862; Mon – Fri, 8:00 AM – 5:00 PM, PST or email benefitbridge@keenan.com

Here’s what you can do on BenefitBridge:

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

Registration and Login

Already have login credentials?

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

Need to create login credentials?

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

Enrolling in Benefits

Access your enrollment via the “Make Changes to My Benefits” button

For BenefitBridge technical assistance only, please contact BenefitBridge Customer Care at 800-814-1862
Monday - Friday, 8:00 AM - 5:00 PM, PST or email benefitbridge@keenan.com
# Medical Plans

The District offers the choice between four medical plans, two HMO plans and two PPO plans. The medical plan offerings are Kaiser HMO, Kaiser Deductible HMO (DHMO), Modern Care PPO, and Bronze PPO. The HMO plans are fully insured health plans, while the PPO plans are self-funded health plans.

## Kaiser High HMO and Kaiser Low Deductible HMO (DHMO) Medical Plans

This matrix is a brief summary of your benefits. You must read the entire evidence of coverage in order to understand the details of your coverage. Please review the detailed Evidence of Coverage document or Summary Plan Document. All EOCs/SPDs can be found on the District Human Resources Employee Benefits website.

<table>
<thead>
<tr>
<th>General Plan Provisions</th>
<th>Kaiser High HMO</th>
<th>Kaiser Low Deductible HMO (DHMO)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Calendar Year Deductible</td>
<td>None</td>
<td>$2,000 individual/$4,000 family</td>
</tr>
<tr>
<td>Calendar Year Out-of-Pocket Maximum</td>
<td>$1,500 individual/$3,000 family</td>
<td>$4,000 individual/$8,000 family</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Service/Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Office visit copay</td>
</tr>
<tr>
<td>Preventative care</td>
</tr>
<tr>
<td>Well-baby and Well-child care</td>
</tr>
<tr>
<td>Most physical, occupational, and speech therapy</td>
</tr>
<tr>
<td>Hospitalization Room and board, surgery, anesthesia, X-rays, lab test, and drugs</td>
</tr>
<tr>
<td>Outpatient surgery and certain other outpatient procedures</td>
</tr>
<tr>
<td>Most X-rays and laboratory tests</td>
</tr>
<tr>
<td>MRI, Most CT, and PET scans</td>
</tr>
<tr>
<td>Emergency Room</td>
</tr>
<tr>
<td>Ambulance</td>
</tr>
<tr>
<td>Mental Health Inpatient</td>
</tr>
<tr>
<td>Mental Health Group Outpatient</td>
</tr>
<tr>
<td>Durable Medical Equipment</td>
</tr>
</tbody>
</table>

## Modern Care PPO Medical Plan – Remains with the same benefits

This matrix is a brief summary of your benefits. You must read the entire evidence of coverage in order to understand the details of your coverage. Please review the detailed Evidence of Coverage document or...
Summary Plan Document. All EOCs/SPDs can be found on the District Human Resources Employee Benefits website.

<table>
<thead>
<tr>
<th>General Plan Provisions</th>
<th>In network</th>
<th>Out of network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Calendar Year Deductible</td>
<td>$400 individual/*see below for family</td>
<td>$5,000 individual</td>
</tr>
<tr>
<td>Calendar Year Out-of-Pocket Maximum</td>
<td>$3,000 individual/**see below for family</td>
<td>$10,000 individual/**see below for family</td>
</tr>
</tbody>
</table>

*For family coverage, an individual within a family shall not have a maximum out of pocket limit that is greater than the maximum out of pocket limit for an individual.

**For participants with Family coverage, the out of pocket will be considered satisfied when 3 individuals each satisfy their individual maximum.

The out of pocket amount includes medical copays, deductible and coinsurance amounts for ‘essential health benefits’ as defined under the Affordable Care Act. Prescription expenses are not included in the Medical Out-of-Pocket maximum.

For the 2022 plan year, the combined Medical and Prescription annual Out of Pocket maximum for covered services received In-Network will not exceed limits of $8,550 per Individual or $17,100 for Family coverage.

| Calendar Year Prescription Out-of-Pocket Maximum | $3,000 individual/$7,500 Family (2.5) |

<table>
<thead>
<tr>
<th>Service/Benefit</th>
<th>In-network</th>
<th>Out-of-network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Office visit copay</td>
<td>$30 per visit</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td>Specialist visit copay</td>
<td>$60 per visit</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td>Preventative care</td>
<td>No charge</td>
<td>No charge</td>
</tr>
<tr>
<td>Well-baby and well-child care</td>
<td>No charge</td>
<td>No charge</td>
</tr>
<tr>
<td>Physical, occupational, and speech therapy</td>
<td>10% coinsurance</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td>Hospitalization room and board</td>
<td>$250 copay per day, up to $750 per admission, plus 10% coinsurance</td>
<td>$250 copay per day, up to $750 per admission, plus 50% coinsurance</td>
</tr>
<tr>
<td>Outpatient surgery and certain other outpatient procedures</td>
<td>Facility - $200 copay, plus 10% coinsurance Ambulatory - $150 copy, plus 10%</td>
<td>Facility - $200 copay, plus 10% coinsurance Ambulatory - $150 copy, plus 10% ($750 copay applies to Summit Surgical)</td>
</tr>
<tr>
<td>Most X-rays and laboratory tests</td>
<td>$30 copay, plus 10% coinsurance</td>
<td>$30 copay, plus 50% coinsurance</td>
</tr>
<tr>
<td>MRI, Most CT, and PET scans</td>
<td>$75 copay, plus 10% coinsurance</td>
<td>$75 copay, plus 10% coinsurance</td>
</tr>
<tr>
<td>Emergency Room</td>
<td>$300 copay, plus 10% coinsurance</td>
<td>$300 copay, plus 10% coinsurance Non-emergency use of ER - $300 copay, plus 50% coinsurance</td>
</tr>
<tr>
<td>Ambulance</td>
<td>10% coinsurance</td>
<td>10% coinsurance Non-emergency use of ambulance - 50% coinsurance</td>
</tr>
<tr>
<td>Mental Health Inpatient</td>
<td>$250 copay per day, up to $750 per admission, plus 10% coinsurance</td>
<td>$250 copay per day, up to $750 per admission, plus 50% coinsurance</td>
</tr>
<tr>
<td>Durable Medical Equipment</td>
<td>10% coinsurance</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td>Retail</td>
<td>Prescription Drugs (mandatory generic required)</td>
<td></td>
</tr>
<tr>
<td>--------</td>
<td>-----------------------------------------------</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Generic drugs (on basic formulary)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>$10</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Preferred band name drugs (on basic formulary)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>$45</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Non-preferred brand name</td>
<td></td>
</tr>
<tr>
<td></td>
<td>$80</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Specialty Drugs</td>
<td></td>
</tr>
<tr>
<td></td>
<td>$250</td>
<td></td>
</tr>
</tbody>
</table>
Bronze PPO Medical Plan

This matrix is a brief summary of your benefits. You must read the entire evidence of coverage in order to understand the details of your coverage. Please review the detailed Evidence of Coverage document or Summary Plan Document. All EOCs/SPDs can be found on the District Human Resources Employee Benefits website.

<table>
<thead>
<tr>
<th>General Plan Provisions</th>
<th>In network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Calendar Year Deductible</td>
<td>$5,000 individual</td>
</tr>
<tr>
<td>Calendar Year Out-of-Pocket Maximum</td>
<td>$6,850 individual/$13,700 family</td>
</tr>
<tr>
<td><strong>Service/Benefit</strong></td>
<td></td>
</tr>
<tr>
<td>Office visit copay</td>
<td>$60 per visit</td>
</tr>
<tr>
<td>Specialist visit copay</td>
<td>$60 per visit</td>
</tr>
<tr>
<td>Preventative care</td>
<td>No charge</td>
</tr>
<tr>
<td>Well-baby and well-child care</td>
<td>No charge</td>
</tr>
<tr>
<td>Physical, occupational, and speech therapy</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td>Hospitalization room and board</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td>Outpatient surgery and certain other outpatient procedures</td>
<td>Facility – 30% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Ambulatory – 30% coinsurance</td>
</tr>
<tr>
<td>Most X-rays and laboratory tests</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td>MRI, Most CT, and PET scans</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td>Emergency Room</td>
<td>$300 copay, plus 30% coinsurance</td>
</tr>
<tr>
<td>Ambulance</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td>Mental Health Inpatient</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td>Durable Medical Equipment</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td><strong>Retail Prescription Drugs (mandatory generic required)</strong></td>
<td></td>
</tr>
<tr>
<td>Generic drugs (on basic formulary)</td>
<td>$10</td>
</tr>
<tr>
<td>Preferred band name drugs (on basic formulary)</td>
<td>$45</td>
</tr>
<tr>
<td>Non-preferred brand name</td>
<td>$80</td>
</tr>
<tr>
<td>Specialty Drugs</td>
<td>$250</td>
</tr>
</tbody>
</table>
About the PPO Medical Plans

Things to know about the PPO plans

- The Modern Care and Bronze PPO medical plans are self-insured plans. The District is part of a Joint Powers Authority (JPA) known as the EdCare Group, which assumes the financial risk of the health plans.

- Both plans use the Anthem Blue Cross PPO provider network nationwide for all benefits except mental health & substance abuse benefits, chiropractic benefits, and speech therapy, occupational therapy, & physical therapy benefits. These benefits have a separate provider network, outside of Anthem Blue Cross. Please see the PPO Plan Administrators listing on the next page regarding how to access in-network benefits and provider networks for these benefits/services.

- When you enroll, you do not need to choose a primary care physician; however, it is recommended to find a primary physician early in order to become an established patient.

- With a PPO plan, each time you need care, you choose whether to receive your care from a PPO (in-network) provider or non-PPO (out-of-network) provider.

- If you choose to go to an out-of-network provider, you will pay for a larger portion of your billed service(s).

- To use in-network benefits, always ask if your provider is a “contracted provider” with the appropriate provider network (Anthem Blue Cross, PhysMetrics, and/or Halcyon). If yes, then they are in-network. If no, then they are out-of-network. You can continue to see an out-of-network provider; however, your out-of-pocket expenses for services will be more.

- When your primary care physician refers you to a specialist, lab, or other service providers, it is your responsibility to ensure they are in-network.

- Referrals are not required by the health plan in order to see a specialist; however, many specialists require a referral from a primary care physician.

- Anthem Blue Cross provides all pre-authorizations.

- If you should access services outside of California, please work with Delta Health Systems to ensure claims are processed correctly.
PPO Plan Administrators of Benefits/Services

**Medical Benefits and Claims - Delta Health Systems (DHS)**
Delta Health Systems is the administrator for all medical claims under the PPO plans. Questions in regards to claims/provider billing should be directed to Delta Health Systems at (800) 433-2566. Members can access provider listings, claim information, print a temporary ID card, access Explanation of Benefits, and much more on the [DHS member portal](#).

**Mental Health and Substance Abuse**
Halcyon Behavioral administers all mental health and substance abuse benefits under the PPO plans. Halcyon Behavioral has its own network of providers for such services/benefits. To access benefits and/or provider listings, please visit [EdCare MHSA](#) or call Halcyon Behavioral at (888) 425-4800.

**Chiropractic**
PhysMetrics administers all chiropractic benefits under the PPO plans. PhysMetrics has its own network of providers. Providers can be found at [EdCare Chiro](#). To access chiropractic services/benefits, call PhysMetrics at (877) 519-8839.

**Speech Therapy, Occupational Therapy & Physical Therapy**
PhysMetrics administers all speech therapy, physical therapy, occupational therapy and speech-language therapy benefits under the PPO plans. PhysMetrics has its own network of providers. Providers can be found at [EdCare Physmetrics](#). To access services/benefits, call PhysMetrics at (877) 519-8839.

**Prescription Drug Benefits with Integrated Prescription Management (IPM)**
Integrated Prescription Management (IPM) is the prescription drug vendor for the PPO plans. Members can get prescription fills at any retail pharmacy. For maintenance prescriptions, after two (2) fills at the retail pharmacy all members are required to go through mail order program for future fills.

Some prescription drugs may be excluded from coverage. For a full listing of IPM’s Standard Exclusion Program, please contact IPM at (877) 860-8846. To access the member portal, please visit [IPM’s member portal webpage](#).
**Mandatory Generic Program**
The plan has a mandatory generic requirement. If a member chooses to use a brand drug over a generic drug when a generic is available, the member is responsible for the cost difference between the generic drug cost and the brand drug cost.

**Variable Copay Assist Program**
This is a program that accepts manufacturers’ assistance for certain high-dollar medications which in turn lowers the cost to the plan and may reduce the copay for members, but will never cost more than the current copay. The program includes many, but not all, brand medications, which includes many specialty medications.

**Step Therapy**
Certain groups of drugs require step therapy. Step therapy requires a member to try a less expensive alternative treatment (drug) **before** “stepping up” to the more expensive version of the drug. Research has shown that the less expensive version has the same efficacy. Step therapy has been proven effective for most people; however, if the alternative treatment does not work the member may be allowed to move up to the more expensive drug. Step therapy helps the member and the plan in regards to costs.

**Prior Authorizations**
Certain medications require prior authorization. Prior authorization is a cost-savings feature that helps ensure the appropriate use of selected, usually higher costs, drugs. Prior authorization must be provided **before** the insurance company will provide coverage for the medication(s). If a prior authorization is required, IPM will work with you, your physician, and your pharmacy.

**Maintenance Prescription Drug Mail Order Requirement**
For all maintenance drugs, after two (2) fills at the retail pharmacy all PPO members are required to go through mail order program for future fills. Maintenance drugs are medications taken for an extended period, usually for chronic, on-going conditions.

BK Pharmacy is the default pharmacy for the mail order program; however, members can elect to move their maintenance drug mail order to Walgreens. Please see the steps below or contact IPM at (877) 860-8846 for assistance.

**BK Pharmacy**
- Members may pick up their mail order maintenance prescriptions at the local BK Pharmacy, located at 6741 N. Willow #106, Fresno, CA 93710.
- You can elect to have your maintenance drug prescription(s) mailed to your home address or if you live in the Fresno/Clovis area, you can have the prescription(s) delivered by courier to your home or office at no additional charge.

**Walgreens**
- Walgreens is an option for the PPO plan mail order maintenance drug program.
- Members may **transfer (from BK Pharmacy)** a maintenance prescription to a Walgreens Pharmacy by having the prescribing physician’s office telephone the new prescription in or by delivering a new written prescription to Walgreens. Please contact IPM at (877) 860-8846 for assistance.
Baby Connect Program for PPO Members

Modern Care and Bronze PPO Members
Available at No Cost

WHO IS ELIGIBLE?
All employees and spouses are eligible for the Baby Connect program. Participants may register for Baby Connect at any time during their pregnancy. To earn incentives, you must be covered under the company medical plan and register during the first trimester.

WHAT ARE THE INCENTIVES?
Not only will you receive the benefit of personalized, one-on-one coaching, but may also qualify for these best-selling tools to help you along the way:

✓ Participants who complete registration within the first trimester will receive a free copy of the book, "WHAT TO EXPECT WHEN YOU'RE EXPECTING"
✓ Participants who successfully complete the program will receive a free copy of the book, "WHAT TO EXPECT THE FIRST YEAR"

HOW DO I GET STARTED?
Take your next step toward a healthy pregnancy and register for Baby Connect today! Registration is completed over the phone and takes just a few minutes. For more information, please contact TeamCare at 866.724.0032 or teamcare@delapro.com - We're here to help!

For questions or assistance contact TeamCare at 888-724-0032 or teamcare@delapro.com

Telemedicine through LiveHealth Online – Medical* for PPO Members
Weight Management Program for PPO Members

The PPO plans provide a weight management program to members who may be candidates for weight-reduction surgery, such as bariatric surgery. The program provides a personal coach to the enrolled member providing knowledge, tools, and motivation to assume control of their health. The program is designed to
improve healthy behaviors, qualify of life and promote a healthy lifestyle.

For more information on this program and to learn more about the authorization process, please contact Santé at (559) 228-5405 or Delta Health Systems at (800) 422-6099.

**Medical ID cards for PPO Members**

Employees who enroll on a PPO medical plan will receive two medical identification cards at time of enrollment. The cards will be issued in the employee’s name only and can be used by all members enrolled on the plan.

Should a member lose an ID card, you can access a virtual copy or print a temporary one by accessing your [DHS member portal](#) or by calling Reina Kemble, Benefits Technician, at (559) 243-7134.

**Member Portals for PPO Members**

Employees enrolled on the PPO plans can access the [Delta Health Systems (DHS) member portal](#) to review medical claims, eligibility, view/print a medical identification card, find providers, and view accumulators toward the deductible and the out of pocket maximum.

The [Integrated Prescription Management (IPM) member portal](#) allows members to access a drug formulary, copay lookup, and find out which prescriptions require step therapy or prior authorization, as well as the member’s prescription claim history.

**Provider Search for PPO Members**

- To search for an in-network PPO medical provider, you can log into your [DHS member portal](#) and click on the provider search link.

- To search for an in-network chiropractor, visit the [EdCare Chiro website](#).

- To search for an in-network physical therapist, occupational therapist, speech therapist, visit the [EdCare PhysMetrics website](#).

- To access Mental Health and Substance Abuse Services and to find in-network providers, call Halcyon at (888) 425-4800 or access the [EdCare MHSA website](#).

**Summary Plan Documents and Benefit Summaries**

All benefit plan summaries and summary plan documents are available on the [District Human Resources Employee Benefits website](#) and [Edcare Group website](#).
About the HMO Medical Plans

Things to know about the Kaiser HMO plans

- The Kaiser High Plan is a traditional HMO plan. The Kaiser Low Plan is a Deductible HMO plan.

- Both plans use Kaiser Hospitals and facilities.

- There are no out-of-network benefits.

- Members of the District’s Kaiser HMO plans are part of the Kaiser Northern Region.

- Most Kaiser Facilities and Medical Centers offer one-stop service – primary care, specialists, lab tests, x-rays, and pharmacy.

- With Kaiser, your doctor, nurses, and other specialists all work together to keep you healthy. They are connected to each other and to you through your electronic health record. That way, you get personalized care that is right for you.

- Kaiser makes it easy to find a doctor who is right for you, and you are free to change doctors at any time, for any reason.

- If you have a condition like diabetes or heart disease, you are automatically enrolled in a disease management program for personal coaching and support.

- Kaiser offers online wellness tools, healthy lifestyle programs, health classes, personal wellness coaching, special rates for members and farmers markets.

Local Kaiser Facilities

Clovis Medical Offices – 2071 E. Herndon Ave., Clovis, CA 93611
First Street Medical Offices – 4785 N. First St., Fresno, CA 93726
Fresno Medical Center – 7300 N. Fresno St., Fresno, CA 93720
Cedar Avenue Medical Offices – 7415 N. Cedar #102, Fresno, CA 93720
Selma Medical Offices – 2651 Highland Ave., Selma, CA 93662
Oakhurst Medical Offices – 40595 Westlake Dr., Oakhurst, CA 93644

Kaiser Health Education Departments

Health Education Departments are available at the Fresno Medical Center, Selma Medical Offices, and the Clovis Medical Offices. Kaiser health classes, program and services range from tobacco cessation classes to weight management to stress relief. Kaiser also offers an online health reference center, DVD and online viewing, community resources and referrals and registered dietician appointments (physician referral only).
Telemedicine Services for Kaiser members
Kaiser offers telemedicine services by e-mail, phone, and video visits.

Fee Schedule for Kaiser Deductible HMO (DHMO) plans
There is a Kaiser Fee Schedule released each year to help members determine the costs of services. Members on the Kaiser Low Deductible HMO plan should review this to determine out-of-pocket costs for services.

Medical ID Cards for Kaiser members
All new members to Kaiser will receive a medical ID card issued in his/her name. If a member should lose an ID card, please contact Kaiser Member Services at (800) 464-4000 to request a new one. Members can also log into their member portal or mobile app to access a virtual ID card.

Member Portal/Mobile App for Kaiser Members
Kaiser members can access a member portal, KP.org, online or through the KP Mobile App.

The member portal and mobile app allows members to schedule appointments, view lab results, email your doctor, view Explanation of Benefits, view bills, and access a wealth of health resources and tools.

Kaiser Care Options While Traveling
No matter where you get urgent or emergency care around the world, you can file a claim for reimbursement. And at many locations outside of Kaiser Permanente states, you will only play your copay or coinsurance – no need to file a claim. Need help finding care or learning what’s covered while you’re away? Call the Away from Home Travel Line at 951-268-3900 or visit kp.org/travel.

- Cigna PPO (Shared Administration) Network providers
- MinuteClinics®, including pharmacies*
- Concentra clinics*

*Payment experiences vary by plan

Evidence of Coverage and Benefit Summaries
All benefit plan summaries, evidence of coverage plan documents, and summary plan documents are available on the District Human Resources Employee Benefits website.
Ways to Save on Health Care and Wellness

**Generic prescriptions**
Each medical plan has tiered copays depending on the type of prescription drug. Generic drugs usually always have the lowest copays. When your doctor provides you with a prescription, you can ask your doctor if there is a generic available with the same efficacy as the brand drug.

Non-preferred brand and brand drugs are more expensive drugs and always have the higher copays.

**Preventative care**
Preventative care is intended to prevent or detect illness before you notice symptoms. Annual check-ups and screenings are an important part of your medical plan and can help you stay healthy. Moreover, when you catch preventable diseases early it can help save you money and keep you well.

**Become educated on your benefits**
Use in-network providers, be your own health advocate and know what your plan covers. Be sure to know what your plan deductibles, copays, and coinsurance will be before receiving care. Different facilities may charge different amounts for the same services. Estimate your share of the costs before you get care.

**Prepare for emergencies**
Be sure to evaluate the impact of the plan out-of-pocket expenses to prepare for emergency care, if needed.

**Urgent Care**
If you need medical care, first call your primary care doctor. Some doctor’s offices have a physician on-call or may be able to provide alternatives if you are unable to get in.

If it is not a life-threatening emergency, call your doctor and ask if you should make an office appointment or find other options that are immediate such as urgent care or telemedicine options. Even if it is after-hours, you may have lower cost and faster alternatives than going to the emergency room.

To help keep your medical costs down, choose a network urgent care center or use the telemedicine services offered through your medical plan.
Dental Insurance Plan

The District offers a dental insurance plan provided through Ameritas PPO. Dental benefits are available for eligible employees and their eligible dependents.

The Ameritas PPO dental plan has in-network and out-of-network benefits. When you use in-network providers, services are provided at a discounted rate. This means you pay less and your benefit dollars go further when you use in-network providers. If you should use an out-of-network provider, you may pay more for services.

**Benefit Incentive levels**

The Ameritas PPO dental plan is an incentive plan that begins paying member claims at 70% and increases 10% each year until the member reaches 100% for all basic, diagnostic and preventative services. *For this reason, we encourage all enrolled members (including dependent members) to use the plan at least once per year in order for the incentive level to increase.*

**Summary of Benefits**

This matrix is a brief summary of your benefits. You must read the entire evidence of coverage in order to understand the details of your coverage. Please review the detailed Evidence of Coverage document or Summary Plan Document. All EOCs/SPDs can be found on the District Human Resources Employee Benefits website.

<table>
<thead>
<tr>
<th>Services</th>
<th>Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preventive Services</td>
<td>Covered at incentive level 70%, 80%, 90%, or 100%</td>
</tr>
<tr>
<td>Deductible</td>
<td>None</td>
</tr>
<tr>
<td>Basic Services</td>
<td>Covered at incentive level 70%, 80%, 90%, or 100%</td>
</tr>
<tr>
<td>Major Services</td>
<td>Covered at 50%</td>
</tr>
<tr>
<td>Annual Plan Maximum</td>
<td>$1,750 in-network/$1,500 out-of-network per calendar year</td>
</tr>
<tr>
<td>Accidental Injury Plan</td>
<td>$1,000 per calendar year for conditions caused directly by external,</td>
</tr>
<tr>
<td>Maximum</td>
<td>violent and accidental means</td>
</tr>
<tr>
<td>Orthodontia</td>
<td>Covered at 50% up to $1,250 (lifetime benefit)</td>
</tr>
<tr>
<td>Pre-determination of Benefits</td>
<td>When a course of dental treatment is expected to exceed $300, a</td>
</tr>
<tr>
<td></td>
<td>predetermination of benefits is recommended.</td>
</tr>
</tbody>
</table>

**Dental ID Cards**

All new members to Ameritas PPO dental will receive two dental identification cards at time of enrollment.
The cards will be issued in the employee’s name only and can be used by all members enrolled on the plan.

If a member should lose their dental ID card, the member can log into their Ameritas member portal to print a copy. Members can also contact Reina Kemble, Benefits Technician, at (559) 243-7134 to request a new hard copy card.

**Dentist Provider Search**

For a listing of Ameritas PPO Dental In-Network Providers, please visit the Ameritas Find a Provider webpage.

**Member Portal for Ameritas Dental**

Members can access the Ameritas member portal to review dental benefits, incentive level, explanation of benefits, and claims.

**Plan Documents and Benefit Summaries**

All benefit plan summaries and plan documents are available on the District Human Resources Employee Benefits website.
Vision Insurance Plan

The District offers a vision insurance plan provided through Vision Service Plan (VSP). Vision benefits are available for eligible employees and their eligible dependents.

The Plan will provide benefits, up to the amounts shown below, for the vision services and supplies listed below.

**Summary of Benefits**

This matrix is a brief summary of your benefits. You must read the entire evidence of coverage in order to understand the details of your coverage. Please review the detailed Evidence of Coverage document or Summary Plan Document. All EOCs/SPDs can be found on the District Human Resources Employee Benefits website.

<table>
<thead>
<tr>
<th>Service</th>
<th>Benefit</th>
</tr>
</thead>
</table>
| WellVision Exam and Prescription Glasses     | $10 copay for examinations and prescription glasses  
Once every 12 months                                                                                |
| Contact Lenses (in lieu of glasses)          | Up to $60 copay for contact lens fitting/evaluation  
$130 allowance for contact lenses  
Once every 12 months                                                                               |
| Lenses for Glasses (per pair)                | One pair every 12 months.  
Single vision, lined bifocal and lined trifocal lenses covered 100%.  
Various co-pays apply to lens enhancements. Includes Standard progressive lens                     |
| Frames                                       | One pair every 24 months.  
Participating provider allowance of $170.  
$100 allowance at Costco Optical.                                                                 |
| Primary Eyecare                              | $20 copay  
Treatment and diagnosis of eye conditions like pink eye, vision loss and monitoring of cataracts, glaucoma and diabetic retinopathy.  
Limitations and coordination with medical coverage may apply.                                        |

**Added Benefits**

The District’s VSP plan also offers Eyeconic, VSP’s online site to purchase glasses directly with your VSP plan. When you log onto your VSP member portal you can access Eyeconic along with other valuable added benefits such as diabetes care resources, LASIK discounts, and TruHearing (hearing aids) discounts.

**Vision ID Cards**

VSP does not provide ID cards. To use services, simply notify the provider you have VSP and they will verify your eligibility.

**Vision Provider Search**

To find in-network VSP providers, please visit the VSP Our Doctor Network webpage.
Member Portal for VSP Vision
VSP members can access the VSP member portal to review benefits, claims, order glasses through Eyeconic, and see other added benefits.

Plan Documents and Benefit Summaries
All benefit plan summaries and plan documents are available on the District Human Resources Employee Benefits website.
Employee Assistance Program (EAP)

The District offers an Employee Assistance Program (EAP) through Halcyon Behavioral. **EAP services are available to eligible employees and anyone within the eligible employee’s household.**

Halcyon EAP provides confidential, professional referrals and face-to-face counseling for a wide array of personal and work-related concerns.

**Benefit Summary**

Eligible employees and members of their households can access EAP Benefits. Halcyon EAP benefits are available 24 hours a day, 7 days a week, 365 days a year.

**Counseling**

Available for stress, anxiety, relationship problems, grief and loss, anger management, work-related stress, education guidance, identity theft recovery, substance abuse, and more. The program offers three (3) free sessions in a six-month period, per issue.

**Web based services**

Web based services such as scheduled video, telephonic, and web chat counseling services through the eConnect platform, articles and tip sheets for personal and work-related topics, search engines and directories for childcare, elder care, education, legal, and finance, as well as skill builders, self-assessment tools, and more.

**Work-Life Referrals**

Halcyon EAP can provide you with referrals and information for services such as: child care, elder care, pet care, adoption assistance, school/college assistance, health and wellness, convenience referrals, stress, substance abuse, and other issues impacting your quality of life.

**Legal Assist**

Halcyon EAP offers up to 30 minutes of free telephonic or face-to-face legal consultation with an attorney.

**Financial Assist**

Halcyon EAP offers referrals and information for services relating to expert financial planning and consultation.

**EAP Provider Search**

To get a confidential referral to an in-network provider, please call (888) 425-4800 to speak with an EAP clinical counselor. The clinician will triage you and provide you a referral.

**EAP Member Portal**

To access the EAP member portal, which includes a wealth of online tools and resources, please visit the [Halcyon EAP](#) webpage. The username is edcare.
Life Insurance and Accidental Death & Dismemberment (AD&D) Insurance

The District provides Group Term Basic Life Insurance and Accidental Death & Dismemberment (AD&D) insurance for benefit eligible employees. The life and AD&D insurance is offered through VOYA Financial.

Summary of Benefits
This is a brief summary of your benefits. You must read the entire evidence of coverage in order to understand the details of your coverage.

Group Term Life Insurance
The life insurance plan provides $50,000 of basic life and AD&D insurance to you, the employee, and $5,000 of life insurance coverage for your enrolled spouse/registered domestic partner and dependent(s) on the medical plan, all at no cost to you. Management and Confidential employees also receive an additional employer-paid, age-based benefit under the life insurance plan.

Benefit Reductions
Upon reaching the age of 70, the amount of life insurance decreases by 50%.

Accelerated Death Benefits
If you have been determined to have a terminal condition and your life expectancy is no more than twelve (12) months, you or your legal representative may apply for the Accelerated Death Benefit, which provides up to 50% of your life insurance amount.

Accidental Death & Dismemberment (AD&D) Insurance
If you suffer a covered loss due to a covered accident, you could apply for AD&D benefits. Such covered losses include life, both hands, either feet, or sight of both eyes, and speech. For a full listing of covered losses and additional AD&D benefits, please view the summary plan document for the life insurance plan.

Additional Services Provided by the Life Insurance Plan

Voya Travel Assistance
For enrolled members, when traveling more than 100 miles from home, VOYA Travel Assistance offers four types of services – pre-trip information, emergency personal services, medical assistance services, and emergency transportation services.

Funeral Planning and Concierge Services
Enrolled members have access to Funeral Planning and Concierge Services to assist with funeral planning and negotiation at time of need as well as pre-planning tools that can be used to research and document decisions and wishes.

Will Preparation Program
Enrolled members have access to free online will preparation through Estate Guidance.
**Life Insurance Beneficiary Designation**
At time of hire, all employees elect a beneficiary upon enrolling in the life insurance. The beneficiary designations are on file with the District Human Resources Office. In the event the employee passes away, the life insurance benefit will be paid out to the last designated beneficiary on file.

Employees can update their designated beneficiary information at any time and may do so by submitting the VOYA Beneficiary Designation Form and submitting to the District Human Resources Office. For more information and assistance, please contact Reina Kemble, Benefits Technician, at (559) 243-7134.

**Plan Documents and Benefit Summaries**
All benefit plan summaries and plan documents are available on the District Human Resources Employee Benefits website.
Voluntary Long-Term Disability Insurance

The District provides all benefit eligible employees the opportunity to purchase voluntary long-term disability (LTD) insurance coverage offered through VOYA.

Employees who enroll during their initial time of hire period (within 30-days after date of hire) are provided a guaranteed issued plan.

If you do not enroll at initial time of hire, you may apply during the annual open enrollment period. Enrollment is subject to approval by VOYA. You will be required to go through an Evidence of Insurability (EOI) Questionnaire.

Summary of Benefits
This is a brief summary of your benefits. You must read the entire evidence of coverage in order to understand the details of your coverage.

Long-term disability insurance is a policy that provides income replacement for employees who become unable to work (unpaid) due to illness or injury for a long period of time. The long-term disability insurance plan provides a monthly disability benefit of 60%, up to a maximum $5,000, of the employee’s eligible income after the employee qualified for benefits and has met the elimination period in accordance to the Long-Term Disability Summary Plan Document.

Premium Rates
The voluntary long-term disability premium rate is based on your age and your salary at the start of the current policy year (October 1). Contributions are deducted on a post-tax basis.

LTD income Rates based on Age (per $100)

<table>
<thead>
<tr>
<th>Age</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 25</td>
<td>$0.10</td>
</tr>
<tr>
<td>25-29</td>
<td>$0.14</td>
</tr>
<tr>
<td>30-34</td>
<td>$0.20</td>
</tr>
<tr>
<td>35-39</td>
<td>$0.29</td>
</tr>
<tr>
<td>40-44</td>
<td>$0.44</td>
</tr>
<tr>
<td>45-49</td>
<td>$0.63</td>
</tr>
<tr>
<td>50-54</td>
<td>$0.87</td>
</tr>
<tr>
<td>55-59</td>
<td>$1.11</td>
</tr>
<tr>
<td>60-64</td>
<td>$1.17</td>
</tr>
<tr>
<td>65-69</td>
<td>$1.17</td>
</tr>
<tr>
<td>70+</td>
<td>$1.17</td>
</tr>
</tbody>
</table>

Monthly Disability Income Premium Calculator

1. Take your annual salary and divide by 12 to find your monthly earnings.
2. Next, take your monthly earnings and multiply it by 60%. The outcome is the monthly amount which is 60% of your monthly salary.
3. Next, calculate the 60% benefit contribution per $100.
4. If your 60% monthly salary is $4,999 or less, then take your 60% monthly salary and divide by 100 (e.g. 2400/100=24).
5. If your 60% monthly salary is $5,000 or more, then take $5,000 and divide by 100. *Remember, $5,000 is the maximum benefit allowed.*

6. Next, find your LTD income rate based on your age as of October 1, 2019 (see LTD income rates above).

7. Next, take your monthly 60% benefit amount in Step 3 and multiply by your age rate from #4.

8. The final figure will be the monthly cost for the voluntary long-term disability benefit.

Example: Jane’s date of birth is 03/12/1990. Based on her current annual salary, she makes $46,000. Jane’s monthly salary is $3,833.33 (step 1). 60% of her salary is $2,300 and when divided by $100, this equals 23 (steps 2 & 3). Based on her age as of October 1, 2019, she is 29, so her age rate is $0.14. Jane’s voluntary long-term disability monthly premium rate will be $3.22 (23 x .14=3.22).

**Plan Documents and Benefit Summaries**

For more information on the voluntary LTD insurance plan benefits, including exclusions, income offsets, pre-existing condition clauses, please review the summary plan document on the [District Human Resources Employee Benefits website](#).
Section 125 Flexible Spending Accounts

Flexible Spending Accounts (FSA) are a great cost savings tool to help with qualified out of pocket health insurance expenses and/or dependent care expenses. The District offers Flexible Spending Accounts to eligible employees.

The plan administrator is American Fidelity.

Plan year runs October 1 through September 30 of the following year.

Summary
Section 125 Flexible Spending Accounts (FSA) are governed by the IRS and allow eligible employees to deduct their employee payroll deduction toward the medical plan pre-taxed, as well as set aside pre-tax funds to use toward approved out-of-pocket medical, dental and vision expenses as well as dependent day care expenses.

Flexible Spending Account funds are a use it or lose it benefit. This means any unused funds left over in your FSA accounts at the end of the plan year, September 30, are no longer yours. Therefore, all claims for FSA reimbursements should be submitted prior to the plan year ending. For more information on the use it or lose it rule, please contact American Fidelity at (559) 230-2107 extension 0.

Dependent Day Care FSA
A Dependent Day Care FSA account allows you to contribute pre-tax dollars to qualified dependent care. A Dependent Day Care FSA is used to reimburse yourself for eligible dependent care expenses incurred to allow you (and your spouse if you are married) to work or look for work. For more information and a list of eligible expenses relating to the Dependent Day Care FSA, visit the American Fidelity support page.

The current maximum amount you may contribute to the Dependent Day Care FSA account each year is $5,000 (or $2,500 if married and filing separately). Dependent Day Care FSA account funds are available as contributions are received and payable when services have been provided.

Health FSA
A Health FSA account allows you to set aside pre-taxed dollars to reimburse yourself for qualified health care expenses for you and your qualified dependents. This could include copays, deductibles, prescriptions, glasses, contacts, as well as other expenses allowable under Section 125 guidelines. For more information and a list of eligible expenses relating to the Health FSA, visit the American Fidelity support page.

The current maximum amount you may contribute to the Health FSA each year is $2,750. Health FSA account funds are available to you on October 1st of the plan year.

Enrollment
Eligible employees may enroll in a flexible spending account at time of hire, within 30-days from date of hire, or during the annual open enrollment period.

Employees who choose to elect an FSA account must enroll/re-enroll each year during the annual open enrollment period as these plans and their elections do not renew automatically.

To enroll in a flexible spending account, please contact American Fidelity at (559) 230-2107, extension 0.
How to Submit Claims for Reimbursements
American Fidelity offers different ways to be reimbursed from your FSA accounts.

- Electing to use a debit card for your health care expenses. The money you set aside in your FSA account(s) for medical expenses is available on your card. When you pay for these expenses, you do not need to pay out-of-pocket and wait for reimbursement – expenses are automatically deducted from your account on the card. You must still obtain and keep a receipt for the purchase should you need to validate the claim.
- You can submit claims online through American Fidelity’s member claim portal. You will need to submit a copy of your receipt, explanation of benefits, or provider bill.
- You can use the AF mobile app to access your FSA account and submit reimbursement claims. You will need to submit a copy of your receipt, explanation of benefits, or provider bill.

For detailed information relating to FSA reimbursements, please review the American Fidelity FSA webpage.
Voluntary Benefit Products

The District offers a variety of voluntary benefit products and employee payroll deductions. Depending on the product/deduction, enrollment can occur either during the initial enrollment period, the annual open enrollment period, or at any time throughout the year. Please contact the vendor for more information.

Life

Employees can purchase supplemental life insurance at cost for themselves and/or their dependents. Life insurance plans can be purchased through American Fidelity or AFLAC.

To enroll in a supplemental life insurance plan, please contact the vendor directly.
- American Fidelity – (559) 230-2107 Ext. 0
- AFLAC - (559) 224-5004 or e-mail Agent Jodie Boehner

Accident, Short-Term Disability, Critical Illness, Cancer Insurance, and other Miscellaneous Insurance Products

Employees can purchase voluntary supplemental insurance coverage including short-term disability, cancer insurance, and critical illness insurance through American Fidelity or AFLAC.

To enroll in a voluntary product, please contact the vendor directly.
- American Fidelity – (559) 230-2107 Ext. 0
- AFLAC - (559) 224-5004 or e-mail Agent Jodie Boehner

Tax Sheltered Annuities

As an employee of an educational institution, you may elect to participate in a tax-deferred retirement program as authorized by Internal Revenue Code Section 403(b) and 457. With these programs, you elect to deduct a certain portion of your pay before state and federal income taxes. Funds are taxed when you withdraw.

403(b) Plans

TCG Administrators administers the 403(b) plans. For more information about the 403(b) plans, including a list of vendors, please visit 403bcompare.

To start a 403(b), you will need to choose which vendor(s) you wish to invest with and open an account with them directly. Then call TCG Administrators at (800) 943-9179, let them know you are opening a 403(b) plan for State Center Community College District, which vendor(s) you choose and how much you want deducted from your paycheck.

457 Plans

The 457 plan is offered through CalPERS 457. For more information or to enroll, please contact District Payroll at (559) 243-7100.
Child Care Centers

There are several Child Development Centers (CDC) within our District. The District does not offer any benefits toward childcare and there may be a waitlist at the individual CDC sites.

For more information, please visit the individual childcare center webpages:

- Clovis Community College CDC
- Fresno City College CDC
- Madera Community College Center CDC
- Reedley College CDC
Retirement Benefits

State Center Community College District offers retirement pension options to eligible employees through different systems – CalPERS, CalSTRS, and Public Agency Retirement Services (PARS).

For more information relating to retirement pension benefits, please contact the individual retirement system or District Payroll at (559) 243-7100.

**CalPERS**
California Public Employees’ Retirement System (CalPERS) manages pensions for California public employees, retirees and their beneficiaries.

Members can access real-time details about their CalPERS account, find educational events, and schedule appointments with the local CalPERS office. To access your member portal, visit the myCalPERS webpage.

**CalSTRS**
California State Teachers’ Retirement System (CalSTRS) provides retirement, disability and survivor benefits to California public school educators and their beneficiaries.

Members can access real-time details about their CalSTRS account, find educational events, and schedule appointments with the local CalSTRS office. To access your member portal, visit the myCalSTRS webpage.

**PARS**
Public Agency Retirement Services (PARS ARS) is a retirement account for part-time, seasonal, and temporary employees who work for public agencies.

Members can access real-time details about their PARS account. To access your member portal, visit the SCCCD PARS member portal webpage.

**Retiree Health Insurance**
For retiree health insurance options, please refer to the District’s bargaining unit agreements, board policies, and/or administrative regulations.

**Medicare Eligible Employees and Dependents**
Medicare dictates Medicare eligibility for all individuals.

Based on Medicare’s rules, all individuals reaching the age of 65 must enroll in Medicare Parts A&B, unless he/she has a special circumstance.

Employees and/or eligible enrolled dependents who are approaching Medicare eligibility, age 65, are not required by the District to enroll in Medicare Part B while enrolled on the district health plans as an active employee.

Most individuals must enroll in Medicare Part A upon reaching the age of 65. Some individuals may become early eligible for Medicare, pre-65, and that is determined by Medicare.

Anytime you have questions regarding Medicare eligibility, please review the Medicare and You handbook or contact Medicare directly.
Important Notices

NEWBORNS AND MOTHERS HEALTH PROTECTION ACT
Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean delivery. However, Federal law generally does not prohibit the mother’s or newborn’s attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). If you would like more information, please call your medical plan carrier directly at the number on the back of your medical ID card.

WOMEN’S HEALTH AND CANCER RIGHTS ACT
Under Federal law, group health plans must include coverage for the following post-mastectomy services and supplies when provided in a manner determined in consultation between the attending physician and the patient: (1) reconstruction of the breast on which a mastectomy has been performed, (2) surgery and reconstruction of the other breast to produce symmetrical appearance, (3) breast prostheses, and (4) physical complications of all stages of mastectomy, including lymphedemas. Such coverage may be subject to annual deductibles and coinsurance provisions as may be deemed appropriate and are consistent with those established for other benefits under the plan or coverage. If you would like more information, please call your medical plan carrier directly at the number on the back of your medical ID card.

COBRA General (Initial)
All newly enrolled members will receive COBRA information from Delta Health Systems upon initial enrollment in the District sponsored health benefits. The Consolidated Omnibus Budget Reconciliation Act (COBRA) requires group health plans to offer continuation coverage to covered employees, former employees, spouses, former spouses, and dependent children when group health coverage would otherwise be lost due to certain specific events. Those events include the death of a covered employee, termination or reduction in the hours of a covered employee’s employment for reasons other than gross misconduct, a covered employee’s becoming entitled to Medicare, divorce or legal separation of a covered employee and spouse, and a child’s loss of dependent status (and therefore coverage) under the plan. COBRA sets rules for how and when continuation coverage must be offered and provided, how employees and their families may elect continuation coverage, and what circumstances justify terminating continuation coverage. Employers may require individuals to pay for COBRA continuation coverage. The premium that is charged cannot exceed the full cost of the coverage, plus a 2 percent administration charge.

Creditable Coverage - Medicare Part D Notice
The Medicare Modernization Act (MMA) requires entities (whose policies include prescription drug coverage) to notify Medicare eligible policyholders whether their prescription drug coverage is creditable coverage, which means that the coverage is expected to pay on average as much as the standard Medicare prescription drug coverage. For more information please contact us at District Benefits or call (559) 243-7100.
PART A: General Information
When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment based health coverage offered by your employer.

What is the Health Insurance Marketplace?
The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

Can I Save Money on my Health Insurance Premiums in the Marketplace?
You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?
Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the “minimum value” standard set by the Affordable Care Act, you may be eligible for a tax credit.1

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

How Can I Get More Information?
For more information about your coverage offered by your employer, please check your summary plan description or contact State Center Community College District Human Resources Office at (559) 243-7100.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

1 An employer-sponsored health plan meets the “minimum value standard” if the plan’s share of the total allowed benefits costs covered by the plan is no less than 60 percent of such costs.
PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:
  - All employees. Eligible employees are:
  - Some employees. Eligible employees are:
    * All active regular, contract, or temporary full-time faculty members.
    * All active regular classified employees, confidential employees, classified managers, and academic managers who work thirty (30) hours or more per week during their assignment work year.

- With respect to dependents:
  - We do offer coverage. Eligible dependents are:
    A legally married spouse or a registered domestic partner who meets all eligibility requirements under the individual medical summary plan document, and/or an eligible child under the age of 26 (e.g. biological child, stepchild, legally adopted child, child placed with the employee for legal adoption, or a foster child).
  - We do not offer coverage.

- If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

  ** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, HealthCare.gov will guide you through the process. Here’s the employer information you’ll enter when you visit HealthCare.gov to find out if you can get a tax credit to lower your monthly premiums.
The information below corresponds to the Marketplace Employer Coverage Tool. Completing this section is optional for employers, but will help ensure employees understand their coverage choices.

13. Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible in the next 3 months?
   - ☐ Yes (Continue)
   - ☐ No (STOP and return this form to employee)

   13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage? ________________ (mm/dd/yyyy) (Continue)

14. Does the employer offer a health plan that meets the minimum value standard*?
   - ☒ Yes (Go to question 15)
   - ☐ No (STOP and return form to employee)

15. For the lowest-cost plan that meets the minimum value standard* offered only to the employee (don’t include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/she received the maximum discount for any tobacco cessation programs, and didn’t receive any other discounts based on wellness programs.
   a. How much would the employee have to pay in premiums for this plan? $____
   b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

   If the plan year will end soon and you know that the health plans offered will change, go to question 16. If you don’t know, STOP and return form to employee.

16. What change will the employer make for the new plan year?
   - ☐ Employer won’t offer health coverage
   - ☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)

   a. How much would the employee have to pay in premiums for this plan? $___________
   b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

* An employer-sponsored health plan meets the "minimum value standard" if the plan’s share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)
Frequently Asked Questions

This is not an all-inclusive listing of frequently asked questions. For questions not listed here, please contact District Benefits or call (559) 243-7100.

New Hire Enrollment Frequently Asked Questions

Can I opt out of/waive the District health insurance plans?
No, you cannot opt out or waive coverage for yourself. All District benefit eligible employees must enroll as required under Edcare, bargaining unit agreements, Board Policies, and Administrative Regulations.

Where can I find the enrollment forms?
The District no longer accepts physical enrollment forms. All new hire enrollments will go through BenefitBridge. If you do not have access to a computer, please contact Reina Kemble, Benefits Technician at (559) 243-7134 for assistance.

I have read the Benefit Guide and am unclear on the benefits being offered, what should I do?
Please contact the Reina Kemble, Benefits Technician, at (559) 243-7134 or the general District Human Resources Office line at (559) 243-7100 for assistance.

What is the cost to add my dependents (spouse and/or children) to the health plans?
There is no additional cost to add your dependents to the health plans – medical, dental, vision, life insurance, and the employee assistance program.

Do I have to meet with American Fidelity?
Only if you wish to enroll in a Section 125 Flexible Spending Account or other voluntary products.

What if I do not have copies of the required supporting dependent documents?
In order to enroll your dependents, you must upload the appropriate supporting documents by the deadline. If you should need to order documents, you may do so through the local county recorder’s office, hall of records, or the Department of Public Health.

I have health coverage through my spouse’s employer, what medical plan should I enroll in? Should I enroll my dependents? Can the plans coordinate and if so, how?
PPO plans coordinate with PPO plans. Our Kaiser HMO Plans coordinate with other Kaiser HMO plans. Although our office cannot advise you on which medical plan to enroll in, we can answer questions to help you determine which plan to elect. Please contact Reina Kemble, Benefits Technician, at (559) 243-7134 or Frances Garza. Benefits Coordinator, at (559) 243-7133.

I have a question regarding retirement pensions (CalPERS, CalSTRS, PARS, 457/403b). Who can I contact?
The individual retirement system or District Payroll at (559) 243-7100.

I have a question regarding leaves (sick leave, vacation leave, FMLA, etc). Who should I contact?
Certain leaves are described in the individual bargaining unit agreements, board policies and administrative regulations. You may contact the District Human Resources Office at (559) 243-7100 to be routed to the appropriate staff member.

BILLING/CLAIM QUESTIONS

I received an Explanation of Benefits (EOB) form from the insurance plan, what is it and what do I need to do?
Explanation of Benefits (EOB) forms show you how the claim for services was processed with the insurance company. EOBs provide you with your overall responsibility for the service shown. When you receive these forms, it is recommended to compare to your provider billing to ensure you are only paying the amount you are responsible for and to check for billing errors.

I have a question on how a claim/bill was processed, who should I call?
- If you have the Modern Care or Bronze plan (both PPO), please contact Delta Health Systems directly at (800) 422-6099.
- If you have a Kaiser HMO/DHMO plan, please contact Kaiser at (800) 464-4000.
- If this is for a dental claim issue, please contact Ameritas at (800) 487-5553.
- If this is for a vision claim issue, please contact VSP at (800) 877-7195.

I received a Coordination of Benefits (COB) Form or a Third-Party Liability (TPL) Form. Do I have to complete this?
Yes, even if you do not have other insurance coverage, this is required in order for the insurance company to process your claims and pay the providers. Failure to complete the form will mean the claims will not be paid and your provider may bill you for the whole financial responsibility.

QUESTIONS ABOUT THE HEALTH PLANS
How can I get additional or replacement ID cards?
- If you are a Modern Care or Bronze plan member, you can log into your Delta Health Systems account to print an ID card. You can also request a hard copy ID card by emailing us at District Benefits or by calling the Reina Kemble, Benefits Technician, at (559) 243-7134.
- If you have Kaiser, you will need to contact Kaiser directly at (800) 464-4000 for a new card.
- For dental ID cards, you can log into your Ameritas member portal to print a copy. You can also request a hard copy ID card by emailing us at District Benefits or by calling the Reina Kemble, Benefits Technician, at (559) 243-7134.
- There are no ID cards for Vision.

When is the annual open enrollment period?
The annual open enrollment period runs from mid-August to mid-September of each year.

How do I make sure my preventative care visit is covered at 100%?
Before you see your doctor, check to make sure the type of visit you are going in for is a covered benefit under the Affordable Care Act (ACA) preventative care guidelines. Ensure the visit only includes preventative care items and nothing further.

QUESTIONS ABOUT DEPENDENTS
How long can my dependent child remain on the health plans?
Children are eligible to remain on your medical, dental and vision plans until the end of the month in which they turn age 26.

My dependent child is getting married. What do I have to do with the insurance plans?
If you want your child to remain on the health plans, there is nothing you need to do for the district insurance plans. However, if your child will have another insurance plan(s), he/she should look into coordination of benefits, eligibility, etc. with that plan. If you wish to remove your child from the health plans, you have 30 days after the qualifying event date to do so.
My dependent child received health insurance through his/her employer. What do I have to do with the insurance plans?
If you want your child to remain on the health plans, there is nothing you need to do for the district insurance plans. However, if your child will have another insurance plan(s), he/she should look into coordination of benefits, eligibility, etc. with that plan. If you wish to remove your child from the health plans, you have 30 days after the qualifying event date to do so.

My enrolled spouse/registered domestic partner (RDP) is turning 65, is there anything I need to do in regards to Medicare?
As long as you are actively employed with health benefits, the district does not require you or your spouse/RDP to enroll in Medicare Parts A&B; however, Medicare does have its own guidelines. Please review the Medicare and You handbook or contact Medicare directly. When you retire you and/or your eligible dependent must have Medicare.

My enrolled dependent has passed away. Do I need to notify anyone?
Yes, please contact Frances Garza, Benefits Coordinator, at (559) 243-7133.

Questions? Contact us…
By email: District Benefits
By phone:
Reina Kemble, Benefits Technician, (559) 243-7134
Frances Garza, Benefits Coordinator, (559) 243-7133
District Mainline at (559) 243-7100

For questions regarding BenefitBridge technical assistance, call BenefitBridge Customer Care at 800-814-1862.

For questions regarding the Modern Care or Bronze PPO plans, dental, or vision, you may also contact Barthuli & Associates at (559) 385-7510.
# Websites and Contact Information

## Member Portals

<table>
<thead>
<tr>
<th>Plan</th>
<th>Website</th>
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</thead>
<tbody>
<tr>
<td><strong>BenefitBridge</strong> Benefit Administration Platform</td>
<td><a href="http://www.benefitbridge.com/statecenterccd">www.benefitbridge.com/statecenterccd</a></td>
</tr>
<tr>
<td><strong>PPO Medical</strong> Insurance Member Portal</td>
<td><a href="http://www.deltahealthsystems.com">www.deltahealthsystems.com</a></td>
</tr>
<tr>
<td><strong>PPO Prescription Drug Plan Member Portal</strong></td>
<td><a href="http://www.rxipm.com">www.rxipm.com</a></td>
</tr>
<tr>
<td><strong>Employee Assistance Program</strong> (EAP) – (login password: edcare)</td>
<td><a href="http://www.halcyoneap.com">www.halcyoneap.com</a></td>
</tr>
<tr>
<td><strong>Ameritas PPO Dental</strong> Plan Member Portal</td>
<td><a href="http://www.ameritas.com">www.ameritas.com</a></td>
</tr>
<tr>
<td><strong>PPO Mental Health</strong> Benefits Member Portal</td>
<td><a href="http://www.edcaremhsa.com">www.edcaremhsa.com</a></td>
</tr>
<tr>
<td><strong>PPO PhysMetrics</strong> Member Portal (PPO plan vendor for chiropractic, physical therapy, speech therapy, occupational therapy)</td>
<td><a href="http://www.edcarechiro.com">www.edcarechiro.com</a></td>
</tr>
<tr>
<td><strong>VSP Vision</strong> Plan Member Portal</td>
<td><a href="http://www.vsp.com">www.vsp.com</a></td>
</tr>
<tr>
<td><strong>Kaiser Permanente HMO/DHMO Plan Member Portal</strong></td>
<td><a href="https://healthy.kaiserpermanente.org/">https://healthy.kaiserpermanente.org/</a></td>
</tr>
<tr>
<td><strong>LiveHealth Online – PPO Telemedicine Service</strong></td>
<td><a href="http://www.livehealthonline.com">www.livehealthonline.com</a></td>
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## Customer Service Phone Numbers

<table>
<thead>
<tr>
<th>Plan</th>
<th>Phone Number</th>
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</thead>
<tbody>
<tr>
<td>BenefitBridge Customer Service</td>
<td>(800) 814-1862</td>
</tr>
<tr>
<td>Modern Care and Bronze PPO Medical Plans</td>
<td>(800) 433-2566</td>
</tr>
<tr>
<td>Kaiser Permanente HMO/DHMO Medical Plans</td>
<td>(800) 464-4000</td>
</tr>
<tr>
<td>Ameritas PPO Dental Plan</td>
<td>(800) 487-5553</td>
</tr>
<tr>
<td>VSP Vision Plan</td>
<td>(800) 877-7195</td>
</tr>
<tr>
<td>PhysMetrics (PPO plan vendor for chiropractic, physical therapy, speech therapy, occupational therapy)</td>
<td>(877) 519-8839</td>
</tr>
<tr>
<td>Integrated Prescription Management (PPO Plans prescription drug vendor)</td>
<td>(877) 860-8846</td>
</tr>
<tr>
<td>Halcyon Behavioral (Employee Assistance Program and PPO plan mental health benefits provider)</td>
<td>(888) 425-4800</td>
</tr>
</tbody>
</table>
| **SCCCD Health Benefits Staff**                         | • Email: [District Benefits](mailto:District.Benefits@scccd.edu)  
• Reina Kemble, Benefits Technician at (559) 243-7134  
• Frances Garza, Benefits Coordinator at (559) 243-7133  
• District Human Resources Office at (559) 243-7100  
[www.scccd.edu/employeebenefits](http://www.scccd.edu/employeebenefits) |
| **SCCCD Retirement Questions**                          | District Payroll at (559) 243-7100     |
| **SCCCD Leave Questions**                                | (559) 243-7100 (you will be routed to the appropriate HR staff member) |
The information in this guide is presented for illustrative purposes and is based on information provided by the employer. The text contained in this guide was taken from various summary plan descriptions and benefit information. While every effort was taken to accurately report your benefits, discrepancies or errors are always possible. In case of discrepancy between the guide and the actual plan documents, the actual plan documents will prevail. All information is confidential, pursuant to the Health Insurance Portability and Accountability Act of 1996. If you have any questions, contact the District Human Resources Office at (559) 243-7100.