EMPLOYEE BENEFITS *Guide*

2026

CUESTA COLLEGE

Employee Benefits Guide 2026

General Information

Core Benefits

Other Benefits

Miscellaneous

If you (and/or your dependents) have Medicare or you will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage.

Please see page 57 for more details.

This is a brief summary of the benefits available under Cuesta College's plans. In the event of a discrepancy between this summary and the Plan Document, the Plan Document will prevail.

Introduction

Our Commitment

Our greatest asset, and the key to our success, is our employees. You make the difference for the people we care for and the community we serve. That's why we've designed a benefits program to make a difference for you and your family.

Health insurance is one of the most critical benefits offered by San Luis Obispo County Community College District. A major illness or injury could be financially devastating without adequate insurance. Even the cost of treatment of minor conditions can be prohibitive. With this in mind, our benefit program is designed exclusively to meet the health care needs of you and your family.

Depending on where you live, your personal preference regarding physician choice and type of health care environment you prefer, you may choose the plan that is most suitable for you and your family members.

The benefit choices you make when you and your dependent(s) enroll will remain in place unless you experience a change in family status (e.g., marriage, divorce, or legal separation, birth, adoption, death or spousal change). If you need to change your coverage before the next enrollment period due to one of these occurrences, you must contact the Human Resources Office within 30 days of your family status change.

You can make any changes during the annual Open Enrollment period that occurs in Fall.

During this Open Enrollment period, if you are a benefit eligible employee, you may enroll or change your medical, dental and/or vision plans, as well as add any eligible dependents not previously enrolled under your coverage.

Your dependents are defined as:

- Your spouse (the person who you are legally married to under state law, including a same-sex spouse)
- Your registered domestic partner
- Your child, a child of your spouse or domestic partner, up to age 26; ***or***
- Your legally adopted/foster child to age 26.

Disabled Childeren over age 26 will be required to submit the following:

- Legal Birth Certificate or Hospital Birth Certificate (to include full name of child, parent(s) name and child's DOB)
- Prior year's Federal Tax Form that shows child is claimed as an IRS dependent (First page only, income information may be blocked out.)
- Proof of 6 months prior creditable coverage under the employee/retiree's plan. There can be no break in coverage.
- Completed Anthem Disabled Dependent Certification Form

How to Enroll

Cuesta College is providing every employee with an opportunity to understand their employee benefits, ask questions unique to their situation, and enroll in benefits.

Online Enrollment on BenefitBridge

Self enroll at www.benefitbridge.com/sloccd

You have the ability to make changes via BenefitBridge during the 2027 Open Enrollment that will be held in the summer of 2026.

San Luis Obispo Community College District Online Benefits Enrollment is easy with BenefitBridge!

Need Help?

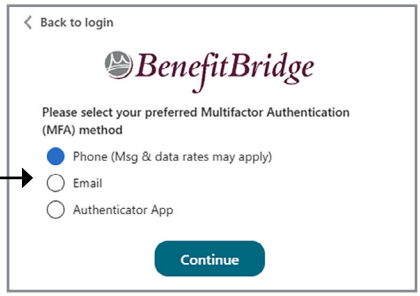
For all questions related to your benefits, please contact your employer's benefits administrator. For BenefitBridge technical assistance ***only***, please contact BenefitBridge Customer Care at 800.814.1862; Mon – Fri, 8:00 a.m. – 5:00 p.m., PST or email benefitbridge@keenan.com.

A Multifactor Authentication (MFA) code is required to confirm your identity each time before you can log in to the system. Below are instructions to help you obtain your MFA code.

Registration and Login

Already have login credentials?

1. Login to BenefitBridge at www.benefitbridge.com/sloccd
2. **For your first login only**, you will be asked to change your password.
   - If you have forgotten your password, click on **Forgot User Name/Password?** And follow the prompts.
3. The MFA selection popup will appear.
4. Select the MFA method you would like to use and select "Continue".
5. Different popup windows will appear, depending on your selection.



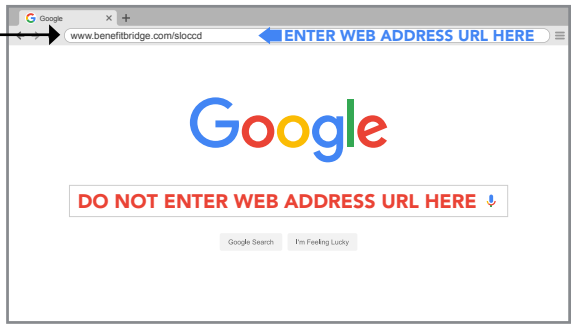
MFA Methods:

1. Select your preferred Multifactor Authentication Method: **Phone, Email or Authenticator App** and follow the prompts. **Download the Authenticator App**
   - Download the Microsoft Authenticator app (or the authenticator app of your choice) to your phone device using the Google Play Store or the Apple App Store.

NOTE: If you do not have a phone number or email listed in BenefitBridge, those options **will not be available** to you as preferred methods. Please contact your Benefits department to have your phone number and email address updated in BenefitBridge.

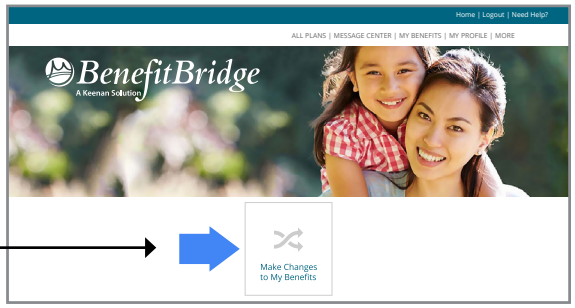
Need to create login credentials?

1. In the **address bar**, type www.benefitbridge.com/sloccd **(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 a picture, as instructed. You will be redirected to the User Login page to sign in.
   - **STEP 4:** Follow instructions in the **MFA Methods** section above.



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.

2026 Premium Rates and Fringe Amounts

The district will contribute fringe toward the cost of the total health and welfare benefits program, defined as only the medical, dental, and vision insurance coverage plans offered by the District

Classified

- **Full-Time Classified Enrolled with Employee only coverage will receive up to $907.00 per month***
- **Full-Time Classified Enrolled with Employee + 1 Coverage will receive up to $955.00 per month***
- **Full-Time Classified Enrolled with Family Coverage will receive up to $1,078.00 per month***

Management/Confidential

- **Full-Time Management/Confidential Enrolled with Employee only coverage will receive $929.00 per month***
- **Full-Time Management/Confidential Enrolled with Employee + 1 coverage will receive $1,140.00 per month***
- **Full-Time Management/Confidential Enrolled with Family coverage will receive $1,465.00 per month***

* subject to change - please visit https://www.cuesta.edu/about/human-resources/benefits/ for updated information

50%-74% Part-Time employees will receive a pro-rated amount based off full-time employee fringe per month and level of medical enrollment

Monthly Premiums for 2026

Classified/Management/Confidential	Employee	Employee + 1	Family
Classified Fringe	$907.00	$955.00	$1,078.00
Management/Confidential Fringe	$929.00	$1,140.00	$1,465.00
Plan Year 1/1/2026 to 12/31/2026			
• Anthem - Plan A 80-E $20	$958.00	$1,868.00	$2,618.00
• Anthem - Plan B 80-G $30	$861.00	$1,684.00	$2,365.00
• Anthem - Plan C 80-L $30	$761.00	$1,484.00	$2,080.00
• Anthem - Plan D 80-M $40	$702.00	$1,360.00	$1,899.00
• Anthem - Plan E HSA 3400	$669.00	$1,297.00	$1,811.00
• Anthem - Plan I 2-Tier MEC 9000	$542.00	$1,036.00	$1,036.00
• Anthem - Plan G Proactive Care Plan Platinum	$889.00	$1,735.00	$2,433.00
• Plan J Waiver Active Benefit Enrollment *(WABE; 9k)*	$542.00	N/A	N/A
All Staff	**Employee**	**Employee + 1**	**Family**
Dental Plans			
• Delta Dental - Group #6736-0001 Plan A	$53.83	$95.72	$138.25
• Delta Dental - Group #6736-0003 Plan B	$60.15	$106.93	$154.50
• Delta Dental - Group #6736-01001 Plan C	$68.36	$121.57	$175.03
• Delta Dental - Group #6736-01003 Plan D	$76.38	$135.80	$196.18
Vision - Group #30071230	$11.37	$18.48	$29.30

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2026 Premium Rates and Fringe Amounts (continued)

Full Time and Part-Time Faculty

The district will contribute fringe toward the cost of the total health and welfare benefits program, defined as only the medical, dental, and vision insurance coverage plans offered by the District

12 Month Fringe

- **Enrolled with Employee only coverage will receive up to $756.27.00 per month***
- **Enrolled with Employee + 1 Coverage will receive up to $1,103.13 per month***
- **Enrolled with Family Coverage will receive up to $1,431.7 per month***

* subject to change - please visit https://www.cuesta.edu/about/human-resources/benefits/ for updated information

Monthly Premiums for 2026 - 12 Months

Faculty - 12 Months - Plan Year 10/1/25- 9/30/26	Employee	Employee + 1	Family
Faculty Fringe	$756.27	$1,103.13	$1,431.70
• SISC Anthem PPO A - Group #40303A	$958.00	$1,868.00	$2,618.00
• SISC Anthem PPO B - Group #40303B	$861.00	$1,684.00	$2,365.00
• SISC Anthem PPO C - Group #40303C	$761.00	$1,484.00	$2,080.00
• SISC Anthem PPO D - Group #40303D	$702.00	$1,360.00	$1,899.00
• SISC Anthem PPO E - Group #40303E	$669.00	$1,297.00	$1,811.00
• SISC Anthem PPO F - Group #70303B *(Employee & child/children ONLY)*	$612.00	$1,171.00	$1,171.00
• SISC Anthem Plan G Proactive Care Platinum - Group #M409	$889.00	$1,735.00	$2,433.00
• SISC Plan H Waiver Active Benefit Enrollment (WABE)	$612.00	N/A	N/A
All Staff - Plan Year 1/1/2026 to 12/31/2026	**Employee**	**Employee + 1**	**Family**
Dental Plans			
• DELTA DENTAL - Group #6736-0001 Plan A	$53.83	$95.72	$138.25
• DELTA DENTAL - Group #6736-0003 Plan B	$60.15	$106.93	$154.50
• DELTA DENTAL - GROUP #6736-01001 Plan C	$68.36	$121.57	$175.03
• DELTA DENTAL - GROUP #6736-01003 Plan D	$76.38	$135.80	$196.18
VISION - Group #30071230	$11.37	$18.48	$29.30

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2026 Premium Rates and Fringe Amounts (continued)

Full Time and Part-Time Faculty

The district will contribute fringe toward the cost of the total health and welfare benefits program, defined as only the medical, dental, and vision insurance coverage plans offered by the District

10 Month Fringe

- **Enrolled with Employee only coverage will receive up to $907.52.00 per month***
- **Enrolled with Employee + 1 Coverage will receive up to $1,323.76 per month***
- **Enrolled with Family Coverage will receive up to $1,718.04 per month***

* subject to change - please visit https://www.cuesta.edu/about/human-resources/benefits/ for updated information

Monthly Premiums for 2026 - 10 Months

Faculty - 12 Months - Plan Year 10/1/25- 9/30/26	Employee	Employee + 1	Family
Faculty Fringe	$907.52	$1,323.76	$1,718.04
• SISC Anthem PPO A - Group #40303A	$1,149.60	$2,241.60	$3,141.60
• SISC Anthem PPO B - Group #40303B	$1,033.20	$2,020.80	$2,838.00
• SISC Anthem PPO C - Group #40303C	$913.20	$1,780.80	$2,496.00
• SISC Anthem PPO D - Group #40303D	$842.40	$1,632.00	$2,278.80
• SISC Anthem PPO E - Group #40303E	$802.80	$1,556.40	$2,173.20
• SISC Anthem PPO F - Group #70303B *(Employee & child/children ONLY)*	$734.40	$1,405.20	$1,405.20
• SISC Anthem Plan G Proactive Care Platinum - Group #M409	$1,066.80	$2,082.00	$2,919.60
• SISC Plan H Waiver Active Benefit Enrollment (WABE)	$734.40	N/A	N/A
All Staff - Plan Year 1/1/2026 to 12/31/2026	**Employee**	**Employee + 1**	**Family**
Dental Plans			
• DELTA DENTAL - Group #6736-0001 Plan A	$64.60	$114.86	$165.90
• DELTA DENTAL - Group #6736-0003 Plan B	$72.18	$128.32	$185.40
• DELTA DENTAL - GROUP #6736-01001 Plan C	$82.03	$145.88	$210.04
• DELTA DENTAL - GROUP #6736-01003 Plan D	$91.66	$162.96	$235.42
VISION - Group #30071230	$13.64	$22.18	$35.16

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Opt Out Options

Opt-out options to be eligible for opt-out fringe ($225/Classified and $265/Management). Benefit Fringe contribution will be available to purchase Dental, Vision, HSA, TSA, Life, and/or Disability Insurance:

- Currently employed below 90% FTE and have coverage elsewhere - Must provide proof of coverage.

  OR

- Enrolled in Medi-Cal, Medicare Plan A and B, TRICARE, and Covered California and receiving a related subsidy (MUST submit proof of coverage and, if applicable, subsidy for Covered California coverage).

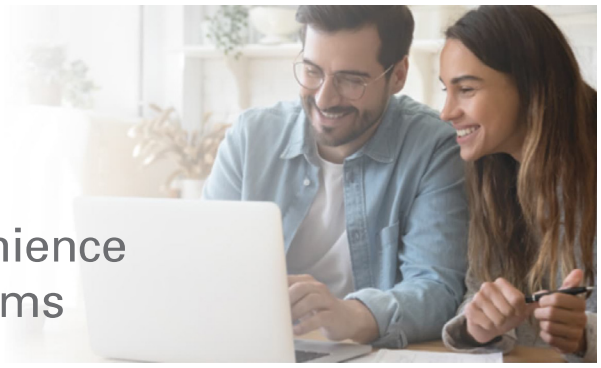
Waiver of Anchor Benefit Enrollment (WABE):

- This option will allow you to waive medical coverage at Cuesta College and have primary insurance elsewhere and retain access to WABE Added Value Programs (must provide proof of coverage to enroll in WABE and sign a declination of coverage form)
- This plan is defined as part of health and wellness, fringe will cover the cost and the remainder can be used for dental and vision plans

Please see WABE Value Adds on the following page

WABE Added Value

SISC
Self-Insured Schools of California
Schools Helping Schools



You get access and convenience to these innovative programs

BENEFIT HIGHLIGHTS	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.	**Call** 800-999-7222 **Visit** anthemEAP.com/SISC
Expert Medical Opinions *Teladoc Medical Experts* Get answers to health care questions and second opinions from world-leading experts.	**Call** 855-380-7828 **Visit** teladoc.com/SISC
24/7 Physician Access—Anytime, Anywhere *MDLive* Consult with doctors and pediatricians over the phone or using online video for common medical conditions and behavioral health issues. Physicians can prescribe medication when appropriate. *copays may apply	**Call** 800-657-6169 **Visit** mdlive.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.	**Call** 855-442-5885 **Visit** vida.com/sisc
Health Screening Program *Quest* Health screening measures your blood pressure, cholesterol, glucose and other important health-risk indicators. You immediately receive your confidential results; no one at your school will have access. Every participant gets a $25 Amazon gift code by email within 30 days of the event.	If your district participates, you will be provided with event information.
Flu Shot Program *Costco* Flu shot clinics are hosted at your school and available to every WABE member and covered family members.	If your district participates, you will be provided with event information.

These programs may not be available to members on the MEC $9000 plan.
Per IRS guidelines, HSA members may need to satisfy a deductible when using these programs.

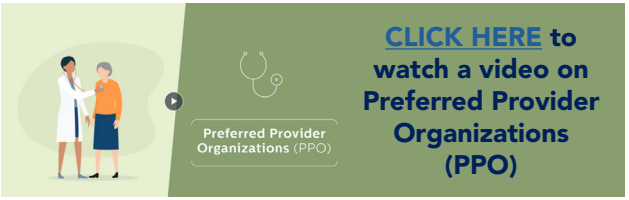
WABE

Plan Benefits

	Anthem						
	80-E $20	80-G $20	80-L $30	80-M $40	HSA $3,400	Platinum	2-Tier MEC $9,000
MEDICAL - CALENDAR YEAR Deductibles & Maximums	**Member Pays**	**Member Pays**	**Member Pays**	**Member Pays**	**Member Pays**	**Member Pays**	**Member Pays**
Individual/Family Deductibles (Ded)	$300/$600	$500/$1,000	$2,000/$4,000	$3,000/$6,000	$3,400/$6,800 (Includes Rx)	$0/$0	$9,000/$18,000 (Includes Rx)
Individual/Family Out-of-Pocket (OOP) Max *(includes medical deductibles, co-insurance and co-pays)*	$1,000/$3,000	$2,000/$4,000	$4,000/$8,000	$4,000/$8,000	$6,000/$12,000 (Includes Rx)	$2,000/$4,000	$9,000/$18,000 (Includes Rx)
PROFESSIONAL SERVICES							
Primary Care* visit co-pay *($0 Copay for 1st 3 cal yr Primary Care OV on Non-HSA PPO plans)*	$20	$20	$30	$40	Deductible, then 10% after Ded	$0	Deductible, then 0% after Ded
Urgent Care co-pay	$20	$20	$30	$40	10% after Ded	$0	0% after Ded
Prenatal, postnatal office visit co-pay	$20	$20	$30	$40	10% after Ded	$0	0% after Ded
Specialists/Consultants co-pay	$20	$20	$30	$40	10% after Ded	$70	0% after Ded
						Non-Hosp/OPH**	
Scans: CT, CAT, MRI, PET etc.	20% after Ded	20% after Ded	20% after Ded	20% after Ded	10% after Ded	$200/$500	0% after Ded
Laboratory Procedures	20% after Ded	20% after Ded	20% after Ded	20% after Ded	10% after Ded	$0/$100	0% after Ded
Diagnostic X-rays	20% after Ded	20% after Ded	20% after Ded	20% after Ded	10% after Ded	$50/$150	0% after Ded
Infertility *(Refer to Plan Document)*	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered
Preventive Care *(includes physical exams & screenings)*	0% after Ded (Ded Waived)	0% after Ded (Ded Waived)	0% after Ded (Ded Waived)	0% after Ded (Ded Waived)	0% after Ded (Ded Waived)	$0	0% after Ded (Ded Waived)

* Primary Care Providers (PCPs) are those without specialty certifications, practicing general pediatrics, internal medicine, family or general practice, or obstetrics and gynecology.

** "non-Hosp" means Labs and Radiology Centers not associated with a hospital system. "OPH" means an outpatient hospital setting



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Plan Benefits (continued)

	Anthem						
	80-E $20	80-G $20	80-L $30	80-M $40	HSA $3,400	Platinum	2-Tier MEC $9,000
HOSPITAL & SKILLED NURSING FACILITY SERVICES							
Emergency Room visit *(copay waived if admitted)* - **Avg Cost: $2,847 | $100+10%: $375 | $100+20%: $649**	20% after Ded $100 co-pay	20% after Ded $100 co-pay	20% after Ded $100 co-pay	20% after Ded $100 co-pay	10% after Ded $100 co-pay	$600	0% after Ded
Inpatient Hospital *(preauthorization required)* - **Avg Cost for one day: $6,067 | 10%: $607 | 20%: $1,213**	20% after Ded	20% after Ded	20% after Ded	20% after Ded	10% after Ded	$400/day	0% after Ded
Surgery, Outpatient *(performed in Surgery Center)*	20% after Ded	20% after Ded	20% after Ded	20% after Ded	10% after Ded	$400	0% after Ded
Surgery, Outpatient *(performed in a Hospital)* - **limits may apply**	20% after Ded	20% after Ded	20% after Ded	20% after Ded	10% after Ded	$1,200	0% after Ded
MENTAL HEALTH & SUBSTANCE ABUSE TREATMENT							
INPATIENT: Facility Based Care *(preauth required)*	20% after Ded	20% after Ded	20% after Ded	20% after Ded	10% after Ded	$400/day	0% after Ded
OUTPATIENT: Facility Based Care *(preauth required)*	20% after Ded	20% after Ded	20% after Ded	20% after Ded	10% after Ded	$0	0% after Ded
OTHER SERVICES							
Ambulance *(Ground or Air)*	20% after Ded $100 co-pay	20% after Ded $100 co-pay	20% after Ded $100 co-pay	20% after Ded $100 co-pay	10% after Ded $100 co-pay	$600	0% after Ded $100 co-pay
Acupuncture - Limits apply	20% after Ded Subject to PA	20% after Ded Subject to PA	20% after Ded Subject to PA	20% after Ded Subject to PA	10% after Ded Subject to PA	$0	0% after Ded Subject to PA
Chiropractic - Limits apply	20% after Ded Subject to PA	20% after Ded Subject to PA	20% after Ded Subject to PA	20% after Ded Subject to PA	10% after Ded Subject to PA	$0	0% after Ded Subject to PA
Physical and Occupational Therapy - Limits apply	20% after Ded	20% after Ded	20% after Ded	20% after Ded	10% after Ded	$0	0% after Ded

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** "non-Hosp" means Labs and Radiology Centers not associated with a hospital system. "OPH" means an outpatient hospital setting

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Plan Benefits (continued)

	Anthem						
	80-E $20	80-G $20	80-L $30	80-M $40	HSA $3,400	Platinum	2-Tier MEC $9,000
Durable Medical Equipment (DME)	20% after Ded	20% after Ded	20% after Ded	20% after Ded	10% after Ded	$0	0% after Ded
Hearing Aids	20% after Ded and Amount in excess of $700 allowance/24 months	20% after Ded and Amount in excess of $700 allowance/24 months	20% after Ded and Amount in excess of $700 allowance/24 months	20% after Ded and Amount in excess of $700 allowance/24 months	10% after Ded and Amount in excess of $700 allowance/24 months	$0 plus the amount in excess of $700 allowance/24 months	Amount in excess of $700 allowance/24 months

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** "non-Hosp" means Labs and Radiology Centers not associated with a hospital system. "OPH" means an outpatient hospital setting

Plan	Rx 7-25	Rx 200/10-35	Rx 200/10-35	Rx 9-35	Rx HSA	Rx 9-35 PC	Rx MEC
PHARMACY BENEFITS							
Pharmacy Benefit Manager	Navitus	Navitus	Navitus	Navitus	Navitus	Navitus	Navitus
Individual/Family Brand & Specialty Rx Deductibles	none	$200/$500	$200/$500	none	Included w/ Medical ded	none	Included w/ Medical ded
Individual/Family Rx Out-of-Pocket *(OOP)* **Max** *(includes Rx deductibles and co-pays)*	$1,500/$2,500	$2,500/$3,500	$2,500/$3,500	$2,500/$3,500	Included w/ Med OOP Max	$2,500/$3,500	Included w/ Med OOP Max
Generic co-pay/30 days supply	$0 at Costco‡ $7 at Other Network	$0 at Costco‡ $10 at Other Network	$0 at Costco‡ $10 at Other Network	$0 at Costco‡ $9 at Other Network	Deductible, then $0 at Costco or $9 at Other Network	$0 at Costco‡ $9 at Other Network	Deductible, then $0 at Costco or $9 at Other Network
Brand co-pay/30 days supply	$25	$35	$35	$35	Deductible, then $35	$35	Deductible, then $35
Specialty co-pay/up to 30 days supply	$25 Must Use Navitus Mail	$35 Must Use Navitus Mail	$35 Must Use Navitus Mail	$35 Must Use Navitus Mail	Deductible, then $35 (Must Use Navitus Mail)	$35 Must Use Navitus Mail	Deductible, then $35 (Must Use Navitus Mail)"
Mail Order *(Generic-Brand co-pay/90 days supply)*	$0-$60‡	$0-$90‡	$0-$90‡	$0-$90‡	Deductible, then $0-$90	$0-$90‡	Deductible, then $0-$90
Mail Order Pharmacy	Costco Mail Order Pharmacy	Costco Mail Order Pharmacy	Costco Mail Order Pharmacy	Costco Mail Order Pharmacy	Costco Mail Order Pharmacy	Costco Mail Order Pharmacy	Costco Mail Order Pharmacy

This comparison displays member cost-share for In-Network services. Out-of-Network services may not be covered. Please refer to the plan documents available through your district for applicable details, limitations, and exclusions. Employee cost/payroll deduction, if applicable, can be requested from the district.

‡ Some narcotic pain and cough medications are not included in the Costco Free Generic or 90-day supply programs.

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SISC Added Value

SISC
Self-Insured Schools of California
Schools Helping Schools

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

BENEFIT HIGHLIGHTS	AVAILABILITY AND HOW TO GET STARTED
24/7 Help with Personal Concerns *SISC Employee Assistance Program* Access free, confidential resources for help with emotional, marital, financial, addiction, legal, or stress issues.	Free to all employees at SISC member districts **Call** 800-999-7222 **Visit** anthemEAP.com and enter SISC
24/7 Virtual Primary Care Doctor *Centivo Care* Virtually connect with a primary care team to manage all of your healthcare needs. Centivo providers diagnose conditions, manage prescriptions, refer to specialists, and answer follow-up questions using video visits or live chat.	Free to Anthem and Blue Shield PPO members **Scan the QR code to download the Centivo Care app, and register for your Centivo Care membership.**
Personal Health Coaching and Therapy *Vida Health* Get access to one-on-one health coaching, therapy, chronic condition management, health trackers and other tools in one convenient smart phone app.	Free to Anthem and Blue Shield members **Call** 855-442-5885 **Visit** vida.com/sisc
24/7 Physician Access—Anytime, Anywhere *MDLive* Access 24/7 virtual urgent care services and appointment-based mental health services (psychiatry and therapy available for ages 10 and up). Physicians can prescribe medication when appropriate.	Anthem and Blue Shield 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. *A deductible may apply to HSA members.*	Anthem and Blue Shield members **Call** 800-774-2678 (press 1) **Visit** costco.com/pharmacy
Virtual Menopause Care *Midi Health* Access virtual visits to address Perimenopause & Menopause symptoms. Expert clinicians can help with treatment plans, prescriptions, & lifestyle changes tailored to individual needs. *A deductible may apply to HSA members* .	Anthem and Blue Shield PPO members standard cost-share applies **Visit** www.joinmidi.com/sisc

Members on HSA & MEC are eligible. Per IRS guidelines, in person services subject to deductible for HSA members.

Cont'd → 1

SISC Added Value (continued)

BENEFIT HIGHLIGHTS	AVAILABILITY AND HOW TO GET STARTED
Expert Medical Opinions *Teladoc Medical Experts* Get answers to healthcare questions and receive advice related to any medical issue or concern. Your case can also be reviewed by world-leading experts who will review your diagnosis and treatment plan to provide a formal expert opinion.	Free to Anthem, Blue Shield, and Kaiser Permanente members **Call** 800-835-2362 **Visit** teladochealth.com/SISC
Physical Therapy for Back or Joint Pain *Hinge Health* Conquer pain, recover from an injury, or reduce joint stiffness with Hinge Health. You'll get personalized exercise therapy, instant feedback, unlimited one-on-one coaching, and a physical therapist all through a convenient smart phone application.	Free to Anthem and Blue Shield PPO members **Call** 855-902-2777 **Visit** hingehealth.com/sisc
24/7 Access to Virtual Maternity and Postpartum Support *Maven* Connect with a care advocate who will guide you through various tools and resources related to pregnancy and postpartum care. Get private visits with gynecologists, specialists, therapists, and 30 other maternity and postpartum provider types.	Free to Anthem and Blue Shield PPO members **Visit** mavenclinic.com/join/SISC
Hip, Knee, and Spine Surgical Benefit *Carrum Health* Consult top-quality surgeons on hip and knee replacements and certain spine surgeries. Benefit covers all related travel and medical bills. *A deductible may apply to HSA members.*	Free to Anthem and Blue Shield PPO members **Call** 888-855-7806 **Visit** info.carrumhealth.com/sisc/
Enhanced Cancer Benefit *Lantern Cancer Care* Get help from a personal oncology nurse who can partner with you on every step of your cancer journey, including a review of your initial diagnosis and development of a care plan.	Free to Anthem and Blue Shield PPO members **Visit** https://lanterncare.com/

Members on HSA & MEC are eligible. Per IRS guidelines, in person services are subject to deductible for HSA members. 2

Employee Assistance Program overview

Everybody needs a helping hand sometimes. That's where your Employee Assistance Program (EAP) comes in. You'll find tools and resources to help you and your household members with everyday issues, big and small. It's available to you 24/7 at no extra cost, and everything you share is confidential.[1] Explore all the support your EAP has to offer.

Counseling

- Access up to 6 visits with a counselor per person, per issue each year[2]
- Choose from in-person or virtual counseling sessions, including text and chat options

Legal resources

- Book a 30-minute phone or in-person consultation with a lawyer for help with legal issues[3]
- Pay a discounted rate if you need continued legal services
- Explore online forms, resources, and seminars to help navigate legal concerns

Financial planning

- Access unlimited phone consultations with a financial professional for help with issues such as retirement, home buying, and debt
- Take charge of your finances with helpful financial tools and calculators

Anthem | SISC Self-Insured Schools of California Schools helping Schools

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SISC Added Value - Anthem EAP (continued)

Identify theft support

- Receive guidance if you're the victim of fraud or identity theft, including help reporting to credit agencies, filling out paperwork, and negotiating with creditors

Work-life resources

- Find guidance on navigating your career, parenting, healthy communication, and balancing work and personal life
- Get help finding high-quality pet, child, and elder care

Online wellness resources

- Access podcasts, articles, videos, and webinars on dozens of topics to help you manage your emotional, mental, and physical well-being

Crisis support

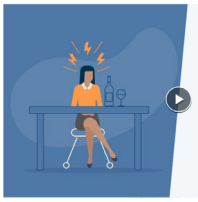
- Call the 24/7 hotline or get online support with planning, coping, and recovery if you're impacted by a tragedy

Emotional Well-being Resources

- Connect to one-on-one coaching and digital self-help tools

Your EAP is here for you

Call us at **800-999-7222**, or go to **www.anthemeap.com/sisc.**



CLICK HERE to watch a video on Employee Assistance Programs

1 In accordance with federal and state law, and professional ethical standards.
2 Appointments are subject to the availability of a therapist.
3 Excludes business, benefits, or employment issues. The free half-hour consultations apply per legal issue, per year. You are eligible for a new consultation for each new issue yearly. If you have Anthem health coverage, your cost for a visit may be similar to what you would pay for an office therapy visit, depending on your benefits, copay, or percentage of the cost. If you're not covered by an Anthem plan, you'll be responsible for paying the full cost for a visit.

Online counseling is not appropriate for all kinds of issues. If you are in crisis or have suicidal thoughts, it's important that you seek help immediately. Please call 988 to reach the 24/7 confidential 988 Suicide & Crisis Lifeline or go to 988lifeline.org. If your issue is an emergency, call 911 or go to your nearest emergency room.

In addition to using a telehealth service, you can receive in-person or virtual care from your own doctor or another healthcare provider in your plan's network. If you receive care from a doctor or healthcare provider not in your plan's network, your share of the costs may be higher. You may also receive a bill for any charges not covered by your health plan.

SISC Added Value - Centivo Care

SISC
Self-Insured Schools of California
Schools Helping Schools

Need a primary care doctor?

Just ask Centivo Care.

As part of your PPO medical benefits from SISC, you and your enrolled adult dependents (18+) have access to free primary care through Centivo Care. We can address health concerns, assist with prescriptions, diagnose and manage chronic conditions and so much more – all from the palm of your hand.

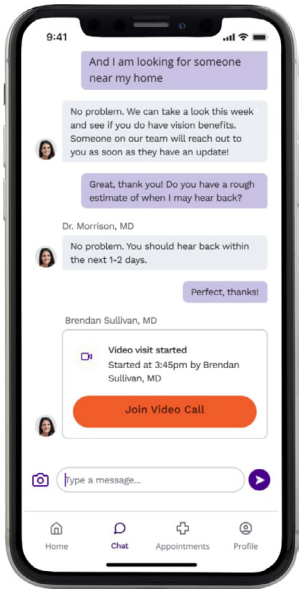
The answer to most of your health questions is now simple: "Just ask Centivo Care."

CARE FROM ANYWHERE

Chat with your doctor live or schedule a video visit

Diagnoses and treatments

Prescription refills



Answers to follow-up care questions

In-network specialist referrals

It's never been easier to stay on top of your health:

96% patient satisfaction	In-app appointment booking	Quick in-app responses from a team of clinicians

CENTIVO Care.

Scan the QR code to register and start accessing great care today

SISC Added Value - Vida Health

Vida Health – your free health benefit through SISC – will match you with a health coach or therapist who will help you manage diabetes, lose weight, feel less stressed, and make lifestyle changes that lead to a happier, healthier life.

Vida will help you get healthier. That's why SISC will cover the cost for you.

With Vida, you'll get a virtual coach or therapist to help you with things like:

- Losing weight
- Managing and preventing diabetes
- Lowering blood pressure or cholesterol
- Getting more exercise
- Reducing stress
- Feeling better and healthier overall

Explore your new benefit now

Visit vida.com/SISC to learn more about Vida. For help signing up, email support@vida.com.

Meet Karen

Because of Vida, I've lowered my blood sugar and my cholesterol. More importantly, I feel better. I have less pain, more energy, and a better relationship with food. I found exercise that I love and made changes that I know will last. Vida has changed my life for the better, perhaps even saved my life.

Anthem and Blue Shield PPO, HSA, and HMO members over the age of 18 (Excluding 65+ Plans) are eligible for Vida Health.

SISC Added Value - MDLIVE

MDLIVE

SISC
Self-Insured Schools of California
Schools Helping Schools

Need a doctor? No long wait. Now $0 copay Always open.

With MDLIVE, you can visit with a doctor 24/7 from your home, office or on-the-go.

Welcome to MDLIVE! Your anytime, anywhere doctor's office.

Visit a doctor by phone, secure video, or MDLIVE App. Pediatricians are available 24/7, and family members are also eligible. Behavioral health and psychiatric visits are available from the convenience of your own home.

Your COPAY is $0

Your copay is $0 for all visits starting October 2025

U.S. board-certified doctors with an average of 15 years of experience.

Consultations are convenient, private and secure.

Prescriptions can be sent to your nearest pharmacy, if medically necessary.

We treat over 50 routine medical conditions including:

- Acne
- Allergies
- Cold / Flu
- Constipation
- Cough
- Diarrhea
- Ear Problems
- Fever
- Headache
- Insect Bites
- Nausea / Vomiting
- Pink Eye
- Rash
- Respiratory Problems
- Sore Throats
- Urinary Problems / UTI
- Vaginitis
- And More

Download the app.
Join for free. Visit a doctor.

MDLIVE.com/sisc
1-800-657-6169

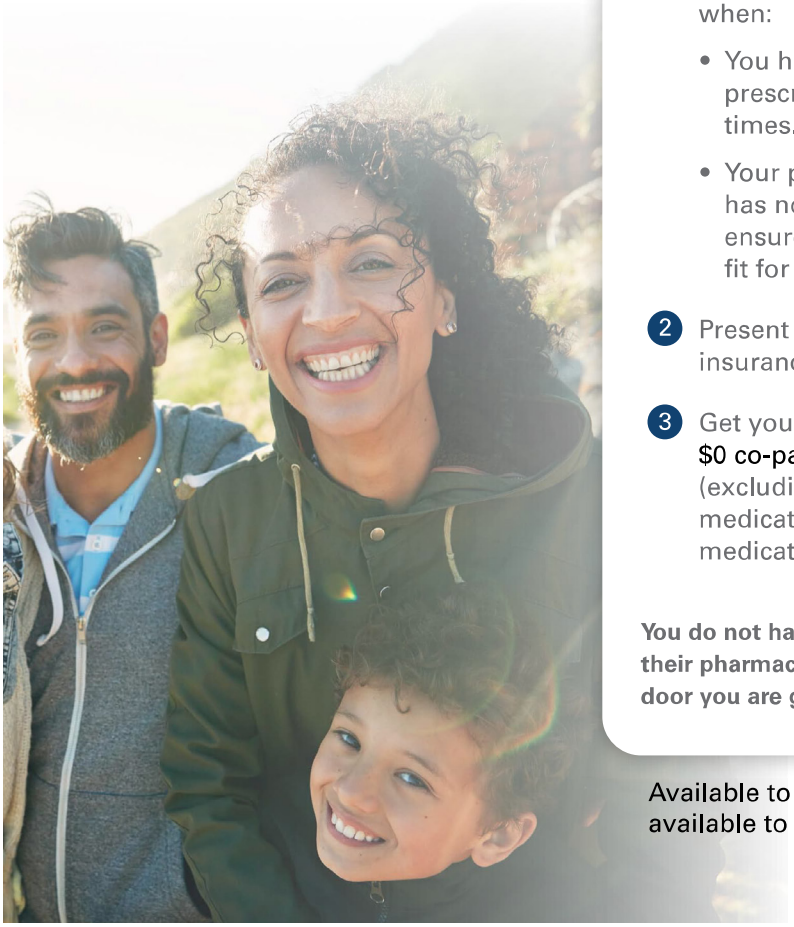
SISC Added Value - Costco Pharmacy

SISC
Self-Insured Schools of California
Schools Helping Schools

Get Free Generic Medications at Costco and Through Mail Order

This program is available to SISC members on participating drug plans.

To locate a Costco near you, call Costco at 1 (800) 774-2678 and press 1.



1. Take your prescription for a generic medication to a Costco Pharmacy. This includes 90-day prescriptions and supplies.

   You can also use your 90-day prescription to start Mail Order service.

   You are eligible for Costco Mail Order when:

   - You have filled your 30-day prescription a minimum of three times.
   - Your prescription, including dosage, has not changed in 90 days. This ensures the drug and dosage is a good fit for a longer-day supply.

2. Present the pharmacist with your insurance card.

3. Get your generic medication with a $0 co-payment. (excluding some narcotic pain medications and some cough medications).

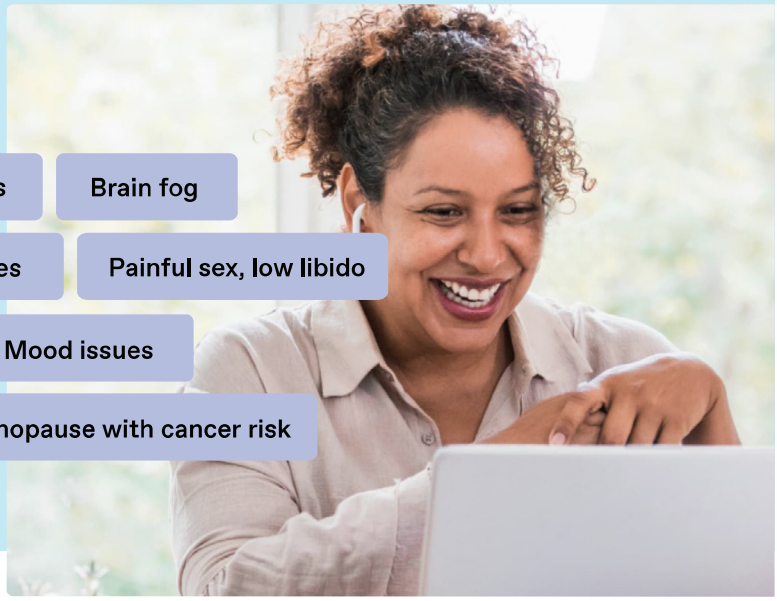
You do not have to be a Costco member to use their pharmacy. Just tell the associate at the front door you are going to their pharmacy.

Available to SISC PPO and HMO Members. Not available to Kaiser Members.

SISC Added Value - Midi Health

SISC Self-Insured Schools of California
Schools Helping Schools
+ MIDI

Get expert menopause telehealth care, covered by insurance.



- Trouble sleeping
- Weight changes
- Brain fog
- Hair & skin changes
- Hot flashes
- Painful sex, low libido
- Period Problems
- Bone Loss
- Mood issues
- Menopause after cancer
- Menopause with cancer risk

Discover real relief

Hormonal changes in midlife can bring on a host of symptoms that are often misunderstood. Midi's expert clinicians can help you find safe, effective solutions.

Midi connects you to expert clinicians via virtual visits. After discussing your symptoms and health history, they help you get any necessary lab tests and create a personalized Care Plan.

Your regimen may include:*

- FDA-approved hormonal medications
- Non-hormonal medications
- Supplements and botanicals
- Lifestyle coaching
- Wellness therapies

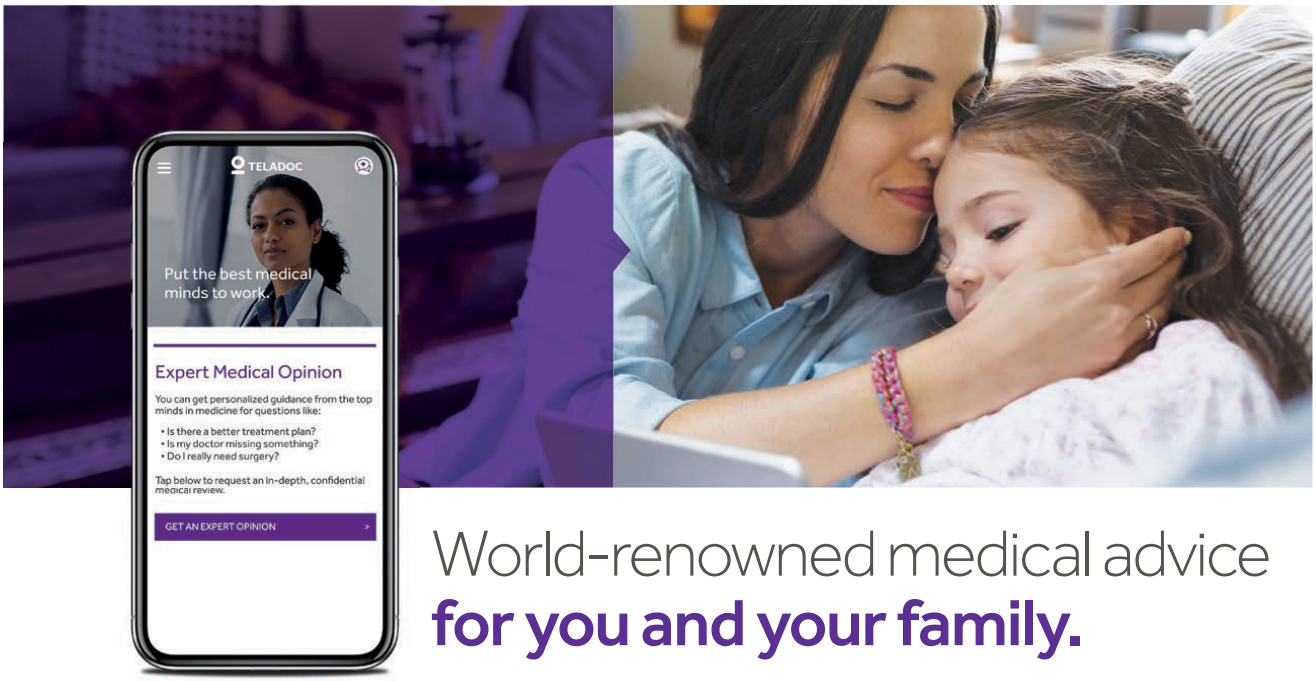
*Coverage for treatment options, including prescriptions, is determined by SISC pharmacy benefits and may vary by plan.

SISC is proud to offer Midi Health's virtual menopause care benefit to eligible employees and their partners/dependents covered under Anthem Blue Cross and Blue Shield of CA PPO Plans. Standard cost-sharing applies.

Start your Midi journey at joinmidi.com/sisc

SISC Added Value - Teladoc Health

TELADOC Medical Experts | SISC Self-Insured Schools of California Schools Helping Schools



World-renowned medical advice **for you and your family.**

If you or a dependent is facing a serious medical issue, make sure you get the right advice.

With Teladoc, you can:

- Have a world-renowned physician review a diagnosis and treatment plan
- Get expert medical guidance if you have been admitted into the hospital
- Get personalized answers to medical questions, big or small
- Find a leading local physician for you and your family

Get the answers you need from our Medical Experts.
Call us to get started: 1-855-380-7828

Visit www.teladochealth.com/sisc | Download the app

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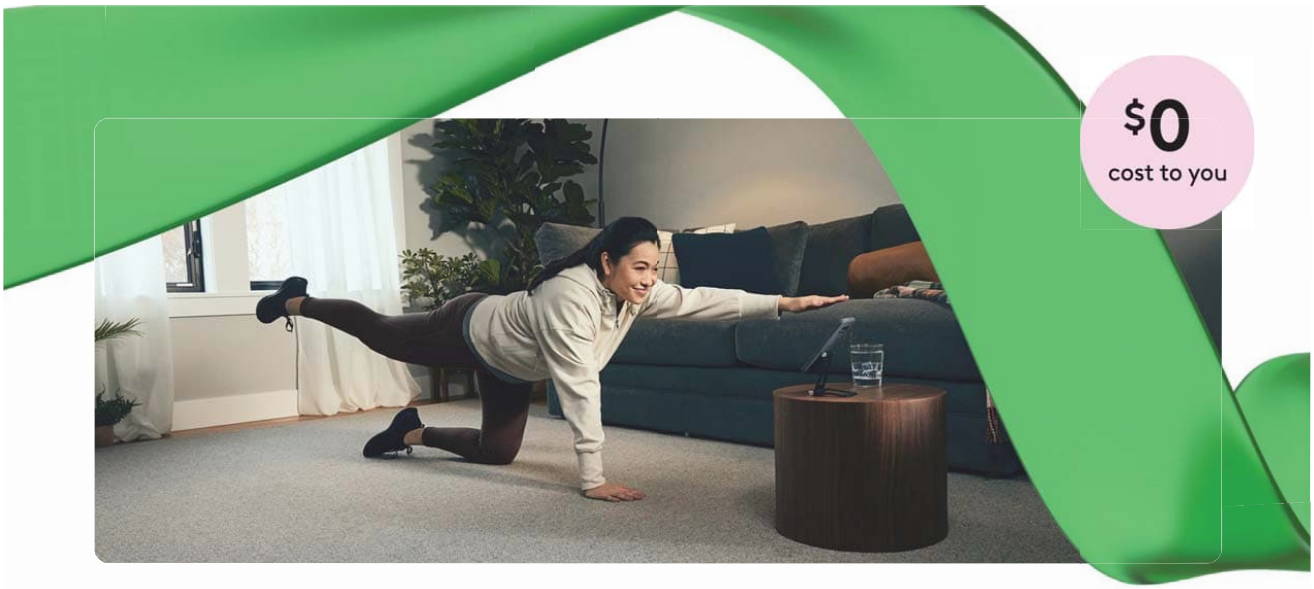
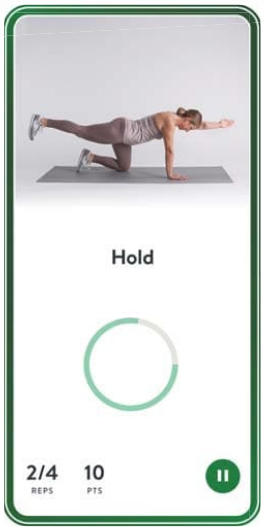
SISC Added Value - Hinge Health



SISC | Hinge Health

Personalized pain care that gets you moving



Relieve joint and muscle pain with personalized exercise therapy **at no cost to you**. On average, participants reduce their pain by 68%.[1]

- **Virtual sessions anytime, anywhere**
- **Unlimited 1-on-1 health coaching**
- **Motion-tracking technology for instant form correction**
- **Pelvic floor care for pregnancy and postpartum, bladder control, and pelvic muscle strengthening**

Your family may be eligible, too!

To learn more and apply, scan the QR code or visit
hinge.health/sisc

Questions? Call (855) 902-2777

Hinge Health está disponible en español
Alivia los dolores articulares y musculares y previene las lesiones con tus beneficios de salud gratuitos. Únete ahora.

Available for free to employees, dependents 18+, and pre-65 retirees enrolled in an Anthem PPO or Blue Shield PPO medical plan with SISC as their primary insurance.

[1]After 12 weeks, in a study of chronic knee and back program participants. Bailey JF, et al. Digital Care for Chronic Musculoskeletal Pain: 10,000 Participant Longitudinal Cohort Study. J Med Internet Res 2020;22(5):e18250.

SISC Added Value - Maven

Virtual care designed for you and your family

SISC is providing PPO members and their partners with free access to Maven for maternity and postpartum virtual care and support. Use Maven for 24/7 access to doctors, specialists and coaches and trustworthy content tailored to your experience.

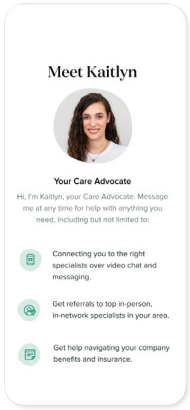
Personalized support for every step of your journey:

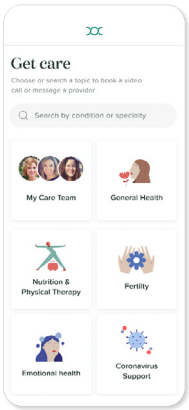
- Pregnancy
- Postpartum
- Pediatricians
- Infant sleep coaching
- Lactation support
- Return-to-work coaching
- Miscarriage & loss
- Birth planning
- Mental health
- Partner support

Your membership includes:

- A personal Care Advocate who serves as a trusted guide to help you navigate the Maven platform and connect you with providers throughout your journey
- Unlimited video chat and messaging with doctors, nurses, and coaches across 35+ specialties, including OB-GYNs, midwives, high-risk obstetricians, nutritionists, lactation consultants, and career coaches
- Provider-led virtual classes and vetted articles—tailored to your journey

Free diaper subscription from SISC if you enroll before the end of your second trimester and complete the Maven Maternity program!





Activate your free membership by scanning the QR code, downloading the Maven Clinic app, or visiting **mavenclinic.com/join/SISC**.

Enrollment in Maven is confidential.

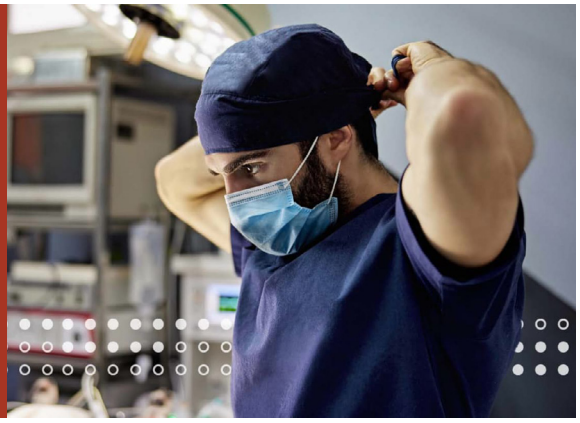
MAVEN | SISC Self-Insured Schools of California *Schools Helping Schools*

SISC Added Value - Carrum Health

carrumhealth

SISC
Self-Insured Schools of California
Schools Helping Schools

Putting off surgery? There's something you should know.



During the early days of the pandemic, many hospitals had to pause elective surgeries due to COVID.

Today, COVID continues to challenge hospitals, now faced with staffing issues. Patients rescheduling tests and procedures ***have led to extremely long wait times for surgery.*** To beat this backlog and avoid the consequences of waiting, start the process as soon as possible.

If you're ready to prioritize your health, we can't wait to help. Carrum Health is a surgery and medical benefit that provides you and your eligible family members access to some of the top surgeons in the country at little to no cost.*

Sometimes surgery may not be the best answer. If you or your eligible family member has received a recommendation for surgery, this benefit provides a free second opinion from one of the top surgeons in the country. Many consultations can even be conducted virtually.

Get started today to beat the backlog and get the medical care you deserve.

An unmatched healthcare experience

Better care
The doctors in our program achieve better outcomes and have 80% fewer readmissions.

Costs are covered
When you get surgery through Carrum, your company covers most, if not all, of the medical costs.*

Dedicated support
Our team takes care of all the planning and paperwork, so you can focus on your health.

Ready to get started?

Visit: carrum.me/sisc

QR CODE

**Carrum Health is a special surgery benefit for SISC members, early retirees (pre-65), COBRA participants, and dependents who are enrolled in an Anthem Blue Cross or Blue Shield PPO plan.*

Due to IRS regulations, members on an HSA plan must pay their deductible, but coinsurance is waived. Per IRS rules, a portion of any covered travel expenses will be reported as taxable income.

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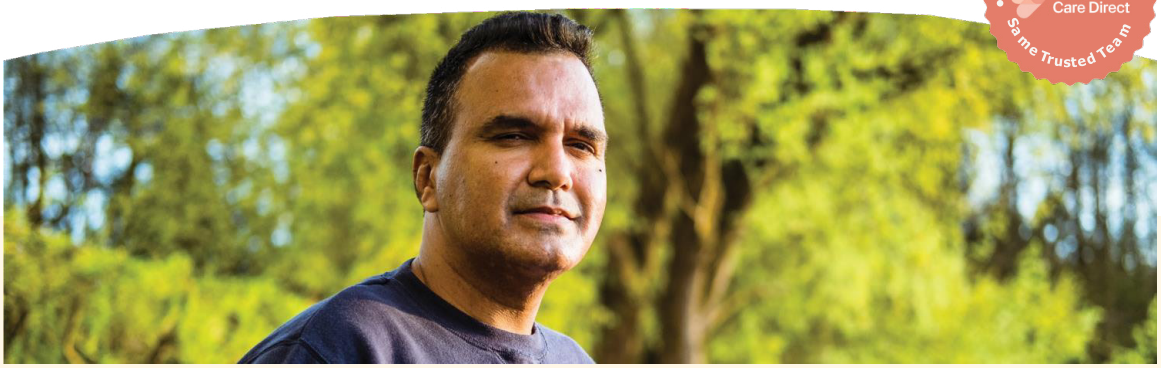
SISC Added Value - Lantern Cancer Care

LANTERN

SISC
Self-Insured Schools of California
Schools Helping Schools

Formerly Known As Cancer Care Direct Same Trusted Team



If You Ever Need Cancer Care, We're Here to Light Your Path

Lantern provides personalized guidance and support throughout the cancer journey. Our expert support team will help you or a loved one navigate the path ahead, connecting you with the best providers while coordinating care along the way.

An Experience with You at the Center

We're here to answer your questions and ensure that you understand the path ahead and that you have confidence in your team and treatment plan. We put the patient and their loved ones at the center of care, as we believe that a better more compassionate experience leads to better outcomes.

Call Us to Learn More at (855) 961-4533

Email: guide@lanterncare.com

Visit Lantern Today.
You can chat with nurses, track appointments and symptoms, and more.

The Lantern Difference

1. **Guided Support**
   Your personal Oncology Nurse Navigator-led team will be with you every step of the journey, coordinating appointments, explaining treatment information, and answering questions.
2. **Accessing Excellent Care**
   We connect you with the best in-network community oncology clinics, hospitals, and National Cancer Institutes for high-quality care as close to home as possible.
3. **Expert Review & Advice**
   Our team will assist in coordinating the expert review of members' diagnoses and treatment plans, recommending second opinions and referrals as needed.

"Because my Oncology Nurse Navigator was able to get appointments within two weeks instead of waiting months and months, I was quickly enrolled into a treatment plan that has me on a path to recovery."

— Craig, Cancer Survivor and Lantern Member

LANTERN

SISC
Self-Insured Schools of California
Schools Helping Schools

Formerly Known As Cancer Care Direct Same Trusted Team

Frequently Asked Questions

Who can benefit from Lantern?

Lantern can help if you or a member of your family has been diagnosed with cancer. It's included as part of your medical benefits through <Client> at no extra cost to you.

I was diagnosed with cancer. What should I do to get started with Lantern?

Reach out to us as soon as you can—our team is only a phone call away and ready to help. Call Lantern at (855) 204-3923. We have Oncology Nurse Navigators and Care Guides available to help Monday through Friday, between 8 a.m. and 5 p.m. CT. You can also email us at guide@lanterncare.com.

I'm already getting cancer treatment. Can Lantern still help?

Yes. We provide guidance and support to our members at any point in their cancer journey, from initial diagnosis to remission. Call our team to see how we can help you.

I've already completed treatment, and I'm in remission. Can you still help me?

Yes. We're here to help you through survivorship. Our team can help you with continued screenings, guidelines, managing treatment late effects and more. We're also here to help you transition back into your daily life after cancer.

What will it cost me to use Lantern?

Lantern doesn't cost you anything. It's included as part of your <Client> medical benefits. You won't be billed for using Lantern.

Can Lantern help get treatment approved for me?

Yes. As your advocates, we work with your doctors and insurance to help get approvals for your treatment.

What do the Lantern Oncology Nurse Navigators and Care Guides do?

Our Oncology Nurse Navigators are experts in the field. They provide timely clinical guidance, coordinate care, facilitate expert advisory support and offer social and emotional support when you need it. Our Care Guides work with our nurses to coordinate any travel and appointments, request medical records and get answers to your questions. They help you handle the details, so you can focus on your health.

Will Lantern help cover the cost of my treatment or surgery?

No. Lantern does not cover the cost of surgeries or treatments. That will still be provided through your medical insurance. Lantern may be able to help with travel costs to and from appointments for your cancer diagnosis. Your team can also connect you with resources in your community that can provide financial help.

I like my oncologist. Do I have to switch doctors to use Lantern?

No. You can stay with your current oncologist and still get help from Lantern. But if you need to find an oncologist or want a second opinion, we can assist with finding a doctor and scheduling your appointments.

What happens if my insurance changes?

If your new insurance doesn't include Lantern as a benefit, our team will work with you to find resources and support in your community as you transition onto your new insurance plan. Our goal is to help you have a seamless transition if it's needed.

If your new insurance includes Lantern as a benefit, you can continue working with your team. If your new insurance doesn't provide Lantern, talk to your human resources department about adding it to your coverage.

Call us to learn more at:

(855) 961-4533

Visit Lantern Today.

You can chat with nurses, track appointments and symptoms, and more.

In the event of a medical emergency, call 911 or visit your nearest emergency room.

Anthem Discounts

Save money with discounts at anthem.com/ca

Saving money is good. Saving money on things that are good for you — that's even better. With SpecialOffers, you can get discounts on products and services that help promote better health and well-being.* It's just one of the perks of being an Anthem member. Check out how much you can save:

Vision, hearing and dental

Glasses.com™ and 1-800-CONTACTS® — Get the latest brand-name frames for just a fraction of the cost at typical retailers — every day. Plus, you get an additional $20 off orders of $100 or more, free shipping and free returns.

EyeMed — Get 30% off a new pair of glasses, 20% off non-prescription sunglasses and 20% off all eyewear accessories.

Premier LASIK — Save $800 on LASIK when you choose any 'featured' Premier LASIK Network provider. Save 15% with all other in-network providers.

TruVision — Save up to 40% on LASIK eye surgery at more than 1,000 locations (over 6.5 million procedures performed in the network).

Nations Hearing — Get hearing screenings and in-home service at no additional cost. All hearing aids start at $599 each, powered by the Beltone network.

Hearing Care Solutions — Digital instruments start at $500. Plus, get a free hearing exam. Hearing Care Solutions has 3,100 locations and eight manufacturers, and offers a three-year warranty, two years of batteries and unlimited visits for one year.

Amplifon — Get 25% off, plus an extra $50 off one hearing aid; $125 off two.

ProClear™ Aligners — Get $1,200 off a set of custom aligners. Improving your smile shouldn't cost a fortune. Now you can get a beautiful, professional smile in the comfort of your own home — all at a 50% savings. No metal braces; no time-consuming dentist visits; no hidden fees. Order now and get a free whitening kit, along with your great-looking smile.

Anthem

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Check out more SpecialOffers on the other side.

Anthem Discounts (continued)

SpecialOffers on anthem.com/ca

Fitness and health

Active&Fit Direct™ — Active&Fit Direct allows you to choose from more than 9,000 participating fitness centers nationwide for $25 a month (plus a $25 enrollment fee and applicable taxes). Offered through American Specialty Health Fitness, Inc.

FitBit — Get fit your way with Fitbit trackers and smartwatches that fit with your lifestyle, budget and goals. Save up to 22% on select Fitbit devices.

Garmin — Get 25% off select Garmin wellness devices.

Jenny Craig — Take advantage of a free, three-month program (food not included) plus $120 in food savings (purchase required), or save 50% off premium programs (food cost separate).

ChooseHealthy — Get discounts on acupuncture, chiropractic, massage and fitness clubs.

Global Fit — Get discounts on gym memberships, fitness equipment, coaching and more.

Family and home

23andMe — Get $40 off each Health + Ancestry kit. Your DNA says a lot about you. Save 20% on a 23andMe kit and learn about your wellness, ancestry and more.

Safe Beginnings® — Babyproof your home while saving 15% on everything from safety gates to outlet covers.

Nationwide Pet Insurance — Receive an automatic 5% discount when you enroll through your company or organization. Save up to 15% when you enroll multiple pets.

ASPCA Pet Insurance — Get 5% off pet insurance. You can choose from three levels of care, including flexible deductibles and custom reimbursements.

WINFertility® — Save up to 40% on infertility treatment. WINFertility helps make quality treatment affordable.

LifeMart® — Get great deals on beauty and skin care, diet plans, fitness club memberships and plans, personal care, spa services and yoga classes, sports gear and vision care.

Medicine and treatment

SelfHelpWorks — Choose one of the online Living programs and save 15% on coaching to help you lose weight, stop smoking, manage stress or diabetes, restore sound sleep or face an alcohol problem.

Brevena — Enjoy a 41% discount on BREVENA® skin care creams and balms for smooth, rejuvenated skin from face to foot.

Puritan's Pride — Choose from a large selection of discounted vitamins, minerals and supplements from Puritan's Pride.

Allergy Control Products — Save 20% on select doctor-recommended products such as allergy friendly bedding, air purifiers and filters, asthma products and more. Plus enjoy free shipping on all orders over $79 when shipping ground within the contiguous U.S.

National Allergy® supply — Save 20% on select National Allergy® Doctor Recommended Products.

- Allergy bedding
- Air purifiers and filters
- Home allergy products
- Personal care
- Humidifiers and dehumidifiers
- Vacuums and steam cleaners

To find the discounts that are available to you, log in to **anthem.com/ca** and select **Discounts**.

* All discounts are subject to change without notice.

Anthem Sydney Health App

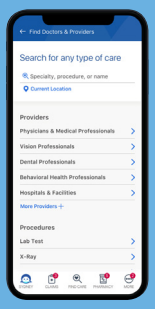
Connect with the care that's right for you

The Find Care tool helps you search for doctors/dentists and compare costs

Choosing a provider you trust is important — and choosing one in your plan's network can help keep your costs down. Finding high-quality, cost-effective care is simple when you use the Find Care tool on the Sydney Health mobile app or **anthem.com/ca.**

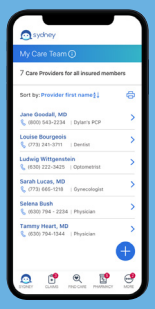
How to use Find Care

The Find Care tool brings together details about doctors, dentists, hospitals, labs, and healthcare facilities in your plan's network. You can easily compare information such as costs, location, and office hours. You can:



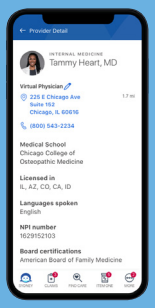
1

Search for providers and facilities in your plan's network by name, specialty, or procedure.



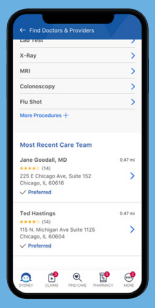
2

Customize the list of providers you see in your search based on factors that are most important to you, such as languages spoken, affiliated hospitals, and location.



3

Review details about doctors/ dentists such as their specialties, gender, educational background, and contact information.



4

Choose a doctor/ dentist from the list to review their patient ratings and compare costs for services.

Choose with confidence

You can start using **Find Care** by downloading the Sydney Health app to your mobile device or logging in to **anthem.com/ca.** Select **Find Care** and the Find Care tool will guide you through the steps.

We're ready to help you

The Find Care tool empowers you to take control of your healthcare by helping you connect with high-quality care options. If you have questions, you can reach us using the interactive chat feature on the Sydney Health app or through the Message Center on **anthem.com/ca.**

Download Sydney Health today to find a provider that's right for you

Use your smartphone camera to scan this QR code.

Anthem

SISC
Self-Insured Schools of California
Schools Helping Schools

Anthem Transition Assistance FAQ

Continuity/Transition of Care FAQ

Anthem

What is Continuity/Transition of Care?

It's a benefit that allows Anthem Blue Cross members to obtain ongoing care for those who are newly enrolling, when their treating doctors aren't in Anthem's provider network or when their provider is no longer part of our network. (Members with an Individual contract aren't eligible except when their prior health benefit plan withdraws from the market.)

How does it work?

Anthem helps eligible members (and their covered dependents) get ongoing care until their treatment is finished or until another network doctor takes it over. Time allowance is reviewed on case by case basis.

Who's eligible for transition of care/ continuity of care?

Members may be eligible if:

- Your primary medical group (PMG), independent physician association (IPA), preferred provider organization (PPO) provider, hospital or other provider leaves or is terminated from your health plan. That's called continuity of care.
- You're a newly covered member to Anthem Blue Cross and the doctor or other provider for that treatment was part of your previous plan, but is not part of your new Anthem Blue Cross plan. That's called transition of care.
- There are other reasons that you have no control over, which put the continuity of your care at risk. (So, members who change their coverage and go outside the network aren't eligible for the program.)

Who is not eligible?

- Members coming from an Individual contract except when their prior health benefit plan withdraws from the market.
- Members who choose to leave a plan that isn't changing and that still contracts with their provider (for example, a member who chooses to change plans or carriers at open enrollment when their employer is not making a change to their plan offerings).
- New enrollees being treated for non-acute or chronic clinical conditions usually aren't eligible for coverage of treatment by non-network providers. New enrollees with chronic conditions and who need help choosing a doctor for ongoing care, should contact our Member Services.
- Members where provider and/or facility has declined the reimbursement rate offered to cover services (member would be balanced billed for charges above max allowed amount under plan).

What kinds of treatment qualify for Continuity/ Transition of Care?

Some conditions that may be eligible for Continuity/ Transition of Care:

- An acute condition. A medical or behavioral health condition that involves a sudden onset of symptoms due to an illness or injury — or one that requires prompt medical attention (but for a limited time). You can likely complete the covered services for the duration of the acute condition.
- Serious chronic condition. A medical or behavioral health condition due to a disease, illness or other medical or behavioral health problem or disorder that is serious and continues without a cure, worsens over time or requires ongoing treatment to keep it in remission or from getting even worse. You can often complete covered services for a period of time for a course of treatment — and to arrange for a safe transfer to another provider, as we determine by consulting with you and your provider and consistent with good professional practice.
- Pregnancy. You can complete covered services for the three trimesters of your pregnancy and the immediate post-partum period.
- Terminal illness. An incurable or irreversible condition that has a high probability of causing death within one year or less. You can complete covered services, even if the duration of the terminal illness goes longer than 12 months from the contract termination date or from the effective date of coverage for a new enrollee.
- Care of a newborn child between birth and 36 months old. Completion of covered services may be considered for a limited period of time, not to exceed 12 months from the contract termination date or 12 months from the effective date of coverage.
- Surgery or other procedure that has been authorized by the previous plan or its delegated provider and is scheduled to occur within 180 days of the contract's termination date or within 180 days of the effective date of coverage for a newly covered enrollee.

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Anthem Transition Assistance FAQ (continued)

Anthem

I just found out my employer is changing health plans and I have a scheduled surgery at a hospital that isn't in the Anthem network. What do I do?

You may be eligible for transition of care. Call Customer Service or fill out the *Continuity/Transition of Care Request Form Request Form* (see below).

What if I have a chronic condition?

If you need ongoing care for a chronic condition and you're not in an acute phase of your illness needing special treatment, you should select a provider from our network. If you do, you don't need to submit the *Continuity/Transition of Care Request Form Request Form*. If you need help choosing a new provider, please call Member Services.

How do I apply? Where do I get my form?

Prior to the first date of treatment or service that is planned after provider's termination date with Anthem, please call the Member Services (Toll number located on the back of your ID card) and they will assist you in completing a *Continuity/Transition of Care Request Form*. Or, if your employer provides you with a paper *Continuity/Transition of Care Request Form*, you can complete it and fax it to the number on the form.

Requests will be processed as soon as the new membership data is loaded into the Anthem Blue Cross system.

What happens after I've sent in my request?

For members, we confirm that we've received their request form by calling them. Our decision to approve or deny the request will happen no later than two business days from when we get all the information needed to make a decision.

How will I know if my request is approved?

When it's approved, we'll call you and send you a letter. Approval means that Anthem and your doctor have agreed to a transition care plan (and a reimbursement rate). You'll only have to pay for any participating deductible, coinsurance or copays that apply.

What if I need approval sooner than five days?

Urgent requests will be decided within two business days when we have all information received to make a decision. You will be notified of the decision by phone. Please note that delays can happen while attempting to work with your provider. If this occurs, we will notify you. To help expedite requests, notify your provider that you will be asking for a *Continuity/Transition of Care approval* from Anthem Blue Cross to continue care for a period of time.

What if the non-network provider doesn't accept Anthem's reimbursement rate for Continuity/Transition of Care and I still want to utilize that provider?

- If you're an HMO or EPO member, you'll have to pay for the full cost of treatment.
- If you're a PPO member, the provider would be considered out-of-network and you may have significant out-of-pocket costs.

What if I don't want to change my doctor, but I don't qualify for Continuity/Transition of Care?

You can still see the non-network doctor you have now, but you'll have higher copays and deductible. It may mean you have to pay the full cost of your doctor's services.

What if I have a Point-of-Service (POS) plan?

If your provider is in Anthem's provider network, you don't need Continuity/Transition of Care. (You have the option to go to a PPO contracted provider outside your HMO network under your POS benefit.) If your provider is not in Anthem's HMO or PPO network, you may be eligible for the benefit and should apply for it.

What if I have more questions?

For more information, please call the Customer Service number on the back of your ID card.

Dental

When it comes to choosing a dental plan, you want benefits that fit the needs of you and your family. Delta PPO offers comprehensive dental coverage, quality care, and excellent customer service.

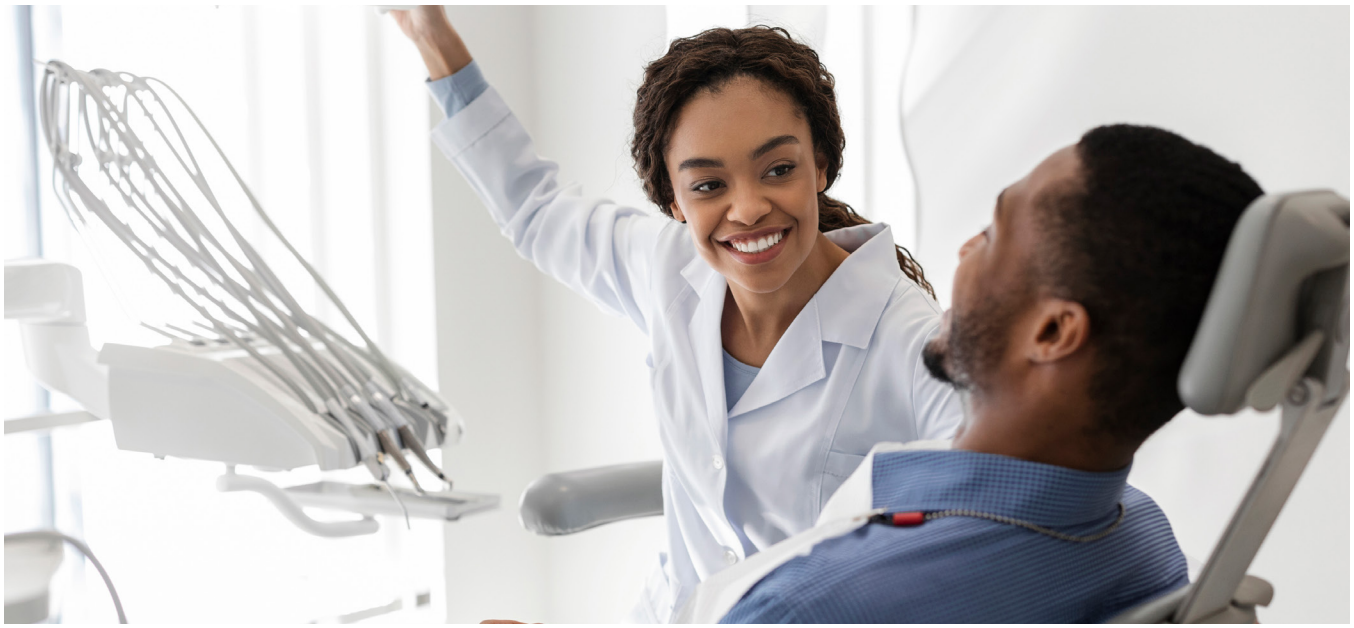
Delta Dental

Delta Dental, our preferred provider organization (PPO) plan, provides access to the largest PPO dentist network in the U.S. Delta Dental dentists agree to accept reduced fees for covered procedures when treating PPO patients. This means your out-of-pocket costs are usually lower when you visit a PPO dentist than when you visit a non-Delta Dental dentist, but you have the freedom to visit any licensed dentist, anywhere in the world.

San Luis Obispo County Community College District offers four comprehensive dental plans for eligible employees through Delta Dental. There is a two-year enrollment commitment; you will not be allowed to cancel coverage until you have been on the plan for two years. If you do cancel your coverage, you will not be allowed to re-enroll for two years.

Benefits and Covered Services*	Benefit Highlights – Delta Dental PPO			
	Plan A	Plan B	Plan C	Plan D
Who is Eligible	Primary enrollee, spouse/domestic partner and eligible dependent children to age 26			
Deductible Waived for Diagnostic and Preventive	Yes	Yes	Yes	Yes
Annual Maximum Benefit				
• In-Network *(Calendar year per person)*	$1,900	$2,500	$2,900	$3,500
• Out-of-Network *(Calendar year per person)*	$1,700	$2,300	$2,700	$3,300
Waiting Period(s)				
• Basic Benefits	None	None	None	None
• Crown and Casts	None	None	None	None
• Orthodontist	None	None	None	None

* Limitations or waiting periods may apply for some benefits; some services may be excluded. Please refer to your Evidence of Coverage or Summary Plan Description for waiting periods and a list of benefit limitations and exclusions.



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

Dental (continued)

Benefits and Covered Services*	Benefit Highlights – Delta Dental PPO							
	Plan A		Plan B		Plan C		Plan D	
	Delta Dental PPO Dentist**	Non-Delta Dental Dentist	Delta Dental PPO Dentist**	Non-Delta Dental Dentist	Delta Dental PPO Dentist**	Non-Delta Dental Dentist	Delta Dental PPO Dentist**	Non-Delta Dental Dentist
Diagnostic and Preventive Benefits *(Oral Exams, [2] Routine Cleanings, X-Rays, Fluoride Treatment, Space Maintainers, Specialist Consultations)*	100%	100%	100%	100%	100%	100%	100%	100%
Basic Benefits *(Fillings, Root Canals, Periodontics [Gum Treatment], Tissue Removal [Biopsy], Oral Surgery [Extractions])*	100%	100%	100%	100%	100%	100%	100%	100%
Crowns, Other Cast Restorations *(Crowns, Inlays, Onlays and Cast Restorations)*	80%	80%	80%	80%	100%	100%	100%	100%
Prosthodontics *(Bridges, Partial Dentures, Full Dentures)*	80%	80%	80%	80%	80%	80%	80%	80%
Orthodontics *(Dependent Children)*	50% Subject to a $500 calendar year maximum per person		50% Subject to a $1,000 calendar year maximum per person		50% Subject to a $500 calendar year maximum per person		50% Subject to a $1,000 calendar year maximum per person	

* Limitations or waiting periods may apply for some benefits; some services may be excluded. Please refer to your Evidence of Coverage or Summary Plan Description for waiting periods and a list of benefit limitations and exclusions.

** Fees are based on maximum plan allowance (MPA) for in-network dentists and the MPA for out-of-network dentists. Reimbursement is paid on Delta Dental contract allowances and not necessarily each dentist's actual fees.

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DELTA DENTAL

Savings to smile about

Support a healthy lifestyle with LifePerks

Wellness is more than oral health

That's why, 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.

How do I get the discounts?

Register and learn more about LifePerks today. After registering for LifePerks, visit the online platform or take advantage of the members-only deals periodically emailed to you.

Special offers	
Oral health	Discounts to help keep your oral health on track
Health & wellness	Access whole body health deals on nutrition, fitness equipment and gym memberships
Lifestyle	Save big on childcare, groceries, home services, pet insurance and financial and auto services
Travel & entertainment	Keep the whole family entertained with discounted access to movie theaters, theme parks, vacation planning and travel services
Customer service	24/7 email **customer support**

Register and learn more about LifePerks today.

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

LifePerksML.lifemart.com

DELTA DENTAL®

Plan Ahead with the Cost Estimator

Get an estimate of dental costs in your area

Planning on a major procedure? Don't get surprised by the bill! Receive a cost estimate beforehand to know what to expect.

Advantages

- **Local.** Enter your ZIP code to receive an estimate based on prices in your area.
- **Comprehensive**. Whether you need braces or dentures, the Cost Estimator has you covered. Choose from nearly 60 common procedures.
- **Based on real data.** Estimates are calculated from Delta Dental dentists' actual fees.

Look up these services and more!

anesthesia • bleaching • braces • cleaning • crown • denture • exam • extraction • filling • fluoride • gum graft • implant • root canal • scaling and root planing • sealant • veneers • wisdom tooth removal • x-rays

What does my estimate mean?

Your estimate shows the average dentist fee in your area. You can use this amount to figure out your share based on your plan's benefits.

1.	**You get an estimate for crowns in your area.** That's how much your dentist may charge, but it doesn't mean you'll have to pay the whole amount!	**$1,240 to $1,438**
2.	**You check your benefits** and see that crowns are covered at **60%**. Since you plan on visiting an in-network dentist, you can count on paying no more than the remaining **40%** of the bill.[1]	**x 40%**
3.	**You multiply the estimate by 40%.** That leaves your expected bill **between $496 and $575.20**.	**$496 to $575.20**

[1] Your share may be higher if you have reached any applicable maximums or have not met your deductible.

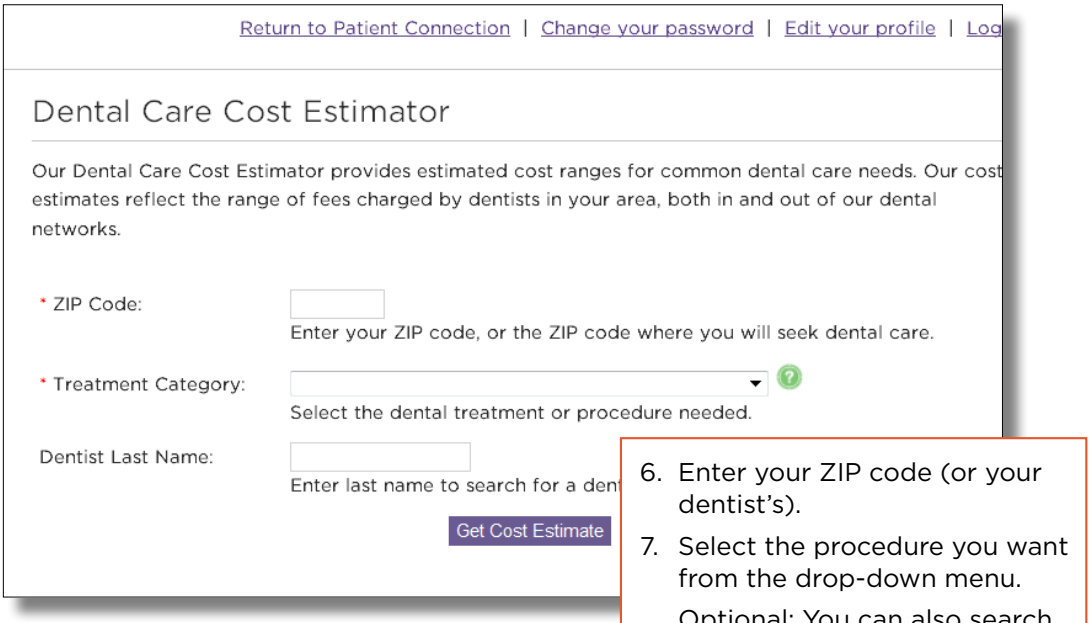
We keep you smiling®
deltadentalins.com/enrollees

Dental (continued)

Get an estimate

Ready to try it out?

1. Log in to your Online Services account at **deltadentalins.com.** (Don't have an account? Sign up in less than a minute.)
2. Click on **Cost Estimator** by your name. You will be redirected to the Delta Dental Plans Association website.
3. Log in again with the same username and password.
4. Select **Dental Care Cost Estimator** from the menu on the left.
5. Click **Agree** to accept the terms of use.



6. Enter your ZIP code (or your dentist's).
7. Select the procedure you want from the drop-down menu.

   Optional: You can also search for a specific dentist.
8. Click **Get Cost Estimate.**

On mobile? You can try the cost estimator on the Delta Dental app. Download the free app from the App Store or Google Play.

vsp vision care

Make Eye Health a Priority with VSP!

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

VSP members save an annual average of

$471*

More Ways to Save

Extra $20 to spend on Featured Frame Brands†

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

Up to 40% Savings on lens enhancements‡

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

Enroll through your employer today. Questions?

vsp.com or **800.877.7195**

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

Routine eye exams have saved lives.

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

Savings you'll love.

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

The choice is yours!

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

vsp PREMIER edge

Preferred private practice and retail in-network choices

private practice doctors Visionworks

Getting started is easy!

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

†Only available to VSP members with applicable plan benefits. Frame brands and promotions are subject to change. ‡Savings based on doctor's retail price and vary by plan and purchase selection; average savings determined after benefits are applied. Ask your VSP network doctor for more details.
*Based on state and national averages for eye exams and most commonly purchased brands. This represents the average savings for a VSP member with a full-service plan at an in-network provider. Your actual savings will depend on the eyewear you choose, the plan available to you, the eye doctor you visit, your copays, your premium, and whether it is deducted from your paycheck pre-tax. Source: VSP book-of-business paid claims data for Aug-Jan of each prior year. **Full Picture of Eye Health, American Optometric Association, 2020. +Coverage with a retail chain may be different or not apply.

VSP guarantees member satisfaction from VSP providers only. Coverage information is subject to change. In the event of a conflict between this information and your organization's contract with VSP, the terms of the contract will prevail. Based on applicable laws, benefits may vary by location. In the state of Washington, VSP Vision Care, Inc., is the legal name of the corporation through which VSP does business. TruHearing is not available directly from VSP in the states of California and Washington. Premier Edge™ is not available for some members in the state of Texas.

To learn about your privacy rights and how your protected health information may be used, see the VSP Notice of Privacy Practices on **vsp.com**. Visionworks and Eyeconic are VSP-affiliated companies.

Vision (continued)

Your VSP Vision Benefits Summary

Prioritize your health and your budget with a VSP plan through Cuesta College.

Provider Network:
VSP Choice
Effective Date:
01/01/2026

vsp vision care

BENEFIT	DESCRIPTION	COPAY	FREQUENCY
YOUR COVERAGE WITH A VSP DOCTOR			
WELLVISION EXAM	• Focuses on your eyes and overall wellness • Routine retinal screening	$0 Up to $39	Every 12 months
ESSENTIAL MEDICAL EYE CARE	• Retinal imaging for members with diabetes covered-in-full • Additional exams and services beyond routine care to treat immediate issues from pink eye to sudden changes in vision or to monitor ongoing conditions such as dry eye, diabetic eye disease, glaucoma, and more. • Coordination with your medical coverage may apply. Ask your VSP network doctor for details.	$20 per exam	Available as needed
PRESCRIPTION GLASSES			
FRAME[+]	• $320 Featured Frame Brands allowance • $300 frame allowance • 20% savings on the amount over your allowance	$0	Every 12 months
LENSES	• Single vision, lined bifocal, and lined trifocal lenses • Impact-resistant lenses for dependent children	$0	Every 12 months
LENS ENHANCEMENTS	• Standard progressive lenses • Premium progressive lenses • Custom progressive lenses • Average savings of 30% on other lens enhancements	$0 $95 - $105 $150 - $175	Every 12 months
CONTACTS (INSTEAD OF GLASSES)	• $200 allowance for contacts and contact lens exam (fitting and evaluation) • 15% savings on a contact lens exam (fitting and evaluation)	$0	Every 12 months
VSP LIGHTCARE™[+]	• $300 allowance for ready-made non-prescription sunglasses, or ready-made non-prescription blue light filtering glasses, instead of prescription glasses or contacts.	$0	Every calendar year
ADDITIONAL SAVINGS	**Glasses and Sunglasses** • Discover all current eyewear offers and savings at **vsp.com/offers**. • 20% savings on unlimited additional pairs of prescription or non-prescription glasses/sunglasses, including lens enhancements, from a VSP provider within 12 months of your last WellVision Exam.		
	Laser Vision Correction • Average of 15% off the regular price; discounts available at contracted facilities.		
	Exclusive Member Extras for VSP Members • Contact lens rebates, lens satisfaction guarantees, and more offers at **vsp.com/offers**. • Save up to 60% on digital hearing aids with TruHearing®. Visit **vsp.com/offers**/special-offers/hearing-aids for details. • Enjoy everyday savings on health, wellness, and more with VSP Simple Values.		

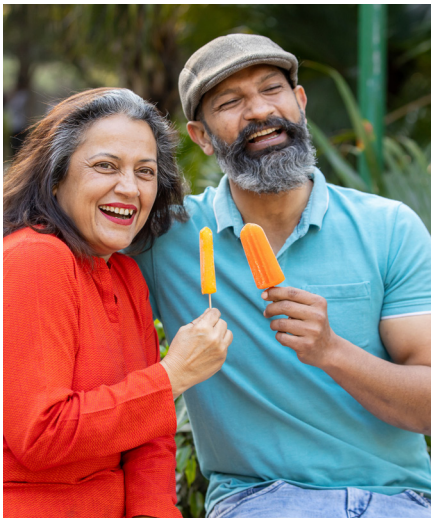
COVERAGE WITH AN OUT-OF-NETWORK DOCTOR

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

Exam ..... up to $50
Frame ..... up to $40
Single Vision Lenses ..... up to $43
Lined Bifocal Lenses ..... up to $60
Lined Trifocal Lenses ..... up to $75
Progressive Lenses ..... up to $60
Contacts ..... up to $120

Madison National Life AD&D Insurance





CUESTA COLLEGE

DID YOU KNOW...

As a Cuesta College employee you qualify for a FREE $2,000 AD&D Insurance Policy!

- **All Employees:** You are entitled to a free Madison National AD&D Insurance policy of $2,000.00. If you are interested in this free coverage, please complete the beneficiary section on the free Madison National AD&D option in your Benefit Bridge account.

The Beneficiary Form protects your family and is a very important document for Cuesta College to have on file to ensure that your benefits are paid.

ARRANGED BY:
Keenan®

Madison® National Life
a Horace Mann company

CUESTA COLLEGE

Optional Life and AD&D

This schedule shows the benefits that are available under the voluntary Madison National Policy. You and your dependents will only be insured for the benefits:

- for which you and your dependents become and remain eligible;
- which you elect, if subject to election; ***and***
- which are in effect.

This plan is only available for employees working 50% and above.

Plan Benefits	Optional Life Insurance	Optional AD&D Insurance
For Active Employees	Increments of $10,000	Option 1: $10,000 Option 2: $25,000 Option 3: $50,000 Option 4: $100,000 Option 5: $250,000 Option 6: $500,000
Accelerated Benefit Option	Up to 25% of your Basic Life amount; not to exceed $250,000	N/A
Maximum Life Benefit	Lesser of 5x salary or $500,000	$500,000
DEPENDENTS		
For Your Spouse	Increments of $10,000 up to a maximum of $500,000	60% of employee amount
For Each of Your Children		
• Children	Option 1: $2,500 Option 2: $5,000 Option 3: $10,000	25% of employee amount; maximum of $50,000

Guaranteed Issue Plan Amounts (For New Hires Only): Employee $100,000 (Or 2x salary, not to exceed $100,000), Spouse $20,000 Child(ren) $10,000. Larger plan amounts for new hires, and all existing employees who elect a new coverage amount, will need to go through the Evidence of Insurability process for approval.

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AMERICAN FIDELITY ASSURANCE COMPANY

Cuesta College

Benefits Overview

Central California Branch Office
3649 W. Beechwood Ave., Suite 103
Fresno, CA 93711
866-504-0010 · 559-230-2107
americanfidelity.com

AMERICAN FIDELITY
a different opinion

SB-30560-0816

Cuesta College

Dear Cuesta College employee:

Out of all the items on your to-do list, enrolling in your employer's benefits program likely isn't at the top. But it's more significant than you may think, as protecting yourself and your family is vitally important.

That's where we come in. American Fidelity provides financial solutions to employees just like you, and we offer benefits tailored for your specific needs.

Your benefit program includes a Section 125 Plan, which not only allows you to pre-tax premiums for qualified benefits, it also allows you to enjoy a tax-saving way to pay for eligible medical or dependent day care expenses with a reimbursement account that deducts pre-tax dollars from your paycheck. Simply choose the amount to be deducted, and the funds are set aside to be used for eligible expenses throughout the year. You can choose from several types of plans.

You only have one chance each year to get educated on all available benefit options and choose the ones that best meet your needs. And because benefits can be confusing, we're here to help you every step of the way. We'll walk you through all available options, answer any questions you may have, and help you build a package that's perfect for you.

An interest form is attached for you to complete and return, and a representative will touch base with you soon to discuss your available options.

Sincerely,

American Fidelity Assurance Company

For more information, contact your local American Fidelity representative.

American Fidelity, a different opinion in employee benefits.

Central California Branch Office
3649 W. Beechwood Ave., Suite 103
Fresno, CA 93711
866-504-0010 · 559-230-2107
americanfidelity.com

AMERICAN FIDELITY
a different opinion

SB-30534-0716

American Fidelity (continued)

Cuesta Community College

Plan for tomorrow, today.

Everyone knows health insurance doesn't pay for everything. Do you feel fully protected? Reviewing and updating your coverage each year is important.

Get help with your options. Stop by and see an American Fidelity account manager.

Accident Only Insurance

AF™ **Limited Benefit Accident Only Insurance**

- may help manage out-of-pocket costs to treat injuries resulting from a covered accident
- provides benefit payments directly to you

americanfidelity.com/info/accident

Cancer Insurance

AF™ **Limited Benefit Individual Cancer Insurance**

- may help ease the financial burden of cancer treatment, so you can focus on recovery
- provides benefit payments directly to you

americanfidelity.com/info/cancer

Disability Income Insurance

AF™ **Disability Income Insurance**

- can help protect your finances in case of a covered injury or illness
- provides a benefit to help cover costs while you are unable to work
- pays some of your gross monthly earnings

americanfidelity.com/info/disability

Life Insurance

AF™ **Life Insurance** may help ensure your family is financially protected in the event of a loss. You own the policy, so you can take it with you to a different job or into retirement.

americanfidelity.com/info/life

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a different opinion

EMPLOYER BENEFIT SOLUTIONS FOR EDUCATION

Each year, about **2.8 million children** between the ages of 5 and 14 are treated for sports and recreational-related injuries.

National Safety Council, Injury Facts; 2019 Web.

American Fidelity (continued)

Critical Illness Insurance

AF™ **Limited Benefit Critical Illness Insurance**

- pays a benefit upon diagnosis of certain covered life-altering illnesses
- helps with costs not covered by medical insurance

americanfidelity.com/info/critical-illness

Hospital Indemnity Insurance

AF™ **Limited Benefit Hospital Indemnity Insurance**

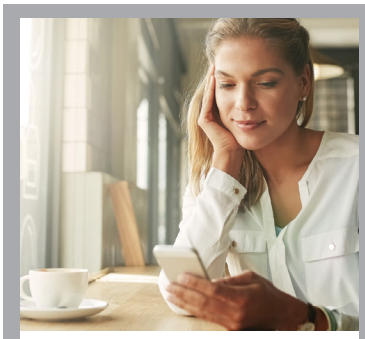
- helps pay for out-of-pocket costs, like a hospital stay
- when used with a Health Savings Account allows for a tax benefit and potential savings

americanfidelity.com/info/hospital-indemnity

Dependent Care Accounts

- allow you to repay yourself for eligible dependent care costs incurred during the plan year
- let you withhold your money from your paycheck, pre-tax, reducing your overall tax burden

americanfidelity.com/info/fsa



Educational Videos

Through short videos, we offer multiple ways to learn about your benefits options.

This video library includes enrollment tips, insurance information, stories, and support options.

americanfidelity.com/videos

Flexible Spending Accounts

Everyone likes saving money.

Flexible spending accounts (FSA) allow you to save part of your paycheck, before taxes, to pay for eligible costs throughout the year.

Types of Accounts

- Healthcare FSAs
- Limited Purpose FSAs
- Dependent Care Accounts

Explore your savings options at americanfidelity.com/info/fsa

To calculate medical costs that may not be covered by insurance, visit americanfidelity.com/fsa-worksheet

Examples of Eligible Expenses

- Asthma treatments
- Chiropractic care
- Contact lenses
- Copays
- Dental services
- Eye exam/eyeglasses
- Fertility treatments
- Laser eye surgery
- Over-the-counter bandages
- Physical exams
- Physical therapy
- Prescriptions
- Prenatal care
- Sunscreen with 15 SPF or higher
- Walkers/wheelchairs

americanfidelity.com/eligible-expenses

American Fidelity (continued)

Annuities

It's never too early to plan for retirement.

When you think about your retirement, do you envision opportunities to travel, learn a new hobby, or spend time with family? No matter your retirement goals, it's important to start saving early.

Even with government retirement systems, you may need to consider personal retirement options to make the best of your golden years.

That's where annuities—or retirement savings plans—can help.

How It Works:

1. **Select** the right account for you
2. **Determine** a contribution amount
3. **Contribute** from your paycheck
4. **Monitor** your investment performance

When it comes to your retirement, it's important to save early and often. Learn more about retirement savings plans at americanfidelity.com/info/annuities.

File Your Claims Faster

AFmobile®

Our mobile app is the easiest way to submit your claims and documentation. Upload documentation* directly from your device's picture gallery.

americanfidelity.com®

Filing online is convenient, secure, and provides faster claim processing than filing by paper. From your laptop or desktop, log in to file a claim and upload documentation*.

Need assistance?

Visit americanfidelity.com/fileaclaim

**The Internal Revenue Code regulations require proof of eligible expenses using itemized receipts or other documentation showing the date of service, person for whom service was provided and description of the expense. Depending on the type of expense, documentation may come in the form of third party itemized statements or Explanation of Benefits.*

American Fidelity (continued)

Cuesta Community College

24/7 Access with AFmobile®

Manage your insurance benefits and reimbursement accounts all from the palm of your hand.

View account balances

Manage claims and reimbursements

Submit documentation

Receive alerts

Maintain personal information

Get Started

Register at **americanfidelity.com/register** or **download AFmobile** and select the New User link.

Please allow one business day after you enroll before registering for an online account. If you already have an account, your username and password will be the same for AFmobile.

Central California Branch Office
3649 W. Beechwood Ave., Suite 103
Fresno, CA 93711
866-504-0010 · 559-230-2107
SB-33041-0120

American Fidelity Assurance Company
americanfidelity.com

Limitations, exclusions and waiting periods may apply.

Flexible Spending Accounts

Plan Today for Tomorrow's Costs.

With medical costs continuing to rise, tools to help manage out-of-pocket medical expenses can be a popular choice.

One option is a Healthcare Flexible Spending Account (HCFSA). Healthcare FSAs allow you to set aside money tax-free for eligible medical costs, such as doctor visits, prescription drugs, prescription contact lenses, and dental procedures. Additionally, your entire election amount is available to you at the beginning of your plan year.

Here's How It Works

Select the amount you wish to elect from your paycheck each month

Make an eligible medical purchase

Snap a photo of your itemized receipt

Submit a reimbursement claim electronically

Success! Receive funds via direct deposit

Learn how to file reimbursement claims at **americanfidelity.com/fileaclaim**

Paycheck Savings Example

In the example to the right, Jane makes $4,000 per paycheck and is paid monthly. By participating in an HCFSA, she would save $82.96 a month.

That's a savings of $995.52 a year.

To calculate your possible savings, visit **americanfidelity.com/s125-calculator**

Earnings & Hours	Without FSA	With FSA
Gross Pay	$4,000	$4,000
Health Insurance	-$300	-$300
Health FSA Contribution	*N/A*	-$300
Taxable Income	***$3,700***	***$3,400***
Taxes (Federal & State @ 20%)	-$740	-$680
Less Estimated FICA (7.65%)	-$283.05	-$260.10
Out-of Pocket Medical Expenses	-$300	*N/A*
Take Home Pay	***$2,376.95***	***$2,459.90***

Examples of Eligible Expenses

- Over-the-counter drugs and medicines without a prescription
- Prescription contacts
- Prenatal care
- Copays/Co-insurance
- Physical exams
- Asthma treatments
- Dental services
- Laser eye surgery
- Chiropractic care
- Eye exams/eyeglasses
- Physical therapy
- Deductibles
- Menstrual products

For a list of eligible expenses visit americanfidelity.com/eligible-expenses

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a different opinion

American Fidelity (continued)

Flexible Spending Accounts

Internal Revenue Code (IRC) Requirements

IRC guidelines are strict where tax breaks are made available. As your plan provider, we are required to follow IRC rules.

First, the money you set aside operates under a "use or lose" system. That means you'll want to use all of your funds prior to the next plan year or you will lose whatever amount is left.

Ask if your employer's plan includes a Runoff Period and Carryover Provision or Grace Period.

- **Runoff Period**
  A period typically up to 90 days after the plan year ends when you can submit claims that you incurred during the previous plan year, but have not been submitted for reimbursement.
- **Carryover Provision**
  This provision allows you to carry over up to $550 of unused contributions from one plan year to the next.
- **Grace Period**
  An additional two and a half months following the end of the plan year in which you can incur claims and receive reimbursement.

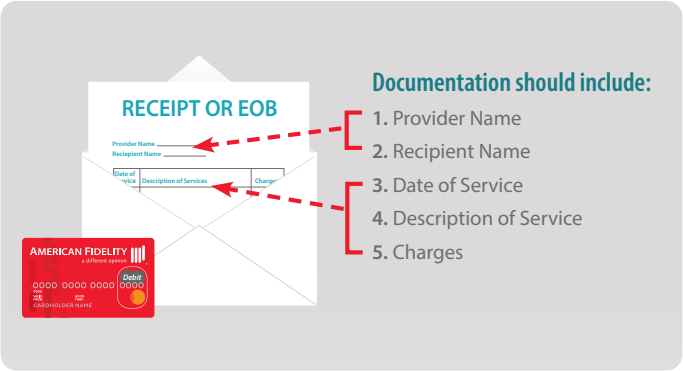
Second, the IRC requires proof for eligible expenses. For expenses that aren't validated at the time of debit card swipe, an itemized receipt or Explanation of Benefits (EOB) must be submitted to prove eligibility of the expense. Submitting documentation through AFmobile® or online is the fastest way to validate a claim.

Using your Benefits Debit Card

A Benefits Debit Card allows you to pay for eligible medical expenses using the funds in your Healthcare FSA. The card may be used at locations who accept Mastercard® and have been identified as an authorized medical merchant.

To verify transactions, submit an EOB or itemized receipt after your transaction or if you receive a documentation request letter.

Learn more about your debit card at **americanfidelity.com/debit-card**



American Fidelity Assurance Company
americanfidelity.com

SB-32928-1120

Contact Information

Below is a listing of the toll-free numbers you may call with questions about the plans available to you. You may also use the website to access information from providers.

Plan	Phone Number	Website/Email
Medical		
• Anthem	SISC - 800-825-5541	anthem.com/ca/sisc
• Navitus *(pharmacy)*	866-333-2757	www.Navitus.com
Dental		
• Delta Dental	888-335-8227	www.deltadentalins.com
Vision		
• VSP	800-877-7195	www.vsp.com
EAP		
• SISC - Anthem	800-999-7222	www.anthemeap.com/sisc
Voluntary Life and AD&D		
• Madison National Life/NIS	800-627-3660	www.NISBenefits.com
Retirement		
• PERS	888-225-7377	www.calpers.ca.gov
• STRS	800-228-3870	www.calstrs.com
Section 125		
American Fidelity		
• Corporate Office	800-654-8489	www.americanfidelity.com
• Fresno Office	559-230-2107	afes-fresnobranch@americanfidelity.com
Investment		
• Envoy Plan Services	800-248-8858	www.envoyplanservices.com
• Dan Buster, Financial Advisor	909-247-1112	dbuster@zukfinancial.com

Important Notices

No Surprises Act Notice

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

Discrimination is Against the Law

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

Newborns' and Mothers' Health Protection Act (NMHPA)

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

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

Your plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services, including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema. For more information, you should review the Summary Plan Description or call your Plan Administrator at 805.546.3129

Patient Protections

The medical plan requires the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. Until you make this designation, the plan will designate one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, please contact anthem.com/ca/sisc.

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

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

Networks/Claims/Appeals

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

Notice of Extended Coverage to Children Covered as Students

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

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

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

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

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

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

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

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

COBRA Continuation Coverage

This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under covered medical, dental, and vision plans (the "Plan"). **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to receive it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally does not accept late enrollees.

WHAT IS COBRA CONTINUATION COVERAGE?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "Qualifying Event." Specific Qualifying Events are listed later in this notice. After a Qualifying Event, COBRA continuation coverage must be offered to each person who is a "Qualified Beneficiary." You, your spouse, and your dependent children could become Qualified Beneficiaries if coverage under the Plan is lost because of the Qualifying Event. Under the Plan, Qualified Beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a Qualified Beneficiary if you lose coverage under the Plan because of the following Qualifying Events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a Qualified Beneficiary if you lose your coverage under the Plan because of the following Qualifying Events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than their gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or,
- You become divorced or legally separated from your spouse.

Your dependent children will become Qualified Beneficiaries if they lose coverage under the Plan because of the following Qualifying Events:

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

WHEN IS COBRA CONTINUATION COVERAGE AVAILABLE?

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

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

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

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

NOTICE AND ELECTION PROCEDURES

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

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

ELECTION AND ELECTION PERIOD

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

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

HOW IS COBRA CONTINUATION COVERAGE PROVIDED?

Once the Plan Administrator receives notice that a Qualifying Event has occurred, COBRA continuation coverage will be offered to each of the Qualified Beneficiaries. Each Qualified Beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation on behalf of their dependent children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain Qualifying Events, or a second Qualifying Event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

Important Notices (continued)

DISABILITY EXTENSION OF THE 18-MONTH PERIOD OF COBRA CONTINUATION COVERAGE

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. This disability would have to have started some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage. (See Notice and Election Procedures.)

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

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

OTHER OPTIONS BESIDES COBRA CONTINUATION COVERAGE

Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, Children's Health Insurance Program (CHIP), or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

ENROLLMENT IN MEDICARE INSTEAD OF COBRA

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an eight-month special enrollment period[1] to sign up for Medicare Part A or B, beginning on the earlier of:

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

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

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

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

IF YOU HAVE QUESTIONS

For more information about the Marketplace, visit www.healthcare.gov.

The U.S. Department of Health and Human Services (HHS), through the Centers for Medicare & Medicaid Services (CMS), has jurisdiction with respect to the COBRA continuation coverage requirements of the Public Health Service Act (PHSA) that apply to state and local government employers, including counties, municipalities, public school districts, and the group health plans that they sponsor (Public Sector COBRA). COBRA can be a daunting and complex area of federal law. If you have any questions or issues regarding Public Sector COBRA, you may contact the Plan Administrator or email HHS at phig@cms.hhs.gov.

[1] http://www.socialsecurity.gov/

KEEP YOUR PLAN INFORMED OF ADDRESS CHANGES

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

EFFECTIVE DATE OF COVERAGE

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

COST OF CONTINUATION COVERAGE

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

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

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

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

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

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

Uniformed Services Employment and Reemployment Rights Act (USERRA)

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

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

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

Special Enrollment Rights Notice

CHANGES TO YOUR HEALTH PLAN ELECTIONS

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

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

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

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

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

For information about Special Enrollment Rights, please contact:

Human Resources
805.546.3128
HR@Cuesta.edu

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

Cuesta College Group Health Plan (Plan) maintains a Notice of Privacy Practices that provides information to individuals whose protected health information (PHI) will be used or maintained by the Plan. If you would like a copy of the Plan's Notice of Privacy Practices, please contact Human Resources at 805.546.3128 or HR@Cuesta.edu

Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: GENERAL INFORMATION

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

WHAT IS THE HEALTH INSURANCE MARKETPLACE?

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

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

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

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

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

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

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

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

STATES WITH INDIVIDUAL MANDATE

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

PART B: INFORMATION ABOUT HEALTH COVERAGE OFFERED BY YOUR EMPLOYER

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

3. Employer name Cuesta College	**4. Employer Identification Number (EIN)** 52-2018681	
5. Employer address P O Box 8106	**6. Employer phone number** 805-546-3129	
7. City San Luis Obispo	**8. State** CA	**9. ZIP code** 93403
10. Who can we contact about employee health coverage at this job? Human Resources		
11. Phone number (if different from above)	**12. Email address** HR@Cuesta.edu	

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

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

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

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

WHEN CAN YOU JOIN A MEDICARE DRUG PLAN?

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

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

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

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

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

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

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

If you are Medicare eligible and go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have creditable coverage. For example, if you go 19 months without creditable coverage, your premium may be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) the entire time you have Medicare prescription drug coverage.

FOR MORE INFORMATION ABOUT YOUR OPTIONS UNDER MEDICARE PRESCRIPTION DRUG COVERAGE

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

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

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

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

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

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

If you live in one of the following States, you may be eligible for assistance with paying your employer health plan premiums. The following list of states is current as of July 31, 2025. Contact your State for more information on eligibility.

ALABAMA - Medicaid
Website: http://myalhipp.com/
Phone: 1-855-692-5447

ALASKA - Medicaid
The AK Health Insurance Premium Payment Program
Website: http://myakhipp.com/
Phone: 1-866-251-4861
Email: CustomerService@MyAKHIPP.com
Medicaid Eligibility:
https://health.alaska.gov/dpa/Pages/default.aspx

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

CALIFORNIA - Medicaid
Health Insurance Premium Payment (HIPP) Program Website:
http://dhcs.ca.gov/hipp
Phone: 1-916-445-8322
Fax: 1-916-440-5676
Email: hipp@dhcs.ca.gov

COLORADO - Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
Health First Colorado Website:
https://www.healthfirstcolorado.com/
Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711
CHP+: https://hcpf.colorado.gov/chp
CHP+ Customer Service: 1-800-359-1991/ State Relay 711
Health Insurance Buy-In Program (HIBI):
https://www.mycohibi.com/
HIBI Customer Service: 1-855-692-6442

FLORIDA - Medicaid
Website:
https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html
Phone: 1-877-357-3268

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

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

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

Important Notices (continued)

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

KENTUCKY - Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website:
https://www.chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx
Phone: 1-855-459-6328
Email: KIHIPP.Program@ky.gov
KCHIP Website: https://kynect.ky.gov
Phone: 1-877-524-4718
Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms

LOUISIANA - Medicaid
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp
Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)

MAINE - Medicaid
Enrollment Website:
https://www.mymaineconnection.gov/benefits/s/?language=en_US
Phone: 1-800-442-6003 | TTY: Maine relay 711
Private Health Insurance Premium Webpage:
https://www.maine.gov/dhhs/ofi/applications-forms
Phone: 1-800-977-6740 | TTY: Maine relay 711

MASSACHUSETTS - Medicaid & CHIP
Website: https://www.mass.gov/masshealth/pa
Phone: 1-800-862-4840 | TTY: 711
Email: masspremassistance@accenture.com

MINNESOTA - Medicaid
Website: https://mn.gov/dhs/health-care-coverage/
Phone: 1-800-657-3672

MISSOURI - Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm
Phone: 1-573-751-2005

MONTANA - Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: 1-800-694-3084
Email: HHSHIPPProgram@mt.gov

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

NEVADA - Medicaid
Medicaid Website: https://dhcfp.nv.gov
Medicaid Phone: 1-800-992-0900

NEW HAMPSHIRE - Medicaid
Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program
Phone: 1-603-271-5218
Toll free number for the HIPP program: 1-800-852-3345, ext. 15218
Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov

NEW JERSEY - Medicaid & CHIP
Medicaid Website:
https://www.nj.gov/humanservices/dmahs/clients/medicaid/
Phone: 1-800-356-1561
CHIP Premium Assistance Phone: 1-609-631-2392
CHIP Website: https://njfamilycare.dhs.state.nj.us/
CHIP Phone: 1-800-701-0710 (TTY 711)

NEW YORK - Medicaid
Website: https://www.health.ny.gov/health_care/medicaid/
Phone: 1-800-541-2831

NORTH CAROLINA - Medicaid
Website: https://medicaid.ncdhhs.gov/
Phone: 1-919-855-4100

NORTH DAKOTA - Medicaid
Website: https://www.hhs.nd.gov/healthcare
Phone: 1-844-854-4825

OKLAHOMA - Medicaid and CHIP
Website: http://www.insureoklahoma.org/
Phone: 1-888-365-3742

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

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

RHODE ISLAND - Medicaid and CHIP
Website: http://www.eohhs.ri.gov/
Phone: 1-855-697-4347, or 1-401-462-0311 (Direct RIte Share Line)

SOUTH CAROLINA - Medicaid
Website: https://www.scdhhs.gov
Phone: 1-888-549-0820

SOUTH DAKOTA - Medicaid
Website: http://dss.sd.gov
Phone: 1-888-828-0059

Important Notices (continued)

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

UTAH - Medicaid & CHIP
Utah's Premium Partnership for Health Insurance (UPP) Website:
https://medicaid.utah.gov/upp/
Email: upp@utah.gov
Phone: 1-888-222-2542
Adult Expansion Website: https://medicaid.utah.gov/expansion/
Utah Medicaid Buyout Program Website:
https://medicaid.utah.gov/buyout-program/
CHIP Website: https://chip.utah.gov/

VERMONT - Medicaid
Website: https://dvha.vermont.gov/members/medicaid/hipp-program
Phone: 1-800-250-8427

VIRGINIA - Medicaid & CHIP
Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select
Medicaid/CHIP Phone: 1-800-432-5924

WASHINGTON - Medicaid
Website: https://www.hca.wa.gov/
Phone: 1-800-562-3022

WEST VIRGINIA - Medicaid and CHIP
Website: https://dhhr.wv.gov/bms/
http://mywvhipp.com/
Medicaid Phone: 1-304-558-1700
CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)

WISCONSIN - Medicaid & CHIP
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm
Phone: 1-800-362-3002

WYOMING - Medicaid
Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/
Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2025, or for more information on special enrollment rights, contact either:

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

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

Glossary

Affordable Care Act and Patient Protection (ACA)

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

Allowed Amount

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

Balance Billing

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

Brand Name Drug

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

COBRA (Consolidated Omnibus Budget Reconciliation Act)

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

Children's Health Insurance Program (CHIP)

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

Claim

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

Coinsurance

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

Copayment (Copay)

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

Comprehensive Coverage

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

Deductible

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

Formulary

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

Generic Drug

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

High-Deductible Health Plan (HDHP)

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

Glossary (continued)

Health Savings Account (HSA)

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

Health Reimbursement Arrangements (HRAs)

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

In-Network

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

Non-Preferred Provider

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

Out-of-Pocket Maximum

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

Out-Of-Network

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

Out-Of-Pocket Limit

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

Plan Year

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

Preferred Provider

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

Premium

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

Preventive Care

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

Qualifying Life Event

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

Skilled Nursing Care

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

Urgent Care

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