2025-2026
BENEFITS

BENEFITS IN FOCUS

SANTA ROSA JUNIOR COLLEGE

CONTENTS

MEDICARE PART D NOTICE

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

GETTING STARTED

2025-2026 BENEFITS
October 1, 2025
through
September 30, 2026

This guide is for regular Classified, Contract Faculty and Management employees at Santa Rosa Junior College (SRJC). It provides an overview of your healthcare coverage and more.

If you're **Associate Faculty**, please refer to the Associate Faculty benefits page for your medical benefits.

Whether you're enrolling in benefits for the first time, nearing retirement, or somewhere in between, SRJC supports you with benefit programs and resources to help you thrive today and prepare for tomorrow.

You'll find tips to help you understand your medical coverage, save time and money on healthcare, reduce taxes, and balance your work and home life. Review the coverage and tools available to you to make the most of your benefits package.

WHO'S ELIGIBLE FOR BENEFITS?

Employees

You are eligible for SRJC medical, dental, vision and life insurance if you are a Classified, Contract Faculty or Management employee working 20 or more hours per week. If you are a Classified employee who works less than 20 hours per week, you are eligible for dental and vision insurance.

Employees with variable hours and seasonal schedules may be considered eligible for benefits. Refer to "Determining Eligibility" later in this guide for details.

Eligible dependents

- Legally married spouse.
- Registered Domestic Partner (RDP), where applicable by state law, is eligible for coverage if you are certified with the State of California.
- Natural, adopted or stepchildren, or children of a domestic partner up to age 26.
- Children over age 18 who are disabled and depend on you for support.
- Children named in a Qualified Medical Child Support Order (QMCSO).
- Children under legal guardianship up to age 18.

For additional information, please refer to the benefit booklets for each benefit.

Who is not eligible

Members who are not eligible for coverage include (but are not limited to):

- Parents, grandparents and siblings.
- Temporary employees not on SRJC payroll, Employees who work less than 20 hours per week unless Classified, or employees residing outside the United States.

CHANGING YOUR BENEFITS

Click to play video

LIFE HAPPENS

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

THREE RULES APPLY TO MAKING CHANGES TO YOUR BENEFITS DURING THE YEAR:

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

When you can enroll

You can enroll in benefits as a new hire or during the annual open enrollment period. New hire coverage begins the 1st of the month following your date of hire. Employees hired on the 1st of a month have their coverage start on the 1st of that month. You must enroll within 30 days of becoming eligible.

If you miss the enrollment deadline, you'll need to wait until the next open enrollment (the one time each year that you can make changes to your benefits for any reason).

Changing your benefits

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

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

You must submit your change within 30 days after the event.

Please see next page for more information on dependent verification.

ELIGIBILITY DOCUMENTATION CHECKLIST

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

Dependent Type	Required Documentation
Spouse	▪ Page 1 of prior year's Federal Tax Form 1040 that shows the couple was married (financial information may be blocked out) ▪ Official copy of Marriage certificate ▪ 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). ▪ Page 1 of prior year's Federal Tax Form 1040 for each person (financial information may be blocked out)
Children, Stepchildren, and/or Adopted Children up to age 26	▪ Legal Birth Certificate (to include full name of child, parent(s) name & child's DOB) ▪ Legal Adoption Documentation
Legal Guardianship up to age 18	▪ Legal U.S. Court Documentation establishing Guardianship
Disabled Dependents over age 26	**BLUE SHIELD (All items listed below are required)** ▪ Legal Birth Certificate (to include full name of child, parent(s) name and child's DOB) ▪ Page 1 of prior year's Federal Tax Form 1040 that shows child is claimed as an IRS dependent (income information may be blocked out) ▪ Proof of 6 months prior creditable coverage under the employee/retiree's plan. There can be no break in coverage. ▪ Completed Declaration of Disability form for Overage Dependent Child **KAISER (All items listed below are required)** ▪ Legal Birth Certificate (to include full name of child, parent(s) name & child's DOB) ▪ Page 1 of prior year's Federal Tax Form 1040 that shows child is claimed as an IRS dependent (income information may be blocked out) ▪ Proof of 6 months prior creditable coverage ▪ Completed Disabled Dependent Enrollment Application ▪ Most recent Kaiser Disability Certification notice (if available)
Retirees and/or Dependents on a Retiree Plan Age 65 or Over	▪ Proof of enrollment in Medicare Part A & Part B (copy of current Medicare card or Medicare enrollment confirmation letter showing effective dates of Part A and Part B)

ENROLLING FOR BENEFITS

MID-YEAR CHANGES

- Mid-year changes should be initiated through HR – HR may reach out for additional verification.

Before you enroll

- Know the date of birth, social security number and address for each dependent you will cover.
- Review your enrollment materials to understand your benefit options and costs for the coming year.
- Compile the required dependent documentation.

Getting started

Click the link below to download your enrollment forms.

- hr.santarosa.edu/benefit-enrollment-forms

- Please email all completed forms to Christie Colón in Human Resources.

Medical

OUR PLANS

BLUE SHIELD OF CALIFORNIA PPO

BLUE SHIELD OF CALIFORNIA HMO

BLUE SHIELD OF CALIFORNIA HDHP (HSA)

KAISER PERMANENTE HMO

KAISER PERMANENTE HDHP (HSA)

We offer 5 comprehensive medical plans through Kaiser Permanente and Blue Shield of California. The medical plans meet the Affordable Care Act (ACA) requirements for affordable minimum essential coverage that provides minimum value for full-time employees.

Which Plan Is Right For You?

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

Do you prefer specific doctors or hospitals?

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

What are your usual healthcare needs?

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

Consider the bottom line

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

UNDERSTANDING PLAN TYPES

SRJC offers 3 medical plan types so that you can pick the plan that best fits your budget and healthcare needs.

Some plans (like HMOs) restrict you to in-network doctors. Other plans (like PPOs) allow you to see any doctor, but you will pay a higher coinsurance percentage if the doctor is out-of-network.

	HMO Health Maintenance Organization	**PPO** Preferred Provider Organization	**HDHP** High Deductible Health Plan
Deductible	✓ (For Blue Shield - Deductible is for Brand Name or Specialty drugs only)	✓ (Deductible is for Brand Name or Specialty drugs only)	✓ (Deductible is for medical services and all prescription drugs)
Out-of-Network Care Covered		✓	✓
Referral Needed to see Specialist	✓		
Must select Primary Care Physician	✓		
Pros	• More predictable costs	• You can go anywhere, whether in-network or out-of-network	• An HMO or PPO with a high deductible, but with the advantage of a tax-free Health Savings Account (HSA)
Cons	• Less flexibility • No out-of-network coverage • May have to select Primary Care Physician	• You pay more for out-of-network providers	• More responsibility for out-of-pocket costs until the deductible is met

Click to play video

All About Medical Plans

Medical plans can seem hard to understand, but once you understand the building blocks you will be able to choose the best plan for you and your dependents.

Medical PPO Plan

You always pay the copayment ($). The coinsurance (%) shows what percentage you pay.

	Blue Shield of California PPO		
	In-Network		**Out-of-Network**
Calendar Year Deductible[1] Individual Family	 $0 $0		 $0 $0
Calendar Year Out-of-Pocket Maximum[1] Individual Family Embedded/Aggregate[2]	 $1,000 $3,000 Embedded		 $1,000 $3,000 Embedded
Office Visit Primary Care Specialist	 $20 per visit $20 per visit		 50% 50%
Preventive Services	No charge		Not covered
Chiropractic	No charge (up to 20 visits/year)		Not covered
Lab and X-ray	No charge		Not Covered
Urgent Care	$20 per visit		50%
Emergency Room	$100 per visit (waived if admitted)		$100 per visit (waived if admitted)
Inpatient Hospitalization	No charge		All charges above $600
Outpatient Surgery	No charge		All charges above $350
PRESCRIPTION DRUGS (Navitus)			
Plan Year (Brand/Specialty) Deductible[3]	$200 Individual/$500 Family		Not covered
Out-of-Pocket Maximum	$2,500 Individual/$3,500 Family		Not covered
Retail Generic Brand Specialty	**In- Network (30-day)** $10 $35 N/A	**Costco (30-day/90-day)** No Charge/No Charge $35/$90 N/A	Not covered
Mail Order Generic Brand Specialty	**Navitus (30-day)** N/A N/A $35	**Costco (90-day)** No Charge $90 N/A	Not covered

[1]Deductibles and out-of-pocket maximums accumulate on a calendar year from January 1 through December 31.
[2]An embedded family maximum means the plan will cover 100% for an individual member as soon as they reach their individual maximum. All covered expenses including your medical deductibles and prescription copays accumulate towards the out-of-pocket maximum.
[3]Deductible only applies to Brand and Specialty drugs. Copays apply only after the brand deductible is met.

Medical HMO Plans

You always pay the copayment ($).

	Kaiser Permanente HMO	Blue Shield of California HMO	
	In-Network	In-Network	
Calendar Year Deductible[1] Individual Family	 $0 $0	 $0 $0	
Calendar Year Out-of-Pocket Maximum[1] Individual Family Embedded/Aggregate[2]	 $1,500 $3,000 Aggregate	 $2,000 $4,000 Embedded	
Office Visit Primary Care Specialist	 $25 per visit $25 per visit	 $25 per visit $25 per visit (referred by PCP) / $30 per visit (self-referral)	
Preventive Services	No charge	No charge	
Chiropractic & Acupuncture Services	$10 per visit (up to 30 visits/year combined)	$10 per visit (up to 30 visits/year combined)	
Lab and X-ray	No charge	No charge	
Urgent Care	$25 per visit	$25 per visit	
Emergency Room	$100 per visit (waived if admitted)	$100 per visit (waived if admitted)	
Inpatient Hospitalization	No charge	$500 per admission	
Outpatient Surgery	$25 per procedure	$300 per procedure	
PRESCRIPTION DRUGS			
Plan Year (Brand/Specialty) Deductible[3]	$0	$200 Individual / $500 Family	
Out-of-Pocket Maximum	Included with Medical	$2,500 Individual / $3,500 Family	
Retail Generic Brand Specialty	 $10 (up to 100-day supply) $25 (up to 100-day supply) $25 (up to 30-day supply)	**In-Network (30-day)** $10 $35 N/A	**Costco (30-day/90-day)** No Charge/No Charge $35/$90 N/A
Mail Order Generic Brand Specialty	 $10 (up to 100-day supply) $25 (up to 100-day supply) N/A	**Navitus (30-day)** N/A N/A $35	**Costco (90-day)** No Charge $90 N/A

[1]Deductibles and out-of-pocket maximums accumulate on a calendar year from January 1 through December 31.
[2]An aggregate maximum means your family must meet the entire family out-of-pocket maximum before the plan pays 100% for any member. All covered expenses including prescriptions accumulate towards the out-of-pocket maximum, including your deductibles.
[3]Deductible only applies to Brand and Specialty drugs. Copays apply only after the brand deductible is met.

Medical HDHP Plans (HSA Compatible)

You always pay the deductible and copayment ($). The coinsurance (%) shows what you pay after the deductible has been met.

	KAISER PERMANENTE HDHP	BLUE SHIELD OF CALIFORNIA HDHP		
	In-Network	In-Network		Out-of-Network
Calendar Year Deductible[1] Individual Family Embedded/Aggregate[2]	 $1,700 $3,400 Embedded	 $1,700 $3,400 Embedded		 $1,700 $3,400 Embedded
Calendar Year Out-of-Pocket Maximum[1] Individual Family Embedded/Aggregate[3]	 $3,500 $7,000 Embedded	 $3,400 $6,800 Embedded		 None None Embedded
HSA Employer Contribution Individual Family	$1,200 $1,800	$1,200 $1,800		
Office Visit[4] Primary Care Specialist	 10% 10%	 10% 10%		 50% 50%
Preventive Services	$0	$0		Not covered
Chiropractic[4] (up to 20 visits/year)	Not covered	10%		Not covered
Lab and X-ray[4]	10%	10%		Not covered
Urgent Care[4]	10%	10%		50%
Emergency Room[4]	10%	$100/visit plus 10% (copay waived if admitted)		
Inpatient Hospitalization[4]	10%	10%		All charges above $600
Outpatient Surgery[4]	10%	10%		All charges above $350
PRESCRIPTION DRUGS (Navitus)				
Plan Year Deductible Individual Family	 $1,500 $3,000	 $1,700 $3,400		Not Covered
Out-of-Pocket Maximum Individual Family	 $3,000 $6,000	 $3,400 $6,800		Not Covered
Retail[4] Generic Brand Specialty	 $10 (up to 30-day supply) $30 (up to 30-day supply) $30 (up to 30-day supply)	**In- Network (30-day)** $9 $35 N/A	**Costco (30-day/90-day)** No Charge $35/$90 N/A	Not Covered
Mail Order[4] Generic Brand Specialty	 $20 (up to 100-day supply) $60 (up to 100-day supply) N/A	**Navitus (30-day)** N/A N/A $35	**Costco (90-day)** No Charge $90 N/A	Not Covered

[1]Deductibles and out-of-pocket maximums accumulate on a calendar year from January 1 through December 31.
[2] An embedded family deductible means the plan begins to make payments for a member when they reach their individual deductible.
[3]An embedded family maximum means the plan will cover 100% for an individual member as soon as they reach their individual maximum.
All covered expenses including your medical deductibles and prescription copays accumulate towards the out-of-pocket maximum.
[4]After deductible.

HEALTH SAVINGS ACCOUNT (HSA)

Click to play video

ARE YOU ELIGIBLE?

The HSA is not for everyone. You're eligible only if you are:

1. Enrolled in the Kaiser Permanente High Deductible Health Plan with HSA or Blue Shield of California High Deductible Health Plan with HSA.
2. Not enrolled in other non-HDHP medical coverage, including Medicare, Medicaid or Tricare.
3. Not a tax dependent.
4. Not enrolled in a healthcare Flexible Spending Account (FSA), unless it's a "limited purpose" FSA for dental and vision expenses.

A personal savings account for healthcare

A Health Savings Account (HSA) is an easy way to pay for healthcare expenses that you have today and save for expenses you may have in the future.

How the Fidelity HSA works

- You must be enrolled in one of SRJC's High Deductible Health Plans (HDHP)
- Your HSA account is set up automatically after you enroll.
- You can contribute up to the 2025 annual limit set by the IRS:
  Individual: $4,300 per year
  Family: $8,550 per year
  Are you age 55 **or over?** You can contribute an additional $1,000 per year
- To help you get started, SRJC makes a contribution to your HSA (this is included in the IRS maximums noted above):
  Individual: $100/month
  Family (2 or more): $150/month
- You can use your HSA debit card to pay for eligible expenses like office visits, lab tests, prescriptions, dental and vision care, and even some drugstore items.

Four reasons to love an HSA

1. **Tax-free.** No federal tax on contributions, or state tax in most states. Withdrawals are also tax-free as long as they're for eligible healthcare expenses.
2. **No "use it or lose it."** Your balance rolls over from year to year. You own the account and can continue to use it even if you change medical plans or leave your SRJC employment.
3. **Use it now or later.** Use your HSA for healthcare expenses you have today or save it to use in the future.
4. **Boosts retirement savings.** After you retire, you can use your HSA for healthcare expenses tax-free, or for regular living expenses, taxable but no penalties.

Find out more

- Eligible Expenses
- Ineligible Expenses

SISC Value Added Services

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

BENEFIT HIGHLIGHTS	AVAILABILITY & HOW TO GET STARTED
24/7 Help with Personal Concerns **SISC Employee Assistance Program** Access free, confidential resources for help with emotional, marital, financial, addiction, legal or stress issues.	*All employees* **Call** 800-999-7222 **Visit** anthemEAP.com/SISC
Online Counseling and Therapy **Talkspace** Digital platform that supports behavioral health and emotional wellness needs from a secure, HIPAA-compliant app. Up to 6 counseling sessions per situation.	*All employees* **Visit** talkspace.com/associatecare and enter SISC as your organization name
Expert Medical Opinions **Teladoc Medical Experts** Get answers to health care questions and second opinions from world-leading experts.	*Blue Shield and Kaiser members* **Call** 855-380-7828 **Visit** teladoc.com/SISC
Personal Health Coaching **Vida Health**[1] Get one-on-one health coaching, therapy, chronic condition management, health trackers and other tools and resources online or via phone.	*Blue Shield members* **Call** 855-442-5885 **Visit** vida.com/sisc
24/7 Physician Access—Anytime, Anywhere **MDLive**[2] Access to virtual visits with psychiatrists and therapists for members age 10 and up. Virtual urgent care services are available to all members. Physicians can prescribe medication when appropriate.	*Blue Shield members* **Call** 800-657-6169 **Visit** mdlive.com/sisc
Free Generic Medications **Costco** Access most generic medications at no cost through Costco retail and mail order pharmacies. You don't need to be a Costco member.	*Blue Shield members* **Call** 800-774-2678 (press 1) **Visit** costco.com

[1] Not available to SISC HSA Members.
[2] Copays may apply.
Per IRS guidelines, SISC HSA Members may not be eligible for these programs.

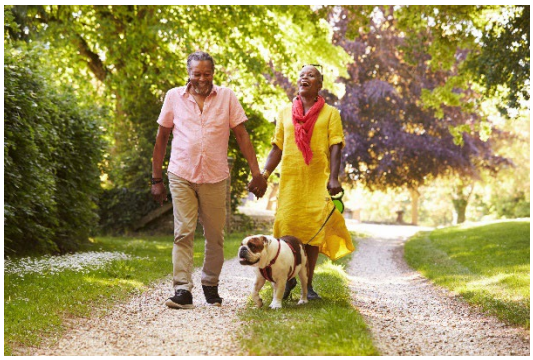
SISC Value Added Services

BENEFIT HIGHLIGHTS	AVAILABILITY & HOW TO GET STARTED
Virtual Expert Menopause Care **Midi Health**[1] Access to expert care for menopause through a specialized virtual clinic. The Midi team can provide personalized care for symptoms like hot flashes, mood changes, poor sleep, and more.	*Blue Shield PPO members* **Visit** joinmidi.com/sisc
Physical Therapy for Back or Joint Pain **Hinge Health**[1] Get access to free wearable sensors and monitoring devices, unlimited one-on-one coaching and personalized exercise therapy.	*Blue Shield PPO members* **Call** 855-902-2777 **Visit** hingehealth.com/sisc
24/7 Virtual Primary Care Doctor **Centivo Care** Virtually connect with a primary care physician to manage all your physical and mental healthcare needs. Centivo Care providers diagnose conditions, manage prescriptions, refer to in-network specialists, and answer follow up questions using video visits or live chat.	*Blue Shield PPO members* **Visit** centivocare.com/sisc or download the app
24/7 Access to Virtual Maternity & Postpartum Support **Maven** Consult with a care advocate who connects you with trustworthy content delivered by doctors, specialists' coaches and other maternity providers to help deal with pregnancy and postpartum concerns.	*Blue Shield PPO members* **Visit** mavenclinic.com/join/SISC
Hip, Knee, and Spine Surgical Benefit **Carrum Health** Consult top-quality surgeons on hip and knee replacements and certain spine surgeries. Benefit covers all related travel and medical bills.	*Blue Shield PPO members* **Call** 888-855-7806 **Visit** info.carrumhealth.com/sisc/
Enhanced Cancer Benefit **Lantern Cancer Care** Get help from a personal oncology nurse who can partner with you on every step of your cancer journey, including a review of your initial diagnosis and development of a care plan.	*Blue Shield PPO members* **Visit** lanterncare.com

[1] Not available to SISC HSA Members.

Per IRS guidelines, SISC HSA Members may not be eligible for these programs.

RESOURCES FOR KAISER MEMBERS



FINDING A KAISER PROVIDER

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

MY HEALTH MANAGER

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

24/7 care advice

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

Kaiser Away From Home

Kaiser Members are covered for emergency and urgent care anywhere in the world. Visit healthy.kaiserpermanente.org/get-care/traveling to learn about what to do if you need emergency or urgent care during your trip.

One Pass Select Affinity by Optum

Through One Pass Select Affinty from Optum members can choose a fitness plan and get unlimited access to all locations available within that plan, plus extensive digital resources.

Members can choose the plan that fits their needs, with competitive plans starting at $10 per month. Members that sign up can also access the Optum Additional service include healthy meal delivery and 20% discounts on chiropractors, acupuncturists and massage therapists. Learn more at healthy.kaiserpermanente.org/health-wellness/fitness-offerings.

Headspace App

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

Calm App

The Calm app uses meditation and mindfulness to help lower stress, reduce, anxiety, and improve sleep quality. Adult members can get Calm at kp.org/selfcareapps.

Online wellness tools

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

RESOURCES FOR BLUE SHIELD MEMBERS

FINDING A BLUE SHIELD PROVIDER

To find a provider in your plan network, please visit blueshieldca.com/provider.

BLUESHIELDCA.COM & MOBILE APP

Register at blueshieldca.com or download the Blue Shield app from the App Store℠ or Google Play® to access tools to help you improve your health, make informed decisions about your care, and find options to save you money.

BLUE SHIELD ID CARDS

For PPO and HDHP plans, one ID card will be issued to subscriber and one to spouse/domestic partner. Two cards will be issued in the subscriber's name for subscriber plus child(ren) contracts. ID cards with child dependent names can be requested by calling the member service number on the ID card. For HMO plans, ID cards will be issued to each member enrolled. HMO/PPO enrollees will also receive an Navitus ID card to access pharmacy benefits.

Save on fitness club memberships

This program gives you access to more than 800 fitness centers in California and more than 10,000 nationwide starting at $19 a month. The wellness discount programs also include acupuncture and chiropractic services; therapeutic massage; and eye exams, frames, contact lenses, and LASIK surgery. Learn more at blueshieldca.com/wellnessdiscounts.

Care Management Program

Get support managing your health needs for conditions such as diabetes, depression, chronic pain, cancer, as well as other conditions. Services include personalized health coaching, care plan development, provider coordination, plus more. To learn more, go to blueshieldca.com and click on Conditions and care programs, and then select Shield Support. You can also call (877) 455-6777 to find out if you're eligible.

Maven Maternity Program

The Maven Maternity Program, to support you every baby step of the way. With Maven, you and your partner can get access to virtual care for pregnancy, postpartum, and returning to work after parental leave. Plus, you'll enjoy 24/7 access to Care Advocates, specialists, and coaches – as well as content tailored to your experience. To learn more, go to blueshieldca.com/maven.

Headspace App

As the world's most science-backed meditation app, Headspace can help you reduce stress, increase resilience, and get a better night's rest. By dedicating just a few minutes a day you can join 70 million Headspace members worldwide using meditation to improve mental well-being. Visit wellvolution.com/mentalhealth to get started.

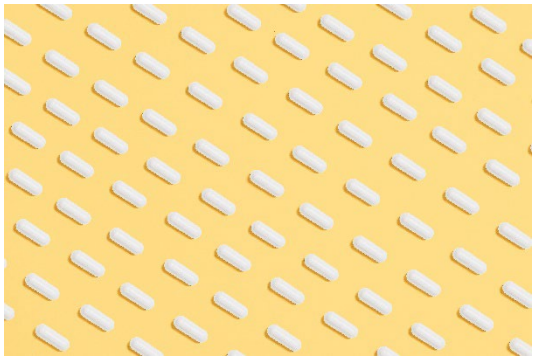
Virtual or walk-in health care at CVS (PPO members only)

You can get virtual and in-person non-emergency health care seven days a week by board-certified nurse practitioners at CVS locations across California through MinuteClinic. You can find hours of operation and a list of services at cvs.com/minuteclinic.

Solera4Me – Diabetes Prevention

With the Diabetes Prevention Program, you can learn more about wellness, makes changes to start losing weight and reduce your risk of developing type 2 diabetes. When you enroll, you get to choose the type of support you prefer, whether it's in-person, online, or even through a smartphone app. For more information visit solera4me.com.

PRESCRIPTION DRUGS FOR BLUE SHIELD MEMBERS – NAVITUS



NAVITUS APP

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

NAVITUS FORMULARY

You can also find a list of formulary and preventive medications on navitus.com.

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

Understanding Your Pharmacy Benefits

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

With the Costco Home Delivery Pharmacy

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

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

Get the most from your coverage

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

KNOW WHERE TO GO

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

Type	Appropriate for	Examples	Access	Cost
Nurseline 	Quick answers from a trained nurse	▪ Identifying symptoms ▪ Decide if immediate care is needed ▪ Home treatment options and advice	24/7	**$0**
Online visit 	Many non-emergency health conditions	▪ Cold, flu, allergies ▪ Headache, migraine ▪ Skin conditions, rashes ▪ Minor injuries ▪ Mental health concerns	24/7	**$**
Office visit 	Routine medical care and overall health management	▪ Preventive care ▪ Illnesses, injuries ▪ Managing existing conditions	Office Hours	**$$**
Urgent care, walk-in clinic 	Non-life-threatening conditions requiring prompt attention	▪ Stitches ▪ Sprains ▪ Animal bites ▪ Ear-nose-throat infections	Office Hours, or up to 24/7	**$$$**
Emergency room 	Life-threatening conditions requiring immediate medical expertise	▪ Suspected heart attack or stroke ▪ Major bone breaks ▪ Excessive bleeding ▪ Severe pain ▪ Difficulty breathing	24/7	**$$$$$**

WABE: Waiver of Active Benefit Enrollment

What is WABE?

The WABE allows eligible employees to “opt out” of medical and prescription drug plans while maintaining access to valuable wellness services.

You don’t pay a monthly premium for the WABE plan.

Why Choose WABE?

- Ideal for employees already covered by a spouse or partner’s health plan.
- Preserves access to important wellness services.

Important Things to Know

- If you have other coverage through a spouse or Domestic Partner, check their group health plan requirements before electing WABE. Some employer plans may require dependents to enroll in their own available group coverage. Failure to comply with those requirements could impact your coverage eligibility.
- The Employee must stay enrolled until the next Open Enrollment unless a mid-year Qualifying Event occurs. Examples of Qualifying Events include:
  - Loss of other coverage
  - Divorce or legal separation
  - Death of a spouse or partner
- WABE covers wellness services such as those listed below but does not provide medical or prescription coverage.
- Dental coverage through Redwood Health Services and vision coverage through VSP remain available.

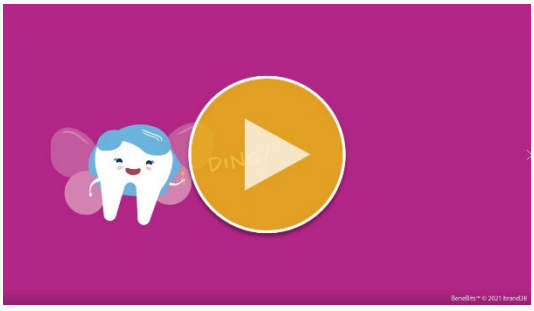
WABE Benefits	How To Get Started
24/7 Help with Personal Concerns **SISC Employee Assistance Program**	**Call** (800) 999-7222 **Visit** anthemEAP.com/SISC
Expert Medical Opinions **Teladoc Medical Experts**	**Call** (855) 380-7828 **Visit** teladoc.com/SISC
Personal Health Coaching **Vida Health**	**Call** (855) 442-5885 **Visit** vida.com/sisc
24/7 Physician Access **MDLive**	**Call** (800) 657-6169 **Visit** mdlive.com/sisc
Health Screenings & Flu Shots **Quest & Costco**	Free onsite screenings and seasonal flu shots, where available

Dental

OUR PLANS

Redwood Health Services

Click to play video



We offer a dental plan through Redwood Health Services.

Why Sign Up For Dental Coverage?

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

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

Dental insurance covers three types of treatments:

- **Preventive** care includes exams, cleanings and x-rays
- **Basic** care focuses on repair and restoration with services such as fillings, root canals, and gum disease treatment
- **Major** care goes further than basic and includes bridges, crowns and dentures

Dental

The coinsurance (%) shows what percentage you pay.

	Redwood Health Services[3]		
	Level 1[2]	**Level 2[2]**	**Level 3[2]**
Plan Year Deductible[1]	None		
Plan Year Maximum	$1,700		
Diagnostic & Preventive	20%	10%	No charge
Basic Services Fillings Root Canals Periodontics	40%	30%	10%
Major Services	40%	30%	10%

[1]Plan year is October 1, 2025, through September 30, 2026.
[2]Dental plan is an incentive plan. All subscribers start at Level 1. Once you reach 100% coverage, you remain at that level.
[3]A PPO network will be available for those outside the range of the current network.

What you need to know about this plan

Features:
This is an incentive plan. All subscribers begin at Level 1. If go to the dentist during your 1st plan year, you move to Level 2, etc. until you reach Level 3. Once Level 3, 100% preventive coverage is reached, you remain at that level.

Am I restricted to in-network providers?
Yes. If you live outside the current network area, a PPO Network will be made available to you.

Do I have to select a primary dentist?
No. Simply choose a dentist from the provider list.

Can I use my HSA or FSA?
If you participate in a healthcare FSA, limited purpose FSA, or HSA, you can use your account to pay for dental expenses.

Where can I get more details?
Contact Redwood Health Services at (800) 548-7677, option 2 or email rhscustomerservice@rhs.org
Customer Service hours:
Monday-Friday, 7:30am – 4:00pm PST

Vision

OUR PLANS

VSP Vision

Click to play video

We offer a vision plan through VSP.

Why Sign Up For Vision Coverage?

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

Vision

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

	VSP
	In-Network
Exams	
Benefit	$10 copay
Materials	Combined with exam copay
Frequency[1]	Once every plan year
Eyeglass Lenses	
Single Vision Lens	Combined with exam copay
Bifocal Lens	Combined with exam copay
Trifocal Lens	Combined with exam copay
Progressive Lens	$0-160 copay (depending on selection)
Lens Enhancements	35-40% savings
Frequency	Once every plan year
Frames	
Benefit	$150 allowance for frames $170 allowance for featured frame brands $150 allowance for Walmart/Sam's Club $80 allowance for Costco frames
Frequency	Once every other plan year
Contacts (Elective)	
Conventional and Medically Necessary	$120 allowance for contact and contact lens exam
Frequency	Once every plan year

[1]Plan year is October 1 through September 30

What you need to know about this plan

Features:	Get the most out of your benefits and greater savings with a VSP network doctor.
Will I receive an ID card?	No. VSP does not issue insurance ID cards. Simply tell the provider you have VSP. If you'd like a card as reference, you can print one on www.vsp.com.
Eyeglasses are expensive. Will I still be able to afford them, even with insurance?	Look for moderately priced frames and remember that your benefit is higher in-network. If you participate in the HSA plan, you can use your account to pay for vision care and eyewear with tax-free dollars.
Where can I get more details?	Call (800) 877-7195 or visit www.vsp.com

Basic Life and AD&D

YOUR BENEFICIARY = WHO GETS PAID

If the worst happens, your beneficiary—the person (or people) on record with the life insurance carrier—receives the benefit. Make sure that you name at least one beneficiary for your life insurance benefit, and change your beneficiary as needed if your situation changes.

Basic Life and AD&D

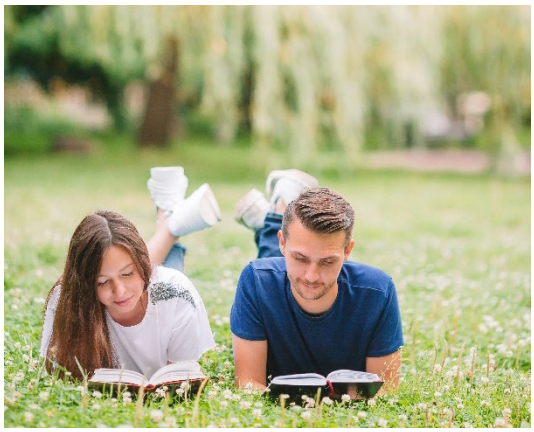
For Contract Faculty, Classified and Management employees

Basic Life Insurance pays your beneficiary a lump sum if you die. AD&D (Accidental Death & Dismemberment) coverage provides a benefit to you if you suffer from loss of a limb, speech, sight, or hearing, or to your beneficiary if you have a fatal accident. Basic Coverage is provided by Standard Insurance Company and premiums are paid in full by Santa Rosa Junior College.

- Basic Life Insurance with matching Accidental Death & Dismemberment (AD&D) in the amount of $50,000
- Basic Dependent Life and AD&D insurance in the amount of $5,000

The benefit amounts above will be reduced if you are age 70 or older. Refer to the plan document for details.

VOLUNTARY LIFE AND AD&D INSURANCE



GUARANTEED ISSUE

If you purchase supplemental life insurance within 120 days of your hire date, the Medical History Statement is not needed. $100,000 Supplemental coverage for employees and $6,500 for dependents is guaranteed issue with timely enrollment.

If you purchase supplemental life insurance coverage after your initial eligibility period, you will need to submit the Medical History Statement in order for the insurance company to approve the amount of coverage.

Protecting those you leave behind

Voluntary Life Insurance allows you to purchase additional supplemental life insurance to protect your family's financial security. Coverage is provided by Standard Insurance Company and is available for your spouse and/or child(ren).

In the event of a serious or fatal accident

Voluntary AD&D Insurance allows you to purchase supplemental accidental death and dismemberment coverage that pays your beneficiary if you have a fatal accident. If you experience a serious injury such as a loss of a limb, speech, sight or hearing, the plan pays a benefit to you.

Coverage is provided by Standard Insurance Company and is available for your spouse and/or child(ren).

Voluntary Life and AD&D

Contract Faculty and 10-month employees

You can purchase Employee-paid supplemental benefits for yourself:

- Supplemental Life and AD&D Insurance in the amount of $50,000 (costs $12/month)
- Supplemental Plus Life and AD&D Insurance for an additional amount of $50,000 (costs another $12/month)

You can purchase Employee paid supplement benefits for your dependents:

- Dependents Life Insurance Buy-Up option in the amount of $1,500. This option costs $.42 per month.
- Dependents Life Insurance Voluntary option in the amount of $5,000. This option costs $1.20 per month.

12-month employees

You can purchase Employee paid supplemental benefits for yourself:

- Supplemental Life and AD&D Insurance in the amount of $50,000 (costs $10/month)
- Supplemental Plus Life and AD&D Insurance for an additional amount of $50,000 (costs another $10/month)

You can purchase Employee paid supplement benefits for your dependents:

- Dependents Life Insurance Buy-Up option in the amount of $1,500. This option costs $.35 per month.
- Dependents Life Insurance Voluntary option in the amount of $5,000. This option costs $1.00 per month.

The benefit amounts above will be reduced if you are age 70 or older. Refer to the plan document for details.
Your Supplemental Plus Life and AD&D Insurance benefit ends at age 65.

ENGAGE

FIND OUT MORE ABOUT fitSRJC RESOURCES

1. Employee Fitness Classes
2. Fitness Sessions & Calendar
3. Fitness Challenges

fit.santarosa.edu

Health Enhancing Programs

fitSRJC was created for employees by employees to fulfill the SRJC Mission to "promote personal and professional growth and cultivate joy at work in lifelong learning."

Our fitSRJC goals are to increase staff holistic wellness by encouraging a workplace culture of wellness and build community across silos centered on the culture of holistic wellness.

IMPORTANT PLAN INFORMATION

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

- Your benefit contributions
- Contact information for our benefit carriers and vendors
- A summary of the health plan notices you are entitled to receive annually, and where to find them
- A Benefits Glossary to help you understand important insurance terms.
- Annual Notices
    - Medicare Part D Notice
    - Women's Health and Cancer Rights Act
    - Newborns' and Mothers' Health Protection Act
    - HIPAA Notice of Special Enrollment Rights
    - Michelle's Law
    - Availability of Privacy Practices Notice
    - Notice of Choice of Providers
    - ACA Disclaimer
    - Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

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

YOUR MONTHLY BENEFIT COSTS

The total amount that you pay for your benefits coverage depends on the plans you choose and how many dependents you cover. Your healthcare costs are deducted from your pay on a pre-tax basis — before federal, state, and social security taxes are calculated — so you pay less in taxes. The monthly premiums you'd owe are listed below. For employees working less than full-time, benefits will be pro-rated.

1.0 FTE Management (12 month)

	Single	Double	Family
Kaiser HMO	$60.00	$120.00	$180.00
Kaiser HSA	$0.00	$0.00	$0.00
Blue Shield HSA	$0.00	$0.00	$0.00
Blue Shield HMO	$179.00	$413.00	$600.00
Blue Shield PPO	$303.00	$687.00	$986.00
SRJC Dental	$0.00	$0.00	$0.00
Vision	$0.00	N/A	$11.53

1.0 FTE Classified (12 month)

	Single	Double	Family
Kaiser HMO	$0.00	$0.00	$0.00
Kaiser HSA	$0.00	$0.00	$0.00
Blue Shield HSA	$0.00	$0.00	$0.00
Blue Shield HMO	$119.00	$293.00	$420.00
Blue Shield PPO	$243.00	$567.00	$806.00
SRJC Dental	$0.00	$0.00	$0.00
Vision	$0.00	N/A	$11.53

1.0 FTE Contract Faculty & 10-month Classified

	Single	Double	Family
Kaiser HMO	$0.00	$0.00	$0.00
Kaiser HSA	$0.00	$0.00	$0.00
Blue Shield HSA	$0.00	$0.00	$0.00
Blue Shield HMO	$142.80	$351.60	$504.00
Blue Shield PPO	$291.60	$680.40	$967.20
SRJC Dental	$0.00	$0.00	$0.00
Vision	$0.00	N/A	$13.84

PLAN CONTACTS

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

Plan Type	Provider	Phone Number	Website
MEDICAL	Blue Shield of California	855-599-2657	blueshieldca.com
MEDICAL	Kaiser Permanente	800-464-4000	kp.org
PHARMACY	Navitus RX	866-333-2757	Navitus.com/members
DENTAL	Redwood Health Services	800-548-7677 ext. 2	services.hi-techhealth.com/rhs/pages/member_signon.shtml
VISION	VSP	800-877-7195	vsp.com
LIFE & AD&D	The Standard	800-522-0406	standard.com
EMPLOYEE ASSISTANCE PROGRAM (EAP)	Anthem	800-999-7222	anthemeap.com/sisc

GLOSSARY

-A-

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

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

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

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

-B-

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

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

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

-C-

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

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

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

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

-D-

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

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

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

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

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

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

-E-

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

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

-F-

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

-G-

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

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

-H-

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

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

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

GLOSSARY

-I-

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

-L-

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

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

-M-

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

-O-

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

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

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

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

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

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

-P-

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

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

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

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

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

-S-

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

-T-

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

-U-

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

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

-V-

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

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

Medicare Part D Notice

Important Notice from Santa Rosa Junior College About Your Prescription Drug Coverage and Medicare

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

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

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

When Can You Join A Medicare Drug Plan?

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

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

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

If you decide to join a Medicare drug plan, your Santa Rosa Junior College coverage will not be affected. See below for more information about what happens to your current coverage if you join a Medicare drug plan.

Since the existing prescription drug coverage under the Plan is creditable (e.g., as good as Medicare coverage), you can retain your existing prescription drug coverage and choose not to enroll in a Part D plan; or you can enroll in a Part D plan as a supplement to, or in lieu of, your existing prescription drug coverage.

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

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

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

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

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

Contact the person listed below for further information or call Human Resources at (707) 527-4954. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Santa Rosa Junior College changes. You also may request a copy of this notice at any time.

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

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

For more information about Medicare prescription drug coverage:

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

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at socialsecurity.gov, or call them at 800-772-1213 (TTY 800-325-0778).

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

Date:	August 1, 2025
Name of Entity/Sender:	Santa Rosa Junior College
Contact-Position/Office:	Human Resources
Address:	1501 Mendocino Avenue, Santa Rosa, CA 95401-4395
Phone Number:	(707) 527-4954

Women's Health and Cancer Rights Act

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

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Therefore, the following deductibles and coinsurance apply. If you would like more information on WHCRA benefits, call your plan administrator (707) 527-4954.

Newborns' and Mothers' Health Protection Act

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). If you would like more information on maternity benefits, call your plan administrator at (707) 527-4954.

HIPAA Notice of Special Enrollment Rights

If you decline enrollment in Santa Rosa Junior College health plan for you or your dependents (including your spouse) because of other health insurance or group health plan coverage, you or your dependents may be able to enroll in Santa Rosa Junior College health plan without waiting for the next open enrollment period if you:

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

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

Note: If your dependent becomes eligible for a special enrollment right, you may add the dependent to your current coverage or change to another health plan. Any other currently covered dependents may also switch to the new plan in which you enroll.

Michelle's Law

The Santa Rosa Junior College plan may extend medical coverage for dependent children if they lose eligibility for coverage because of a medically necessary leave of absence from school. Coverage may continue for up to a year, unless your child's eligibility would end earlier for another reason.

Extended coverage is available if a child's leave of absence from school — or change in school enrollment status (for example, switching from full-time to part-time status) — starts while the child has a serious illness or injury, is medically necessary and otherwise causes eligibility for student coverage under the plan to end. Written certification from the child's physician stating that the child suffers from a serious illness or injury and the leave of absence is medically necessary may be required.

If your child will lose eligibility for coverage because of a medically necessary leave of absence from school and you want his or her coverage to be extended, Human Resources as soon as the need for the leave is recognized. In addition, contact your child's health plan to see if any state laws requiring extended coverage may apply to his or her benefits.

Availability of Privacy Practices Notice

We maintain the HIPAA Notice of Privacy Practices for Santa Rosa Junior College describing how health information about you may be used and disclosed. You may obtain a copy of the Notice of Privacy Practices by contacting Santa Rosa Junior College

Notice of Choice of Providers

The Santa Rosa Junior College Plan allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact Human Resources at (707) 527-4954.

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

You do not need prior authorization from Santa Rosa Junior College Plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the Human Resources at (707) 527-4954.

ACA Disclaimer

This offer of coverage may disqualify you from receiving government subsidies for an Exchange plan even if you choose not to enroll. To be subsidy eligible you would have to establish that this offer is unaffordable for you, meaning that the required contribution for employee only coverage under our base plan exceeds 9.02% in 2025, and 9.96% in 2026 of your modified adjusted household income.

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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of **March 17, 2025**. Contact your State for more information on eligibility—

ALABAMA – Medicaid
Website: http://myalhipp.com/ | Phone: 1-855-692-5447
ALASKA – Medicaid
The AK Health Insurance Premium Payment Program | Website: http://myakhipp.com/ | Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com | Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid
Website: http://myarhipp.com/ | Phone: 1-855-MyARHIPP (855-692-7447)
CALIFORNIA – Medicaid
Health Insurance Premium Payment (HIPP) Program website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 | Fax: 916-440-5676 | Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943 | State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991 | State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ | HIBI Customer Service: 1-855-692-6442
FLORIDA – Medicaid
Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268
GEORGIA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra | Phone: 678-564-1162, press 2

INDIANA – Medicaid
Health Insurance Premium Payment Program All other Medicaid Website: https://www.in.gov/medicaid/ | http://www.in.gov/fssa/dfr/ | Family and Social Services Administration Phone: (800) 403-0864 | Member Services Phone: (800) 457-4584
IOWA – Medicaid and CHIP (Hawki)
Medicaid Website: Iowa Medicaid | Health & Human Services | Medicaid Phone: 1-800-338-8366 Hawki Website: Hawki - Healthy and Well Kids in Iowa | Health & Human Services | Hawki Phone: 1-800-257-8563 HIPP Website: Health Insurance Premium Payment (HIPP) | Health & Human Services (iowa.gov) HIPP Phone: 1-888-346-9562
KANSAS – Medicaid
Website: https://www.kancare.ks.gov/ | Phone: 1-800-792-4884 | HIPP Phone: 1-800-967-4660
KENTUCKY – Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx | Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kynect.ky.gov | Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms
LOUISIANA – Medicaid
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 | TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 800-977-6740 | TTY: Maine relay 711
MASSACHUSETTS – Medicaid and CHIP
Website: https://www.mass.gov/masshealth/pa | Phone: 1-800-862-4840 | TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid
Website: https://mn.gov/dhs/health-care-coverage/ | Phone: 1-800-657-3672
MISSOURI – Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm | Phone: 573-751-2005
MONTANA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 | email: HHSHIPPProgram@mt.gov
NEBRASKA – Medicaid
Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 | Lincoln: 402-473-7000 | Omaha: 402-595-1178
NEVADA – Medicaid
Medicaid Website: http://dhcfp.nv.gov | Medicaid Phone: 1-800-992-0900
NEW HAMPSHIRE – Medicaid
Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 | Toll-free number for the HIPP program: 1-800-852-3345, ext. 15218 Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov
NEW JERSEY – Medicaid and CHIP
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ | Phone: 800-356-1561 CHIP Premium Assistance Phone: 609-631-2392 | CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710 (TTY: 711)
NEW YORK – Medicaid
Website: https://www.health.ny.gov/health_care/medicaid/ | Phone: 1-800-541-2831

NORTH CAROLINA – Medicaid
Website: https://medicaid.ncdhhs.gov/ | Phone: 919-855-4100
NORTH DAKOTA – Medicaid
Website: https://www.hhs.nd.gov/healthcare | Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP
Website: http://www.insureoklahoma.org | Phone: 1-888-365-3742
OREGON – Medicaid and CHIP
Website: http://healthcare.oregon.gov/Pages/index.aspx | Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP
Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html | Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) | CHIP Phone: 1-800-986-KIDS (5437)
RHODE ISLAND – Medicaid and CHIP
Website: http://www.eohhs.ri.gov/ | Phone: 1-855-697-4347 or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid
Website: https://www.scdhhs.gov | Phone: 1-888-549-0820
SOUTH DAKOTA – Medicaid
Website: http://dss.sd.gov | Phone: 1-888-828-0059
TEXAS – Medicaid
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493
UTAH – Medicaid and CHIP
Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/ Email: upp@utah.gov | Phone: 1-888-222-2542 | Adult Expansion Website: https://medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/ CHIP Website: https://chip.utah.gov/
VERMONT – Medicaid
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427
VIRGINIA – Medicaid and CHIP
Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select or https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid
Website: https://www.hca.wa.gov/ | Phone: 1-800-562-3022
WEST VIRGINIA – Medicaid and CHIP
Website: https://dhhr.wv.gov/bms/ or http://mywvhipp.com/ Medicaid Phone: 304-558-1700 | CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm | Phone: 1-800-362-3002
WYOMING – Medicaid
Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ | Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since March 17, 2025, or for more information on special enrollment rights, contact either:

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

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

SANTA ROSA
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