san josé·evergreen
COMMUNITY COLLEGE DISTRICT

2026 – 2027 Retiree Benefit Guide

Better Together

CONTENTS

Medicare Part D Notice

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

GETTING STARTED

2026-2027 BENEFITS

October 1, 2026
through
September 30, 2027

Please visit our Benefits Page!

IMPORTANT NOTE:
This guide is a summary overview and does not provide a complete description of all benefit provisions. For more detailed information, please refer to your plan documents including your benefit summaries, summary of benefits and coverage (SBCs) and summary plan descriptions (SPDs). The plan documents determine how all benefits are paid.

Whether you're newly eligible for retiree benefits or have been retired for years, San José–Evergreen Community College District is committed to supporting your health and well-being throughout retirement.

This guide provides an overview of the retiree benefits available to you, including healthcare coverage and other valuable resources. You'll also find information to help you understand your coverage options, make informed decisions, and take full advantage of the benefits available to you and your family.

CHANGING YOUR BENEFITS

Click to play video

Life Happens

A change in your life may allow you to update your benefit choices. Watch the video for a quick take on your options.

Three Rules Apply To Making Changes To Your Benefits During The Year:

1. Any change you make must be consistent with the change in status.
2. You must make the change within 30 days of the date the event occurs.
3. All proper documentation is required to cover dependents(marriage certificates, birth certificates, etc.).

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

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

You must submit your change within 30 days after the event. Any change you make must be consistent with the change in status. All proper documentation is required to cover dependents (marriage certificates, birth certificates, etc.).

DEPENDENT ELIGIBILITY DOCUMENT REQUIREMENTS

Making changes to dependents is subject to eligibility verification in order to ensure only eligible individuals are participating in our plans. You will be required to provide proof of one or more of the following within 30 days of their eligibility. If you do not supply the proper documentation to make changes to dependents within the 30-day period, you will not be able to add the dependent(s) until the next open enrollment period.

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

Dependent Type	Required Documentation
Spouse	▪ Prior year's Federal Tax Form that shows the couple was married filing jointly or married filing separately (financial information may be blocked out) ▪ For newly married couples where prior year tax return is not available a marriage certificate will be accepted.
Domestic Partner	▪ Certificate of Registered Domestic Partnership issued by State of California (AB 205 Compliant)
Children, Stepchildren, and/or Adopted Children up to age 26	▪ Legal Birth Certificate or Hospital Birth Certificate (to include full name of child, parent(s) name & child's DOB) ▪ Legal Adoption Documentation
Legal Guardianship up to age 18	▪ Legal Court Documentation establishing Guardianship
Disabled dependents over age 26	**ANTHEM BLUE CROSS (ALL ITEMS LISTED BELOW ARE REQUIRED)** ▪ Legal Birth Certificate or Hospital Birth Certificate (to include full name of child, parent(s) name & child's DOB) ▪ Prior year's Federal Tax Form that shows child is claimed as an IRS dependent (income information may be blocked out) ▪ Proof of 6 months prior creditable coverage ▪ Completed Anthem Disabled Dependent Certification Form **KAISER (ALL ITEMS LISTED BELOW ARE REQUIRED)** ▪ Legal Birth Certificate or Hospital Birth Certificate (to include full name of child, parent(s) name & child's DOB) ▪ Prior year's Federal Tax Form that shows child is claimed as an IRS dependent (income information may be blocked out) ▪ Proof of 6 months prior creditable coverage ▪ Completed Disabled Dependent Enrollment Application ▪ Most recent Kaiser Certification notice (if available)

MEDICAL

OUR PLANS

***NEW!* Kaiser HMO $10 –** Early Retiree

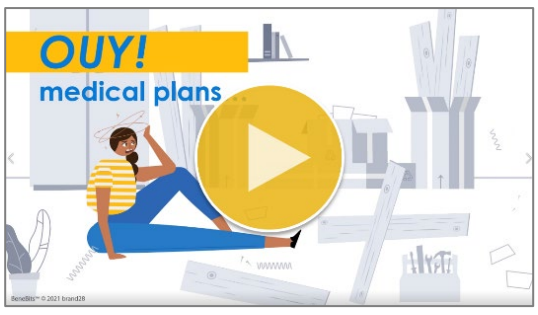
Kaiser Senior Advantage – Retiree 65+

Companion Care – Retiree 65+

***NEW!* Anthem Blue Cross PPO 100B –** Early Retiree

Anthem Blue Cross PPO 100A –Retiree 65+

All About Medical Plans



Which Plan Is Right For You?

That depends on your healthcare needs, favorite doctors, and budget. Here are some considerations.

Do you prefer specific doctors or hospitals?

If you want to stay with your favorite doctors and facilities, check whether they are in the plan's network. If they are not, but you are comfortable paying a bit more to see them, consider a plan with both in-network and out-of-network benefits.

What are your usual healthcare needs?

Do you have frequent doctor or urgent care visits? Do you have a condition that requires a specialist? Do you take prescription medications? Compare how each plan covers the services you need most often.

Consider the bottom line

How much is the monthly payroll deduction? Do you have to meet a deductible? What is the out-of-pocket maximum? How much of the cost is covered by the plan? How much are any copayments for office visits, prescriptions, etc. All of these factors together affect your total cost for healthcare.

NEW! MEDICAL: KAISER HMO PLAN – EARLY RETIREE

Here is an overview of our HMO medical plan offered through Kaiser Permanente for **Early Retirees (< 65 years old)**.

	Kaiser Permanente HMO - $10 Early Retiree
	In-Network
Annual Deductible	$0 Per individual $0 Family limit
Annual Out-of-Pocket Max	$1,500 Per individual $3,000 Family limit
Lifetime Max	Unlimited
Office Visit	
Primary Provider	$10 copay then plan pays 100%
Specialist	$10 copay then plan pays 100%
Preventive Services	Plan pays 100%
Chiropractic & Acupuncture Care	$10 Copay per visit (up to 30 visits/year combined)
Lab and X-ray	Plan pays 100%
Inpatient Hospitalization	Plan pays 100%
Outpatient Surgery	$10 copay then plan pays 100%
Urgent Care	$10 copay then plan pays 100%
Emergency Room	$100 copay then plan pays 100% (copay waived if admitted)
Ambulance	$50 per trip
Prescription Plan – Kaiser Permanente	
	In-Network
Annual Out-of-Pocket Limit	Prescriptions subject to medical out-of-pocket
Pharmacy	
Generic	$10 copay then plan pays 100%
Preferred Brand	$10 copay then plan pays 100%
Non-preferred Brand	Not covered
Supply Limit	100 days
Mail Order	
Generic	$10 copay then plan pays 100%
Preferred Brand	$10 copay then plan pays 100%
Non-preferred Brand	Not covered
Supply Limit	100 days

MEDICAL: KAISER SENIOR ADVANTAGE– RETIREE 65+

Kaiser Permanente provides integrated medical and prescription drug coverage, including preventive care, office visits, hospital services, prescription medications, and wellness resources. Members have access to coordinated care through Kaiser Permanente's network of doctors, hospitals, pharmacies, and specialists. This plan is for **Retirees 65+**.

	Kaiser Permanente Senior Advantage (HMO) with Part D – Retiree 65+
	In-Network
Annual Deductible	$0 Per individual
Annual Out-of-Pocket Max	$1,000 Per individual
Lifetime Max	Unlimited
Office Visit	
Primary Provider	Plan pays 100%
Specialist	Plan pays 100%
Preventive Services	Plan pays 100%
Chiropractic Care	$10 Copay per visit (up to 30 visits/year)
Lab and X-ray	Plan pays 100%
Inpatient Hospitalization	Plan pays 100%
Outpatient Surgery	Plan pays 100%
Urgent Care	Plan pays 100%
Emergency Room	$50 copay then plan pays 100% (copay waived if admitted)
Ambulance	$50 per trip
Prescription Plan: Kaiser Permanente	
Initial Coverage Stage (Until you have spent $2,100 in 2026)	$5 copay for up to a 100-day supply
Catastrophic Coverage Stage	Plan pays 100%

RESOURCES FOR KAISER MEMBERS

My Health Manager

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

Finding A Kaiser Provider

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

Kaiser Away From Home

Kaiser Members are covered for emergency and urgent care anywhere in the world. Whether you're traveling in the United States or a foreign country, Kaiser's travel website will explain what to do if you need emergency or urgent care during your trip.

One Pass Select Affinity by Optum

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

24/7 Care Advice

Get medical advice and care guidance in the moment from a Kaiser Permanente provider at (866) 454-8855.

Headspace Care App

The Headspace Care app offers immediate 1-on-1 support for coping with many common challenges — from stress and low mood to issues with work and relationships, and more. Headspace Care's highly trained emotional support coaches are ready to help 24/7, and adult Kaiser Permanente members can use Headspace Care for 90 consecutive days at no cost. Get started today at kp.org/selfcareapps.

Calm

Try the Calm app for self-care and better sleep. Calm is an app that uses meditation and mindfulness to help lower stress, reduce, anxiety, and improve sleep quality. Adult members can get Calm at kp.org/selfcareapps .

Online Wellness Tools

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

Health Classes

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

Personal Wellness Coaching

Get help reaching your health goals. Work one on one with a wellness coach by phone at no cost. Find out more at healthy.kaiserpermanente.org/health-wellness/wellness-coaching or call (866) 862-4295.

MEDICAL: COMPANION CARE – RETIREE 65+

These are available to **retirees turning age 65 enrolled in Medicare Parts A and B**. 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 Individual Retiree Plans.

CompanionCare Medicare Supplement Plan – Retiree 65+	
Services	**In-Network**
Inpatient Hospital (Part A)	Pays $1,736 (1st 60 days) Pays $434 a day (61-90 days) Pays $868 a day (91-150 days) Pays 100% after Medicare and Lifetime reserve are exhausted up to 365 days per lifetime
Skilled Nursing Facilities (Must be approved by Medicare)	Pays nothing Pays $217 a day for 21st to 100th day Pays nothing after 100th day
Deductible (Part B)	Pays $283
Basis of Payment (Part B)	Pays 20% Medicare Advantage charges including 100% of Medicare Part B deductible
Medical Services (Part B)	Pays 20% Medicare Advantage charges
Doctor, x-ray, appliances, & ambulance **Lab**	Pays 20% Medicare Advantage charges Pays nothing
Physical/Speech Therapy (Part B)	Pays 20% Medicare Advantage charges up to the Medicare annual benefit amount. (Physical & Speech Therapy Combined)
Blood (Part B)	Pays 1st 3 pints un-replaced blood and 20% Medicare Advantage charges
Travel Coverage **(when outside the US for less than 6 consecutive months)**	Pays 80% inpatient hospital, surgery, anesthetist and in hospital visits for medically necessary services for 90 days of treatment per lifetime
Outpatient Prescription Drugs (Navitus)	Generic: $9 co-pay for a 30-day supply at a retail pharmacy or $18 co-pay for a 90-day supply through home delivery service Brand: $35 co-pay for a 30-day supply at a retail pharmacy or $90 co-pay for a 90-day supply through home delivery service

NEW! MEDICAL: ANTHEM PPO - EARLY RETIREE

The Anthem PPO plan provides comprehensive medical coverage through Anthem's network of providers. Prescription drug coverage is administered through Navitus. This is available to **Early Retirees.**

	Anthem Blue Cross PPO – 100B Early Retiree & Retiree 65+	
	In-Network	**Out-Of-Network**
Annual Deductible	$100 Per individual $300 Family limit	$100 Per individual $300 Family limit
Annual Out-of-Pocket Max	$1,000 Per individual $3,000 Family limit	Unlimited
Lifetime Max	Unlimited	Unlimited
Office Visit		
Primary Provider	$0 Copay then plan pays 100% For the first three visits Then $10 Copay for visits after - **(deductible waived)**	Plan pays 100% of fee schedule. Member pays remaining amount.
Specialist	$10 Copay then plan pays 100% - **(deductible waived)**	Plan pays 100% of fee schedule. Member pays remaining amount.
Preventive Services	Plan pays 100% **(deductible waived)**	Not Covered
Chiropractic Care	Plan pays 100%	Not Covered
Acupuncture	Plan pays 100% (12 visits/calendar year)	50% of maximum allowed, (12 visits/calendar year)
Lab and X-ray	Plan pays 100%	Not Covered
Inpatient Hospitalization	Plan pays 100%	Member pays all billed amounts exceeding $600/day
Outpatient Surgery	Plan pays 100%	Plan pays 50% of maximum allowed amount
Urgent Care	$10 Copay then plan pays 100% **(deductible waived)**	Member pays remaining amount billed amount exceeding $350/admit
Ambulance	$100 per trip	$100 per trip
Emergency Room	$100 Copay then 100% (copay waived if admitted) - **Deductible Applies**	$100 Copay then 100% of maximum allowed amount - **Deductible Applies**
Prescription Plan – Navitus		
	In-Network	**Out-Of-Network**
Annual Out-of-Pocket Limit	$1,500 Per individual $2,500 Family limit	Not Applicable
Pharmacy		
Generic	**Costco:** plan pays 100%; **Retail:** $5 copay then plan pays 100%	Not Covered
Preferred Brand	$20 copay then plan pays 100%	Not Covered
Non-preferred Brand	Not Covered	Not Covered
Supply Limit	30 days	Not Applicable
Mail Order		
Generic	**Costco:** plan pays 100%	Not Covered
Preferred Brand	**Costco:** $50 copay then plan pays 100%	Not Covered
Non-preferred Brand	Not Covered	Not Covered
Supply Limit	90 days	Not Applicable

MEDICAL: ANTHEM PPO - RETIREE 65+

The Anthem PPO plan provides comprehensive medical coverage through Anthem's network of providers. Prescription drug coverage is administered through Navitus. This is available to **Early Retirees.**

	Anthem Blue Cross PPO – 100A Retiree 65+	
	In-Network	**Out-Of-Network**
Annual Deductible	None	None
Annual Out-of-Pocket Max	$1,000 Per individual $3,000 Family limit	Unlimited
Lifetime Max	Unlimited	Unlimited
Office Visit		
Primary Provider	No charge	Plan pays 100% of fee schedule. Member pays remaining amount.
Specialist	No charge	Plan pays 100% of fee schedule. Member pays remaining amount.
Preventive Services	Plan pays 100% **(deductible waived)**	Not Covered
Chiropractic Care	Plan pays 100%	Not Covered
Acupuncture	Plan pays 100% (12 visits per plan year)	50% of maximum allowed, (12 visits/calendar year)
Lab and X-ray	Plan pays 100%	Not Covered
Inpatient Hospitalization	Plan pays 100%	Member pays all billed amounts exceeding $600/day
Outpatient Surgery	Plan pays 100%	Plan pays 50% of maximum allowed amount
Urgent Care	No charge	Member pays remaining amount billed amount exceeding $350/admit
Ambulance	$100 per trip	$100 per trip
Emergency Room	$100 Copay then 100% (copay waived if admitted) - **Deductible Applies**	$100 Copay then 100% of maximum allowed amount - **Deductible Applies**
Prescription Plan – Navitus		
	In-Network	**Out-Of-Network**
Annual Out-of-Pocket Limit	$1,500 Per individual $2,500 Family limit	Not Applicable
Pharmacy		
Generic	**Costco:** plan pays 100%; **Retail:** $5 copay then plan pays 100%	Not Covered
Preferred Brand	$10 copay then plan pays 100%	Not Covered
Non-preferred Brand	Not Covered	Not Covered
Supply Limit	30 days	Not Applicable
Mail Order		
Generic	**Costco:** plan pays 100%	Not Covered
Preferred Brand	**Costco:** $20 copay then plan pays 100%	Not Covered
Non-preferred Brand	Not Covered	Not Covered
Supply Limit	90 days	Not Applicable

PRESCRIPTION DRUGS – NAVITUS (ANTHEM MEMBERS)

Navitus App

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

Navitus Formulary

You can also find a list of formulary and preventive medications on Navitus Website.

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

Understanding Your Pharmacy Benefits

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

With Costco Home Delivery Pharmacy

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

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

Get The Most From Your Coverage

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

RESOURCES FOR ANTHEM MEMBERS

Finding An Anthem Provider

To find a provider in the Anthem PPO network, please visit www.anthem.com/ca/sisc.

Sydney Mobile App

Use Sydney[SM] Health to keep track of your health and benefits- all in one place. Access your plan details, Member Services, virtual care, and wellness resources. You can also set up an account at anthem.com/ca/register to access most of the same features from your computer.

Silver & Fit

As a Silver&Fit member, you can receive a fitness center membership at one of 15,000+ participating fitness centers or select YMCAs. You can also choose one (1) Stay Fit Kit and up to 2 Home Fitness Kits per benefit year. Kits are mailed directly to you! To learn more, visit www.silverandfit.com or call 877-427-4788.

24/7 Nurse Line

Health issues can arise at the most inconvenient times and places for you and your loved ones. Whether it's 3 a.m. at home or 10 a.m. while you're in the office. You have access to a nurse you can talk to any time, day or night, 365 days a year. Just call the number on the back of your ID card.

Lark Diabetes Management

Track your progress, check in with your coach, and learn more about prediabetes right in Lark's free mobile app. This program is flexible, convenient, and follows guidelines from the Centers for Disease Control and Prevention (CDC) to help you make small changes that can improve your health and decrease your risk over time.

HIP, KNEE, AND SPINE SURGERIES: BLUE DISTINCTION+ REQUIREMENT

In order to be covered by the Preferred Provider Organization (PPO) plan, hip and knee replacements and certain inpatient spine surgeries must be performed at an Anthem Blue Cross Blue Distinction+ center. BD+ Centers meet affordability criteria and deliver better results — including fewer complications and readmissions — than other hospitals. For a specific list of hip, knee and spine procedures that are part of the program, please call the Customer Service number on the back of your ID card. **To find BD+ hospital, go to anthem.com/ca/sisc/find-care/ and scroll down to "Blue Distinction Centers and Centers of Medical Excellence".**

SISC Added Value Programs

Take advantage of these benefits to help you get and stay healthy.

BENEFIT HIGHLIGHTS	AVAILABILITY & HOW TO GET STARTED
24/7 Help with Personal Concerns **SISC Employee Assistance Program** Access free, confidential resources for help with emotional, marital, financial, addiction, legal, or stress issues.	*Anthem and Kaiser members* **Call** 800-999-7222 **Visit** anthemEAP.com and enter SISC
Online Counseling and Therapy **Talkspace** Digital platform that supports behavioral health and emotional wellness needs from a secure, HIPAA-compliant app. Up to 6 counseling sessions per situation.	*Anthem and Kaiser members* **Call** 800-999-7222 **Visit** talkspace.com/associatecare and enter SISC as your organization name
Expert Medical Opinions **Teladoc Medical Experts** Get answers to health care questions and second opinions from world-leading experts.	*Anthem and Kaiser members* **Call** 800-835-2362 **Visit** teladoc.com/SISC
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 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.	*Anthem members* **Call** 888-632-2738 **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. Prescriptions also be delivered through Instacart.	*Anthem members* **Call** 800-774-2678 (press 1) **Visit** costco.com

SISC Added Value Programs

Benefit Highlights	Availability & How To Get Started
Virtual Menopause Care **Midi Health** Expert menopause care from home. Get personalized treatment plans, prescriptions when appropriate, and lifestyle support through virtual visits.	*Anthem members* **Visit** joinmidi.com/sisc
Physical Therapy for Back or Joint Pain **Hinge Health** Conquer pain and restore mobility with personalized exercises and one-on-one guidance from a physical therapist. Plus, access to orthopedic specialists for extra support.	*Anthem members* **Call** (855) 902-2777 **Visit** hingehealth.com/sisc
24/7 Virtual Primary Care Doctor **Centivo Care** Skip the waiting room and get quick answers with primary care in your pocket. Use the Centivo app for same-day appointments, prescriptions, and follow-up care through secure video or live chat.	*Anthem members* **Visit** centivocare.com/sisc/ or download the app
24/7 Access to Virtual Maternity & Postpartum Support **Maven** Connect with specialists and a care advocate from pregnancy to postpartum and enjoy a free 6-month diaper subscription when you enroll before your third trimester.	*Anthem members* **Visit** mavenclinic.com/join/SISC
Hip, Knee, & Spine Surgical Benefit **Carrum Health** Consult top-quality surgeons on hip and knee replacements and certain spine surgeries. Benefit covers all related travel and medical bills.	*Anthem members* **Call** (888) 855-7806 **Visit** info.carrumhealth.com/sisc
Enhanced Cancer Benefit **Lantern Cancer Care** Get help from a personal oncology nurse who can partner with you on every step of your cancer journey, including a review of your initial diagnosis and development of a care plan.	*Anthem members* **Visit** lanterncare.com
Autoimmune Support **WellTheory** Take control of your autoimmune health. Work with expert coaches to fill gaps left by medications and ease chronic symptoms like pain, fatigue, and digestive issues.	*Anthem members* **Visit** welltheory.com/partner/sisc

DENTAL

OUR PLANS

DELTA DENTAL DPPO

DID YOU KNOW?

Keeping your teeth and gums healthy isn't the only reason you should practice preventive dental care. With good dental hygiene, you can greatly reduce your risk of getting cavities, gingivitis, periodontitis, and other dental problems.

You can also reduce your risk of secondary problems caused by poor oral health such as diabetes, heart disease, osteoporosis, respiratory disease and even cancer.

We offer dental coverage through Delta Dental.

Why Sign Up For Dental Coverage?

It's important to go to the dentist regularly. Brushing and flossing are great, but regular exams catch dental issues early before they become more expensive and difficult to treat.

That's where dental insurance comes in. Dental insurance makes it easier and less expensive to get the care you need to maintain good oral health.

Dental insurance covers four types of treatments:

- **Preventive** care includes exams, cleanings and x-rays
- **Basic** care focuses on repair and restoration with services such as fillings, root canals, and gum disease treatment
- **Major** care goes further than basic and includes bridges, crowns and dentures
- **Orthodontia** treatment to properly align teeth within the mouth.

DELTA DENTAL DPPO

	Delta Dental DPPO		
	PPO (In-Network)	**Premier** (Out-Of-Network)	**Non-Delta** (Out-Of-Network)
Calendar Year Deductible	None	None	None
Annual Plan Maximum	Unlimited	Unlimited	Unlimited
Diagnostic and Preventive **Basic Services** **Major Services**	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% UCR* 1st Year 80% UCR* 2nd Year 90% UCR* 3rd Year 100% UCR* 4th Year and After
Prosthodontics & Implants			
Prosthodontics & Implants	60%	50%	50%
Implant Maximum	$2,000		
Orthodontic Services			
Orthodontia (Adults and Children)	Plan pays 100%	Plan pays 100%	Plan pays 100%
Lifetime Maximum	$3,000		

Important:
Delta Dental will pay 70% of the Covered Fees for the Diagnostic, Preventive, Basic, Crown and Restorative Benefits during the first calendar year of eligibility. This percentage increases 10% each consecutive year the dentist is visited to a maximum of 100%. If you do not use your program, the percentage remains at the level you reached the previous year. It drops back to 70% if you lose eligibility and then become eligible again.

SAVE WITH A PPO DENTIST

DELTA DENTAL RESOURCES

Delta Dental Mobile App

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

Finding a Delta Provider

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

SmileWay® Wellness Benefits

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

Virtual Dentistry

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

Cost Estimator

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

Amplifon & Qualsight Discounts

With the Amplifon discount, Delta Dental members get an average savings of 62% off the latest retail hearing aid price. PPO members may even be able to use their plan benefits in coordination with Amplifon discounts. There is also a QualSight discount for Delta Dental members. Members receive 40-50% off the national average price of traditional LASIK eye surgery when you use an experienced QualSight LASIK surgeon.

LifePerks

As a Delta Dental member, you have access to a wide variety of local and national offers and discounts to help you care for your whole body and maintain a healthy life. Register and learn more about LifePerks at discountmember.lifecare.com.

VISION

OUR PLANS

VSP VISION

Click to play video

We offer vision coverage through VSP.

Why Sign Up For Vision Coverage?

Vision coverage helps with the cost of eyeglasses or contacts. But even if you don't need vision correction, an annual eye exam checks the health of your eyes and can even detect more serious health issues such as diabetes, high blood pressure, high cholesterol, and thyroid disease.

You'll even find discounts on services like LASIK and PRK, rebates on contact lenses, and money off on hearing aids and other related services. Visit the plan's website to check out these extra savings.

VSP VISION PLAN

Your vision checkup is fully covered after your Exam copay. After any Materials copay, the plan covers frames, lenses, and contacts as described below.

	VSP Vision	
	In-Network	**Out-Of-Network**
Examination		
Benefit	No Copay	Reimbursed up to $35
Frequency	Every 12 months	In-network limitations apply
Materials	No Copay	Reimbursed based on below schedule
Eyeglass Lenses		
Single Vision Lens	Plan pays 100% of basic lens	Reimbursed up to $25
Bifocal Lens	Plan pays 100% of basic lens	Reimbursed up to $40
Trifocal Lens	Plan pays 100% of basic lens	Reimbursed up to $50
Lens Enhancements		
Standard Progressive Lenses	$55 Copay	Not Included
Premium Progressive Lenses	$95 - $105 Copay	Not Included
Custom Progressive Lenses	$150 - $175 Copay	Not Included
Other Lens Enhancements	Average savings of 40% on other lens enhancements	Not Included
Frequency	Every 12 months	In-network limitations apply
Frames		
Benefit	Retail: $150 Allowance Featured Frame: $170 Allowance $150 Walmart/Sam's Club/Costco Allowance 20% savings on the amount over your allowance	Reimbursed up to $30
Frequency	Every 12 months	In-network limitations apply
Contacts (Elective)		
Benefit	$150 Allowance (instead of eyeglasses)	Reimbursed up to $90 (in-network limitations apply)
Frequency	Every 12 months	In-network limitations apply

VSP SAVINGS AND RESOURCES

Access To Over $3,000 In Exclusive Member Savings

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

Extra Savings on Glasses and Sunglasses

Get an extra $20 to spend on featured frame brands. Go to vsp.com/specialoffers for details. You can also save 30% on additional glasses and sunglasses, including lens enhancements, from the same VSP provider on the same day as your WellVision Exam. Or get 20% from any VSP provider within 12 months of your last WellVision Exam.

LASIK - Laser Vision Correction

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

TruHearing® Hearing Aid Discount

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

- One year of follow-up visits for fittings, adjustments, and cleanings
- 60-day trial
- Three-year manufacturer warranty for repairs and one-time loss and damage replacement
- 80 free batteries per hearing aid for non-rechargeable models

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

Retinal Screening

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

Essential Medical Eye Care

With your vision benefits from VSP, you have access to supplemental coverage for urgent and medical eye care. Essential Medical Eye Care includes:

Fully covered retinal screening for members with diabetes

Exams and services to treat immediate issues like pink eye and sudden changes in vision

Treatment options to monitor ongoing health conditions such as dry eye, diabetic eye disease, glaucoma, and more

If you need treatment, contact your VSP network doctor to schedule an appointment or visit vsp.com to find a doctor.

KNOW WHERE TO GO

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

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

ALTERNATIVE FACILITIES

If you have time to evaluate your options for non-emergency health treatments, these alternative facilities can provide the same results as a hospital at a fraction of the cost.

Need	Alternative	Features	Savings
Surgery 	Ambulatory Surgery Center (ASC)	▪ Specializes in same-day surgeries ▪ Cataracts, colonoscopies, upper GI endoscopy, orthopedic surgery and more ▪ Held to same safety standards as hospitals	Up to 50% over hospital stay*
Physical therapy 	Free-standing physical therapy center	▪ Important part of the recovery process after an injury or surgery	40 to 60% over a hospital setting*
Sleep study 	Home testing	▪ Diagnoses sleep apnea and other conditions ▪ Cost is often covered by insurance if considered medically necessary	Approx. $4,500*
Infusion therapy 	Home or outpatient infusion therapy	▪ For drugs that must be delivered by intravenous injections, or epidurals ▪ Delivered by licensed infusion therapy provider ▪ Maintain normal lifestyle and comfort of home or outpatient center	Up to 90% over hospital stay*

**in-network*

How to find an alternative treatment facility

Ask your doctor if your treatment must be delivered in the hospital. You can also search for surgical centers, physical therapy, etc. on your plan's website; or call member services for assistance.

Online tools such as healthcarebluebook.com and healthgrades.com help you compare costs and doctor ratings. Some alternative services include a facility fee to cover overhead costs. To avoid a surprise on your bill, ask about facility fees before you schedule your appointment.

PRESCRIPTIONS BREAKING YOUR BUDGET? – ANTHEM MEMBERS

Click to play video

The Formulary Drug Tiers Determine Your Cost

$	Generic Drug
$$	Brand Name Drug
$$$	Specialty Drug

Understanding The Formulary Can Save You Money

If your doctor prescribes medicine, especially for an ongoing condition, don't forget to check your health plan's drug formulary. It's a powerful tool that can help you make informed decisions about your medication options and identify the lowest cost selection.

What Is A Formulary?

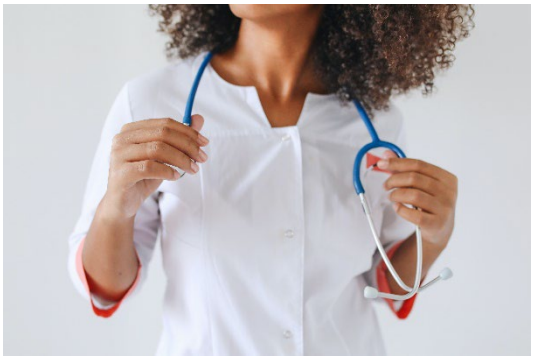
A drug formulary is a list of prescription drugs covered by your medical plan. Most prescription drug formularies separate the medications they cover into four or five drug categories, or "tiers." These groupings range from least expensive to most expensive cost to you. "Preferred" drugs generally cost you less than "non-preferred" drugs.

Get The Most From Your Coverage

To get the most out of your prescription drug coverage, note where your prescriptions fall within your plan's drug formulary tiers and ask your doctor for advice. Generic drugs are usually the lowest cost option. If a brand drug is dispensed when a generic equivalent is available, then you will be responsible for the generic copayment plus the cost difference between the generic and brand. Generics are required by the Food and Drug Administration (FDA) to perform the same as brand-name drug equivalents.

To find out if a drug is on your plan's formulary, visit the plan's website or call the customer service number on your ID card.

PREVENTIVE CARE SCREENING BENEFITS



TYPICAL SCREENINGS FOR ADULTS

- Blood pressure
- Cholesterol
- Diabetes
- Colorectal cancer screening
- Depression
- Mammograms
- OB/GYN screenings
- Prostate cancer screening
- Testicular exam

You Take Your Car In For Maintenance. Why Not Do The Same For Yourself?

Annual preventive checkups can help you and your doctor identify your baseline level of health and detect issues before they become serious.

What is Preventive Care?

The Affordable Care Act (ACA) requires health insurers to cover a set of preventive services at no cost to you, even if you haven't met your yearly deductible. The preventive care services you'll need to stay healthy vary by age, sex, and medical history.

Visit **cdc.gov/prevention** for recommended guidelines.

Preventive care is covered in full only when obtained from an IN-NETWORK provider.

Not All Exams And Tests Are Considered Preventive

Exams performed by specialists are generally not considered preventive and may not be covered at 100 percent.

Additionally, certain screenings may be considered diagnostic, not preventive, based on your current medical condition. You may be responsible for paying all or a share of the cost for those services.

If you have a question about whether a service will be covered as preventive care, contact your medical plan.

EMPLOYEE ASSISTANCE PROGRAM (EAP)

Contact The Eap

Phone	800-999-7222
Website	Anthemeap.com
Company Code	SISC

Help For You And Your Household Members

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

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

No Cost EAP Resources

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

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

Counseling Benefits

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

Parenting & Childcare

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

Financial Coaching

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

Legal Consultation

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

Eldercare Resources

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

Online Resources

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

RETIREE OPTIONS

LIFETIME MEDICAL COVERAGE*:

The district shall pay the premium for all eligible employees who retire and their spouses of record at the time of retirement enrolled in the District's Anthem Blue Cross or Kaiser Permanente Plan provided they meet the following eligibility:

CSEA Unit Members (per Article 21.1 of the Collective Bargaining Agreement):

Full-time regular Unit members hired on or before February 16, 1982, that are age 55 or older with ten (10) or more years, including the entire work year immediately preceding the date of retirement. Upon retirement, dental and/or vision coverage may also be continued provided the retiree pay 100% of the premium directly to SISC.

AFT Unit Members (per Article 18 of the Collective Bargaining Agreement):

Full-time regular Unit members hired on or before September 7, 1982, that are age 55 or older with ten (10) or more years. Upon retirement, dental and/or vision coverage may also be continued provided the retiree pay 100% of the premium directly to SISC.

MSC Members (per Article 13.2 of the MSC Handbook):

Full-time regular Unit members hired on or before June 30, 1983, that are age 55 or older with ten (10) or more years, including the entire work year immediately preceding the date of retirement. Upon retirement, dental and/or vision coverage may also be continued provided the retiree pay 100% of the premium directly to SISC.

**Upon age 65, the District will only pay the premium for the District plan that supplements Medicare. Participants must enroll in and maintain Medicare Parts A&B for their District coverage to continue, or they must pay the difference in premium quarterly and in advance. Once terminated from coverage either voluntarily or involuntarily, re-enrollment/reinstatement shall not be allowed. Please note, it is the District Retiree that has lifetime medical coverage. Should the retiree pass before the spouse, the spouse will be offered the option of remaining on the District's plan provided they pay 100% of the premium timely.*

RETIREE OPTIONS (cont'd)

CSEA Unit Members	see Article 21.5 of your CBA
AFT Unit Member	see Article 18 of your CBA
MSC Members	See Article 13.2 of your Handbook

Bridge Plan 58 for Full-Time Faculty, MSC, and CSEA Employees

The District shall pay the medical premium of the appropriate District plan for all eligible full-time, regular employees (AFT, MSC, and CSEA members) who retire with at least Eighteen (18) years of service and are at least age 58 years old immediately preceding retirement. The Bridge Plan will cover eligible retirement to the month they turn 65 or become eligible for Medicare, whichever is first.

Upon end of eligibility for the Bridge Plan, the retiree may elect to remain on the District's plan provided they pay 100% of the premium, monthly to SISC. They may also elect COBRA continuation coverage. Continued coverage for eligible dependents is also allowed upon retirement provided the retiree pays 100% of their **premium** to the District quarterly and in advance. For specific eligibility rules please refer your collective bargaining agreement/handbook.

Retiree Dental Coverage

All employees will be given the option upon retirement to elect to continue the District's dental plan for themselves and any eligible dependent(s) by paying the full premium. The retiree may elect dental regardless of whether or not they are enrolled in a District retiree medical plan. Retirees who do not elect to continue dental coverage or any coverage for their dependent upon retirement will not have the option of enrolling at a later date.

The only option for vision coverage is COBRA.

BRIDGE PLAN 60:

The District shall pay the medical premium of the appropriate District plan for all eligible full-time, regular employees (CSEA, AFT, and MSC members) who retire with at least fifteen (15) years of service and are at least age 60 years old immediately preceding retirement. The Bridge Plan will cover eligible retirement to the month they turn 65 or become eligible for Medicare, whichever is first.

RETIREE OPTIONS (cont'd)

MSC - Tier 2-

i. The employee must have been employed full-time in the District for at least eighteen (18) consecutive years immediately preceding retirement from the District

ii. The employee must not have had a break in service during the eighteen-year period as noted above. For the purpose of this section, sabbaticals, other approved paid leaves of absence, and paid or unpaid legally protected leaves do not constitute a break in service. Other approved unpaid leaves of absence do constitute a break in service

iii. The employee must have reached the age of 58 prior to the effective date of the employee's retirement.

13.1.3 Upon retirement, the retiree may elect to continue coverage for his/her eligible dependent(s) for the period of time the retiree is enrolled; however, the retiree must pay the full premium for each dependent, quarterly and in advance. Once terminated for non-payment, the dependent(s) will not be reinstated. The District shall not contribute to the cost of any dependent(s) coverage if this is the impact.

All Other Retirees (Including Those Ending Coverage Under The Bridge Plan):

In addition to the continuation of coverage options you have under Federal COBRA laws, all full-time employees retiring from the District and CalSTRS and/or CalPERS may elect to continue coverage in a District retiree plan. Enrollment must be elected upon retirement. Once coverage is cancelled, either voluntarily or involuntarily (non-payment), re-enrollment will not be allowed.

CSEA Unit Members (per Board Policy 7380):

Full-time regular Unit members may elect to continue their medical and/or dental benefits provided they enroll upon retirement. If applicable, they may elect to continue coverage for their current spouse (enrolled in the plan the day before their retirement), as well as their dependent child(ren) by paying 100% of the premium directly to SISC. Dependent eligibility rules continue to apply.

AFT Unit Members (per Education Code §7000):

Full-time regular Unit members may elect to continue their medical and/or dental benefits provided they enroll upon retirement. If applicable, they may elect to continue coverage for their current spouse (enrolled in the plan the day before their retirement), as well as their dependent child(ren) by paying 100% of the premium directly to SISC. Dependent eligibility rules continue to apply.

MSC Members (per Board Policy 7380):

Full-time regular members may elect to continue their medical and/or dental benefits provided they enroll upon retirement. If applicable, they may elect to continue coverage for their current spouse (enrolled in the plan the day before their retirement), as well as their dependent child(ren) by paying 100% of the premium directly to SISC. Dependent eligibility rules continue to apply.

MEDICARE:

The district does not contribute towards any enrollee's premium for Medicare.

IMPORTANT PLAN INFORMATION

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

- Contact information for our benefit carriers and vendors
- A Benefits Glossary to help you understand important insurance terms.
- A summary of the health plan notices you are entitled to receive annually, and where to find them

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

PLAN CONTACTS

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

Plan Type	Provider	Phone Number	Website
Medical	Kaiser Permenente	(800) 464-4000	kp.org/SISC
Medical	Anthem Blue Cross	(800) 825-5541	www.anthem.com/ca/SISC
Medical	Medicare	(800) 633-4227	www.medicare.gov
Medical Rx (Anthem)	Navitus Health Solutions	(866) 333-2725	www.navitus.com
Dental	Delta Dental	(800) 765-6003	www.deltadentalins.com
Vision	VSP	(800) 877-7195	www.vsp.com
Employee Assistance Program	Anthem	(800) 999-7222	www.anthemeap.com

GLOSSARY

-A-

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

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

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

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

-B-

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

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

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

-C-

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

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

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

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

-D-

Deductible
The amount of healthcare expenses you have to pay for with your own money before your health plan will pay. The deductible does not apply to preventive care and certain other services.

Family coverage may have an ***aggregate*** or ***embedded*** deductible. Aggregate means your family must meet the entire family deductible before any individual expenses are covered. Embedded means the plan begins to make payments for an individual member as soon as they reach their individual deductible.

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

Dental Diagnostic & Preventive Generally includes routine cleanings, oral exams, x-rays, and fluoride treatments.
Most plans limit preventive exams and cleanings to two times a year.

Dental Major Services
Complex or restorative dental work such as crowns, bridges, dentures, inlays and onlays.

Dependent Care Flexible Spending Account (FSA)
An arrangement through your employer that lets you pay for eligible child and elder care expenses with tax-free dollars. Eligible expenses include day care, before and after-school programs, preschool, and summer day camp for children underage 13. Also included is care for a spouse or other dependent who lives with you and is physically incapable of self-care.

-E-

Eligible Expense
A service or product that is covered by your plan. Your plan will not cover any of the cost if the expense is not eligible.

Excluded Service
A service that your health plan doesn't pay for or cover.

-F-

Formulary
A list of prescription drugs covered by your medical plan or prescription drug plan. Also called a drug list.

-G-

Generic Drug
A drug that has the same active ingredients as a brand name drug but is sold under a different name. For example, Atorvastatin is the generic name for medicines with the same formula as Lipitor.

Grandfathered
A medical plan that is exempt from certain provisions of the Affordable Care Act (ACA).

-H-

Health Reimbursement Account (HRA) An account funded by an employer that reimburses employees, tax-free, for qualified medical expenses up to a maximum amount per year. Sometimes called Health Reimbursement Arrangements.

Healthcare Flexible Spending Account (FSA)
A health account through your employer that lets you pay for many out-of-pocket medical expenses with tax-free dollars. Eligible expenses include insurance copayments and deductibles, qualified prescription drugs, insulin, and medical devices, and some over-the-counter items.

High Deductible Health Plan (HDHP) A medical plan with a higher deductible than a traditional insurance plan. The monthly premium is usually lower, but you pay more health care costs (the deductible) before the insurance company starts to pay its share. A high deductible plan (HDHP) may make you eligible for a health savings account (HSA) that allows you to pay for certain medical expenses with money free from federal taxes.

GLOSSARY

-I-

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

-L-

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

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

-M-

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

-O-

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

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

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

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

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

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

-P-

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

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

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

Preventive Care Services
Routine healthcare visits that may include screenings, tests, check-ups, immunizations, and patient counseling to prevent illnesses, disease, or other health problems. Many preventive care services are fully covered. Check with your health plan in advance if you have questions about whether a preventive service is covered.

Primary Care Provider (PCP)
The main doctor you consult for healthcare issues. Some medical plans require members to name a specific doctor as their PCP and require care and referrals to be directed or approved by that provider.

-S-

Short Term Disability Insurance
Insurance that replaces a portion of your income if you are temporarily unable to work due to surgery and recovery time, a prolonged illness or injury, or pregnancy issues and childbirth recovery.

-T-

Telehealth / Telemedicine / Teledoc
A virtual visit to a doctor using video chat on a computer, tablet or smartphone. Telehealth visits can be used for many common, non-serious illnesses and injuries and are available 24/7. Many health plans and medical groups provide telehealth services at no cost or for much less than an office visit.

-U-

UCR (Usual, Customary, and Reasonable)
The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service. The UCR amount sometimes is used to determine the allowed amount.

Urgent Care
Care for an illness, injury or condition serious enough that care is needed right away, but not so severe it requires emergency room care. Treatment at an urgent care center generally costs much less than an emergency room visit.

-V-

Vaccinations
Treatment to prevent common illnesses such as flu, pneumonia, measles, polio, meningitis, shingles, and other diseases. Also called immunizations.

Voluntary Benefit
An optional benefit plan offered by your employer for which you pay the entire premium, usually through payroll deduction.

IMPORTANT PLAN INFORMATION

WHAT YOU NEED TO KNOW ABOUT THE "NO SURPRISES" RULES

The "No Surprises" rules protect you from surprise medical bills in situations where you can't easily choose a provider who's in your health plan network. This is especially common in an emergency situation, when you may get care from out-of-network providers. Out-of-network providers or emergency facilities may ask you to sign a notice and consent form before providing certain services after you're no longer in need of emergency care. These are called "post-stabilization services." You shouldn't get this notice and consent form if you're getting emergency services other than post-stabilization services. You may also be asked to sign a notice and consent form if you schedule certain non-emergency services with an out-of-network provider at an in-network hospital or ambulatory surgical center.

The notice and consent form informs you about your protections from unexpected medical bills, gives you the option to give up those protections and pay more for out-of-network care, and provides an estimate of what your out-of-network care might cost. You aren't required to sign the form and shouldn't sign the form if you didn't have a choice of health care provider or facility before scheduling care. If you don't sign, you may have to reschedule your care with a provider or facility in your health plan's network.

View a sample notice and consent form (PDF).

This applies to you if you're a participant, beneficiary, enrollee, or covered individual in a group health plan or group or individual health insurance coverage, including a Federal Employees Health Benefits (FEHB) plan.

IMPORTANT PLAN INFORMATION

HEALTH PLAN NOTICES

These notices must be provided to plan participants on an annual basis and are available in the Annual Notices document, located in the following slides:

- **Medicare Part D Notice:** Describes options to access prescription drug coverage for Medicare eligible individuals
- **Women's Health and Cancer Rights Act:** Describes benefits available to those that will or have undergone a mastectomy
- **Newborns' and Mothers' Health Protection Act:** Describes the rights of mother and newborn to stay in the hospital 48-96 hours after delivery
- **HIPAA Notice of Special Enrollment Rights:** Describes when you can enroll yourself and/or dependents in health coverage outside of open enrollment
- **HIPAA Notice of Privacy Practices:** Describes how health information about you may be used and disclosed
- **Notice of Choice of Providers:** Notifies you that your plan requires you to name a Primary Care Physician (PCP) or provides for you to select one
- **The 'No Surprises' Rules:** Explains rules that protect you from surprise medical bills
- **Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP):** Describes availability of premium assistance for Medicaid eligible dependents.

COBRA CONTINUATION COVERAGE

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

DEADLINE FOR FILING LAWSUIT UNDER ERISA AFTER EXHAUSTION OF ALL CLAIMS PROCEDURES

Any lawsuit must be filed within 36 months of the final decision on the claim. Exhaustion of all claims and appeals procedure is required prior to filing suit. Please refer to the WRAP Summary Plan Description for the plan specific statute of limitations.

Medicare Part D Notice

Important Notice from San José • Evergreen Community College District About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with San José • Evergreen Community College District and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

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

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. San José • Evergreen Community College District has determined that the prescription drug coverage offered by the San José • Evergreen Community College District is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your San José • Evergreen Community College District coverage will not be affected. See below for more information about what happens to your current coverage if you join a Medicare drug plan Since the existing prescription drug coverage under Health Plan is creditable (e.g., as good as Medicare coverage), you can retain your existing prescription drug coverage and choose not to enroll in a Part D plan; or you can enroll in a Part D plan as a supplement to, or in lieu of, your existing prescription drug coverage.

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

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

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

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

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

Contact the person listed below for further information SJECCD Human Resources at (408) 223-6713. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through San José • Evergreen Community College District changes. You also may request a copy of this notice at any time.

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

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

For more information about Medicare prescription drug coverage:

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

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

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

Date:	10/01/2026
Name of Entity/Sender:	San José • Evergreen Community College District
Position/Office:	SJECCD Human Resources
Address:	40 South Market Street San Jose, CA 95113
Phone Number:	(661) 636-4156

Women's Health and Cancer Rights Act

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

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. If you would like more information on WHCRA benefits, call your plan administrator .

Newborns' and Mothers' Health Protection Act

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

HIPAA Notice of Special Enrollment Rights

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

- Lose other health insurance or group health plan coverage. You must request enrollment within 30 days after the loss of other coverage.
- Gain a new dependent as a result of marriage, birth, adoption, or placement for adoption. You must request health plan enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.
- Lose Medicaid or Children's Health Insurance Program (CHIP) coverage because you are no longer eligible. You must request medical plan enrollment within 60 days after the loss of such coverage.

If you request a change due to a special enrollment event within the 30 day timeframe, coverage will be effective the date of birth, adoption or placement for adoption. For all other events, coverage will be effective the first of the month following your request for enrollment. In addition, you may enroll in San José • Evergreen Community College District health plan if you become eligible for a state premium assistance program under Medicaid or CHIP. You must request enrollment within 60 days after you gain eligibility for medical plan coverage. If you request this change, coverage will be effective the first of the month following your request for enrollment. Specific restrictions may apply, depending on federal and state law.

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

Availability of Privacy Practices Notice

We maintain the HIPAA Notice of Privacy Practices for San José • Evergreen Community College District describing how health information about you may be used and disclosed. You may obtain a copy of the Notice of Privacy Practices by contacting your human resources department.

Notice of Choice of Providers

The Health plan generally requires the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the health plan.

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

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

ACA Disclaimer

This offer of coverage may disqualify you from receiving government subsidies for an Exchange plan even if you choose not to enroll. To be subsidy eligible you would have to establish that this offer is unaffordable for you, meaning that the required contribution for employee only coverage under our base plan exceeds 9.96% in 2026 of your modified adjusted household income.

WHAT YOU NEED TO KNOW ABOUT THE "NO SURPRISES" RULES

The "No Surprises" rules protect you from surprise medical bills in situations where you can't easily choose a provider who's in your health plan network. This is especially common in an emergency situation, when you may get care from out-of-network providers. Out-of-network providers or emergency facilities may ask you to sign a notice and consent form before providing certain services after you're no longer in need of emergency care. These are called "post-stabilization services." You shouldn't get this notice and consent form if you're getting emergency services other than post-stabilization services. You may also be asked to sign a notice and consent form if you schedule certain non-emergency services with an out-of-network provider at an in-network hospital or ambulatory surgical center.

The notice and consent form informs you about your protections from unexpected medical bills, gives you the option to give up those protections and pay more for out-of-network care, and provides an estimate of what your out-of-network care might cost. You aren't required to sign the form and shouldn't sign the form if you didn't have a choice of health care provider or facility before scheduling care. If you don't sign, you may have to reschedule your care with a provider or facility in your health plan's network.

View a sample notice and consent form (PDF).

This applies to you if you're a participant, beneficiary, enrollee, or covered individual in a group health plan or group or individual health insurance coverage, including a Federal Employees Health Benefits (FEHB) plan.

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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of **January 31, 2026**. Contact your State for more information on eligibility.

Alabama – Medicaid
Website: myalhipp.com
Phone: (855) 692-5447

Alaska – Medicaid
The AK Health Insurance Premium Payment Program
Website: myakhipp.com
Phone: (866) 251-4861
Email: CustomerService@MyAKHIPP.com
Medicaid eligibility:
health.alaska.gov/dpa/Pages/default.aspx

Arkansas – Medicaid
Website: myarhipp.com
Phone: (855) MyARHIPP (692-7447)

California – Medicaid
Health Insurance Premium Payment (HIPP) Program
website: dhcs.ca.gov/hipp
Phone: (916) 445-8322
Email: hipp@dhcs.ca.gov
Fax: (916) 440-5676

Colorado – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
Health First Colorado website: healthfirstcolorado.com
Health First Colorado Member Contact Center: (800) 221-3943 (TTY: 711)
CHP+: hcpf.colorado.gov/child-health-plan-plus
CHP+ Customer Service: (800) 359-1991 (TTY: 711)
Health Insurance Buy-In Program (HIBI): mycohibi.com
HIBI Customer Service: (855) 692-6442

Florida – Medicaid
Website:
flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp
Phone: (877) 357-3268

Georgia – Medicaid
GA HIPP Website: medicaid.georgia.gov/health-insurance-premium-payment-program-hipp
Phone: (678) 564-1162, press 1
GA CHIPRA Website: medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra
Phone: (678) 564-1162, press 2

Indiana – Medicaid

Health Insurance Premium Payment Program
All other Medicaid
Website: in.gov/medicaid
Website: in.gov/fssa/dfr
Family and Social Services Administration
Phone: (800) 403-0864
Member Services phone: (800) 457-4584

Iowa – Medicaid and CHIP (Hawki)

Medicaid website: hhs.iowa.gov/programs/welcome-iowa-medicaid
Medicaid phone: (800) 338-8366
Hawki website: hhs.iowa.gov/programs/welcome-iowa-medicaid/iowa-health-link/hawki
Hawki Phone: (800) 257-8563
HIPP website: hhs.iowa.gov/programs/welcome-iowa-medicaid/fee-service/hipp
HIPP Phone: (888) 346-9562

Kansas – Medicaid

Website: kancare.ks.gov
Phone: (800) 792-4884
HIPP Phone: (800) 967-4660

Kentucky – Medicaid

Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) website:
chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx
Phone: (855) 459-6328
Email: KIHIPP.PROGRAM@ky.gov
KCHIP website: kynect.ky.gov
Phone: (877) 524-4718
Medicaid website: chfs.ky.gov/agencies/dms

Louisiana – Medicaid

Louisiana Medicaid website: ldh.la.gov/healthy-louisiana
Medicaid Customer Service Line: (888) 342-6207
Louisiana Medicaid email: healthy@la.gov
Louisiana Health Insurance Premium Program (LaHIPP)
Website: ldh.la.gov/lahipp
LaHIPP phone: (877) 697-6703
LaHIPP email: La.HIPP@la.gov
LaHIPP fax: (888) 716-9787
LaHIPP mailing address: 100 Crescent Centre Parkway, Suite 1000, Tucker, GA 30084

Maine – Medicaid

Enrollment website: mymaineconnection.gov/benefits
Phone: (800) 442-6003 (TTY: 711)
Private Health Insurance Premium webpage:
maine.gov/dhhs/ofi/applications-forms
Phone: (800) 977-6740 (TTY: 711)

Massachusetts – Medicaid and CHIP

Website: mass.gov/masshealth/pa
Phone: (800) 862-4840 (TTY: 711)
Email: masspremassistance@accenture.com

Minnesota – Medicaid

Website: mn.gov/dhs/health-care-coverage/
Phone: (800) 657-3672

Missouri – Medicaid

Website: mydss.mo.gov/mhd/healthcare
Phone: (573) 751-2005

Montana – Medicaid

Website: dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: (800) 694-3084
Email: HHSHIPPProgram@mt.gov

Nebraska – Medicaid

Website: ACCESSNebraska.ne.gov
Phone: (855) 632-7633
Lincoln: (402) 473-7000
Omaha: (402) 595-1178

Nevada – Medicaid

Medicaid website: dhcfp.nv.gov
Medicaid phone: (800) 992-0900

New Hampshire – Medicaid

Website: dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program
Phone: (603) 271-5218
Toll free number for the HIPP program: (800) 852-3345, ext. 15218
Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov

New Jersey – Medicaid and CHIP

Medicaid website:
state.nj.us/humanservices/dmahs/clients/medicaid
Phone: (800) 356-1561
CHIP Premium Assistance Phone: (609) 631-2392
CHIP website: njfamilycare.org/index.html
CHIP phone: (800) 701-0710 (TTY: 711)

New York – Medicaid

Website: health.ny.gov/health_care/medicaid
Phone: (800) 541-2831

North Carolina – Medicaid

Website: medicaid.ncdhhs.gov
Phone: (919) 855-4100

North Dakota – Medicaid
Website: hhs.nd.gov/healthcare
Phone: (866) 614-6005

Oklahoma – Medicaid and CHIP
Website: insureoklahoma.org
Phone: (888) 365-3742

Oregon – Medicaid and CHIP
Website: healthcare.oregon.gov
Phone: (800) 699-9075

Pennsylvania – Medicaid and CHIP
Website: pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html
Phone: (800) 692-7462
CHIP website: dhs.pa.gov/CHIP/Pages/CHIP.aspx
CHIP phone: (800) 986-KIDS (5437)

Rhode Island – Medicaid and CHIP
Website: eohhs.ri.gov
Phone: (855) 697-4347 or (401) 462-0311 (Direct RIte Share Line)

South Carolina – Medicaid
Website: scdhhs.gov
Phone: (888) 549-0820

South Dakota – Medicaid
Website: dss.sd.gov
Phone: (888) 828-0059

Texas – Medicaid
Website: hhs.texas.gov/services/financial/health-insurance-premium-payment-hipp-program
Phone: (800) 440-0493

Utah – Medicaid and CHIP
Utah's Premium Partnership for Health Insurance (UPP) website: medicaid.utah.gov/upp
Phone: (888) 222-2542
Email: upp@utah.gov
Adult Expansion website: medicaid.utah.gov/expansion
Utah Medicaid Buyout Program website: medicaid.utah.gov/buyout-program
CHIP website: chip.utah.gov

Vermont – Medicaid
Website: dvha.vermont.gov/members/medicaid/hipp-program
Phone: (800) 250-8427

Virginia – Medicaid and CHIP
Website: coverva.dmas.virginia.gov/learn/premium-assistance/famis-select
Website: coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs
Medicaid/CHIP phone: (800) 432-5924

Washington – Medicaid
Website: hca.wa.gov
Phone: (800) 562-3022

West Virginia – Medicaid and CHIP
Website: dhhr.wv.gov/bms
Website: mywvhipp.com
Medicaid phone: (304) 558-1700
CHIP toll-free phone: (855) MyWVHIPP (699-8447)

Wisconsin – Medicaid and CHIP
Website: dhs.wisconsin.gov/badgercareplus/p-10095.htm
Phone: (800) 362-3002

Wyoming – Medicaid
Website: health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/
Phone: (800) 251-1269

To see if any other states have added a premium assistance program since **January 31, 2026**, or for more information on special enrollment rights, contact either:

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

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

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

san josé • evergreen
COMMUNITY COLLEGE DISTRICT