SISC
Self-Insured Schools of California
Schools Helping Schools

HEALTH BENEFITS MANUAL

SCHOOL-EMPLOYEES TRUST – TULARE COUNTY (SET-TC)

2020-2021

WHAT'S SPECIAL ABOUT SISC

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

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

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

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

We've rewritten the rules of insurance coverage

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

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

All SISC personnel are public school employees

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

This ensures that SISC policies are in the best interest of schools. As a public entity, SISC doesn't operate on profit margins. We are relentless about doing what's best for our members.

2020-2021 Changes

- Effective 10/1/20, all Non-HSA PPO plans will feature $0 copays for the first three primary care visits each calendar year.
- Plan 90-C $30 is changing to 90-C $20.
- Delta and Anthem dental plan premiums decreased up to 5.1%.
- New Added Value Products
  - Vida Digital Health Coaching
  - Oncology Center of Excellence with City of Hope
- New SISC secure web portal: SISCconnect.
- SISC Voluntary Life Insurance Guarantee Issue amounts increased to:
  - $250,000 per employee
  - $50,000 per spouse
  - $10,000 per child
- All Domestic Partners must be registered with the State of California in order to be eligible for the SISC plans.

SISC Renewal Reminders

District Plan Changes: All Open Enrollment plan changes for October 1, 2020, are due to SISC by July 1, 2020. No exceptions. Plan changes outside of Open Enrollment require a minimum notification of 75 calendar days.

Open Enrollment Activity: All activity relating to October 1st Open Enrollment is due in the SISC office by September 1, 2020. Activity received after this date may not be updated in the carrier systems when benefits become effective.

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

ALL CHANGES EFFECTIVE OCTOBER 1, 2020 AND PRIOR AS NOTED

SISC III HEALTH BENEFITS MANUAL

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

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

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

The signed JPA and letter must be received by SISC at least 60 calendar days prior to the effective date of coverage. The signed and completed Enrollment Forms must be received by SISC 45 calendar days prior to the effective date. The school district is responsible for notifying its current carrier of cancellation according to the agreement in place. Additionally, payment of benefits for claims incurred prior to the effective date of SISC coverage is the responsibility of the school district or its prior carrier.

EMPLOYEE GROUPS

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

School districts may have three Employee Groups (Bargaining Units) Certificated, Classified and Management. If the Confidential Management does not split out into their own employee group they must enroll in the same benefits as either the certificated or classified employee group that the employee group agrees to follow. Retirees may not participate without their active employee group and must be offered the same benefits as their active employee group.

Are Board Members and/or Retirees an Employee Group?

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

NUMBER OF PLAN OPTIONS PER EMPLOYEE GROUP

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

If you have questions about benefit changes, please contact your consultant JoeAnna Todd, Gallagher Benefit Services.

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

RATE STRUCTURES

What Rate Structures Are Available?

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

When the school district has a three-tier rate for their active employee group, the retirees will have the same three-tier rate as active employees.

OPEN ENROLLMENT PERIOD

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

BENEFIT OR CONTRIBUTION CHANGES FOR DISTRICTS AND/OR EMPLOYEE GROUPS

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

How Much Notice Does SISC Require for a Benefit Change Effective Date other than October 1 (Nov.–Sept.)?
Due to the Affordable Care Act (ACA), it is the district's responsibility to notify employees and retirees of any plan changes 60 days prior to the effective date. Therefore, benefit changes for an effective date other than October 1 require a **75-calendar-day** written notification to SISC.

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

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

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

- When a district offers a new plan(s) employees/ retirees may only move to the new plan(s)
- When a district modifies existing plans employees/retirees may only move to or from the modified plan(s)
- When there is a significant increase or decrease in the district contribution

Contact your consultant JoeAnna Todd, Gallagher Benefit Services, for details.

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

Please fax a signed copy of the Notification of Plan Change form to the attention of JoeAnna Todd or Diana Velasquez at (559) 750-5466. You may also scan a signed copy and email it directly to JoeAnna Todd or Diana Velasquez.

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

Because the PPO plan's eligibility and claims system is driven by the ID number (Social Security number or Health Care ID number), when a member's group number changes, claims continue to process using the member's current deductible and co-insurance amounts with no processing problems due to the group number change. However, the prescription drug benefit is driven by both the ID number and the group number. If the member neglects to tell the pharmacist that they have a

new group number, the claim will reject as “member not eligible” or “member canceled”.

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

Our District is Considering a Change to the Contribution Strategy. Does this Affect our Eligibility in the SISC Program?
Contact JoeAnna Todd, Gallagher Benefit Services, to discuss details when considering contribution changes.

BILLING AND PREMIUM PAYMENTS

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

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

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

Example:

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

How Do I Remit Payment to SISC?
Please include a copy of the first page of your SISC invoice along with your payment to SISC and mail the payment to:

SISC Finance
P.O. Box 1808
Bakersfield, CA 93303-1808

COBRA/CALCOBRA/HIPAA ADMINISTRATION

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

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

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

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

Districts that administer their own COBRA Benefits

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

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

District Responsibility Regardless of Who Administers COBRA Benefits

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

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

SISC Responsibility

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

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

WHO IS ELIGIBLE?

Active Employees (Probationary and Permanent)

Classified permanent or probationary employees who work a minimum of 20 hours per week; Certificated employees currently under contract and who work a minimum of 50% of a Certificated job (even though the hours worked may be less than 20 hours per week) are eligible to participate in one of the options offered by the district.

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

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

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

Variable Hour, Temporary, Seasonal and Other Employees

Variable hour, temporary, seasonal and other employees are only eligible to enroll in the Two-Tiered Anchor Bronze PPO medical plan. This plan excludes coverage for dental, vision and life insurance. The two tiers are Employee Only and Employee plus Child(ren). Spouses and Domestic Partners are not eligible for this plan. (See the SISC Minimum Value Plan Options" page in the "Medical Plans" section for more details.)

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

Dependents

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

Who is an Eligible Dependent?

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

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

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

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

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

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

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

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

SURVIVING SPOUSE/DOMESTIC PARTNER PER CALIFORNIA EDUCATION CODE 7000

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

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

Are There Benefits for Classified Employees, Retirees and/or Surviving Spouse/ Domestic Partner?

There is no law for classified retirees; however, if the district has a Board policy that allows classified retirees to continue coverage, they are eligible. SISC must be notified in writing of this policy. If the school district does not have a policy, the retiree may be entitled to COBRA.

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

How Do I Enroll a Surviving Spouse/ Domestic Partner?
A separate enrollment form must be submitted to enroll a surviving spouse/domestic partner as they become the subscriber.

Can a Surviving Spouse/Domestic Partner Add a New Spouse/Partner or Dependent Child Once They Become a Subscriber?
No. Per California Education Code.

APPROVED LEAVE OF ABSENCE

Employees on a Board approved Leave of Absence (LOA) may remain covered the same as an active employee. If they continue coverage while on an approved LOA, they must remain enrolled in all coverage offered through SISC by the district. Payments for employees on an approved LOA should be made directly to the district.

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

They must also be offered the opportunity to continue coverage under COBRA. If they do not wish to pay for dental, vision or life coverage, the district may terminate their coverage and SISC will offer them continuation of medical coverage only under COBRA. Dental and vision coverage are optional under COBRA. Life coverage may not be continued through COBRA.

BOARD MEMBERS

Board Members may enroll when the district allows participation and contributes at least 50% of the district contribution to benefits. Board Members must elect coverage when first eligible following SISC enrollment guidelines. For eligibility purposes, Board Members are treated the same as part time employees.

- **Board Member Enrollment:** Board Members receiving an annual compensation of $400 or more are considered to have “active employment status” from the district supplying the health coverage. These Board Members should be enrolled as active employees and are subject to the SISC participation guidelines for active employees. A district offering life insurance may offer coverage to all sitting Board Members, regardless of compensation.

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

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

PARTICIPATION REQUIREMENTS

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

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

Who May Decline Coverage?

- An eligible employee who works less than 90% of the full-time equivalent for the applicable job classification or receives less than 90% of the amount that is contributed towards an eight-hour full-time employee.

- Active employees who are enrolled in Medi-Cal must show proof of enrollment in Medi-Cal. Documentation must reflect the effective date of enrollment in Medi-Cal.
- Active employees, who are eligible, enrolled in Medicare Parts A and B must show proof of enrollment.
- Active employees who are enrolled in TRICARE must show proof of enrollment. Documentation must reflect the effective date of enrollment in TRICARE. TRICARE rules should be reviewed before a declination is permitted.
- Active employees, who are eligible, enrolled in a Covered California medical plan and receiving a related subsidy must show proof of enrollment and subsidy.

If they decline, they must decline all SISC benefits offered by the district and must complete a Declination of Coverage Form, unless the active employee is taking the WABE option. Employees may not receive any incentives to opt-out of coverage (i.e., cash in lieu of benefits). An example of the Declination of Coverage for Less Than Full-Time Active Employees and HIPAA Notification form can be found on the SISC secure web portal (SISCconnect) at **siscconnect.org**.

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

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

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

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

Waiver of Anchor Bronze Enrollment (WABE Option)

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

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

Employees taking this option have access to the following value-added services:

- 24/7 Physician Line (MDLive)
- Employee Assistance Program—EAP (Anthem Blue Cross)
- Expert Medical Opinions (Advance Medical)
- Biometric Screenings (if offered by district)

The WABE option is only used to satisfy the medical participation requirement. As a reminder, employees enrolled in WABE or a SISC medical plan must enroll in SISC dental, vision, and/or life if offered by the district.

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

GUIDELINES FOR RETIREES

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

Retirees should be enrolled on an over-65 group number the first of the month in which Medicare Parts A and B are effective.

Is Medicare Required for Retiree Enrollment?
Yes. Retirees and their spouses/domestic partners that are 65 years of age or older are required to provide proof of Medicare Parts A and B. A copy of the retiree's and spouse's/domestic partner's Medicare card must be sent to SISC prior to the first of the month in which they turn 65 (or first of the prior month if their birthday is on the 1st). Retirees must have continuous enrollment in Medicare while enrolled in a SISC retiree plan.

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

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

It will be the district's responsibility to follow up and contact the member to remind them to submit a copy of their Medicare card and provide SISC with a copy.

Who is Responsible for Getting a Copy of the Medicare Card from the Retiree and/or Spouse/Domestic Partner?
It is the district's responsibility to get a copy of the Medicare card from the retiree or spouse/domestic partner and submit a copy to the SISC office.

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

Is There Dental and/or Vision Coverage for Retirees?
Yes. Retirees may enroll at the time of retirement if the district offers dental and/or vision benefits through SISC. All retirees can elect to enroll in the SISC Direct Bill Dental & Vision only plans at their own cost.

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

If the retiree declines or terminates coverage, they should complete a Declination of Coverage for Retirees. This form is retained at the district and protects you from the "nobody told me" syndrome. The Declination of Coverage for Retirees form can be found on the SISC website.

ELIGIBLITY FOR RETIREES

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

A retiree who does not meet the retirement qualifications of the school district, STRS or PERS is not eligible to continue coverage as a retiree with the district and will be offered COBRA. Through STRS, a member may be considered an eligible retiree due to a disability. STRS has two types of disability elections and only one of the two types qualifies as a disability retirement.

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

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

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

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

When are Retirees Allowed to Make Plan Changes?
Retirees are allowed the same Open Enrollment period as active employees. When an employee retires, they may also elect another plan offered by the district at the time of retirement. If the retiree is required to pay more out of pocket, SISC would allow a plan change when turning age 65.

The only exception to this would be if the retiree is choosing to enroll in the CompanionCare Medicare Supplement plan. This plan requires 45 days advance notice for enrollment per CMS guidelines. They can enroll in this plan once they turn age 65 and do not have to wait until Open Enrollment.

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

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

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

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

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

> Individual Retiree Plans require 45-calendar-day advance notice for termination.

If a Retiree Fails to Pay Premium to the District, Can the Coverage be Retroactively Terminated?
SISC will allow you to terminate the retiree current plus two months retro for failure to pay premium. However, if any claims have been incurred, the retiree may be responsible for reimbursement to the provider(s).

> Individual Retiree Plans do not allow retroactive terminations.

What Happens in the Event of a Retiree's Death?
A retiree who passes away while enrolled on a PPO plan, must be terminated from benefits the first of the month following the day of passing. SISC will allow a termination back to the date of passing, not to exceed 12 months retro credit.

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

MEDICARE PARTS A, B AND D

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

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

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

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

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

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

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

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

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

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

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

REPORTING PROCEDURES

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

Employee Additions or Changes

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

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

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

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

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

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

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

Dependent Additions

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

When Can a Covered Employee or Retiree Add a Domestic Partner to Coverage?
A subscriber can add a domestic partner to coverage during Open Enrollment or first of the month following a qualifying event. If enrolling eligible dependent children they must be added at the same time.

- on the first of the month following the date they register with the State of California.
- Or during any Open Enrollment period

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

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

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

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

Employee Plan Changes

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

- During the designated Open Enrollment period for an October 1st effective date; or
- If the district contribution changes significantly for active employees and/or retiree

Does SISC Allow Employees to Change Plans at their Retirement?
Yes. When an employee retires, they may elect another plan offered by the district at the time of retirement. All subsequent plan changes are subject to the rules listed in the "Eligibility for Retirees" section of this manual.

Employee Terminations

When Should I Terminate an Employee's Coverage?
Employees should be removed at the end of the month in which their qualifying event occurs. A district may not bargain to extend benefits beyond this date. Less than 12-month employees, who have completed their contractual obligation to teach/work through a given date, may be terminated at the end of the contract/agreement. It is the district's responsibility to report activity timely. Late reporting may result in the wrong benefits applied to a claim, which could result in additional liability for the district. Please refer to "Retiree" section for terminations due to retirement.

Can a Part-Time Employee Opt Out of Benefits?
Yes. A part-time employee may only opt out of benefits during the next Open Enrollment period or as the result of a qualifying event.

What is the SISC Retroactive Termination Policy?
SISC will terminate during Open Enrollment or due to a qualifying event. If you fail to report the termination timely, we will allow you to terminate the employee/retiree and /or qualified dependent(s) current plus two months retro from the time the request is received by SISC. However, if any claims have been incurred in the meantime, the employee/retiree or the employee's/retiree's dependents will be responsible for any amounts paid.

Dependent Terminations

What are the Employee and District Responsibilities Regarding Spouse/Domestic Partner and/or Dependent Children Terminations?
It is the employee's responsibility to notify the district of any changes in eligibility status for their spouse/domestic partner or dependent(s). The district is required to notify SISC in a timely manner of these changes. Paid claims on a non-eligible spouse/domestic partner or dependent(s) will be recovered.

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

What Is the SISC Retroactive Termination Policy for Dependents?
SISC will terminate during Open Enrollment or due to a qualifying event. If you fail to report the termination timely, we will allow you to terminate the qualified dependent(s) current plus two months retro from the time request is received by SISC.

Reporting Process

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

- The employee completes the Applicant section of the SISC Enrollment Form, and the district completes the District section. These forms can be found on the SISC secure web portal (SISCconnect) at **siscconnect.org**.
- If the employee is electing dependent coverage, attach the **required** proof of eligibility (see the "Dependent Eligibility Documentation Chart" in this manual).
- If the employee is enrolling as the result of a qualifying event, attach the **required** documentation of the event.
- Once the Enrollment Form and supporting documentation are complete, add the enrollment paperwork to the monthly batch of activity that is faxed or e-mailed to SISC by the 15th of each month.

Adding Dependents

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

- The employee completes and signs a **SISC Membership Change Form** which can be found on the SISC website.
- If the employee is adding a dependent during Open Enrollment or outside of Open Enrollment, attach the required documentation of the qualifying event.
- Please refer to the "Dependent Eligibility Documentation Chart" for a list of all **required** documentation when adding a dependent:
- SISC reserves the right to request additional documentation to substantiate eligibility.
- Once the paperwork is complete, add to your monthly batch of activity to be sent to SISC. The completed enrollment paperwork and required documentation must be submitted to SISC within 31 days of the qualifying event or Open Enrollment.

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

How Do I Remove a Dependent from an Employee's Coverage? (See "Dependent Termination" section above.)
The employee must complete and sign a SISC Membership Change Form and provide appropriate documentation.

If the termination is due to a divorce, a divorce decree is required. If the domestic partnership is being nullified, a copy of the Notice of Termination of Domestic Partnership is required. Once this is complete, add to your monthly batch of activity to be sent to SISC.

How Do I Report an Employee's Plan Change to SISC?
Plan changes must be reported on a MAR Transfer Form. This form can be found on the SISC website. This should be included in the monthly batch of activity to be sent to SISC.

How Do I Report a Subscriber's Termination of Coverage?
Terminations of coverage must be reported to SISC on a MAR Terminations Form. This form can be found on **siscconnect.org**.

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

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

What Happens if the Employee or District Fails to Provide the Required Documentation?
Failure to submit the supporting documentation (marriage certificate, birth certificate, Medicare card, proof of qualifying event, etc.) may result in coverage being denied.

Life Insurance Reporting

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

DEPENDENT ELIGIBILITY DOCUMENTATION CHART

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

Dependent Type	Required Documentation
Spouse	• Prior year's Federal Tax Form that shows the couple was married (financial information may be blocked out). • For newly married couples where prior year tax return is not available a marriage certificate will be accepted.
Domestic Partner	• Certificate of Registered Domestic Partnership issued by State of California (Enrolling a Domestic Partner may cause the employer contribution to become taxable)
Children, Stepchildren, and/or Adopted Children up to age 26	• Legal Birth Certificate or Hospital Birth Certificate (to include full name of child, parent(s) name, and child's DOB) • Legal Adoption Documentation
Legal Guardianship up to age 18	• Legal U.S. Court Documentation establishing Guardianship
Disabled Dependents over age 26	**Anthem Blue Cross (All items listed below are required)** • Legal Birth Certificate or Hospital Birth Certificate (to include full name of child, parent(s) name and child's DOB) • Prior year's Federal Tax Form that shows child is claimed as an IRS dependent (income information may be blocked out) • Proof of 6 months prior creditable coverage • Completed Anthem Disabled Dependent Certification Form

QUALIFYING EVENTS OR STATUS CHANGES OUTSIDE OF OPEN ENROLLMENT

Effective date will be determined by the qualifying event date that allows for no lapse in coverage.
This does not apply to CompanionCare.
This table is not all inclusive and is subject to SISC approval, retro, and participation guidelines.

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

(Continued on next page.)

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

DUE DATES AND REPORTING METHODS

When is the District Activity Due to SISC?
District activity is due to SISC by 4 PM the 15th of the month prior to the effective date. If the 15th falls on a weekend or holiday the activity is due to SISC by 4pm the Friday before. The Activity Schedule is posted on the SISC secure web portal (SISCconnect) at **siscconnect.org**. Activity should be sent complete with all supporting documentation in one monthly batch.

How Do I Send My Activity to SISC?
Districts will only have two options to submit monthly activity*:

1. Secure fax: 661-636-4094: the fax cover sheet must note the SISC Billing and Eligibility Technician's name; or
2. SISC secure file transfer system at **siscconnect.org**: this address is reserved for district activity only. Instructions for the SISC secure file transfer system may be found in the SISC secure web portal (SISCconnect) at **siscconnect.org**.

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

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

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

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

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

How Do I Know if SISC Received My Monthly Activity?
Activity received in the SISC office by the scheduled due date should appear on the district's next bill. It is the district's responsibility to review the SISC monthly invoice to ensure that all activity received by the due date was processed. If the district chooses to send activity using the SISC secure file transfer system, a confirmation email will be sent when the file has been picked up by SISC.

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

SISC SECURE WEB PORTAL (SISCCONNECT)

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

Each district must designate authorized users and their level of access by completing a SISCconnect Registration form found on the SISC website. Authorized users will be sent a login ID with a temporary password.

What are the Reports and Menu Options?

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

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

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

Quick Downloads Menu Items

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

Communication

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

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

VALUE-ADDED SERVICES OFFERED BY SISC 2020-2021

Get Started	Program Details	Who Is Eligible
SISC EAP **Call** 800-999-7222 OR **Go to** anthemEAP.com and enter SISC	**24/7 Help with Personal Concerns** ***SISC Employee Assistance Program*** Access free, confidential resources if you or a family member needs help with emotional, marital, financial, addiction, legal, or stress issues.	All employees at member districts (including Kaiser) **No Cost**
Advance Medical **Call** 855-201-9925 OR **Go to** advance-medical.net/sisc	**Expert Medical Opinions** ***Advance Medical*** Get answers to your health care questions and medical opinions from world-leading experts.	All SISC members (including Kaiser) **No Cost**
MDLive **Register** by calling 888-632-2738 OR **Go to** mdlive.com/sisc	**24/7 Physician Access—Anytime, Anywhere** ***MDLive*** Consult with doctors and pediatricians over the phone or using online video for medical conditions such as cold, fever, sore throat, flu, infection, and children's health issues. Physicians can prescribe medication when appropriate. Online behavioral health visits are also available.	Anthem and Blue Shield PPO and HMO members **Low Cost**
Costco To find a Costco location, **Call** 800-774-2678 (press 1) OR **Go to** costco.com	**Free Generic Medications** ***Costco*** On most pharmacy plans, our PPO and HMO members can get free generic medications at Costco and through Costco Mail Order (excludes certain pain and cough medications). Just take your prescription to a Costco pharmacy; you don't need to be a Costco member.	Anthem and Blue Shield PPO and HMO members (participating plans) **No Cost**

These programs are not available to retired Medicare members enrolled on Retiree Group Medicare Plans. Per IRS guidelines, HSA members may need to satisfy a deductible on these programs.

Continued →

Get Started	Program Details	Who Is Eligible
Vida Health **Call** 855-442-5885 OR **Go to** vida.com/sisc	**Digital Health Coaching App** ***Vida Health*** Get one-on-one health coaching, therapy, digital programs and other tools and resources via online or mobile access. This program helps you prevent, manage or reverse conditions such as pre-diabetes, diabetes, hypertension, obesity, depression, anxiety, etc.	Anthem and Blue Shield PPO and HMO members 18 and older No Cost
Oncology Center of Excellence Program **Go to** sisc.hdplus.com OR **Call** 877-220-3556	**Enhanced Cancer Benefit** ***Oncology Center of Excellence Program*** Consult experts who can help you navigate the complex world of cancer treatment. Services include assistance in receiving an accurate initial diagnosis and developing a comprehensive care plan. Also covers care coordination services with a home provider, transportation benefits and more.	Anthem and Blue Shield PPO members No Cost
Carrum Health **Call** 888-855-7806 OR **Go to** carrumhealth.com/sisc	**No Cost Hip, Knee, and Spine Surgical Options** ***Carrum Health*** Consult top-quality surgeons at Scripps with no out-of-pocket cost. All medical bills, including deductibles, coinsurance and even travel expenses are covered.	Anthem and Blue Shield PPO members No Cost
Hinge Health **Go to** hingehealth.com/sisc OR **Call** 855-902-2777	**Digital Programs for Back or Knee Pain** ***Hinge Health*** Get access to free wearable sensors and monitoring devices, unlimited one-on-one coaching and personalized exercise therapy.	Anthem and Blue Shield PPO members No Cost

These programs are not available to retired Medicare members enrolled on Retiree Group Medicare Plans.
Per IRS guidelines, HSA members may need to satisfy a deductible on these programs.

Additional Value-Added Services Offered by SISC

COBRA/CalCOBRA Administration

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

Direct Billing Self-Pay Retirees

Districts have the option of allowing SISC to manage the monthly billing and collection of premium for their self-pay retirees on qualified products. SISC will administer this program for our member districts at no additional cost. For more information please refer to the "Retiree" section of this book.

Section 125 Plan "SISC Flex"

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

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

WELLNESS SCREENINGS

The School Employees Trust (SET-TC) offers a health improvement program for members and their families. It is a voluntary and confidential benefit offered at no cost to our members.

Onsite Biometric Health Screening

SET-TC offers free onsite health screening events for Member Districts. The screening event provides an opportunity for members to learn their blood pressure, cholesterol and blood glucose, along with other health indicators. Program information is available in January and the events may be scheduled February–May.

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

To host an onsite health screening event, please contact JoeAnna Todd, Gallagher Benefit Services.

Onsite Flu Shot Clinics

SET-TC has partnered with Elite Corporate Wellness to sponsor free flu shot clinics for districts and bargaining units. Working in schools is a major risk factor for the flu so flu vaccines are especially important for you and your employees. Program information is available in August and the clinics may be scheduled in the Fall.

Condition Management

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

- Diabetes
- Coronary artery disease (CAD)

BLUECARD OUT OF STATE

Protection When Traveling or Living Outside Your Home State

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

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

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

Claim Filing Information

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

To Learn More about Blue Cross Blue Shield Global Core:

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

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

HEALTH SAVINGS ACCOUNT (HSA)

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

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

An “eligible individual” or HSA owner is an individual:

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

Qualified medical expenses are defined in Internal Revenue Code Section 213 [d]. In general they include specified deductibles, co-payments and other medical expenses not covered under the HDHP or in any other manner.

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

HSA Advantages

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

Frequently Asked Questions

Q: Who can contribute to an HSA?

A: The HSA is funded by contributions from an eligible employee, employer or both.

Q: What is the calendar year maximum amount that can be contributed to an HSA?

A: $3,550 per individual and $7,100 per family (2020)

Q: How does the HSA plan work?

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

Q: Who do I contact to set up an HSA (Health Savings Account)?

A: Any bank, credit union or other entity that currently meets the IRS standards can be an HSA trustee or custodian. Districts and/or employees may choose a financial institution to administer the savings account.

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

Please contact JoeAnna Todd, Gallagher Benefit Services. regarding plan design details.

SISC MINIMUM VALUE/ANCHOR BRONZE HSA PLAN OPTIONS

The objective of the Minimum Value Plans is to provide a lower cost, minimum value plan to assist districts in complying with employer requirements under the Affordable Care Act.

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

Frequently Asked Questions	Minimum Value PPO Plan	Two-Tiered Anchor Bronze PPO Plan
Is the provider network restricted?	No, this plan uses the same network providers as the current PPO plans offered in this manual.	No, this plan uses the same network providers as the current PPO plans offered in this manual.

SECTION 125 PLAN "SISC FLEX"

What is the SISC Flex Plan?

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

- **Premium Only Plan (POP)**
- **Health Care Expense Account:** $2,700 maximum annual election
- **Limited Purpose Expense Account:** $2,700 maximum annual election
- **Dependent Care Expense Account:** $5,000 maximum annual election

Employer Advantages

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

Participant Advantages

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

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

Questions

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

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

PPO PLANS

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

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

PPO PLAN OPTIONS

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

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

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

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

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

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

Plans shown on this page are non-HSA compliant.

HSA PLANS

	HSA-A Single Coverage	HSA-A Family Coverage	HSA-B Plan
Calendar Year Out-of-Pocket (OOP) Maximums	**Member Pays**	**Member Pays**	**Member Pays**
Individual/Family Deductibles (unless otherwise noted, all services are subject to deductible)	$1,500/$3,000	$2,800/$3,000	$3,000/$5,200
Individual/Family Out-of-Pocket Maximums (includes deductibles and co-pays)	$3,000/$6,000	$3,000/$6,000	$5,000/$10,000
Professional Services			
Office Visit/Urgent Care Co-pay	10%		10%
Specialists/Consultants Co-pay	10%		10%
Prenatal, Postnatal Office Visit Co-pay	10%		10%
Scans: CT, CAT, MRI, PET, etc.	10%		10%
Diagnostic X-ray and Laboratory Procedures	10%		10%
Infertility Services (see benefit booklet for details)	Not covered		Not covered
Preventive Care Services (includes physical exams and screenings)	0%, ded waived		0%, ded waived
Hospital and Skilled Nursing Facility Services			
Emergency Room Visit (co-pay waived if admitted)	10% $100 co-pay		10% $100 co-pay
Inpatient Hospital Co-pay (preauthorization required)	10%		10%
Outpatient Hospital Co-pay	10%		10%
Surgery, Outpatient (performed in an ambulatory surgery center)	10%		10%
Surgery, Outpatient (performed in a hospital)	10%		10%
Mental Health Services and Substance Abuse Treatment			
Inpatient Care—Facility-based care (preauthorization required)	10%		10%
Outpatient Care—Facility-based care (preauthorization required)	10%		10%
Other Services			
Acupuncture—Limits apply	10%		10%
Ambulance (ground or air)	10% $100 co-pay		10% $100 co-pay
Chiropractic—Limits apply	10%		10%
Durable Medical Equipment (DME)	10%		10%
Hearing Aids ($700 benefit allowance per 24-month period)	Cost in excess of allowance		Cost in excess of allowance
Physical and Occupational Therapy—Limits apply	10%		10%
Prescription Drug Plans			
Generic Co-pay/Days Supply	After ded, $9/30-day		After ded, $9/30-day
Brand Co-pay/Days Supply	After ded, $35/30-day		After ded, $35/30-day
Mail Order (generic-brand co-pay/days supply)	After ded, $0–90/90-day		After ded, $0–90/90-day

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

MINIMUM VALUE—ANCHOR BRONZE PLANS

	Minimum Value	Anchor Bronze
Calendar Year Out-of-Pocket (OOP) Maximums	**Member Pays**	
Individual/Family Deductibles	$5,000/$10,000	
Individual/Family Out-of-Pocket Maximums (includes deductibles and co-pays)	$6,350/$12,700	
Professional Services		
Office Visit/Urgent Care Co-pay	30% after deductible	
Specialists/Consultants Co-pay	30% after deductible	
Prenatal, Postnatal Office Visit Co-Pay	30% after deductible	
Scans: CT, CAT, MRI, PET, etc.	30%	
Diagnostic X-ray and Laboratory Procedures	30%	
Infertility (see benefit booklet for details)	Not covered	
Preventive Care Services (includes physical exams and screenings)	0%, deductible waived	
Hospital and Skilled Nursing Facility Services		
Emergency Room Visit Co-pay (waived if admitted)	30% after $100 co-pay	
Inpatient Hospital Co-pay (preauthorization required)	30%	
Outpatient Hospital Co-pay	30%	
Surgery, Outpatient (performed in an ambulatory surgery center)	30%	
Surgery, Outpatient (performed in a hospital)	30%	
Mental Health Services and Substance Abuse Treatment		
Inpatient Care Facility-based care (preauthorization required)	30%	
Outpatient Care Facility-based care (preauthorization required)	30%	
Other Services		
Acupuncture—Limits apply	30%	
Ambulance (ground or air)	30% after $100 co-pay	
Chiropractic—Limits apply	30%	
Durable Medical Equipment (DME)	30%	
Hearing Aids ($700 benefit allowance per 24-month period)	30% plus any cost in excess of allowance	
Physical and Occupational Therapy—Limits apply	30%	
Prescription Drug Plans		
Generic Co-pay/Days Supply	After deductible, $9/30-day	
Brand Co-pay/Days Supply	After deductible, $35/30-day	
Mail Order (generic-brand co-pay/days supply)	After deductible, $18–90/90-day	

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

ADDITIONAL MEDICAL PLAN NOTATIONS

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

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

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

PHARMACY BENEFIT INFORMATION

Generic Substitution

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

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

**Some restrictions apply.*

Mail Order Pharmacy Service

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

What is a Specialty Medication?

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

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

Deductible Plans (on brand name drugs only)

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

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

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

PRESCRIPTION DRUG PLANS 2020-2021

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

Costco Pharmacies are open to non-Costco members.

		WALK-IN			MAIL	
	DAYS SUPPLY	NETWORK 30	COSTCO 30	COSTCO 90	COSTCO 90	NAVITUS 30
Plan 5-20	Generic	$5	**FREE**	**FREE**	**FREE**	N/A
	Brand	$20	$20	$50	$50	N/A
	Specialty*	N/A	N/A	N/A	N/A	$20
	Out-of-Pocket Maximum	$1,500 Individual/$2,500 Family			$1,500 Individual/$2,500 Family	N/A
Plan 7-25	Generic	$7	**FREE**	**FREE**	**FREE**	N/A
	Brand	$25	$25	$60	$60	N/A
	Specialty*	N/A	N/A	N/A	N/A	$25
	Out-of-Pocket Maximum	$1,500 Individual/$2,500 Family			$1,500 Individual/$2,500 Family	N/A
Plan 9-35	Generic	$9	**FREE**	**FREE**	**FREE**	N/A
	Brand	$35	$35	$90	$90	N/A
	Specialty*	N/A	N/A	N/A	N/A	$35
	Out-of-Pocket Maximum	$2,500 Individual/$3,500 Family			$2,500 Individual/$3,500 Family	N/A
Plan 200 10-35	Brand/Specialty Deductible**	$200 Individual/$500 Family			$200 Individual/$500 Family	N/A
	Generic	$10	**FREE**	**FREE**	**FREE**	N/A
	Brand	$35	$35	$90	$90	N/A
	Specialty*	N/A	N/A	N/A	N/A	$35
	Out-of-Pocket Maximum	$2,500 Individual/$3,500 Family			$2,500 Individual/$3,500 Family	N/A
Plan 200 15-50	Brand/Specialty Deductible**	$200 Individual/$500 Family			$200 Individual/$500 Family	N/A
	Generic	$15	**$5**	**$15**	**$15**	N/A
	Brand	$50	$50	$135	$135	N/A
	Specialty*	N/A	N/A	N/A	N/A	$50
	Out-of-Pocket Maximum	$2,500 Individual/$3,500 Family			$2,500 Individual/$3,500 Family	N/A

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

Free Generic Drugs at Costco as well as through Mail Order

- **The $200/$15-$50 Rx Plan features reduced generic copays at Costco (not free).**
- **Some narcotic pain and cough medications are not included in the Costco Free Generic or 90-day supply programs.**
- **Due to Medicare Part D restrictions, this program does not apply to the CompanionCare pharmacy benefit.**

Generic Co-Pays for Lancets and Syringes

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

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

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

RETIREE GROUP MEDICARE PLANS (RGMP)

In addition to district retiree plans SISC offers an Individual Retiree Group Medicare Plan (RGMP) option. This is available to retirees turning age 65 enrolled in Medicare Parts A and B when offered by the district.

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

- **CompanionCare Medicare Supplement Plan (COC):** Must reside within the United States

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

Why is a 45-Calendar-Day Advance Notice Required for Enrollment and Disenrollment?
Centers for Medicare and Medicaid Services (CMS) require advance notice for enrollment and disenrollment in order to set up the account.

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

How do I Submit Activity for the Individual Retiree Plans?
Drop off activity to using the secure file transfer system at **siscconnect.org**.

It needs to be sent separate from the district activity and should include "RGMP documents" as part of the file name. If the district chooses to submit by fax, the fax cover sheet should clearly indicate "RGMP documents".

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

The following document that will be affected is the CompanionCare Application along with a copy of the retiree's Medicare card.

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

Are Retro Enrollments and Disenrollments Allowed?
No. Retro enrollments and disenrollments are not allowed on the CompanionCare.

Are Retirees Allowed to go Back to a District Plan Once They Have Enrolled in an RGMP?
Yes. Upon district approval a retiree may return to a district medical plan at open enrollment as long as there is no break in SISC coverage

How Should I Keep Track of Our Retirees?
Send out an annual letter requesting confirmation of contact information that you have on file.

COMPANIONCARE MEDICARE SUPPLEMENT PLAN

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

How Does CompanionCare Coordinate with Medicare?
The provider will need to submit claims to Medicare for payment and to Anthem Blue Cross for CompanionCare to pay. Medicare pays 80% of allowable charges and CompanionCare will pay for the other 20% of allowable charges.

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

When Can a Retiree Enroll?
A retiree with Medicare Parts A and B may enroll at any time. They do not need to wait for Open Enrollment.

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

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

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

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

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

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

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

DIRECT BILLING SELF-PAY RETIREES

SISC offers this value added service to our member districts at no cost to the retiree or the district. Districts now have the option of SISC managing the monthly billing and collection of premium. The plans that will be offered for Direct Bill are listed below. SISC will manage medical, dental and/or vision benefits for the district.

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

- The retiree must pay 100% of their medical, dental and vision coverage (if offered by SISC)
- The retiree can only be enrolled in one of the following retiree plans:
  - CompanionCare Medicare Supplement
- The retiree will have the option of the following dental and/or vision plan:
  - Delta Dental Premier Plan $1,500*
  - VSP C $20*

**If your district offers dental and vision through SISC, dental and vision plans listed above are the only choices offered under this program. This dental plan does not include an incentive level.*

If the retiree currently has a different dental or vision plan with the school district and they wish to continue with one or both of these products, they will have to change to the plans listed above in order to participate in this program.

The retiree will not have the option of staying on the district dental and/or vision plan.

Dental and vision are optional products and do not have to be purchased; however, the retiree must be currently participating in the dental and/or vision product in order to purchase them from SISC.

Acceptable Payment Methods: Retiree can enroll in the Automatic Payment Program (APP) and SISC will deduct the monthly premium from their checking account or they can mail in a check or money order.

Billing: Invoices are generated on the 1st of each month. Payment is due to SISC by the 10th of each month. If payment is not received, delinquency notices will follow and may lead to possible termination of benefits.

If the district makes any type of monthly contribution toward the retiree's benefits (health, dental and/or vision) the retiree will be obligated to make the full premium payment amount as SISC will only accept one payment from the retiree for this benefit. SISC will not accept partial payments.

District Responsibility: It will be the district's responsibility to notify retirees of benefit options. Provide the appropriate application/enrollment form to the retirees. Submit the completed and signed form to SISC, along with a copy of the retiree's Medicare card 45 calendar days prior to the effective date.

SISC Responsibility: If the district elects for SISC to provide this service, the retiree's benefits will be administered entirely by the SISC Health Benefits Department and no longer by the individual school district. All communication regarding the retiree's benefits and payments will be coming from, and directed to, the SISC office.

If you are interested in this program and would like additional information, please contact the SISC office at 661-636-4410. SISC will need a 60-calendar-day advance notice to implement this program.

COMPANIONCARE MEDICARE SUPPLEMENT PLAN, NORTHERN REGION

Benefit Summary

(As of 1/1/20—Based on Calendar Year)

Services	Medicare 2020 Benefits	CompanionCare Based on 2020 Medicare Benefits
Inpatient Hospital (Part A)	• Pays all but first $1,408 for 1st 60 days • Pays all but $352 a day for the 61st–90th day • Pays all but $704 a day • Lifetime Reserve for 91st to 150th day • Pays nothing after Lifetime Reserve is used (refer to Evidence of Coverage)	• Pays $1,408 • Pays $352 a day • Pays $704 a day • Pays 100% after Medicare and Lifetime Reserve are exhausted, up to 365 days per lifetime
Skilled Nursing Facilities (must be approved by Medicare)	• Pays 100% for 1st 20 days • Pays all but $176 a day for 21st to 100th day • Pays nothing after 100th day	• Pays nothing • Pays $176 a day for 21st to 100th day • Pays nothing after 100th day
Deductible (Part B)	• $198 Part B deductible per year	• Pays $198
Basis of Payment (Part B)	• 80% Medicare-approved (MA) charges after Part B deductible	• Pays 20% MA charges Including 100% of Medicare Part B deductible
Medical Services (Part B) • Doctor, x-ray • Appliances and ambulance lab	 • 80% MA charges • 100% MA charges	 • Pays 20% MA charges • Pays nothing
Physical/Speech Therapy (Part B)	• 80% MA charges up to the Medicare annual benefit amount	• Pays 20% MA charges up to the Medicare annual benefit amount (PT and ST combined)
Blood (Part B)	• 80% MA charges after 3 pints	• Pays 1st 3 pints unreplaced blood and 20% MA charges
Travel Coverage (when outside the US for less than 6 consecutive months)	• Not covered	• Pays 80% inpatient hospital, surgery, anesthetist and in-hospital visits for medically necessary services for 90 days of treatment per hospital stay. For details call Anthem customer service at 1-800-825-5541.

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

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

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

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

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

Provider Network: Physicians who accept Medicare Assignment

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

Rate Effective October 1, 2019	Total Cost Per Person
Retirees with Medicare Parts A and B (SISC will enroll members in Part D)	Northern Region: $402.00

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

DIRECT BILL RETIREE DENTAL

Dental Benefit Summary 2020-2021

Annual Benefit Maximum		
• The maximum benefit paid per calendar year is $1,700* per person in-network (this amount includes the additional $200 for using a Delta PPO dentist. • The maximum benefit paid per calendar year is $1,500 per person out-of-network		
Services	**Delta Dental Dentists****	**Non-Delta Dental Dentists****
Diagnostic and Preventive — Exams, 2 cleanings per calendar year, x-rays	100% covered	100% covered
Fillings and Other Basic Services Fillings, simple tooth extractions, sealants	100% covered	100% covered
Endodontics (root canals) — Covered Under Basic Services	100% covered	100% covered
Periodontics (gum treatment) — Covered Under Basic Services	100% covered	100% covered
Oral Surgery— Covered Under Basic Services	100% covered	100% covered
Major Restorative Services— Crowns, inlays, onlays, and cast restorations	100% covered	100% covered
Dentures, Bridges and Dental Implants	50% covered	50% covered
Dental Accident Benefits	100% (separate $1,000 maximum per person per calendar year)	

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

Rates	
Single	$57.00
Two-party	$114.00
Family	$150.00

DIRECT BILL RETIREE VISION

Vision Benefit Summary 2020-2021

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

Co-pay and Rates	
Exam and Materials Co-pay	**$20**
Single	$12.30
Two-party	$24.60
Family	$36.90

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DELTA DENTAL—PPO INCENTIVE PLAN

Benefit Summary and 2020–2021 Monthly Rates

Services	In-Network	Out-Of-Network	
Provider Network	**PPO Dentists**	**Premier Network Dentists**	**Non-Delta Dentists**
	When using a PPO contracted dentist, the annual maximum will be **increased by $200**.	When using a Delta Premier contracted dentist, Delta will pay up to the Annual Maximum elected by the district or bargaining unit.	When using a non-Delta Dentist, Delta will pay Usual, Customary and Reasonable (UCR) Charges, up to the Annual Maximum elected by the district or bargaining unit.
Diagnostic and Preventive Exams, X-rays, Cleanings	70% 1st year 80% 2nd year 90% 3rd year 100% 4th year and after	70% 1st year 80% 2nd year 90% 3rd year 100% 4th year and after	70% UCR 1st year 80% UCR 2nd year 90% UCR 3rd year 100% UCR 4th year and after
Other Basic Services Oral Surgery, Fillings, Periodontic Procedures, Root Canals and Sealants	70% 1st year 80% 2nd year 90% 3rd year 100% 4th year and after	70% 1st year 80% 2nd year 90% 3rd year 100% 4th year and after	70% UCR 1st year 80% UCR 2nd year 90% UCR 3rd year 100% UCR 4th year and after
Crowns Crowns, Jackets and Cast Restorations	70% 1st year 80% 2nd year 90% 3rd year 100% 4th year and after	70% 1st year 80% 2nd year 90% 3rd year 100% 4th year and after	70% UCR 1st year 80% UCR 2nd year 90% UCR 3rd year 100% UCR 4th year and after
Prosthodontics Dentures, Bridges, and Implants**	50%	50%	50% UCR

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

Annual Plan Maximum	$1,000	$1,500	$2,000	Unlimited**
Rates for Active Employees Only				
Composite	$80.00	$98.00	$109.00	$133.00

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

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

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

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

Locate a provider at: www.deltadentalins.com

DELTA DENTAL PPO PLANS

Benefit Summary and 2020–2021 Monthly Rates

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

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

Annual Plan Maximum	$1,500	$2,000	$3,000	Unlimited**
Rates for Active Employees Only				
Composite	$91.00	$97.00	$102.00	$118.00

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

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

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

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

Locate a provider at: www.deltadentalins.com

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

2020–2021 Monthly Rates

Maximum*	$500	$1,000	$1,500	$2,000	$3,000
Coverage for Dependent Children Only					
Composite	$3.50	$7.00	$10.50	$14.00	$21.00
Coverage for Adults and Dependent Children					
Composite	$4.10	$8.20	$12.30	$16.40	$24.60

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

Third Cleaning Option	
Composite	$2.60

Dental benefit includes two cleanings per calendar year.

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

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

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

NEW! ANTHEM BLUE CROSS DENTAL ESSENTIAL CHOICE

Benefit Summary 2020–2021

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

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

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

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

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

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

Annual Plan Maximum	$4,000
Rates for Active Employees Only	
Composite	$102.00

VISION SERVICE PLAN (VSP) SIGNATURE PLAN

Benefit Summary 2020-2021

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

Patient Options

Patients who choose to purchase lens options may do so with a **35–40% savings on all non-covered lens options**. The patient should check with a VSP participating doctor to verify whether items are covered or are considered options. Examples of options patients may choose include:

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

These cosmetic options are not covered in full by VSP; however, due to our agreements with VSP participating doctors and laboratories, these services are provided at a controlled cost, available only to VSP subscribers.

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

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

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

VISION SERVICE PLAN (VSP)—SIGNATURE PLAN

2020-2021 Monthly Rates

Single Co-pay Plans*					
Exam and Materials Co-pay	$0	$5	$10	$15	$20
PLAN A (Exam every 12 months, lenses and frames every 24 months)					
Composite	$18.60	$17.10	$16.60	$15.60	$14.70
PLAN B (Exam and lenses every 12 months, frames every 24 months)					
Composite	$22.10	$20.40	$19.70	$18.60	$17.50
PLAN C (Exam, lenses and frames every 12 months)					
Composite	$27.70	$25.50	$24.70	$23.30	$21.90

Dual Co-pay Plans*					
Exam Co-pay	$0	$5	$10	$15	$20
Materials Co-pay	$25	$25	$25	$25	$25
PLAN A (Exam every 12 months, lenses and frames every 24 months)					
Composite	$15.70	$14.40	$14.00	$13.20	$12.40
PLAN B (Exam and lenses every 12 months, frames every 24 months)					
Composite	$18.70	$17.20	$16.60	$15.70	$14.70
PLAN C (Exam, lenses and frames every 12 months)					
Composite	$23.40	$21.50	$20.80	$19.60	$18.50

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

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

VISION SERVICE PLAN (VSP) CHOICE PLAN

Benefit Summary 2020-2021

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

Patient Options

Patients who choose to purchase options may do so with a 20–25% savings on all non-covered lens options. The patient should check with a VSP participating doctor to verify whether items are covered or are considered options. Examples of options patients may choose include:

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

These cosmetic options are not covered in full by VSP; however, due to our agreements with VSP participating doctors and laboratories, these services are provided at a controlled cost, available only to VSP subscribers.

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

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

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

Locate a provider at: www.vsp.com

VISION SERVICE PLAN (VSP)—CHOICE PLAN RATES

2020-2021 Monthly Rates

Employees & Retirees					
Exam and Materials Co-pay	$0	$5	$10	$15	$20
PLAN A (Exam every 12 months, lenses and frames every 24 months)					
Composite	$15.50	$14.30	$13.80	$13.00	$12.30
PLAN B (Exam and lenses every 12 months, frames every 24 months)					
Composite	$18.40	$17.00	$16.40	$15.50	$14.60
PLAN C (Exam, lenses and frames every 12 months)					
Composite	$23.10	$21.30	$20.60	$19.40	$18.30

BASIC LIFE INSURANCE

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

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

What are the Monthly Rates for the Basic Group Life Insurance? (rates guaranteed to 10/1/2022)

Employee Group	Rate per $1,000 of Benefit—
K–12 School District Employees (excluding Confidential and Management)	$0.095
College and University Employees (excluding Confidential and Management)	$0.143
Confidential and Management Employees	$0.195

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

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

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

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

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

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

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

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

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

Contact your consultant JoeAnna Todd, Gallagher Benefit Services. if you are considering changes to your life insurance offering.

VOLUNTARY TERM LIFE INSURANCE

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

Who Can Enroll on The Voluntary Term Life Insurance Coverage through SISC?
Employees receiving Basic Life Insurance from their district may enroll in coverage within the first 31 calendar days of hire or of becoming newly eligible **without** having to provide evidence of good health.

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

What are the Monthly Rates?

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

How Much Coverage Can Be Purchased Through SISC?
Employees can purchase up to $250,000 (increments of $10,000) for themselves, up to $50,000 (increments of $5,000) for a spouse/domestic partner, and $10,000 for each dependent child. If an employee requests higher amounts of coverage, evidence of insurability will be required.

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

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

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

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

Does the Voluntary Term Life Benefit Ever Reduce?
Yes. The benefit and corresponding premium are reduced by 50% when an employee reaches age 70 and continues to reduce by 50% every five years until the employee reaches age 80. The reduction will be made on the January 1st that coincides with or follows the day the employee attains the specified age. The benefit is reduced according to the Age Discrimination in Employment Act (ADEA) chart (see the schedule of benefits section of the "Voluntary Term Life" policy).

Is There a Cash Value to this Policy?
No.

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

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

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

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

Additional Life Insurance Provisions

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

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

Life Insurance Reporting

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

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

If a Newly Eligible Employee is Enrolling on Voluntary Term Life Insurance, Do I Need to Submit a Voluntary Term Life Enrollment Form to SISC?
Yes. If a newly eligible employee would like to enroll in the Voluntary Term Life Insurance, the employee must complete the Voluntary Term Life Insurance Enrollment Form within the first 31 calendar days of hire or of becoming newly eligible.

It is the district's responsibility to keep the original enrollment form in the employee's personnel file. A copy of the enrollment form should be uploaded to SISC via **siscconnect.org**. If the district chooses to submit by fax, the fax cover sheet should clearly indicate "Voluntary Life Insurance Activity."

How Do I Report Voluntary Term Life Terminations to SISC?

Voluntary Term Life terminations should be submitted in writing through SISC Connect. It is the district's responsibility to keep a copy of the employee's requested termination in the employee's personnel file.

How Do I Report Voluntary Term Life Decreases of Coverage to SISC?

Requests for decreases of coverage should be submitted in writing through SISC Connect. It is the district's responsibility to keep a copy of the employee's requested changes in the employee's personnel file.

Beneficiaries and How to File a Life Insurance Claim

How Does an Employee Change a Beneficiary?

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

Do I Need to Send Life Insurance Beneficiary Change Forms to SISC?

No. It is the district's responsibility to keep any beneficiary change forms in the employee's personnel file.

What is a Primary Beneficiary?

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

What is a Secondary Beneficiary?

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

Can a Minor Child be a Beneficiary?

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

What Happens If No Beneficiaries are Named?

If an employee does not name a beneficiary or if no beneficiary survives the employee, benefits will be paid in the following order:

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

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

How Do I File a Claim?

In the event of a claim, it is the district's responsibility to provide the appropriate forms to the claimant. Life Claim form can be found on SISC Connect. Completed claims should consist of the Life Claim form, Basic life and Voluntary Term life enrollment form(s), Certificate of Death, and any Funeral Assignment forms if applicable. The forms should be mailed to the SISC office at PO Box 1847, Bakersfield, CA 93303. Districts should keep a copy of all forms submitted to SISC.

How Long Does a Claim Take to Process?

It takes the insurance carrier about 31 days to fully review each claim submitted. If additional information is required by the carrier, this may further delay the processing time.

FORMS AND RESOURCES

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

- Address Change Form (SISC use to notify District of returned mail)
- CompanionCare Application kit
- Declination of Coverage: Less Than Full-Time Active Employees and HIPAA Notification (for district use only)
- Declination of Coverage for Dependents of Active Employees and HIPAA Notification (for district use only)
- Declination of Coverage for Retirees: (for district use only)
- Delta Dental Designation Form: (for district use only)
- RGMP Disenrollment Form
- Maintenance Activity Report (MAR) Transfers
- Maintenance Activity Report (MAR) Terminations
- Membership Change Form (change member address, name, add/delete dependents etc.)
- Notification of Plan Changes: District's making changes: return to SISC
- SISCconnect Registration Form
- Universal Enrollment Form
- Notices sent by SISC to members (subject to change without notice)
  - CMS Notice of Rx Creditable Coverage Disclosure
  - HIPAA Notice of Privacy Practices
  - Women's Health (included with HIPAA Notice of Privacy Practices)
  - Medicare Eligible Notification Letter (turning-65 letter)
- Annual Notices sent to district's via SISC Health email (subject to change without notice)
  - Benefits Provided to Domestic Partners as Taxable Income
  - Open Enrollment Reminder
  - SISC Activity Schedule
- Affordable Care Act (ACA) resources contact your consultant JoeAnna Todd, Gallagher Benefit Services.

TELEPHONE NUMBERS—WHO TO CONTACT

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

Claims and Customer Service		
Anthem Blue Cross	www.anthem.com/ca/sisc	See ID Card
COBRA—SISC—Hilda Tapia	hitapia@kern.org	661-636-4214
Delta Dental of California	www.deltadentalins.com	866-499-3001
Employee Assistance Program (EAP) Anthem Blue Cross (EAP)	www.anthemeap.com	800-999-7222
Advance Medical	www.advance_medical.net/sisc	855-201-9925
I.D. Cards	See Vendor Website	
Individual Retiree Plans/ Medicare Advantage Plans • CompanionCare		800-825-5541
Life Insurance—SISC—Hilda Tapia	www.hitapia@kern.org	661-636-4214
MD Live	www.mdlive.com/sisc	800-657-6169
Navitus—Customer Service and Mail Order Service	www.navitus.com	866-333-2757
SISC Direct Bill Retirees—Cristina Arias	crarias@kern.org	661-636-4651
Vision Service Plan	www.vsp.com	800-877-7195

SISC Eligibility Technicians

SISC Main Telephone Number 661-636-4410

Secure document upload for activity only—**siscconnect.org** or Fax 661-636-4094

Christina Lele'a	chlelea@kern.org	661-636-4394
Maria Pierce	mapierce@kern.org	661-636-4397
Denise Puente	depuente@kern.org	661-636-4869
Shawna Smith	shsmith@kern.org	661-636-4508
Eleanor Maldonado	elmaldonado@kern.org	661-636-4307

GALLAGER BENEFITS SERVICE TEAM

Fax 559-750-5466

JoeAnna Todd, Area President	**JoeAnna_Todd@ajg.com**	(559) 635-3523
Diana Velasquez, Office Supervisor	**Diana_Velasquez@ajg.com**	(559) 635-3537
Judy Fussel, Area President	**Judy_Fussel@ajg.com**	(559) 635-3573

SISC Account Management Team

Fax 661-636-4893

Cassady Clifton	**caclifton@kern.org**	661-636-4669
Karen Morovich	**kamorovich@kern.org**	661-636-4622

CUSTOMER SERVICE PHONE NUMBERS AND ADDRESSES FOR CLAIMS INFORMATION AND PROCESSING

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

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

Provider	Address	Phone Number
Anthem Blue Cross PPO Plans	**Foundation for Medical Care of Tulare & Kings Counties, Inc.** 3335 South Fairway Visalia, CA 93277	559-734-1321 800-662-5502