2024

Open Enrollment Dates:
August 15 to September 15, 2023

Employee Benefits Guide 2023 – 2024

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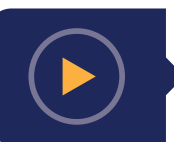

Click this icon in your benefits guide to watch a video explaining the associated topic.
See page 79 for a glossary of terms.

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

Please see page 73 for more details.

This brochure highlights the main benefits of Riverside Community College District's Employee Benefit Program. It is designed to assist you in selecting benefits for you and your family. This booklet does not include plan details or specific rules, which are provided in the legal documents such as plan Document / Summary Plan Descriptions (SPDs), Evidence of Coverage (EOC), and plan contracts. If there are any inconsistencies between this brochure and the legal plan documents, the plan documents will prevail.

What's New For 2023–24

Open Enrollment

Your 2023 Open Enrollment Checklist

Open enrollment is August 15 through September 15, 2023

- Visit www.rccd.edu/Admin/hrer/pages/benefits.aspx to learn more about your benefit options.
- Check important dates and open enrollment meeting schedule.
- Review the medical comparison chart, dental and vision highlights and life insurance information.
- **Enroll or make changes using BenefitBridge:** www.benefitbridge.com/rccd
- Upload required dependent documentation in BenefitBridge by Thursday, September 15, 2023.

Detailed benefit plan information and more can be found in the Benefits Guide or online at:

www.rccd.edu/Admin/hrer/pages/benefits.aspx | 951-222-8136 | Edwina.Cardenas@rccd.edu

You are encouraged to reference this guide throughout the year.

DELTA DENTAL®

Support for chronic conditions

Your plan offers additional dental coverage to support your overall health

Chronic conditions and the medications used to treat them can impact your oral health. If you or a covered family member has been diagnosed with a chronic medical condition like diabetes, cancer or rheumatoid arthritis, you may benefit from additional teeth and gum cleanings.

Take advantage of expanded coverage to help safeguard your oral health. To qualify, you or a covered family member must be diagnosed with any of the following:

- Amyotrophic lateral sclerosis (ALS)
- Cancer
- Chronic kidney disease
- Diabetes
- Heart disease
- HIV/AIDS
- Huntington's disease
- Joint replacement
- Lupus
- Opioid misuse and addiction
- Parkinson's disease
- Rheumatoid arthritis
- Sjögren's syndrome
- Stroke

SmileWay® Wellness Benefits[1]

100% coverage	One periodontal scaling and root planing procedure per quadrant (D4341 or D4342) per calendar or contract year[2]
Four of the following (any combination) per calendar or contract year:[2]	
100% coverage	Prophylaxis (teeth cleaning) (D1110 or D1120)
	Periodontal maintenance procedure (D4910)
	Scaling in presence of moderate or severe gingival inflammation (D4346)

[1] Known as SmileWay Enhanced Benefits in Texas.
[2] This coverage is subject to any applicable maximums and deductibles under the terms and conditions outlined in your plan's Evidence of Coverage. Please review your plan booklet for specific details about your coverage.

Delta Dental PPO™ is underwritten by Delta Dental Insurance Company in AL, DC, FL, GA, LA, MS, MT, NV and UT and by not-for-profit dental service companies in these states: CA — Delta Dental of California; PA, MD – Delta Dental of Pennsylvania; NY — Delta Dental of New York, Inc.; DE — Delta Dental of Delaware, Inc.; WV — Delta Dental of West Virginia, Inc. In Texas, Delta Dental Insurance Company provides a dental provider organization (DPO) plan.

Opt in by visiting **www1.deltadentalins.com/smileway** or by calling Customer Service Monday through Friday.

deltadentalins.com/enrollees

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Save The Date - RCCD Health Fairs

Human Resources Employee Relations cordially invites you to the 2023 Health & Wellness Fairs

Monday, August 21
11:00 a.m. - 1:00 p.m.

Location: CAADO Rooftop
Riverside Community College District

Thursday, August 24
10:00 a.m. - 2:00 p.m.

Location: Student Center Room CSS217
Norco College

Thursday, August 31
10:00 a.m. - 2:00 p.m.

Location: Student Academic Services (SAS) Room 103
Moreno Valley College

Wednesday, September 6
10:00 a.m. - 2:00 p.m.

Location: Hall of Fame
Riverside City College

In partnership with:

RIVERSIDE COMMUNITY COLLEGE DISTRICT

Introduction

Riverside Community College District employees receive excellent compensation packages. Benefits include 100% employer-paid health, dental and life insurance for the full-time Active employee. Including paid vacation, holiday and sick leave, and contributions to CalSTRS, CalPERS or PARS retirement plans. In addition, Riverside Community College District offers education achievement incentives, professional training, workshops, and advancement opportunities. Please call Human Resources for more information.

Annual Enrollment for Current Employees

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

Riverside Community College District is fortunate to be able to pay for the benefits for you and your family members. Choosing the right plan is a very personal thing.

Use this booklet to find one that's Right for your lifestyle, Right for your needs, Right for your peace of mind.

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

The benefit elections you make during open enrollment (August 15 to September 15) will stay in effect from October 1, 2023 through September 30, 2024 if you remain eligible for benefits. However, after open enrollment ends, you can make plan changes ONLY if you have a qualified status change. Please refer to **"Making Mid Year Changes to Your Benefits"** on page 3 for more information.

Introduction (continued)

What is Happening with Health Insurance in 2023-2024

You may have heard in the news or seen advertising about the Affordable Care Act (ACA) and Covered California (also known as the Health Insurance Exchange or Marketplace). Many people are still unaware of the huge changes taking place in our health care system, the decisions they will need to make and the impact on their personal health care costs. Under the ACA, most people were required to have health insurance coverage by January 1, 2014, or they will have to pay a tax penalty. You may already be enrolled in or may be eligible for health coverage through Riverside Community College District. We will be offering our eligible employees health coverage during our regular enrollment period again this year. Please visit Riverside Community College District's Human Resources Benefits Website, www.rccd.edu/Admin/hrer/pages/benefits.aspx for additional information.

Qualifying Events

In accordance with the provisions of Riverside Community College District's Flexible Benefits Plan (a copy can be obtained from Human Resources), changes outside of the open enrollment period can only be made for one of the following reasons:

- Changes due to "a change in the Participant's family status." (Section 5.5) Changes must be made within 30 days of the change in family status. Failure to make changes within 30 days of the change in family status will require that the employee wait for the next open enrollment period.
- Changes due to a "significant change in the cost of coverage of the benefits previously elected by the Participant." (Section 5.6)
- Employees may request to drop coverage through the District's health plan in order to become covered under a spouse's health plan outside of the District's open enrollment period, ONLY IF the spouse has just become eligible for coverage. The spouse's employer must provide proof that their employee has just become eligible for this coverage. Otherwise, the employee must wait until the next open enrollment period.

Changes are not permitted outside of the open enrollment period except as provided under "Qualifying Events". Said changes of an election outside of the open enrollment period must be consistent with the change in status.

Employees are responsible for informing the Benefits Department of any changes in dependent status within 30 days of said change. Failure to do so will result in no coverage for your eligible dependents(s) / spouse.

Do You Need to Do Anything?

The answer is "No" unless you want to:

- Change your plan election
- Add or delete coverage for an eligible dependent

See "Making Mid-Year Changes to Your Benefits" on the next page for more information. Keep in mind that after the Open Enrollment period, you cannot change your benefit elections during the year unless you have a qualifying life event.

Drop Dependent

The effective date used when you drop a dependent will be the first of the month following the date of notification to the College District.

CLICK HERE to watch a video on Qualifying Life Events

About Your Coverage

If you and your spouse are both covered as employees under the District's plans, each employee may enroll as a subscriber and each may enroll your dependents.

When Are You Covered?

If an employee is hired between the 1st – 15th of the month, coverage becomes effective the first day of the month following date of hire. If an employee is hired the 16th of the month or after, coverage becomes effective the first of the month following 30 days of employment. Your family members are covered. Do not delay in making your changes!

- For all existing family members, on the date you are covered;
- For a new spouse and step child, the first day of the month after the date your spouse and step child become a family member(s) due to marriage;
- The date a child becomes your family member due to birth, adoption, or legal guardianship.

Making Mid-Year Changes to Your Benefits

The benefit elections you make during open enrollment will stay in effect from October 1, 2023 through September 30, 2024 if you remain eligible for benefits. Each year, during open enrollment, you have the opportunity to change your coverage elections for the following plan year. However, after open enrollment ends, you can make plan changes ONLY if you have a qualified status change. Qualified status changes include:

- Marriage or registration of a domestic partner*
- Divorce or legal separation from a spouse
- Birth, adoption, placement for adoption, or legal guardianship of a child
- Death of a spouse / domestic partner or a child
- Child's loss of eligibility due to age
- You or your spouse has a change in employment status that results in gaining or losing eligibility for benefits coverage. You must submit proof of gain or loss of coverage.
- Full-time / part-time employment status change resulting in an insurance eligibility change
- Commencement of or return from an unpaid leave of absence
- Change for an individual eligible for Medicare or Medicaid
- QMED - Qualified Medical Child Support order/national medical support notice
- CHIP - Children Health Insurance Program

* Domestic Partner Group Benefits are available to the bona fide domestic partner of a District employee. Such benefits are available only to domestic partner relationships that meet the State of California standards for registered domestic partners.

As an employee with the Riverside City College District, you will be asked to sign an affidavit that you understand that under applicable federal and state tax law, District provided benefits coverage of the domestic partner could result in imputed taxable income to the employee, subject to income tax withholding and applicable payroll taxes.

Over-Age Dependents

Health care reform legislation has mandated that group health plans offer coverage to dependent children until they attain age 26.

Important Notice About Dependent Eligibility

- You are an employee and meet the eligibility requirements.
- If you do not add newly eligible family members to your health plan within the 30-day period of eligibility, you will have to wait until the next open enrollment period before you can enroll them.
- Your former spouse / domestic partner, parents, parents-in-law, other relatives, and children over age 26, are not eligible for coverage under your health care plans.
- They must be your natural, step, or adopted children (children for whom you may be a legal guardian for are also eligible).

If you do not have the legal documents, please notify the Benefit Specialist immediately.

GROUP BENEFITS FOR DOMESTIC PARTNERS - AFFADAVIT

Domestic Partner Group Benefits are available to the bona fide domestic partner of a District employee. Such benefits are available only to domestic partner relationships that meet the State of California standards for registered domestic partners.

As an employee with the Riverside Community College District, I acknowledge that I have read ***AP 6515 Group Benefits for Domestic Partners*** and understand that under applicable federal and state tax law, District provided benefits coverage of the domestic partner could result in imputed taxable income to the employee, subject to income tax withholding and applicable payroll taxes.

Employee Information

____________________________ ______________________ ______

Last Name First Name MI

____

Social Security Number

Domestic Partner

____________________________ ______________________ ______

Last Name First Name MI

______________________________ ________________

Employee Signature Date

3801 Market Street
Riverside, CA 92501
(951) 222-8000
www.rccd.edu

Eligibility

Employees

Riverside Community College District provides a very generous health and welfare benefit package for its employees. Visit the Human Resources website, www.rccd.edu/Admin/hrer/pages/benefits.aspx for more information.

- Those employees working less than full time and less than 12 months may receive a pro-rata share of the benefit package.
- Associate Faculty are able to participate in Kaiser Permanente and Health Net medical coverage only if they meet the qualifications.
- Contracted Short-term and student employees are not eligible for benefit participation.
- Employees have an option to waive coverage

Required Proof of Eligibility

You will need to provide proof of eligibility the first time you request the following:

- **Spouse:** Copy of marriage certificate.
- **Domestic Partner:** Copy of State of California Domestic Partnership Registration. A signed Domestic Partners Affidavit
- **Children:** Copy of birth certificate or certificate from the hospital, or legal guardianship/adoption documents.

Government agencies may have delays, please notify the Benefit Specialist if this is the case.

Eligible Dependents

An employee may enroll their spouse/domestic partner and/or children. "Spouse" is defined as the legally recognized marital partner of a covered employee; "Domestic Partner" is defined as the employee's domestic partner under a legally registered and valid domestic partnership or one that meets certain requirements and provides an affidavit of domestic partnership. "Child(ren)" is defined as the subscriber's or spouse's child(ren) including stepchildren, children placed under a "qualified medical child support order," adopted children or children placed for adoption and children in which you have established legal guardianship. Dependent children are eligible for medical coverage until they attain age 26. To enroll qualified dependents you must provide proper documentation (e.g., marriage/birth certificates, state/court documents, etc.).

- **Disabled Child(ren):** A disabled child who reaches age 26 may be eligible for continued benefits. See the Benefits Department for additional information.
- **Kaiser Permanente Enrollees:** Children whose parent is a Dependent under your family coverage (including adopted children or children placed with your Dependent for adoption, but not including foster children), if they are under age 26.

All newly eligible dependents MUST be enrolled through the Benefits Department within 30 days of the qualifying event (i.e., birth, adoption, marriage, legal guardianship, etc.). Employees who fail to add dependents within the 30 day eligibility period will not be able to add their dependent until the next open enrollment period.

Important

You must notify the Benefits Department within 30 days of a change in status, or the District will not be able to change your benefit elections.

Eligibility (continued)

Dependents	Documentation Required
Spouse	Marriage Certificate
State Registered Domestic Partner	Certificated Domestic Partnership issued by the California Secretary of State and Affidavit of Tax Status for Domestic Partners Form
Biological Children	Government-issued Birth Certificate reflecting that the child is the Employee's child
Stepchild	Copy of child's Birth Certificate showing your spouse's or domestic partner's name and a copy of marriage certificate or documentation of domestic partnership
Adopted Child	Government-issued Adoption Order, AND government issued Birth Certificate, or foreign adoption approved by the INS or legal adoption documents from foreign country AND home government-issued Birth Certificate
Guardianship Child	Court Order
Disabled Dependent Child	Notice of disability determination from medical carrier or Social Security Administration prior to attaining age 26 AND child documentation (biological/ step/adopted/guardianship

When a dependent is no longer eligible, including when they turn 26 years of age, it is the employee's responsibility to drop this dependent. The dependent will be eligible for COBRA upon termination. Please see Page 68 for details.

Any carrier and/or benefit changes you make during the Open Enrollment period will be effective October 1, 2023 and continue through September 30, 2024.

Prepare for making your elections.

You will need to make choices on which plans to select for you and your family.

1. Review your plan options. The Medical Plans section of this Guide provides a summary of what each plan covers. Does your plan choice adequately cover the services you use most or will need in the future?
2. Check with your doctors to find out which plans they participate in; verify plan service areas and provider availability; research available Doctor offices within the plan.
3. If you take any prescription medications regularly, contact the new plan to find out how these drugs are covered. Call the prescription plan's member services or visit its website.
4. If you are waiving medical coverage, send a copy of your proof of other group coverage to edwina.cardenas@rccd.edu
5. **Estimate your life insurance coverage needs for you and your family:**
   - Determine who you will designate as your beneficiary for your term life insurance and obtain their address/phone information.
6. Learn about a Flexible Spending Account to see if you would benefit from establishing one. Estimate your out-of-pocket health care and dependent care expenses to decide how much you want to contribute to each account.
7. **Have the right information handy. When you start the enrollment process, you'll need:**
   - Your Social Security number; ***and***
   - The names, birth dates, and Social Security numbers of any dependents you wish to enroll.
   - Copies of the required documents to confirm dependent eligibility status (see chart under Required Proof of Dependent Eligibility) will need to be emailed the edwina.cardenas@rccd.edu within 7 days of completing your enrollment.

What Happens After Enrollment

You will receive your medical cards in the mail. If you enrolled in one of the HMOs, you will receive cards for each member in your family. If you enrolled in the RCCD Self-Funded PPO, you will receive 2 cards for your medical and 2 cards for Express Scripts. The cards can be used for each member in the family. Delta Dental PPO and VSP do not issue cards.

You are encouraged to establish an online account with your insurance providers.

Change in Dependent Eligibility

You are responsible for dis-enrolling any dependent who loses eligibility (e.g., divorce, termination of a domestic partners, death, dependent reaching age

limit) within 30-days of the dependent's eligibility status change. If family court orders continued benefits for ex-spouse, you would need to elect COBRA continuation coverage or purchase coverage privately; divorced spouses cannot stay on employee's coverage.

IMPORTANT: Regardless of the timing of notice to the District, coverage for an ineligible dependent will end on the last day of the month in which the dependent loses eligibility. Failure to delete ineligible dependents within 30-days of a change in status may result in a loss of continuation coverage (COBRA) rights for your dependents(s), and you may also become financially responsible for the cost of premiums and any services received by your dependent(s) after the loss of eligibility.

When your Benefits End

If you terminate employment with the District between the 1st -15th of the month, your medical, dental, and vision coverage ends on the last day of that month. If you terminate between the 16th-31st of them month, your coverage will terminate the first of the month following 30-day of termination. You and covered family member(s) will be eligible to continue your coverage under COBRA law. Please refer to the COBRA provisions in this guide.

Retiree Health Benefits

The Board of Trustees of the Riverside Community College District, recognizing the value of continuity of service in the District by its employees, shall provide for retirees (certificated / academic, classified / confidential, management) who qualify, District paid medical insurance after retirement and until the retiree reaches age 65. Provisions are applied consistent with Board AP 7380 – Retiree Health Benefits. Visit the Human Resources Benefits website at: www.rccd.edu/Admin/hrer/pages/benefits.aspx.

For those who do not qualify, based on years of service or age at retirement, the opportunity shall be provided to continue in the District's group medical insurance program by reimbursement to the District of the total cost of the premium until age 65.

In addition employees who resign, or are terminated, are eligible for continued medical and dental insurance coverage under the provisions of COBRA and AB528, at full cost to the individual.

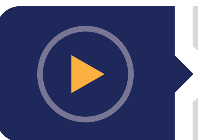
Decision Guidelines

It is important to review the Medical Plan Summaries provided in this booklet for help in selecting the right health plan.

Things to Consider

Here are some things to think about as you decide which health plan is right for you:

- Life changes you may be thinking about, such as starting a family, retiring or moving out of the area.
- Chronic health conditions or disabilities that you or family members have.
- If you or anyone in your family will need care for the elderly.
- Care for family members who travel a lot, attend college, or spend time at two homes.
- Are the family doctors and specialists your family prefers part of the network? If not, are you willing to change doctors?
- If provider location is important to you, check to see if the network facilities are close to your home, your workplace or your child's school.
- How much money do you and your family typically spend on health care each year? How much are you willing to pay out-of-pocket for health care expenses? Remember that the PPO plan pays a higher percentage of expenses when you use network providers. HMO requires specific copays for most services, with no deductible, but you must use only HMO providers to have your expenses covered.
- **What do you value more –** having the lowest possible out-of-pocket costs (HMO options) or the flexibility to see any provider you wish (PPO options) and navigating your own healthcare?



CLICK HERE to watch a video on Health Maintenance Organizations (HMO)

Benefits Comparison

The following benefits comparison provides an overview of your medical plan options through Riverside Community College District. This comparison is intended to give a general description and overview of available plans and is not intended to replace the carriers Summary Plan Description. See individual plan material for detailed information.

Plan Benefits	Health Net HMO	Kaiser Permanente HMO	RCCD PPO Health Now Administrative Services (HNAS)	
			Preferred Providers In-Network	Non-Preferred Providers Out-of-Network
Calendar Year Deductible	None	None	$100/individual $300/family	
Out-of-Pocket Maximum for Eligible Charges *(Calendar Year)*	$1,500/one member $3,000/two members $4,500/family	$1,500/individual $3,000/family	$100/individual $400/family	
Lifetime Maximum	Unlimited	Unlimited	Unlimited	
Hospital Room and Board Ancillary Charges *(Inpatient)*	100%	100%	100%	100%
Outpatient Surgery	100%	100%	100%	100%
Surgeon, Assistant Surgeon and Anesthesiologist	100%	100%	100%	100%
Emergency Room Care	$35 copay (waived if admitted)	$35 copay (waived if admitted)	100% True Emergency	100% True Emergency
Urgent Care	$0 copay for all facilities owned by or contracted with member's assigned medical group; all others not covered	100%	100%	80%
Ambulance *(when authorized)*	100%	100%	90%	90%
Physician Office Visit	100%	100%	100%	80%
Well Child Care	100%	100%	100%	Not covered
Routine Maintenance Exam	100%	100%	100%	Not covered
Vision and Hearing Screenings	100%	100%	Not covered	Not covered
Hearing Aids	$5000 allowance every 3 years	$2500 Allowance/Device; 1 Device/Ear; 2 Device/36 months	$2500 allowance per hearing aid every 3 years	
Physical, Occupational and Speech Therapy	100%	100%	Physical: 100% All Others: 80%	80%
Durable Medical Equipment	100%	100%	80%	80%
Skilled Nursing Facility	100%; limited to 100 days/cal year	100%; limited to 100 days/benefit period	100%	80%
Home Health Care	100% first 30 days $10 copay thereafter	100%; 100 visits/cal year	80%; limited to one visit/day/specialty	80%; limited to one visit/day/specialty
Mental Health and Substance Abuse				
• Inpatient	100%	100%	100%	80%
• Outpatient	100%	100%	100%	80%
Prescriptions	$3 Generic $5 Brand Name Up to 30-day supply	$5 Generic $5 Brand Name Up to 100-day supply	$2 Generic $10 Preferred Brand Drugs Up to 34-day supply	

The information described in this chart is only intended to provide an overview of the benefits and does not include all benefit provisions, limitations, exclusions or qualifications for coverage. Please review each carrier Summary Plan Description (SPD) for a complete summary of benefits. If this information in this chart conflicts in any way with the SPD, the SPD will prevail.

Health Net HMO

This plan is considered Grandfathered.

Plan Benefits	Health Net
Deductibles	None
Lifetime Maximums	None
Out-of-Pocket Maximum *(Once your payments for covered services equals the amount shown in any one calendar year, no additional copays for covered services are required for the remainder of the calendar year. Once an individual member in a family meets the individual out-of-pocket maximum, the other enrolled family members must continue to pay copays for covered services and supplies until the total amount of copays paid by the family reaches the family out-of-pocket maximum or each enrolled family member individually meets the individual out-of-pocket maximum. Payments for any supplemental benefits or services not covered by this plan will not count toward this calendar year out-of-pocket maximum, unless otherwise noted. You will need to continue making payments for any additional benefits.)*	
One member	$1,500
Two members	$3,000
Family *(three members or more)*	$4,500
Professional Services *(These copays apply to professional services only. Services that are rendered in a hospital or an outpatient center are also subject to the hospital or outpatient center services copay. See "Hospitalization Services" and "Outpatient Services" in this section to determine if any additional copays may apply.)*	
• Physician Visits	Covered in full
• Specialist Consultations	Covered in full
• Pre-natal and Post-natal office visits	Covered in full
• Normal delivery, cesarean section, newborn inpatient care	Covered in full
• Treatment of complications of pregnancy, including medically necessary abortions	See note below *
• Surgeon or assistant surgeon services	Covered in full
• Administration of anesthetics	Covered in full
• Lab procedures and diagnostic imaging *(including x-ray)* services	Covered in full
• Rehabilitative therapy *(includes physical, speech, occupational, and respiratory therapy)*	Covered in full
• Organ and stem cell transplants *(non-experimental and non-investigational)*	Covered in full
• Chemotherapy	Covered in full
• Radiation therapy	Covered in full
• Vision and hearing examinations *(for diagnosis or treatment)*	Covered in full
• Hearing Aids *(Services are offered through Hearing Care Solutions. See Page 17)*	$5000 allowance every 3 years

Self-referrals are allowed for obstetrics and gynecological services including preventive care, pregnancy and gynecological ailments. Copay requirements may differ depending on the services provided.

Surgery includes surgical reconstruction of a breast incident to mastectomy, including surgery to restore symmetry; also includes prosthesis and treatment of physical complications at all stages of mastectomy, including lymphedema. While Health Net and your physician group will determine the most appropriate services, the length of hospital stay will be determined solely by your PCP.

* Applicable copay or coinsurance requirements apply to any services and supplies required for the treatment of an illness or condition, including but not limited to, complications of pregnancy. For example, if the complication requires an office visit, then the office visit copay or coinsurance will apply.

The information described in this chart is only intended to provide an overview of the benefits and does not include all benefit provisions, limitations, exclusions or qualifications for coverage. Please review each carrier Summary Plan Description (SPD) for a complete summary of benefits. If this information in this chart conflicts in any way with the SPD, the SPD will prevail.

Health Net HMO (continued)

Plan Benefits	Health Net
Preventive Care For preventive health purposes, covered services include, but are not limited to, periodic health evaluations, diagnostic preventive procedures and preventive vision and hearing screening examinations, based on recommendations published in the U. S. Preventive Services Task Force. In addition, an annual cervical cancer screening test is covered and includes a Pap test, a human papilloma virus *(HPV) screening test that is approved by the federal Food and Drug Administration (FDA)*, and the option of any cervical cancer screening test approved by the FDA.	
• Adult	
– Periodic health evaluations, including well-woman exam and annual preventive physical examinations *(age 18 and older)*	Covered in full
– Immunizations *(age 18 and older)*	Covered in full
• Child	
– Periodic health evaluations, including newborn, well-baby care, annual preventive physical examinations and immunizations birth through 30 days	Covered in full
– 31 days through age 17	Covered in full
Allergy treatment and other injections *(except for infertility injection)*	
• Allergy testing	Covered in full
• Allergy serum	Covered in full
• Allergy injection services	Covered in full
• Immunizations *(to meet foreign travel requirements)*	20%
• Immunizations *(to meet occupational requirements)*	20%
• Injectable drugs administered by a physician *(per dose)*	Covered in full
• Self injectable drugs	Covered in full
Outpatient Facility Services	
• Outpatient facility services *(other than surgery)*	Covered in full
• Outpatient surgery *(surgery performed in a hospital or outpatient surgery center only)*	Covered in full
Hospitalization Services	
• Semi-private hospital room or special care unit with ancillary services, including maternity care *(per admission; unlimited days)*	Covered in full
• Hospitalization for infertility services	50%
• Skilled nursing facility stay *(per admission; limited to 100 days/cal year)*	Covered in full
• Physician visit to hospital or skilled nursing facility	Covered in full
Emergency Health Coverage Copays for emergency room or urgent care center visits will not apply if the member is admitted as an inpatient directly from the emergency room or urgent care center. A visit to one of the urgent care centers that is owned and operated by the member's physician group will be considered an office visit and the office visit copay, if any, will apply.	
• Emergency room *(professional and facility charges)*	$35
• Urgent care center *(professional and facility charges)*	$0 copay for all facilities owned by or contracted with member's assigned medical group; all others not covered.
Ambulance Services	
• Ground	Covered in full
• Air	Covered in full

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

Health Net HMO (continued)

Plan Benefits	Health Net
Prescription Drug Coverage Please refer to the "Prescription drug program" section of this SB / DF for applicable definitions, benefit descriptions and limitations. Copays for prescription drugs do not apply to the out-of-pocket maximum, except copays for peak flow meter and inhaler spacers used for the treatment of asthma, and diabetic supplies.	
• Retail participating pharmacy *(up to a 30-day supply)*	
– Level I *(primarily generic)*	$3
– Level II *(primarily brand name drugs, peak flow meters, inhaler spacers and diabetic supplies, including insulin)*	$5
– Smoking Cessation Drugs * *(covered up to a 12 week course of therapy/cal year if you are concurrently enrolled in a comprehensive smoking cessation behavioral modification support program)*	50%
– Appetite suppressants	50%
– Lancets	Covered in full
– Contraceptive devices *(including diaphragms and cervical caps)*	Covered in full
• Mail order program *(up to a 90-day supply)*	
– Level I *(primarily generic)*	$3
– Level II *(primarily brand name drugs, peak flow meters, inhaler spacers and diabetic supplies, including insulin)*	$5
– Lancets	Covered in full

For information about Health Net's Recommended Drug List, please call the Member Services Department at the telephone number on the back cover.

Generic drugs will be dispensed when a generic drug equivalent is available unless a brand name drug is specifically requested by the physician or the member. When a brand name drug is dispensed and a generic equivalent is commercially available, the member must pay the difference between the generic equivalent and the brand name drug plus the Level I drug copay. However, if the prescription drug order states "dispense as written," "do not substitute" or words of similar meaning in the physician's handwriting to indicate medical necessity, only the Level II drug copay will be applicable.

Copays for prescription drugs do not apply to the out-of-pocket maximum, except copays for peak flow meters, inhaler spacers used for the treatment of asthma and diabetic supplies. Percentage copays will be based on Health Net's contracted pharmacy rate.

If the retail price is less than the applicable copay, then you will pay the retail price prescription drug covered expenses are the lesser of Health Net's contracted pharmacy rate or the pharmacy's retail price for covered prescription drugs.

This plan uses the Recommended Drug List. The Health Net Recommended Drug List (the "List") is the approved list of medications covered for illnesses and conditions. It is prepared by Health Net and distributed to Health Net contracted physicians and participating pharmacies. The List also shows which drugs are Level I or Level II, so you know which copay applies to the covered drug. We may cover drugs that are not on the List at the Level II drug copay when your physician demonstrates medical necessity, as long as these drugs are not excluded or limited from coverage.

All drugs that are not on the List and some drugs that are on the List require prior authorization from Health Net. Urgent requests from physicians for authorization are processed as soon as possible, not to exceed 72 hours, after Health Net's receipt of the request and any additional information requested by Health Net that is reasonably necessary to make the determination. Routine requests from physicians are processed in a timely fashion, not to exceed five (5) days, as appropriate and medically necessary, for the nature of the member's condition after Health Net's receipt of the information reasonably necessary and requested by Health Net to make the determination. For a copy of the Recommended Drug List, call Member Services at the number listed on the back cover of this booklet or visit our website at healthnet.com.

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Health Net HMO (continued)

Plan Benefits	Health Net
Medical Supplies Diabetic equipment covered under the medical benefit *(through "Diabetic Equipment"), includes blood glucose monitors designed for the visually impaired, insulin pumps and related supplies. In addition, the following supplies are covered under the medical benefit as specified: diabetic footwear, visual aids (excluding eyewear) to assist the visually impaired with the proper dosing of insulin are provided through the prostheses benefit; Glucagon is provided through the self-injectable benefit. Self-management training, education and medical nutrition therapy will be covered only when provided by licensed health care professionals with expertise in the management or treatment of diabetes (provided through the patient education benefit). Diabetic equipment and supplies covered under the prescription drug benefit include insulin, specific brands of blood glucose monitors and testing strips, Ketone urine testing strips, lancets and lancet puncture devices, specific brands of pen delivery systems for the administration of insulin (including pen needles)* and specific brands of insulin syringes.	
• Durable medical equipment *(including nebulizers, face masks and tubing for the treatment of asthma)*	Covered in full
• Orthotics *(such as bracing, supports and casts)*	Covered in full
• Diabetic equipment (see the "Prescription drug program" section of this SB / DF for diabetic supplies benefit information	Covered in full
• Diabetic footwear	Covered in full
• Prostheses	Covered in full
Mental Disorders and Chemical Dependency Benefits are administered by MHN Services, an affiliate behavioral health administrative services company which provides behavioral health services. For definitions of severe mental illness or serious emotional disturbances of a child, please refer to the Behavioral health section of this SB/DF, or call Member Services at the number listed on the back cover of this booklet.	Administered by MHN Services
Severe Mental Illness and Serious Emotional Disturbances of a Child	
• Outpatient professional consultation *(psychological evaluation or therapeutic session in an office setting)*	Covered in full
• Inpatient services	Covered in full
Other Mental Disorders	
• Outpatient professional consultation *(psychological evaluation or therapeutic session in an office setting)*	Covered in full
• Inpatient services	Covered in full
Chemical Dependency	
• Acute care detoxification	Covered in full
Each group therapy session requires only one half of a private office visit copay. If two or more members in the same family attend the same outpatient treatment session, only one copay will be applied.	Covered in full
Home Health Services *(copay starts the 31st calendar day after the 1st visit)*	$10
Other Services	
• Infertility services and supplies *(including injections related to covered infertility services)*	50%
• Sterilizations	
– Vasectomy	$50
– Tubal ligation	$150
• Blood, blood plasma, blood derivatives and blood factors	Covered in full
• Renal dialysis	Covered in full
• Hospice services	Covered in full

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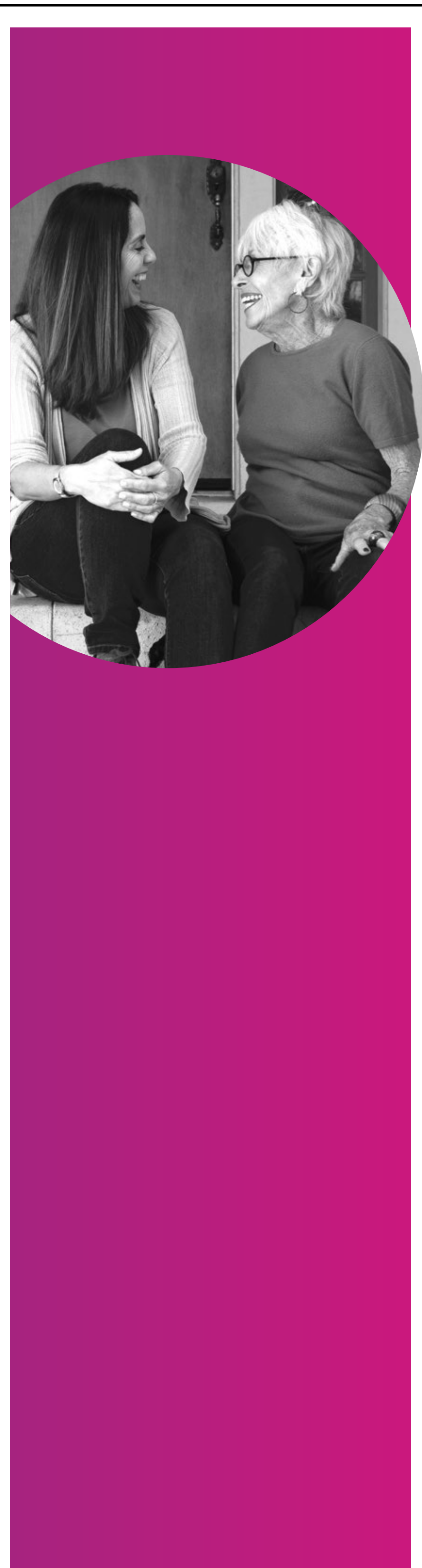

Hearing aids and screenings

Hearing Care Solutions

www.hearingcaresolutions.com
866-344-7756

For more information or to make an appointment, call between Monday–Friday, 5 a.m. to 5 p.m. Pacific time or visit the Hearing Care Solutions website.

Health Net members and their families receive free hearing exams and discounts on hearing aids. All hearing aids include:

- Three-year warranty (includes loss and damage).
- Two-year supply of batteries (up to 128 cells).
- Unlimited follow-up visits for one year.
- 60-day evaluation period.

Kaiser Permanente HMO

Kaiser Permanente

The Services described below are covered only if all of the following conditions are satisfied:

- The Services are Medically Necessary
- The Services are provided, prescribed, authorized, or directed by a Plan Physician and you receive the Services from Plan Providers inside our Southern California Region Service Area (your Home Region), except where specifically noted to the contrary in the Evidence of Coverage (EOC) for authorized referrals, hospice care, Emergency Services, Post-Stabilization Care, Out-of-Area Urgent Care, and emergency ambulance Services

This plan is considered Grandfathered.

Plan Benefits	Kaiser Permanente Traditional Plan
Annual Out-of-Pocket Maximum For services subject to the maximum, you will not pay any more cost sharing during a cal year if the copays and coinsurance you pay for those services add up to one of the following amounts:	
• Self-Only Enrollment *(one member)*	$1,500/cal year
• One Member in a Family of 2+ Members	$1,500/cal year
• Entire Family of 2+ Members	$3,000/cal year
Deductible or Lifetime Maximum	None
Professional Services *(plan provider office visits)*	
• Most primary and specialty care consultations, exams and treatment	No charge
• Routine physical maintenance exams	No charge
• Well-child preventive exams *(through age 23 months)*	No charge
• Family planning counseling	No charge
• Scheduled pre-natal care exams and first post-partum follow-up consultation and exam	No charge
• Eye exams for refraction	No charge
• Hearing exams	No charge
• Hearing Aids	$2500 Allowance/Device; 1 Device/Ear; 2 Device/36 months
• Urgent care consultations, exams and treatment	No charge
• Physical, occupational and speech therapy	No charge
Outpatient Services	
• Outpatient surgery and certain other outpatient procedures	No charge
• Allergy injections *(including allergy serum)*	No charge
• Most immunizations *(including the vaccine)*	No charge
• Most x-rays and laboratory tests	No charge
• Health education	No charge
– Covered individual health education counseling	No charge
– Covered health education programs	No charge

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Kaiser Permanente HMO (continued)

Plan Benefits	Kaiser Permanente Traditional Plan
Hospitalization Services *(Room and Board, Surgery, Anesthesia, X-Rays, Laboratory Tests and Drugs)*	No charge
Emergency Room *(This cost sharing does not apply if admitted directly to the hospital as an inpatient for covered services; see Hospitalization Services for inpatient cost sharing)*	$35/visit
Ambulance Services	No charge
Prescription Drug Coverage *(Most covered outpatient items in accord with our drug formulary guidelines at plan pharmacies or through our mail-order service)*	$5; up to a 100-day supply
Durable Medical Equipment *(Covered durable medical equipment for home use in accord with our durable medical equipment formulary guidelines)*	No charge
Mental Health Services	
• Inpatient psychiatric hospitalization	No charge
• Individual outpatient mental health evaluation and treatment	No charge
• Group outpatient mental health treatment	No charge
Chemical Dependency Services	
• Inpatient detoxification	No charge
• Individual outpatient chemical dependency evaluation and treatment	No charge
• Group outpatient chemical dependency treatment	No charge
Home Health Services *(Home health care (up to 100 visits/calendar year)*	No charge
Other	No charge
• Eyewear purchased at plan medical offices or plan optical sales offices every 24 months	Amount in excess of $100 allowance
• Skilled nursing facility care *(up to 100 days per benefit period)*	No charge
• Covered external prosthetic devices, orthotic devices, and ostomy and urological supplies	No charge
• Hospice care	No charge

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Kaiser Permanente HMO (continued)

As a member of the Kaiser Permanente Health Maintenance Organization (HMO) plan, you will receive your medical care from an integrated network of physicians and specialists at a Kaiser medical office, Kaiser medical center or affiliated hospital near you. Your care will be provided at Kaiser Permanente facilities which include all service under one roof including primary care, specialists, laboratory, radiology, and pharmacy. Additionally, you are covered for emergency care worldwide. With this Kaiser Permanente health plan, you get a wide range of care and support to help you stay healthy and get the most out of life. We make it simple for you to know what to expect and to get high-quality care for your needs.

- You may choose a primary care doctor for yourself or your family members by reviewing a physician's profile at kp.org/chooseyourdoctor, or receive assistance in selecting a physician and scheduling your first appointment by calling 1-800-464-4000 (for Southern CA)
- Initial referrals for most specialty care services will be coordinated by your Kaiser primary care physician. However, many departments such as OB/GYN, Optometry, Psychiatry and Addiction Medicine allow for self-referral.
- There are no deductibles with the Kaiser Permanente HMO and no claim forms to submit unless you receive emergency services outside of a plan facility.
- **Preventive care is covered at 100%. An abbreviated schedule of covered services under the Kaiser Permanente HMO plan is listed on page nine. For a complete listing of covered services, please refer to your Kaiser Evidence of Coverage (EOC). Kaiser offers many ways to get care:**
- **Telephone appointments and after-hours care with primary care physicians and specialists:** Call 1-866-454-8855 to make a telephone appointment.
- **24/7 Nurse Advice Line to see what type of care you need:** Call 1-833-574-2273
- **Kaiser Telehealth – Schedule a Phone or Video Appointments on your mobile device or computer for primary care, pediatrics, OB/GYN, allergy or psychiatry; your regular office copay will apply. Download Kaiser's app at your device's app store. Type in KP or Kaiser Permanente. Visit:** kp.org/getcare
- Email your physician for simple, direct communications securely through kp.org
- **Travel Line when you are away from home and need medical care:** call 1-951-268-3900 for assistance. Services outside of a Kaiser facility are not covered except if it is a life-threatening emergency.

To enroll in the plan, you must live or work within service area zip codes. If you live outside the service area, but plan to enroll using the District's address (live/work rule), you will receive an "out of area" letter from Kaiser. It does not mean that you don't have coverage with Kaiser; however, home health and durable medical equipment may not be available.

RCCD PPO

Riverside Community College District PPO Plan – Health Now Administrative Services (HNAS)

Blue Shield of California PPO Provider Network

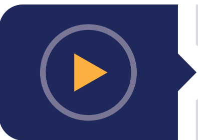
Benefits for Eligible Expenses are divided into two (2) types:

1. Preferred Providers (In-Network)
2. Non-Preferred Providers (Out-of-Network)

The percentages shown in this schedule apply to "charges". For Preferred providers, this means that the percentages apply to the negotiated rates. See "Reasonable and Customary" in the definitions section for more information.

This plan is considered Non-Grandfathered.

Plan Benefits	RCCD PPO Health Now Administrative Services (HNAS)	
	Preferred Providers In-Network	Non-Preferred Providers Out-of-Network
Maximum Lifetime Benefit	Unlimited	
Calendar Year Deductible		
• Individual	$100	
• Family Maximum	$300	
Out-of-Pocket Maximum		
• Individual	$100; Prescription drug copays, premiums, balance-billed charges, penalties and healthcare this plan does not cover does not count toward the out-of-pocket.	
• Family Maximum	$400; Prescription drug copays, premiums, balance-billed charges, penalties and healthcare this plan does not cover does not count toward the out-of-pocket.	
Ambulance		
• Ground service *(per admission)*	90%	90%
• Air service *(per admission)*	90%	90%
Diagnostic Lab and X-Ray, Outpatient *(non-hospital)*	100%	80%
Hospital Services		
• Inpatient care	100%	100%
• Emergency room services	100% True Emergency	100% True Emergency
• Outpatient surgery	100%	100%
Mental Health and Substance Abuse Care		
• Inpatient hospital care	100%	80%
• Outpatient visits	100%	80%



CLICK HERE to watch a video on Preferred Provider Organizations (PPO)

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RCCD PPO (continued)

Eligible Medical Expenses	RCCD PPO Health Now Administrative Services (HNAS)	
	Preferred Providers In-Network	Non-Preferred Providers Out-of-Network
Physician Services		
• Inpatient visits and inpatient consultations *(limited to one visit/day)*	100%	80%
• Emergency room care	100% (true emergencies only)	
• Surgeon, Assistant Surgeon, Anesthesiologist	100%	80%
• Outpatient office and urgent care visits	100%	80%
• Physical therapy	100%	80%
• Chiropractic care	100%	80%
• Home health care *(limit one visit/day/specialty)*	80%	80%
• Acupuncture	100%	80%
• Hearing Aids	$2500 allowance per hearing aid every 3 years	
Preventive Care *(deductible waived)*		
• Colonoscopy and mammograms	100%	Not covered
• Well baby care *(to age 12 months)*	100%	Not covered
Skilled Nursing Facility / Rehabilitation Center	100%	80%
Prescription Drug Coverage *(provided by Express Scripts)*		
• Individual Out-of-Pocket	$200	
• Family Out-of-Pocket	$400	
• Generic	$2 up to 34-day supply	
• Preferred Brand	$10 up to 34-day supply	
Mail Order		
• Generic	$4 co-pay	
• Preferred Brand	$20 brand name up to 90-day supply	

Medical ID cards are mailed within 7-10 business days from the effective date of coverage.

You will receive 2 cards from Blue Shield and 2 cards from Express Scripts. Both cards will be in the employee's name and can be used for every family member covered under the employee's insurance plan. It is recommended that you download the HNAS and Express Scripts apps.

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PPO Definitions

The following terms define specific wording used in this Plan. These definitions should not be interpreted to extend coverage unless specifically provided for under Covered Medical Expenses.

Adverse Benefit Determination: Any of the following:

- A denial in benefits;
- A reduction in benefits;
- A rescission of coverage;
- A termination of benefits; ***or***
- A failure to provide or make payment (in whole or in part) for a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a Claimant's eligibility to participate in the Plan.

Allowed Amount: The maximum amount on which payment is based for covered health care services. The *allowed amount* for participating providers is based on the network negotiated price for health care services. Participating providers can only bill you for the difference between the benefit paid and the *allowed amount* for any service.

The *allowed amount* for non-participating providers is based on a fee schedule chosen by the *plan sponsor* for out-of-network health care services. Fee schedules can include the network negotiated fee schedule or other usual and customary-based fee schedules that value services based on the charge most frequently made to the majority of patients for the same service or procedure in the geographic area where the services or supplies are provided. Non-participating providers may bill you for the difference between the benefit paid and the actual amount billed for any service.

Alternate Recipient : Any child of a participant who is recognized under a medical child support order as having a right to enrollment under this Plan as the participant's eligible dependent. For purposes of the benefits provided under this Plan, an *alternate recipient* shall be treated as an eligible dependent, but for purposes of the reporting and disclosure requirements under *ERISA*, if applicable, an *alternate recipient* shall have the same status as a participant.

Ambulatory Surgical Facility: A public or private facility, licensed and operated according to the law, which does not provide services or accommodations for a patient to stay overnight. The facility must have an organized medical staff of *physicians*; maintain permanent facilities equipped and operated primarily for the purpose of performing surgical procedures; and supply registered professional nursing services whenever a patient is in the facility.

Approved Clinical Trial: A clinical trial that is conducted in relation to treatment of cancer or other life-threatening disease or condition that is:

A federally funded trial approved or funded by one or more of the following:

- The National Institutes of Health (NIH).
- The Centers for Disease Control and Prevention.
- The Agency for Health Care Research and Quality.
- The Centers for Medicare and Medicaid Services.
- Cooperative group or center of any of the entities described above or the Department of Defense or the Department of Veteran Affairs.
- A qualified non-governmental research entity identified in the guidelines issued by the NIH for center support grants.
- The Department of Defense, the Department of Energy, or the Department of Veteran Affairs if 1) the study has been approved through a system of peer review determined to be comparable to the system used by NIH and 2) assures unbiased review of the highest scientific standards by qualified individuals with no interest in the outcome of the review.

A study or investigation conducted under an investigational new drug application reviewed by the Food and Drug Administration.

A study or investigation is a drug trial that is exempt from having such an investigational new drug application.

Balance-billed: When a provider bills you for the balance remaining on the bill that your plan doesn't cover. This amount is the difference between the actual billed amount and the allowed amount. For example, if the provider's charge is $200 and the allowed amount is $110, the provider may bill you for the remaining $90. This happens most often when you see an out-of-network provider. An in-network provider may not bill you for covered services.

PPO Definitions (continued)

Benefit Year: The 12-month period beginning January 1 and ending December 31. All annual deductibles and benefit maximums accumulate during the *benefit year.*

Birthing Center: A public or private facility, other than private offices or clinics of *physicians*, which meets the free standing *birthing center* requirements of the State Department of Health in the state where the covered person receives the services.

The *birthing center* must provide: A facility which has been established, equipped, and operated for the purpose of providing prenatal care, delivery, immediate postpartum care and care of a child born at the center; supervision of at least one (1) specialist in obstetrics and gynecology; a *physician* or certified *nurse* midwife at all births and immediate post partum period; extended staff privileges to *physicians* who practice obstetrics and gynecology in an area *hospital*; at least two (2) beds or two (2) birthing rooms; full-time nursing services directed by an R.N. or certified *nurse* midwife; arrangements for diagnostic x-ray and lab services; the capacity to administer local anesthetic or to perform minor *surgery*.

In addition, the facility must only accept patients with low risk pregnancies, have a written agreement with a *hospital* for emergency transfers, and maintain medical records on each patient and child.

Claims Processor: HealthNow Administrative Services.

Coinsurance: Your share of the costs of a covered health care service, calculated as a percentage (for example, 20%) of the allowed amount for the service.

COBRA: The Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

Copayment: A fixed amount (for example, $15) you pay for a covered health care service, usually when you receive the service. The amount can vary by the type of covered health care service.

Cosmetic Surgery: Any expenses incurred in connection with the care and treatment of, or operations which are performed for plastic, reconstructive, or cosmetic purposes or any other service or supply which are primarily used to improve, alter, or enhance appearance of a physical characteristic which is within the broad spectrum of normal but which may be considered displeasing or unattractive, except when required by an *injury*.

Custodial Care: Services and supplies furnished primarily to assist an individual in the activities of daily living. Activities of daily living include such things as bathing, feeding, administration of oral medicines, or other services that can be provided by persons without the training of a *health care provider*.

Deductible: An amount you could owe during a coverage period (usually one year) for covered health care services before your plan begins to pay. An overall deductible applies to all or almost all covered items and services. A plan with an overall deductible may also have separate deductibles that apply to specific services or groups of services. A plan may also have only separate deductibles.

Dental Care Provider: A *dentist*, *dental hygienist*, *physician*, or *nurse* as those terms are specifically defined in this section.

Dental Hygienist: A person trained and licensed to perform dental hygiene services, such as prophylaxis (cleaning of teeth), under the direction of a licensed *dentist*.

Dentist: A person acting within the scope of their license, holding the degree of Doctor of Medicine (M.D.), Doctor of Dental Surgery (D.D.S.), or Doctor of Dental Medicine (D.M.D.), and who is legally entitled to practice dentistry in all its branches under the laws of the state or jurisdiction where the services are rendered.

Diagnostic Charges: The *allowed amount* for x-ray or laboratory examinations made or ordered by a *physician* in order to detect a medical condition.

Durable Medical Equipment: Equipment and/or supplies ordered by a *health care provider* for everyday or extended use which:

- Can withstand repeated use;
- Is primarily and customarily used to serve a medical purpose; and
- Generally is not useful to a person in the absence of an *illness* or *injury*.

Early Retiree: A former employee of Riverside Community College District who:

- is between the age of 55 and 65, ***and***
- was continuously employed by the Company for a minimum of 10 years.

PPO Definitions (continued)

Electronic Protected Health Information: Protected health information that is transmitted or maintained in any electronic media.

Emergency: A situation or medical condition with symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, would reasonably expect the absence of immediate medical attention to result in: (a) serious jeopardy to the health of the individual (or, with respect to a pregnant woman, the woman's unborn child); (b) serious impairment to bodily functions; or (c) serious dysfunction of any bodily organ or part.

An *emergency* includes, but is not limited to, suspected heart attack or severe chest pain, actual or suspected poisoning, unconsciousness, hemorrhage, acute appendicitis, heat exhaustion, convulsion, or such other acute medical conditions as determined to be *medical emergencies* by the *plan administrator*.

Employer: Riverside Community College District.

ERISA: The Employee Retirement Income Security Act of 1974, as amended.

Experimental/Investigational: Any treatment, therapy, procedure, drug or drug usage, facility or facility usage, equipment or equipment usage, device or device usage, or supplies which are not recognized in accordance with generally accepted professional medical standards as being safe and effective for use in the treatment of the *illness*, *injury*, or condition at issue.

Services which require approval by the Federal government or any agency thereof, or by any State government agency, prior to use and where such approval has not been granted at the time the services or supplies were rendered, shall be considered *experimental* or investigational in nature. Services or supplies which themselves are not approved or recognized in accordance with accepted professional medical standards, but nevertheless are authorized by law or by a government agency for use in testing, trials, or other studies on human patients, shall be considered *experimental* or investigational in nature.

Experimental/investigational items and services are not covered under this Plan unless identified as a covered service elsewhere in this Plan.

FMLA: The Family and Medical Leave Act of 1993, as amended.

General Anesthesia: An agent introduced into the body which produces a condition of loss of consciousness.

Genetic Information: The information about genes, gene products and inherited characteristics that may derive from an individual or a family member. This includes information regarding carrier status and information derived from laboratory tests that identify mutations in specific genes or chromosomes, physical medical examinations, family histories and direct analysis of genes or chromosomes.

GINA: The Genetic Information Nondiscrimination Act of 2008 (Public Law No. 110-233), which prohibits group health plans, issuers of individual health care policies, and employers from discriminating on the basis of *genetic information*.

Habilitation Services: Health care services that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

Health Care Provider: A *physician*, *practitioner*, *nurse*, *hospital* or *specialized treatment facility* as those terms are specifically defined in this section.

HIPAA: The Health Insurance Portability and Accountability Act of 1996, as amended

Home Health Care Agency: An agency or organization that provides a program of home health care and that:

1. is approved as a home health care agency under Medicare;
2. is established and operated in accordance with the applicable laws in the jurisdiction in which it is located and, where licensing is required, has been licensed and approved by the regulatory authority having responsibility for licensing under the law; ***or***
3. meets all of the following requirements:
    a. it is an agency which holds itself forth to the public as having the primary purpose of providing a home health care delivery system bringing supportive services to the home;
    b. it has a full-time administrator;

c. it maintains written records of services provided to the patient;

d. its staff includes at least one registered nurse or it has nursing care by a registered nurse available; ***and***

e. its employees are bonded and it provides malpractice and malplacement insurance.

Hospice Care: A program approved by the attending *physician* for care rendered in the home, outpatient setting or institutional facility to a terminally ill covered person with a medical prognosis that life expectancy is six (6) months or less.

Hospice Facility: A public or private organization, licensed and operated according to the law, primarily engaged in providing palliative, supportive, and other related care for a covered person diagnosed as terminally ill with a medical prognosis that life expectancy is six (6) months or less.

The facility must have an interdisciplinary medical team consisting of at least one (1) *physician*, one (1) registered *nurse*, one (1) social worker, one (1) volunteer and a volunteer program.

A *hospice facility* is not a facility or part thereof which is primarily a place for rest, *custodial care*, the aged, drug addicts, alcoholics, or a hotel or similar institution.

Hospital: The term *hospital* means:

1. an institution constituted, licensed, and operated in accordance with the laws pertaining to *hospitals*, which maintains on its premises all the facilities necessary to provide for the diagnosis and medical and surgical treatment of an *injury* or *illness*, and which provides such treatment for compensation, by or under the supervision of *physicians* on an *inpatient* basis with continuous 24-hour nursing service by registered *nurses*;
2. an institution which qualifies as a *hospital* and a provider of services under *Medicare*, and is accredited as a *hospital* by the Joint Commission on the Accreditation of Health Care Organizations;
3. *a rehabilitation facility*.

The term *hospital* shall also include a *residential treatment* facility specializing in the care and treatment of mental health conditions or substance abuse treatment, provided such facility is duly licensed if licensing is required, or otherwise lawfully operated if licensing is not required.

Regardless of any other Plan provision or definition, the term *hospital* will not include an institution which is other than incidentally, a place of rest, place for the aged or a nursing home.

Illness: Any bodily sickness, disease or mental health disorder. For the purposes of this Plan, pregnancy will be considered an *illness*.

Infertility: The presence of a demonstrated condition recognized by a licensed physician and surgeon as a cause of infertility, or the inability to conceive a pregnancy or to carry a pregnancy to a live birth after a year or more of regular sexual relations without contraception.

Injury: A condition which results independently of an *illness* and all other causes and is a result of an externally violent force or accident.

Inpatient: Treatment in an approved facility during the period when charges are made for room and board.

Intensive Care Unit: A section, ward, or wing within a *hospital* which is operated exclusively for critically ill patients and provides special supplies, equipment and constant observation and care by registered graduate *nurses* or other highly trained personnel. This excludes, however, any *hospital* facility maintained for the purposes of providing normal post-operative recovery treatment or service.

Late Enrollee: An individual who enrolls under the Plan other than during the first 31-day period in which the individual is eligible to enroll under the Plan or during a Special Enrollment Period.

Lifetime: The period of time you or your eligible dependents participate in this Plan. [The period of time you or your eligible dependents participate in this Plan or the prior plan sponsored by Riverside Community College District prior to the restatement date, January 1, 2020].

Maintenance Care: Services and supplies primarily to maintain a level of physical or mental function.

Medically Necessary (Medical Necessity): *Medically necessary*, *medical necessity*, and similar language refers to health care services ordered by a *physician* exercising prudent clinical judgment provided to a participant for the purposes of evaluation, diagnosis or treatment of that patient's *illness* or *injury*. *Medically necessary* services

PPO Definitions (continued)

must be clinically appropriate in terms of type, frequency, extent, site, and duration for the diagnosis or treatment of the patient's *illness* or *injury*. Further, to be considered *medically necessary*, services must be no more costly than alternative interventions, and are at least as likely to produce equivalent therapeutic or diagnostic results for the diagnosis or treatment of the patient's *illness* or *injury* without adversely affecting the patient's medical condition.

A *medically necessary* service must meet all of the following criteria:

- It must not be maintenance therapy or maintenance treatment;
- Its purpose must be to restore the patient's health;
- It must not be primarily custodial in nature; and
- It must not be a listed item or treatment not allowed for reimbursement by CMS (Medicare).

The Plan reserves the right to incorporate CMS (Medicare) guidelines in effect on the date of treatment as additional criteria for determination of *medical necessity*.

Merely because a health care provider recommends, approves, or orders certain care does not mean that it is *medically necessary*. The determination of whether a service, supply, or treatment is or is not *medically necessary* may include findings of the American Medical Association and the Plan Administrator's own medical advisors.

Medicare: Title XVIII (Health Insurance for the Aged) of the United States Social Security Act as amended.

Morbid Obesity: A condition in which the body weight exceeds the normal weight by either 100 pounds, or is twice the normal weight of a person the same height, and conventional weight reduction measures have failed.

The excess weight must cause a medical condition such as physical trauma, pulmonary and circulatory insufficiency, diabetes, or heart disease.

Nurse: A person acting within the scope of their license and holding the degree of registered graduate *nurse* (R.N.), licensed vocational *nurse* (L.V.N.) or licensed practical *nurse* (L.P.N.).

Open Enrollment Period: A period of time designated by the employer prior to each *plan year* during which employees may elect benefits available under this *Plan*. Coverage elected during the *open enrollment period* will be effective the first day of the subsequent *plan year*.

Oral Surgery: Necessary procedures for surgery in the oral cavity, including pre- and post-operative care.

Other Plan: Plans including, but not limited to:

- Any primary payer besides the Plan;
- Any other group health plan;
- Any other coverage or policy covering a claimant;
- Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage;
- Any policy of insurance from any insurance company or guarantor of a responsible party;
- Any policy of insurance from any insurance company or guarantor of a third party;
- Workers' compensation or other liability insurance company; ***or***
- Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

Out-of-Pocket Limit: Yearly amount the federal government sets as the most each individual or family can be required to pay in cost sharing during the *benefit year* for covered, in-network services. Applies to most types of health plans and insurance. This amount may be higher than the out-of-pocket limits stated for your plan.

Outpatient: Treatment either outside a *hospital* setting or at a *hospital* when room and board charges are not incurred.

Partial Hospitalization Treatment Facility: A public or private facility, licensed and operated according to the law, which provides intensive therapy daily by a *physician* and licensed mutual *health care providers* (five (5) days per week for no more than eight (8) hours per day). No room and board charges are incurred. This facility does not provide a place for rest, the aged or convalescent care.

Physically or Mentally Handicapped: The inability of a person to be self-sufficient as the result of a condition such as, but not limited to, mental retardation, cerebral palsy, epilepsy or another neurological disorder and diagnosed by a *physician* as a permanent and continuing condition

preventing the individual from being self- sufficient or other *illness* as approved by the *plan administrator*.

Physician: A person acting within the scope of their license and holding the degree of Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.), and who is legally entitled to practice medicine under the laws of the state or jurisdiction where the services are rendered.

Plan Administrator: The *plan administrator*, Riverside Community College District, is the sole fiduciary of the Plan, and exercises all discretionary authority and control over the administration of the Plan and the management and disposition of the Plan assets. The *plan administrator* shall have the sole discretionary authority to determine eligibility for Plan benefits or to construe the terms of the Plan.

The *plan administrator* has the right to amend, modify or terminate the Plan in any manner, at any time, regardless of the health status of any Plan participant or beneficiary.

The *plan administrator* may hire someone to perform claims processing and other specified services in relation to the Plan. Any such contractor will not be a fiduciary of the Plan and will not exercise any other discretionary authority and responsibility granted to the *plan administrator*, as described above.

Plan Sponsor: Riverside Community College District.

Plan Year: The twelve (12) month period for Riverside Community College District, beginning October 1 and ending September 30.

Practitioner: A *physician* or person acting within the scope of applicable state licensure/certification requirements and/or holding the degree of Doctor of Dental Surgery (D.D.S.), Doctor of Dental Medicine (D.M.D.), Doctor of Podiatric Medicine (D.P.M.), Doctor of Chiropractic (D.C.), Doctor of Optometry (O.D.), Optician, Certified Nurse Midwife (C.N.M.), Registered Physical Therapist (R.P.T.), Psychologist (Ph.D., Psy.D.), Licensed Clinical Social Worker (L.C.S.W.), Master of Social Work (M.S.W.), Speech Therapist or Registered Respiratory Therapist.

Professional Components: Services rendered by a professional technician (e.g. radiologist, pathologist, anesthesiologist) in conjunction with services rendered at a *hospital*, *ambulatory surgical facility* or *physician's* office.

Protected Health Information: Information that is created or received by the *Plan* and relates to the past, present, or future physical or mental health or condition of a *member*; the provision of health care to a *member*; or the past, present, or future payment for the provision of health care to a *member*; and that identifies the *member* or for which there is a reasonable basis to believe the information can be used to identify a *member*. Personal health information includes information of persons living or deceased. The following components of a *member's* information also are considered personal health information:

a. names;
b. street address, city, county, precinct, zip code;
c. dates directly related to a member, including birth date, health facility admission and discharge date, and date of death;
d. telephone numbers, fax numbers, and electronic mail addresses;
e. social security numbers;
f. medical record numbers;
g. health plan beneficiary numbers;
h. account numbers;
i. certificate/license numbers;
j. vehicle identifiers and serial numbers, including license plate numbers;
k. device identifiers and serial numbers;
l. web universal resource locators (URLs);
m. biometric identifiers, including finger and voice prints;
n. full face photographic images and any comparable images; and
o. any other unique identifying number, characteristic, or code.

Qualified Medical Child Support Order: A medical child support order that either creates or recognizes the right of an *alternate recipient* (i.e., a child of a covered participant who is recognized under the order as having a right to be enrolled under the Plan) or assigns to the *alternate recipient* the right to receive benefits for which a participant or other beneficiary is entitled under the Plan.

A medical child support order is a judgment, decree or order (including a settlement agreement) issued by a court

PPO Definitions (continued)

of competent jurisdiction or through an administrative process established under state law that has the force and effect of law in that state, that provides for child support related to health benefits with respect to the child of a group health plan participant, or required health benefit coverage of such child in such plan, and is ordered under state domestic relations law, or that enforces a state medical child support law enacted under Section 1908 of the Social Security Act with respect to a group health plan.

Rehabilitation Facility: A legally operating institution or distinct part of an institution which has a transfer agreement with one or more *hospitals*, and which is primarily engaged in providing comprehensive multidisciplinary physical restorative services, post acute *hospital* and rehabilitative *inpatient* care and is duly licensed by the appropriate governmental agency to provide such services. It does not include institutions which provide only minimal care, *custodial care*, ambulatory or part time care services, or an institution which primarily provides treatment of mental health conditions, substance abuse treatment or tuberculosis except if such facility is licensed, certified or approved as a *rehabilitative facility* for the treatment of medical conditions, mental health conditions or substance abuse treatment in the jurisdiction where it is located, or is credited as such a facility by the Joint Commission on the Accreditation of Health Care Organizations or the Commission for the Accreditation of Rehabilitation Facilities.

Respite Care: *Respite care* rendered through a licensed *hospice facility* for home *custodial care* which provides relief to an immediate family in caring for the day to day needs of a terminally ill individual.

Second/Third Surgical Opinion: Examination by a *physician* who is certified by the American Board of Medical Specialists in a field related to the diagnosis of the proposed *surgery* to evaluate alternatives and/or the medical advisability of undergoing a surgical procedure.

Skilled Nursing Facility/Extended Care Facility: An institution that:

1. primarily provides skilled (as opposed to custodial) nursing service to patients;
2. is approved by the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) and/or *Medicare*.

In no event shall such term include any institution or part thereof that is used principally as a rest facility or facility for the aged or, any treatment facility for mental health condition or substance abuse treatment.

Special Enrollee: A *special enrollee* is an employee or dependent who is entitled to and who requests special enrollment:

1. within thirty (30) days of losing other health coverage because their COBRA coverage is exhausted, they cease to be eligible for other coverage, or *employer* contributions are terminated;
2. for a newly acquired dependent, within thirty (30) days of the marriage, birth, adoption, or placement for adoption; or
3. within sixty (60) days of losing other health coverage through Medicaid or CHIP.

Specialized Treatment Facility: Specialized treatment facilities as the term relates to this Plan include *birthing centers*, *ambulatory surgical facilities*, *hospice facilities*, or *skilled nursing facilities* as those terms are specifically defined.

Surgery: Any operative or diagnostic procedure performed in the treatment of an *injury* or *illness* by instrument or cutting procedure through any natural body opening or incision.

Total Disability (Totally Disabled): The inability to perform all the duties of the covered person's occupation as the result of an *illness* or *injury*. *Total disability* means the inability to perform the normal duties of a person of the same age.

USERRA: The Uniformed Services Employment and Reemployment Rights Act of 1994

Waiting Period: A period of continuous, full-time employment before a newly-enrolled employee or dependent is eligible to receive benefits.

Year: See *benefit year*.

KPCM Program FAQs

Frequently Asked Questions

What is the Keenan Pharmacy Care Management Program?

The Pharmacy Care Management Program (KPCM), managed by USR-x Care, offers an independent, unbiased review of prescription medications by engaging physicians and members directly to ensure that the best possible drug therapies are chosen, based on their clinical effectiveness and overall cost to patients and the plan. In most cases, this program will help not only the plan, but the members reduce their out-of-pocket costs for prescription medications.

What are the benefits of KPCM?

The benefits of KPCM include:

- Expert, independent clinical oversight
- Conformance to established guidelines and best practices
- Plan and copay savings

FOR NON-SPECIALTY MEDICATIONS:

How does KPCM work?

- For non-specialty medications, the focus is on chronic therapies that do not require prior authorization
- KPCM has developed proprietary technology to review a client's claims data and recommend possible drug alternatives to the prescribing physician
- An automated care management system is used to assess the prescriptions being written and identify appropriate therapeutic alternatives
- Recommended prescription modifications are communicated to physicians. If approved by the prescribing physician, new prescriptions are issued

How are savings derived?

Education shifting prescribing from high cost to lower cost therapy alternatives:

- Brand to brand »
- Brand to generic »
- High cost generic to lower cost generic »
- High cost generic to lower cost brand »

One great feature of the KPCM program is that the savings are immediate and easy to measure. Savings occur when a member taking a targeted drug switches to a lower cost, clinically appropriate alternative. Only when the lower cost alternative is dispensed, are the savings calculated.

How am I notified if my prescription is changed?

- Once your physician approves the new prescription, KPCM will contact you by phone to make you aware of your doctor approved alternative
- KPCM will attempt to reach you by phone 3 times, between the hours of 12 pm and 9 pm eastern time, Monday through Friday
- After 3 attempts, KPCM will send you a letter

What if I don't want to take the new non-specialty prescription/want to go back to my original prescription?

You simply contact your physician and let them know that you want to stay on the original prescription.

KPCM Program FAQs (continued)

How can I contact KPCM?

Please feel free to contact a KPCM representative at 1-800-241-8440 Monday - Friday between the hours of 12 pm to 9 pm eastern time if you have any questions or wish to proactively explore potential quality improvement or cost saving alternatives for any medications prescribed by your doctor.

Why does KPCM have access to my private medical information?

The KPCM Pharmacy Care Management Program works in concert with Express Scripts. The program is designed specifically to enhance your pharmacy plan and provide you with ways to improve your quality of care. In most cases, this program will help reduce your out-of-pocket costs for prescription medications too.

None of your private medical information is shared with your health plan or any third party. Your private information is always maintained in strict confidence.

Why would they contact my doctor without my permission?

The KPCM program was put in place by your health plan to work in concert with your Express Scripts program to support the use of clinically equivalent drug therapies at reduced cost. Under the program, your prescribing physician is always contacted first to make sure they are comfortable with your making a switch from one medication to another. Only with the approval of your doctor will a KPCM representative contact you about an opportunity to take advantage of a lower cost therapy equivalent. Your doctor may reach out to directly as well to notify you of an approved alternative.

FOR SPECIALTY MEDICATIONS THAT REQUIRE PRIOR AUTHORIZATION:

How does KPCM work?

All specialty medications require prior authorization for coverage under the pharmacy benefit plan. Specialty medications include high cost injectable and oral medications shipped from specialized pharmacies and often require specialty instructions and/or monitoring for both safety and effectiveness.

If a pharmacy informs you that a medication requires prior authorization, ask them to contact your doctor to initiate a coverage review. The pharmacy is provided the necessary contact information on their computer screen to share with your doctor directing them how to initiate the prior authorization process.

If this is a refill of a medication you have taken in the recent past, US-Rx Care will review the prescription and may authorize an interim supply until a new prior authorization review can be completed. If this is a new (first time fill) prescription, the Prior Authorization review must be completed before your prescription can be filled.

How long does the Prior Authorization process take?

The prior authorization process usually takes between 1-3 business days to complete. In the case of an emergency, an expedited review can occur. To complete the prior authorization review process, your doctor must provide necessary information relative to your condition and medical history.

Medications requiring prior authorization cannot be approved, without the needed information from your doctor. Therefore, you are strongly encouraged to contact your doctor directly as well, to make sure they send in the needed documentation immediately to prevent delays in the review process.

What happens if a prescribed medication is not approved through the Prior Authorization process?

In cases where medical therapy is appropriate, your doctor will be provided with plan covered alternatives. You will also be notified by mail when a medication is not approved and the reasons for disapproval.

You or your doctor can appeal if a prescribed medication is not approved after Prior Authorization review. The letter you will receive with notification of a disapproved medication describes the appeal process also.

Three scenario examples:

Example Scenario if Original Rx is denied and alternative Rx is recommended and accepted by doctor:

> "In their clinical management role, should USRx deny a prescription, an alternative USRx recommends needs to be used. The physician needs to support their request with patient medical records. For example, a member with arthritis, USRx stands by the ACR/AS guidelines (American College of Rheumatology and Arthritis Foundation) for this diagnosis and treatment recommendation. If physician agrees with USRx alternative a prescription will need to be sent to dispensing pharmacy for processing and delivery to member"

Example Scenario is Original Rx is denied and alternative Rx is recommended and not accepted by doctor:

- Doctors can disagree with USRx' recommendations but in their clinical management role, should USRx deny a prescription, an alternative USRx recommends needs to be used. Physicians cannot disagree and prescribe the requested drug based solely on their disagreement. The physician needs to support their request with patient medical records. For example, a member with arthritis, USRx stands by the ACR/AS guidelines (American College of Rheumatology and Arthritis Foundation) for this diagnosis and treatment recommendation.
- If the Doctor disagrees with the denial decision, they can request an Appeal process and a Peer to Peer discussion to review rational. The decision will be discussed and either overturned or remain denied. If remain denied member should contact the plan to discuss their options.

Example Scenario if Original Rx prescribed is Too high of a dose:

- USRx will recommend to taper-down dosage, physician will need to agree or disagree to this trial
- If physician agrees a prescription will need to be sent to dispensing pharmacy for processing and delivery to member
- If the Doctor disagrees with the denial decision, they can request an Appeal process and a Peer to Peer discussion to review rational. The decision will be discussed and either overturned or remain denied. If remain denied member should contact the plan to discuss their options.

I am being told I need to get my medication from a "specialty pharmacy"? Why can't I get the medication at my local pharmacy?

Because specialty medications are typically high cost and/or require special handling, manufacturers do not stock retail pharmacies with these medications. They rely on specialized pharmacies to dispense the medication via mail directly to you or your doctor (if the medication is to be doctor administered). The dispensing pharmacy will also provide specialty instructions and training regarding any medication dispensed for you. It is important that you take any medication as prescribed by your doctor, but particularly important when it comes to specialty medications. Follow your doctor and pharmacies instructions closely to ensure the best clinical outcome for your condition.

I have been taking the same medication for some time but am now being told the medication is no longer covered under the plan?

Medications requiring prior authorization can be approved for up to 12 months at a time. Within that timeframe, all specialty medications undergo a re-review. Though the re-review, experienced independent clinicians review your medical and medication history to determine the best course of treatment at the time. Sometimes, that means changing to a newer, better therapy option, or to lower cost therapy alternatives available at that time, for your condition. You will be notified if a medication has been removed from coverage from your plan for safety or other reasons, which can happen from time to time, in which case there will always be preferred alternatives available through the plan for your doctor to choose from.

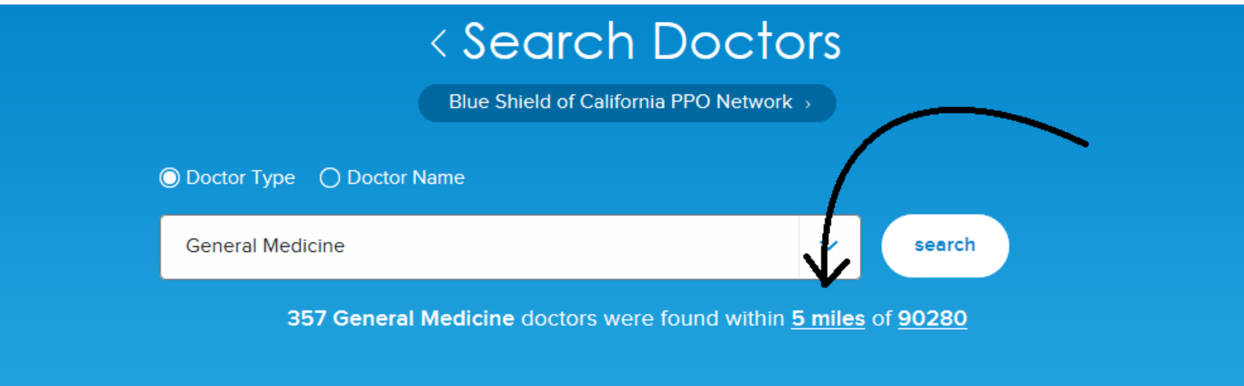
HealthNow Resources

How to Find a Participating Provider

To find a BlueShield of California Participating Provider online, first go to www.blueshieldca.com/networkppo. You should land on the **Find a Provider** page of the website.

- Under **What are you looking for?** select the type of provider that you are searching for—options include doctors, facilities, or equipment and supplies.
- In the **Where are you located?** section, enter your city and state or zip code, click ***Search***.
- To get a printable copy of your search results, click on ***Save results*** above the results and select your preference to download the document or have it emailed to you.

The default distance/radius search is 5 miles. To expand or narrow the search radius, click the mileage listed for your results under your search bar.



To find a BlueCross/BlueShield Participating Provider outside of California, scroll down to the bottom of the page under the heading ***Accessing Care Outside CA***.

- Enter the city and state or zip code where services will be rendered
- Type in the prefix **XEL**.
- Enter your search criteria (e.g. doctor's name, specialty), then click **Go**.

By creating an account on the myhnas.com website, you will have direct access to the www.blueshieldca.com/networkppo link.

Additionally, you may call HNAS at 877.356.0666 for help in finding a Participating Provider.

Health Advocate™
an exclusive resource for you and your family

A 24/7 health concierge service

This unique resource is available at no cost exclusively to HealthNow Administrative Services members and their families — even those family members who don't have coverage through HNAS.

When you or a family member have a health care issue, simply call Health Advocate toll-free at 1-866-695-8622, 24 hours a day, seven days a week, and explain your need to the personal health advocate who immediately begins working to resolve the issue.

Call us toll-free at 1-866-695-8622
healthadvocate.com

How can Health Advocate help you?

- Help navigating health care issues
- Assistance with eldercare concerns
- Research current treatments for medical conditions
- Secure second opinions
- Help scheduling appointments with hard-to-reach specialists
- Unbiased health information to help you make informed decisions
- Untangle claims, billing, and payment issues
- Answers to questions about test results, treatment recommendations, and medications
- Coaching to help you better understand medical conditions

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HealthNow Resources (continued)

GlobalFit®

Simplifying access to wellness

As a valued member, you have special access to the GlobalFit discount gym and wellness program.

GlobalFit inspires you to make better choices — and rewards you when you do. With GlobalFit's Gym Network 360 program, you get access to world-class fitness facilities, virtual and livestreaming classes, personalized nutrition programs, and health-related products and services at discounted rates.

GlobalFit features include:

- Exclusive savings to more than 8,000 national, regional, and local gyms in over 60 major cities and surrounding areas: 24 Hour Fitness, Curves, LA Fitness, Power Pilates, the YMCA, and others
- Access to GlobalFit Anywhere — an innovative app connecting users to in-person and virtual studios, gyms, and trainers with no monthly membership required (pay as you go)
- Discounts on Jenny Craig, Zumba, and home fitness equipment
- The latest deals on spa services, theme parks and attractions, flights, hotels, car rentals, and much more

Over →

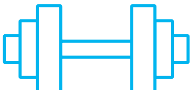
HealthNow Resources (continued)

Follow these three easy steps:

1. Go to **myhnas.com** and log in.
   Then select the *Benefits* menu.

2. Select *Forms*, *Docs*, *Links* and scroll down
   to *Links*. Click the *GlobalFit* link.

3. Click the *Activate Benefit* button to
   get started.



For more information on GlobalFit, please call the customer service number on the back of your member ID card.

GlobalFit® is a separate company.
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myHNAS Online Member Benefits

Welcome to myHNAS!

Access your claims, eligibility, temporary health plan ID card, and other valuable plan information 24/7 through myHNAS. You'll find important documents, links to health-related resources, and answers to frequently asked questions.

Here's what you can do:

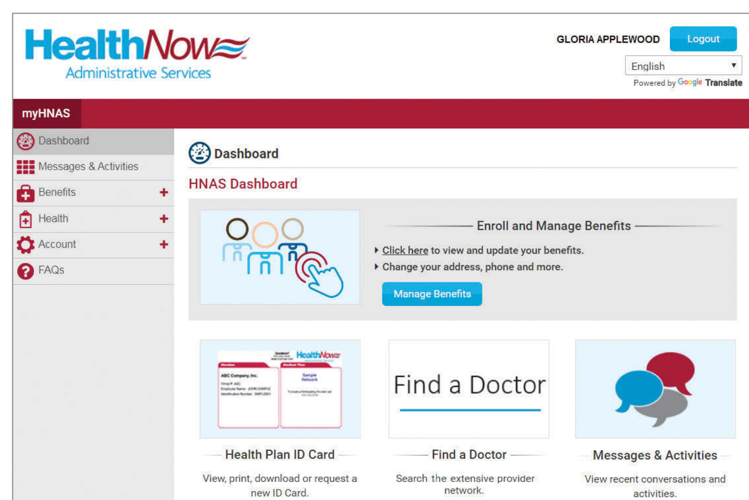
- Review eligibility and plan information for you and your covered dependents
- View claims details for you and your covered dependents*
- Access Explanation of Benefits (EOB) documents related to medical claims
- View, print, or download your current ID card and request new ID cards
- Access an electronic summary of benefits and coverages
- Locate participating doctors or hospitals
- View deductible/accumulator information related to current and past health plan enrollments
- Change your current coverage due to a life event, if applicable

**Privacy rules apply*

Getting started

1. Go to **myHNAS.com**.
2. First-time users, select *Register Now.*
3. Enter the required registration fields and click *Submit.*
4. Read the Term of Service agreement and click *Agree.*
5. Read the Notice of Privacy Practices and click *Agree.*
6. Create a username and password and a security question and answer, then click *Submit.*

   Note: *Your password must include at least six characters and at least one number or symbol (! @ # $ % ^ & * _ + - =).*
7. See your dashboard screen.



myHNAS Mobile

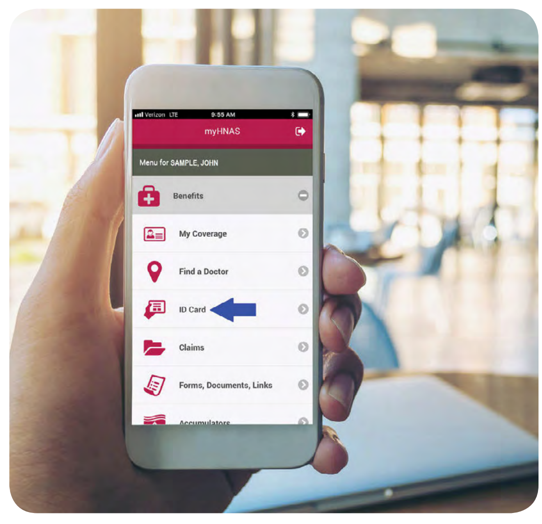
Access on the go!

Have the account information you need, right when you need it most. With the myHNAS mobile app, you can easily access your benefit portal on the go. The mobile app gives you secure access to valuable benefit and plan information anytime you need it. Enjoy all the amenities of the online portal from your Apple or Android device.

Virtual ID card

Carry your virtual ID card in your pocket by using your device to access the myHNAS mobile app. Simply select *ID Card* from the mobile menu, and click *Get ID Card Now*. Your ID card image appears sized on your device screen, easily viewable by your doctor or other provider. This is a valid card and is exactly the same as the most recent card mailed to you. You may use it to access health care services and doctors.

You may also request new ID cards by mail.



Getting started

Already have a myHNAS account? Use your existing myHNAS account username and password to log in to the myHNAS app.

Not registered for a myHNAS account yet?

1. Select *Register*.
2. Enter the required registration fields and tap *Submit*.
3. Read the Terms of Service agreement and tap *Agree*.
4. Read the Notice of Privacy Practices and tap *Agree*.
5. Create a username and password and a security question and answer, and then tap *Submit*.
6. See your menu of services.

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The Express Scripts Mobile App
Pharmacy That Goes Farther.℠

Get the app that drives better decisions and healthier outcomes for members *on the go*.

The **Express Scripts mobile app** helps you stay on track with instant access to your personal medication information – anytime, anywhere. Click here to learn more. Using your mobile device, click here or scan the QR code to download the app now for free!

After downloading the app, log in with your Express-Scripts.com username and password. If you haven't yet registered with Express-Scripts.com, you can create a username and password right from the app – and use the same username and password to access our full website (www.express-scripts.com) or our mobile website (m.express-scripts.com).

From the mobile app, you'll have instant access to these great features:

Claims and History
View your past prescription activity and payment details.

Refills and Renewals†
Running low? One touch and you're good to go. Get home delivery refills right to your door – right here!

Order Status†
On its way? Just swipe the screen with your finger to track your home delivery prescription order status.

Medicine Cabinet
Check interactions, set reminders, manage medications and update your history – all in one spot.

Transfer to Home Delivery†
Save the runaround (and maybe some money) on prescriptions you take on an ongoing basis.

My Rx Choices®†
View lower-cost options available under your plan and discuss them while you're still in the doctor's office!

Pharmacy Care Alerts†
Get personalized alerts to help make sure you're following your doctor's prescribed treatment plan.

Locate a Pharmacy†
Search for the nearest in-network preferred retail pharmacies, view contact information and access directions.

Virtual Member ID Card†
Forgot your wallet? No problem. If you've got your device, you've got your ID.

Drug Information
Search detailed drug information and see potential side effects, drug interactions, pill images and more.

Download the Express Scripts Mobile App today for free!

* The Express Scripts mobile app is available to members using the following mobile devices:
Apple – iPhone® 4, 5 and 6 series, iPad®; Android™ – OS 4.0 & later; Windows Phone®
BlackBerry® – Bold/Tour (OS 4.5 & later), Curve/Curve 2 (OS 4.5 & later) and Storm/Storm 2 (OS 4.7 & later)

† Available if these features are turned on for your group on Express-Scripts.com

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Blue Shield Claim Form

blue of california

Subscriber's Statement of Claim

Send this claim to: Blue Shield of California, P.O. Box 272540, Chico, CA, 95927-2540.

This form is to be used only when the provider of service does not submit your claim directly to Blue Shield.

Check with the Provider to be sure no claim has been submitted.

Duplicate claims will not only be rejected but may delay payment of the original claim.

Important instructions

- Use a separate form for:
  A. Each member of the family
  B. Each different provider of service
  C. Each itemized bill
- Print or type
- Fill in all items completely
- Sign your name in the space provided

Failure to comply with these instructions may result in your claim being delayed or returned to you.

Exceptions:

- Primary Medicare coverage
  A. Submit claim to Medicare first.
  B. Complete boxes 1 and 4 only.
  C. Attach your explanation of Medicare benefits form and a copy of itemized services to this claim and send all to Blue Shield.
- Foreign claims
  Any services rendered outside of the United States or its territories must include the US currency exchange rate or value and the translation for all billed services.

1

Subscriber name (Last, First, MI)		Subscriber number		Group number
Mail address	City	State	ZIP	Is address new? ☐ Yes ☐ No

2

Patient's name	Date of birth (mo/day/yr)	Gender ☐ Male ☐ Female	Relationship to subscriber ☐ Self ☐ Spouse ☐ Child

Describe briefly patient's illness or injury and, if injury, how it occured

Patient was treated for ☐ Injury ☐ Illness ☐ Pregnancy	Date of injury, onset of illness or pregnancy	Is patient retired? ☐ Yes ☐ No	If Yes, effective date

3

Does patient have other health coverage? ☐ Yes ☐ No	If Yes, policy ID number	Name of insuring company	Effective date
Address of insuring company			Type of plan ☐ Group ☐ Individual
Name of policy holder	Gender ☐ Male ☐ Female	Date of birth (mo/day/yr)	Name of employer

4

Was condition related to employment? ☐ Yes ☐ No	Does patient have Medicare? ☐ Yes ☐ No	If Yes, date of birth (mo/day/yr)	Part A effective date	Part B effective date

Subscriber's signature

I certify that the foregoing information is accurate and complete, and authorize the release of any medical information necessary to process this claim.

X ______________________________ Date ____________

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blueshieldca.com

Medicare while Working

If you are eligible to participate in the District medical plans as an active employee and wish to continue working after reaching age 65, you may be able to delay enrollment in some parts of Medicare without incurring a late enrollment penalty at a later date. Your District active medical plan remains primary to Medicare while you are working. That is, the District plan will pay claims first. If you decline Part B when first eligible and you do not remain covered under a group medical plan sponsored by an employer, you may incur a late enrollment penalty.

Medicare coverage consists of the following options:

Part A - Hospital Insurance - covers inpatient hospital stays and related services, skilled nursing facilities, home health care, and hospice services. Part A entitlement is based on age, disability or End Stage Renal Disease (ESRD). For most people entitlement based on age occurs at age 65. Entitlement is automatic if you have reached age 65 and are receiving Social Security benefits. There is usually no premium cost for Part A. However, if you are not receiving Social Security benefits you may apply for Part A benefits separately. It is recommended that you contact your local Social Security office at least three (3) months before age 65 for more information. You generally cannot delay enrollment in Part A penalty free.

Part B - Medical Insurance - covers medically necessary physician services such as office visits, lab and X-ray services, outpatient surgical procedures, and wide variety of other benefits. Part B entitlement generally occurs at the same time as Part A. However, because there is a premium cost to Part B, you may decline coverage. As long as you are covered under a District employee medical plan as an active employee, you can delay enrollment in Part B without incurring a late enrollment penalty when your employment ends. Once your active District medical coverage ends, you have a Medicare Special Enrollment opportunity to sign up for Part B benefits.

Part C - Medicare Advantage Plans - Advantage plans are approved by Medicare and are administered by private companies to provide all of your Part A and Part B benefits. These plans are generally not available until you are no longer covered under a District sponsored plan.

Part D - Prescription Drug Coverage - Individual separate prescription drug plans are usually administered by insurance companies approved by Medicare. Each plan can vary in cost and drugs covered. Part D entitlement generally occurs at the same time as Part A. However, because there is a premium cost to Part D, you may decline coverage. As long as you are covered under a District employee medical plan, you can delay enrollment in Part D without incurring a late enrollment penalty. The prescription coverage for every District sponsored medical plan is considered "creditable" which means that it expects to pay as much as or more than the standard Medicare drug coverage. Once your active District coverage ends, you have a Medicare Special Enrollment opportunity to sign up for Part D benefits, with no late enrollment penalty. For details of what's covered under Medicare, how to enroll, and your options regarding Medicare coverage, contact your local Social Security office or visit www.medicare.gov on the web.

Deer Oaks Employee Assistance Program

Employee Assistance Program

The Deer Oaks Employee Assistance Program (EAP) is a free service provided for you, your dependents, and household members by your employer. This program offers a wide variety of counseling, referral, and consultation services, which are all designed to assist you and your family in resolving work and life issues in order to live happier, healthier, more balanced lives. From stress, addiction, and change management, to locating child care facilities, legal assistance, and financial challenges, our qualified professionals are here to help. These services are completely confidential and can be easily accessed 24/7, offering you around-the-clock assistance for all of life's challenges.

- Program Access: You may access the EAP by calling the toll-free Helpline number, using our iConnectYou App, or instant messaging with a work-life consultant through our online instant messaging system.
- Telephonic Assessments & Support: In-the-moment telephonic support and crisis intervention are available 24/7 along with intake and clinical assessments.
- Short-term Counseling: Counseling sessions with a qualified counselor to assist with issues such as stress, anxiety, grief, marital/family challenges, relationship issues, addiction, etc. Counseling is available via structured telephonic sessions, video, and in-person at local provider offices.
- Referrals & Community Resources: Our team provides referrals to local community resources, member health plans, support groups, legal resources, and child/elder care/daily living resources.
- Advantage Legal Assist: Free 30 minute telephonic or in-person consultation with a plan attorney; 25% discount on hourly attorney fees if representation is required; unlimited online access to a wealth of educational legal resources, links, tools and forms; and interactive online Simple Will preparation.
- Advantage Financial Assist: Unlimited telephonic consultation with an Accredited Financial Counselor qualified to advise on a range of financial issues such as bankruptcy prevention, debt reduction, financial planning, and identity theft; supporting educational materials available; unlimited online access to a wealth of educational financial resources, links, tools and forms (i.e. tax guides, financial calculators, etc.).
- Alternate Modes of Support: Your EAP offers support alternatives in addition to traditional short-term counseling including telephonic life coaching, AWARE stress reduction sessions, and virtual group counseling. During your call with one of our counselors, ask if these programs would be right for you.
- Work-life Services: Our work-life consultants are available to assist you with a wide range of daily living resources such as locating pet sitters, event planners, home repair, tutors, travel planning, and moving services. Simply call the Helpline for resource and referral information.
- Child & Elder Care Referrals: Our child and elder care specialists can help you with your search for licensed child and elder care facilities in your area. They will discuss your needs, provide guidance, resources, and qualified referral packets. Searchable databases and other resources are also available on the Deer Oaks member website.
- Take the High Road Ride Reimbursement Program: Deer Oaks reimburses members for their cab, Lyft and Uber fares in the event that they are incapacitated due to impairment by a substance or extreme emotional condition. This service is available once per year per participant, with a maximum reimbursement of $45.00 (excludes tips).

CONTACT US:
Toll-Free: (888) 993-7650
Website: www.deeroakseap.com
Email: eap@deeroaks.com

DELTA DENTAL

Keep smiling

Delta Dental PPO™

Save with PPO

Visit a dentist in the PPO[1] network to maximize your savings.[2] These dentists have agreed to reduced fees, and you won't get charged more than your expected share of the bill.[3] Find a PPO dentist at **deltadentalins.com**.

Set up an online account

Get information about your plan, check benefits and eligibility information, find a network dentist and more. Sign up for an online account at **deltadentalins.com**.

Check in without an ID card

You don't need a Delta Dental ID card when you visit the dentist. Just provide your name, birth date and enrollee ID or Social Security number. If your family members are covered under your plan, they'll need your information. Prefer to have an ID card? Simply log in to your account to view or print your card.

Coordinate dual coverage

If you're covered under two plans, ask your dental office to include information about both plans with your claim — we'll handle the rest.

Understand transition of care

Generally, multi-stage procedures are covered under your current plan only if treatment began after your plan's effective date of coverage.[4] Log in to your online account to find this date.

Get LASIK and hearing aid discounts

With access to QualSight and Amplifon Hearing Health Care[5], you can receive significant savings on LASIK procedures and hearing aids. To take advantage of these discounts, call QualSight at **855-248-2020** and Amplifon at **888-779-1429**.

Save with a PPO dentist

PPO

NON-PPO

[1] In Texas, Delta Dental Insurance Company provides a dental provider organization (DPO) plan.

[2] You can still visit any licensed dentist, but your out-of-pocket costs may be higher if you choose a non-PPO dentist. Network dentists are paid contracted fees.

[3] You are responsible for any applicable deductibles, coinsurance, amounts over annual or lifetime maximums and charges for non-covered services. Out-of-network dentists may bill the difference between their usual fee and Delta Dental's maximum contract allowance.

[4] Applies only to procedures covered under your plan. If you began treatment prior to your effective date of coverage, you or your prior carrier is responsible for any costs. Group- and state-specific exceptions may apply. If you are currently undergoing active orthodontic treatment, you may be eligible to continue treatment under Delta Dental PPO. Review your Evidence of Coverage, Summary Plan Description or Group Dental Service Contract for specific details about your plan.

[5] Vision corrective services and Amplifon's hearing health care services are not insured benefits. Delta Dental makes the vision corrective services program and hearing health care services program available to you to provide access to the preferred pricing for LASIK surgery and for hearing aids and other hearing health services.

West Virginia: Learn about our commitment to providing access to a quality dentist network at **deltadentalins.com/about/legal/index-enrollee.html**.

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HL_PPO #135419F (rev. 1/23)

Dental (continued)

Plan Benefit Highlights for: Riverside Community College District
(Cert, Class, Mgmt, Confidential & COBRA)

Group No: 07100 – 08301 & 08302

In this incentive plan, Delta Dental pays 70% of the PPO contract allowance for covered diagnostic, preventive and basic services and 70% of the PPO contract allowance for major services during the first year of eligibility. The coinsurance percentage will increase by 10% each year (to a maximum of 100%) for each enrollee if that person visits the dentist at least once during the year. If an enrollee does not use the plan during the calendar year, there will be a 10% decrease from the level attained the previous year. If an enrollee becomes ineligible for benefits and later regains eligibility, the percentage will drop back to 70%.

Eligibility	For eligibility details, refer to the plan's Evidence/Certificate of Coverage (on file with your benefits administrator, plan sponsor or employer).		
Deductibles	None		
Maximums	**Delta Dental PPO dentists:** $2,200 per person each calendar year **Non-Delta Dental PPO dentists:** $2,000 per person each calendar year		
D & P counts toward maximum?	Yes		
Waiting Period (s)	Basic Services None	Major Services None	Prosthodontics None

Benefits and Covered Services*	**Delta Dental PPO dentists****	**Non-Delta Dental PPO dentists****
Diagnostic & Preventive Services (D & P) Exams, (2) cleanings and x-rays	70 - 100 %	70 - 100 %
Basic Services Fillings, posterior composites and sealants	70 - 100 %	70 - 100 %
Endodontics (root canals) Covered Under Basic Services	70 - 100 %	70 - 100 %
Periodontics (gum treatment) Covered Under Basic Services	70 - 100 %	70 - 100 %
Oral Surgery Covered Under Basic Services	70 - 100 %	70 - 100 %
Major Services Crowns, inlays, onlays and cast restorations	70 - 100 %	70 - 100 %
Prosthodontics Bridges and dentures	50 %	50 %
Implant Benefits	75 %	75 %
Implant Maximums	$2,000 Calendar Year	$2,000 Calendar Year
Dental Accident Benefits	100 % (Separate $1,000 maximum per person each 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 non-Delta Dental dentists.

Delta Dental of California	**Customer Service**	**Claims Address**
560 Mission St., Suite 1300 San Francisco, CA 94105	866-499-3001	P.O. Box 997330 Sacramento, CA 95899-7330

deltadentalins.com

This benefit information is not intended or designed to replace or serve as the plan's Evidence of Coverage or Summary Plan Description. If you have specific questions regarding the benefits, limitations or exclusions for your plan, please consult your company's benefits representative. HLT_PPO_INCEN_DDC (Rev. 7/26/2023)

Dental implant

Also known as: Endosseous implant • Dental fixture

Why get implants?

Did you know?
Over 3 million Americans have dental implants — and this number is growing by half a million a year.
American Academy of Implant Dentistry

Replacements for natural teeth and roots, dental implants are an alternative to dentures and bridges. Implants are "anchored" in the jaw, offering comfort and stability.

Advantages

- Improve chewing and speech ability
- Restore natural appearance
- Permanent
- 85–90% effective
- Slow down bone loss

Am I a good candidate for implants?

To be an ideal candidate for implants, you must have:

- good general health
- healthy gums
- sufficient bone structure
- personal commitment to good oral hygiene

Implants might not be the right option if you:

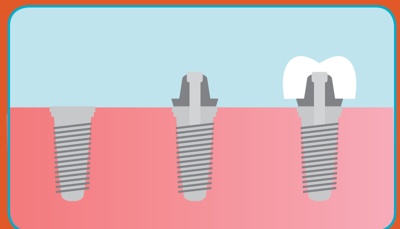
- smoke
- clench or grind your teeth
- have diabetes

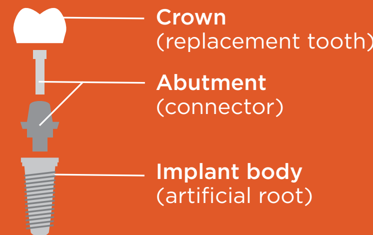
We keep you smiling®
deltadentalins.com/enrollees

Did you know?

The first dental implant was performed on Gösta Larsson in 1965. Carried out in Gothenburg, Sweden, the procedure was a major success, establishing "osseointegration" in the world of dentistry and giving Larsson a set of teeth that lasted for the rest of his life.

Anatomy of an implant





How does the process work?

Placement of dental implants involves a multi-step process that can take several months to a year.

- First, the dentist surgically places the implant body, without the replacement tooth, directly into the jawbone. The bone fuses to the metal, in a process called osseointegration. During this time, you might wear a temporary crown, denture or bridge.
- Next, as soon as the bone has fused to the implant, the connecting piece (abutment) is attached.
- Finally, the crown is attached.

Are implants worth the cost?

Although the cost of implants is significantly higher than that of dentures and bridges, they come with some advantages:

- With proper care, implants can last a lifetime, making them a worthwhile investment.
- Unlike removable prosthetics like dentures, implants are a permanent fixture in your mouth, so you won't ever be caught without your teeth.
- Because they're permanent, implants won't slip during chewing or speaking, giving you the look, feel and function of real teeth.

Not all plans cover implants, so check your plan information for details about your coverage. To find out how much implants will cost you, ask your dentist for a pre-treatment estimate. This free service lets you know up front how much your Delta Dental plan will pay and how much your out-of-pocket expense will be.

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

Want to know more?

Check out related procedures:
crowns • root canals • tooth extraction
mysmileway.com

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EF23 #8919G (rev. 01/17)

DELTA DENTAL

Where's My ID Card?

If you've been looking for your dental plan ID card, we have good news for you: **You don't need one!**

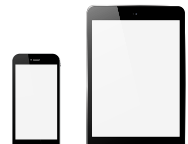
Just tell your dental office the **Delta Dental company** through which you receive benefits and provide your **name,** your **date of birth,** your **enrollee ID number** (or Social Security number) and the **name of your employer.**

Got dependents on your plan? Tell them to provide your details.

Want an ID card anyway?

Print one from your computer

- Go to **deltadentalins.com**
- Log in to your online account > Click on **Print ID Card** > Print



Pull it up on your smartphone

- Download the **Delta Dental** app (by the Delta Dental Plans Association) from the App Store or Google Play
- Log in > Select **My ID card**

Delta Dental of California, Delta Dental of New York, Inc., Delta Dental of Pennsylvania, Delta Dental Insurance Company and our affiliated companies form one of the nation's largest dental benefits delivery systems, covering 36.8 million enrollees. All of our companies are members, or affiliates of members, of the Delta Dental Plans Association, a network of 39 Delta Dental companies that together provide dental coverage to 78 million people in the U.S.

deltadentalins.com/enrollees

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EF11 #121175G (rev. 5/19)

Voluntary Vision

Vision Service Plan (VSP)

Riverside Community College now offers eligible employees the choice of two voluntary vision plans as indicated on this page and the next page.

Plan Benefits	VSP Basic Materials Only Plan		VSP Premier Plan	
	In-Network	Out-of-Network	In-Network	Out-of-Network
	DOCTOR NETWORK – VSP CHOICE			
Frequency				
• Eye Exam	N/A		Once every 12 months	
• Lenses / Contacts	Once every 12 months		Once every 12 months	
• Frames	Once every 24 months		Once every 24 months	
• Contacts *(in lieu of glasses)*	Once every 12 months		Once every 12 months	
Copay	$20 total for materials only		$20 total copay for exam and/or materials	
	PLAN PAYS		PLAN PAYS	
• Exam	N/A	N/A	Well Vision Exam Covered	Up to $45
• Fitting for Contacts	Up to $60 copay	Not covered	Up to $60 copay	Not covered
Prescription Lenses	PLAN PAYS	PLAN PAYS	PLAN PAYS	PLAN PAYS
• Single	100%	Up to $30	100%	Up to $30
• Lined Bifocal	100%	Up to $50	100%	Up to $50
• Lined Trifocal	100%	Up to $65	100%	Up to $65
	PLAN PAYS	PLAN PAYS	PLAN PAYS	PLAN PAYS
Frames	Up to $130; $70 allowance at Costco	Up to $70	Up to $130; $70 allowance at Costco	Up to $70
Contacts *(in lieu of lenses and frames)*	PLAN PAYS	PLAN PAYS	PLAN PAYS	PLAN PAYS
• Medically Necessary	100%	Up to $210	100%	Up to $210
• Elective	Up to $130	Up to $105	Up to $130	Up to $105

How to Find a VSP Choice Provider (Basic and Premier Plans)

- Go to vsp.com
- Click on the "Find a Provider" tab
- Complete the required fields
- For Doctor Network choose "Choice" from the provider drop down

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

Why UV and Blue Light Coverage?

Even if you don't wear prescription glasses, an annual eye exam is an easy and cost-effective way to take care of your eyes and overall health.

With VSP LightCare™, you can use your frame and lens benefit to get non-prescription eyewear from your VSP® network doctor. Sunglasses or blue light filtering glasses may be just what you're looking for.

KEEP YOUR EYES PROTECTED OUTDOORS AND IN:

Always wear sunglasses outdoors. Protect your eyes from the sun's ultraviolet rays that can damage your corneas and cause eye-related diseases like cataracts. 100% UVA and UVB protection is the best choice for your sunglasses.[2]
Wear blue light filtering glasses indoors to combat digital eye strain. Digital screens and fluorescent lighting emit blue light that can contribute headaches, blurred vision, and sore eyes—all possible symptoms of digital eye strain.

PROVIDER CHOICES YOU WANT

The VSP Premier Program includes thousands of **private practice doctors** and more than 700 **Visionworks® retail locations** nationwide.

Prefer to shop online?

At **eyeconic.com®**, you'll be shopping at the preferred online retailer for VSP members where you can connect and use your benefits.[3]

Your VSP LightCare Coverage with a VSP Network Doctor*

Eye Exam

A fully covered comprehensive WellVision Exam®.[1]

Eyewear

Visit a VSP network doctor and choose either prescription eyewear coverage, or use your frame and lens allowance toward ready-to-wear:

- non-prescription sunglasses *or*
- non-prescription blue light filtering glasses

*Register and log in to **vsp.com** to review your benefit information. Based on applicable laws; benefits may vary by location.

Questions? vsp.com | 800.877.7195

1. Less any applicable copay **2.** Tips for Choosing the Best Sunglasses, American Academy of Ophthalmology, June 2021 **3.** To find out whether your employer participates in Eyeconic®, log in to **vsp.com** to check your vision benefits.

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VSP, Eyeconic, eyeconic.com, and WellVision Exam are registered trademarks, and VSP LightCare is a trademark of Vision Service Plan.
All other brands or marks are the property of their respective owners. 103187 VCCM

Classification: Public

Voluntary Vision (continued)

SEE HEALTHY AND LIVE HAPPY WITH HELP FROM RIVERSIDE COMMUNITY COLLEGE DISTRICT AND VSP.

Enroll in VSP® Vision Care to get personalized care from a VSP network doctor at low out-of-pocket costs.

VALUE AND SAVINGS YOU LOVE.
Save on eyewear and eye care when you see a VSP network doctor. Plus, take advantage of Exclusive Member Extras for additional savings.

PROVIDER CHOICES YOU WANT.
It's easy to find a nearby in-network doctor. Maximize your coverage with bonus offers and savings that are exclusive to Premier Program locations—including thousands of private practice doctors and over 700 Visionworks retail locations nationwide.

Visionworks

QUALITY VISION CARE YOU NEED.
You'll get great care from a VSP network doctor, including a WellVision Exam®—a comprehensive exam designed to detect eye and health conditions.

USING YOUR BENEFIT IS EASY!

Create an account on **vsp.com** to view your in-network coverage, find the VSP network doctor who's right for you, and discover savings with exclusive member extras. At your appointment, just tell them you have VSP.

Enroll today.
Contact us: **800.877.7195** or **vsp.com**

Life / AD&D

Plan Benefits	Lincoln Financial
Life / AD&D Benefits	$50,000 Life and Accidental Death & Dismemberment (AD&D)
Eligibility	All full-time employees working 20 or more hours per week in an eligible class are eligible for coverage. A delayed effective date will apply if the employee is not actively at work.
Guarantee Issue	$50,000 Life and AD&D
Benefit Termination	Benefits terminate at retirement

Definitions

Accelerated Death Benefit

Accelerated Death Benefit provides an option to withdraw a percentage of your life insurance coverage when diagnosed as terminally ill (as defined in the policy). The death benefit will be reduced by the amount withdrawn. To qualify, you have satisfied the Active Work rule and have been covered under this policy for the required amount of time as defined by the policy. Check with your tax advisor or attorney before exercising this option.

Accident Plus

If loss occurs due to an accident, you may also receive the following Accident Plus benefits:

- **Coma:** Pays 5% of your principal sum up to a maximum of $5,000 if you are in a coma as a result of an accident covered under the policy and remain in a coma for 31 continuous days.
- **Plegia:** Pays 100% of your principal sum for quadriplegia and 50% of your principal sum for paraplegia and hemiplegia. Plegia must be caused by a covered accident. Benefits are doubled if accident is caused by a common carrier.
- **Repatriation:** Pays up to $5,000 for preparation and transportation of your body when the accident occurs more than 150 miles away from home. Death must be the result of a covered accident.
- **Education:** As a result of your death, this benefit pays 5% of the principal sum up to a maximum of $5,000 or your eligible dependent's post-secondary education. The benefit is paid for up to four years.
- **Spouse Training:** As a result of your death, this benefit pays 5% of your principal sum up to a maximum of $5,000 for your spouse and covers the cost of classes taken to retrain or refresh skills needed for employment. Benefits will be paid for one year and enrollment must occur within 365 days of the covered accident.
- **Child Care:** As a result of your death, this benefit pays 5% of your principal sum up to a maximum of $5,000 for expenses paid to a licensed childcare facility for an eligible dependent attending on a regular basis. The benefit will be paid for up to four consecutive years, or until your child's 13th birthday, whichever comes first.

Accidental Death and Dismemberment (AD&D)

AD&D insurance provides specified benefits for a covered accidental bodily injury that directly causes dismemberment (e.g., the loss of a hand, foot, or eye). In the event that death occurs from a covered accident, both the life and the AD&D benefit would be payable.

Conversion

If you terminate your employment or become ineligible for this coverage, you have the option to convert all or part of the amount of coverage in force to an individual life policy on the date of termination without Evidence of Insurability. Conversion election must be made within 31 days of your date of termination.

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

Life / AD&D (continued)

Guarantee Issue

For timely entrants enrolled within 31 days of becoming eligible, the Guarantee Issue amount is available without any Evidence of Insurability requirement. Evidence of Insurability will be required for any amounts above this, for late enrollees or increase in insurance and it will be provided at your own expense.

Seat Belt, Airbag, and Common Carrier

If you die as a result of a covered auto accident while wearing a seat belt or in a vehicle equipped with an airbag, additional benefits are payable up to $10,000 or 10% of the principal sum, whichever is less. If loss occurs for you due to an accident while riding as a passenger in a common carrier, benefits will be double the amount that would otherwise apply as outlined in the certificate.

Term Life

Coverage provided to the designated beneficiary upon the death of the insured. Coverage is provided for the time period that you are eligible and premium is paid. There is no cash value associated with this product.

Additional Benefits

BeneficiaryConnect^{SM}: Support services for beneficiaries who have experienced a loss.

TravelConnect^{SM}: Travel assistance services for employees and eligible dependents traveling more than 100 miles from home.

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

LifeKeys Services

EstateGuidance® — step-by-step online instructions to:

- Name an executor to manage your estate
- Choose a guardian for your children
- Specify wishes for your property
- Provide funeral and burial instructions

GuidanceResources® — online access to information on:

- Law and regulations
- Money and investing
- Family and relationships
- Health and wellness
- Work and education
- Leisure and home

Identity theft resources — online information to help you:

- Spot the warning signs
- Protect your cell phone, computer, and tax records from fraud
- Repair your credit if you become a victim
- Access credit reporting bureaus, the ID Theft Resource Center, and other essential resources

Support resources for your beneficiaries

LFE-SERV-FLI002_Z05

Because life doesn't always go as planned.

No matter how well you plan your life, you can be sure a few unforeseen challenges will arise. When they do, it's reassuring to know that help and support are close at hand — thanks to *LifeKeys*® services from Lincoln Financial Group. If you are enrolled in life and/or AD&D insurance, this program provides access to a wide array of services to help you and your loved ones through life's ups and downs — and prepare you for whatever lies ahead.

LifeKeys® services include:

Online will preparation
Having a will is important because it allows you to designate who will receive your property and assets when you die. Without one, your state determines how your estate is distributed. EstateGuidance® will preparation is a quick and easy way to create and execute a will.

Information on important life matters
You have access to GuidanceResources® Online, where you'll find articles, tutorials, videos, and "Ask the Expert" advice on a wide range of topics — including legal, financial, family, and career. It's a way to stay "in the know" on important matters that impact both your personal and professional life.

Protection against identity theft
Identity theft is widespread, and everyone is vulnerable. *LifeKeys* includes an online resource for the information you need to recognize and prevent identity theft — and restore your good name.

Guidance and support for your beneficiaries
The *LifeKeys* comprehensive program offers resources to help your loved ones address a range of common concerns. Services include grief counseling, advice on financial and legal matters, and help coping with the occasional challenges of day-to-day life.

See the other side for important services for your beneficiaries. >

Insurance products issued by:
The Lincoln National Life Insurance Company
Lincoln Life & Annuity Company of New York

For your beneficiaries: help, guidance and support at a difficult time

The emotional impact of losing a loved one can be profound and long-lasting. All too often, financial or legal issues can add to the stress. That's why *LifeKeys*® services can be a welcome resource for your beneficiaries.

These services are available for up to one year after a loss. They may be accessed by any combination totaling six in-person sessions for grief counseling, or legal or financial information, and unlimited phone counseling.

Grief counseling — advice, information, and referrals on:
- Grief and loss
- Stress, anxiety, and depression
- Memorial planning information
- Concerns about children and teens

Financial services — online resources or advice from financial specialists on:
- Estate planning
- Budgeting
- Overcoming debt
- Bankruptcy
- Investments

Legal support — access to quick legal information on:
- Estate and probate law
- Real estate transactions
- Social Security survivor and child benefits
- Important documents your beneficiaries need

Help with everyday life — comprehensive information on:
- Planning a memorial service
- Finding child care or elder care
- Selecting a mortgage
- Moving and relocation
- Making major purchases

It's easy to access *LifeKeys*® services. Just call 1-855-891-3684 or visit GuidanceResources.com. (First-time user: Enter Web ID LifeKeys)

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Affiliates are separately responsible for their own financial and contractual obligations.

LCN-1854802-072517
POD 3/19 **Z05**
Order code: LFE-SERV-FLI002

Lincoln Financial Group®

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Lincoln Financial Group®

Group Benefits

Caring support and assistance when you travel

Lincoln *TravelConnect*® services offer security and reassurance – helping make travel less stressful. If you're enrolled in life and/or accidental death and dismemberment insurance, you and your loved ones can count on *TravelConnect*® services 24 hours a day, 7 days a week.

Services you can count on during an emergency

You'll have dedicated support if you face an emergency when you're 100 or more miles from home. *TravelConnect*® helps with:

- Arranging travel if you're injured and need emergency evacuation to a medical facility
- Managing travel for a companion and/or your dependent children, including transportation expenses and accommodations of a qualified escort
- Planning and paying for a safe evacuation because of a natural disaster or a political or security threat
- Arranging transportation of a deceased traveler
- Securing emergency pet boarding and/or return and vehicle return

Ongoing support when you're far from home

From planning the trip until you're home, these *TravelConnect*® services can help you on your way.

- Medical record requests
- Medication and vaccine delivery
- Medical, dental, and pharmacy referrals
- Corrective lenses and medical device replacement
- Legal consultation
- Recovering lost or stolen documents or luggage
- ID recovery assistance
- Language translation services
- Destination information

TravelConnect®

Lincoln Financial Group®

GLOBAL ASSISTANCE PROGRAM

Provided by On Call International
Medical, security, and travel assistance services for participants traveling 100+ miles from home

Visit MyOnCallPortal.com and enter Group ID: **LFGTravel123** for access to plan documents, international calling instructions, and destination information.

LFE-TRVFE-FLI001

TravelConnect (continued)

For a complete list of *TravelConnect*® services, go to **MyOnCallPortal.com** and enter Group ID **LFGTravel123.**

TravelConnect® services are provided by On Call International, Salem, NH. On Call International is not a Lincoln Financial Group® company and Lincoln Financial Group does not administer these services. Each independent company is solely responsible for its own obligations. On Call International must coordinate and provide all arrangements in order for eligible services to be covered. Coverage is subject to contract language that contains specific terms, conditions, and limitations, which can be found in the program description.

The *TravelConnect*® program is not available to insured employees and dependents of policies issued in the states of New York and Washington. Access Only program available to insured employees and dependents of policies issued in the state of Missouri and Texas. Benefits provided under the Access Only program exclude payment for paid services.

Not available in New York and Washington.

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LCN-3885715-102621
MAP 12/21 **Z03**
Order code: LFE-TRVFE-FLI001

If you need medical, security, or travel assistance, regardless of the nature or severity of your situation, contact On Call International 24 hours a day:

Call collect from anywhere in the world:
603-328-1955
Call toll free from U.S. or Canada:
866-525-1955
Email: mail@OnCallInternational.com

Global assistance services must be coordinated and approved by On Call in order to be covered.

See your plan description for full terms and conditions of the services offered in your plan.

On Call International
A member of the **Tokio Marine HCC** group of companies

Understanding Your 403(b) & Roth 403(b)

Overview

The 403(b) is a Tax-Sheltered Account (TSA) developed by the IRS to allow you to save for retirement and supplement your CalSTRS/CalPERS pension plan. On average, your pension replaces 50-65% of income in retirement.[1,2] Currently, studies show that at a minimum, approximately 80% of income replacement is necessary to maintain the same standard of living in retirement.[3] A 403(b) offers school employees a way to bridge that gap while saving for retirement.

403(b)

Taxes

Contributions are made to a 403(b) before taxes are taken from your paycheck, reducing your taxable income. Taxes are paid on withdrawals, typically in retirement when you will likely be in a lower tax bracket.

Withdrawals

You may begin to take withdrawals from a 403(b) at age 59½. Penalties may apply to withdrawals taken before this time.

Loans

A loan may be taken against Roth 403(b) funds while you are still employed. Repayment terms and interest rates are determined by your plan's vendor.

Roth 403(b)

Taxes

Contributions to a Roth 403(b) are made after taxes are taken from your paycheck, allowing your earnings to grow — and withdrawals taken — tax-free if the account has been open for at least fi e years and you are age 59½ or older.

Withdrawals

You may make a withdrawal from a Roth 403(b) when you reach age 59½, upon severance of employment, or in case of hardship, disability or death.

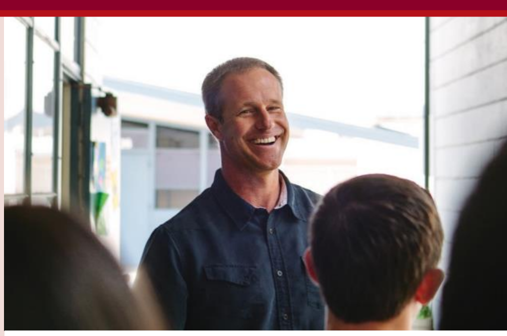
Loans

A loan may be taken against Roth 403(b) funds while you are still employed. Repayment terms and interest rates are determined by your plan's vendor.

Contribution

In 2022, you may contribute up to $20,500 to a 403(b) and/or Roth 403(b), combined. It is possible to contribute up to $9,500 more than the maximum if you meet the following requirements:

- Age 50+ in 2022 = an additional $6,500
- With employer 15+ years = an additional $3,000



Here to help you

The 403(b) administrator for your district is SchoolsFirst Plan Administration. If you have questions, or would like to open a 403(b) account, please contact:

Vanessa Hughes
Retirement Plan Advisor

Phone: 657-699-4239

Email: vhughes@schoolsfirstfcu.org

Scan or Click the QR code to schedule your appointment today!

Understanding Your 403(b)

Overview

The 403(b) is a Tax-Sheltered Account (TSA) developed by the IRS to allow you to save pre-tax dollars for retirement to supplement your CalSTRS/CalPERS pension plan. On average your pension replaces 50-65% of income in retirement.[1,2] Currently, studies show that at a minimum, approximately 80% income replacement is necessary to maintain the same standard of living in retirement.[3] The 403(b) offers school employees a way to bridge that gap while saving for retirement.

Taxes
Contributions are made to a 403(b) before taxes are taken from your paycheck, reducing your taxable income. Taxes are paid on withdrawals, typically in retirement when you will likely be in a lower tax bracket.

Withdrawals
You may begin to take withdrawals from a 403(b) at age 59½. Penalties may apply to withdrawals taken before this time.

Loans
A loan may be taken against 403(b) funds while you are still employed. Repayment terms and interest rates are determined by your plan's vendor.

Contribution Limits
In 2022, you may contribute up to $20,500 to a 403(b).

Catch-up Contributions
It is possible to contribute up to $9,500 more than the maximum if you meet the following requirements:

- Age 50+ in 2022 = an additional $6,500
- With employer 15+ years = an additional $3,000

The Pre-Tax Savings Advantage

Based on a teacher's annual income of $45,000

	403(b) Contribution		
	$100/Month	$300/Month	$500/Month
Monthly gross income	$3,750	$3,750	$3,750
Net paycheck	$2,786	$2,652	$2,518
Change in paycheck	$67	$201	$335

This is a hypothetical example used for illustrative purposes only, and is not indicative of any specific investment. The example does not reflect any fees or charges that may apply.

Here to help you
The 403(b) administrator for your district is SchoolsFirst Federal Credit Union. If you have questions, or would like to open your 403(b) account, please contact:

Vanessa Hughes
Retirement Plan Advisor

Cell
(657) 699-4239

Email
vhughes@schoolsfirstfcu.org

Scan QR code to schedule your appointment today!

Plan Administration, LLC

Understanding Your 457(b)

Overview

The 457(b) is a Deferred Compensation Plan (DCP) developed by the IRS to allow you to save pre-tax dollars for retirement to supplement your CalSTRS/CalPERS pension plan. On average, your pension replaces 50-65% of income in retirement.[1,2] Currently, studies show that at a minimum, approximately 80% of income replacement is necessary to maintain the same standard of living in retirement.[3] A 457(b) offers school employees a way to bridge that gap while saving for retirement.

Taxes

Contributions are made to a 457(b) before taxes are taken from your paycheck, reducing your taxable income. Taxes are paid on withdrawals, typically in retirement when you will likely be in a lower tax bracket.

Withdrawals

You may withdraw from a 457(b) at age 59½ or when you leave your employer, or in the case of death, disability or unforeseeable emergency. Supporting documentation is required and you may be subject to penalty fees. Distributed funds cannot be rolled back into the plan.

Loans

A loan may be taken against 457(b) funds while you are still employed. Repayment terms and interest rates are determined by your plan's vendor.

Contribution Limits

In 2022, you may contribute up to $20,500 to your 457(b). It is possible to make a catch-up contribution of up to $20,500 more than the maximum if you meet the following requirements in 2022:

- Age 50+ = an additional $6,500; or
- Age is within three years of Normal Retirement Age (NRA)* = up to an additional $20,500

The Pre-Tax Savings Advantage

Based on a teacher's annual income of $45,000

	457(b) Contribution		
	$100/Month	$300/Month	$500/Month
Monthly gross income	$3,750	$3,750	$3,750
Net paycheck	$2,786	$2,652	$2,518
Change in your paycheck	$67	$201	$335

*NRA is typically 62 or 65. Check with your plan administrator.
This is a hypothetical example used for illustrative purposes only and is not indicative of any specific investment.
The example does not reflect any fees or charges that may apply.

Here to help you

The 457(b) administrator for your district is SchoolsFirst Plan Administration. If you have questions, or would like to open a 457(b), please contact:

Vanessa Hughes
Retirement Plan Advisor

Cell
(657) 699-4239

Email
vhughes@schoolsfirstfcu.org

Scan QR code to schedule your appointment today!

Plan Administration, LLC

403(b) and 457(b) Online Tools

Online retirement access and tools to help you Educate, Enroll and Take Control

We make it easy to stay on top of your retirement plans from wherever you are — enroll, monitor and adjust your plan. You have all the tools necessary to achieve your goals at your fi   ertips.

My Interactive Retirement Planner[SM]

- Determine how your current account balance may translate into potential retirement income
- Utilize Social Security and pension estimators for a more comprehensive view of your potential future savings

My Health Care Estimator

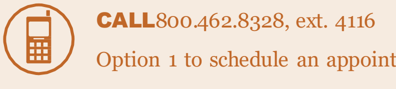
- Understand your potential health care costs in retirement in less than five minutes
- Start preparing with insight into these potential expenses

Access on your terms

- Sign up for an online account to get access to all of these features 24/7
- Learn about budgeting, dollar cost averaging, special considerations and more with a library of videos, relevant articles, and tools

Professional Advice is just a phone call away

- Our advisors are available over the phone or we'll even come to your school or district office for in-person appointments
- Get support and answers to any questions you may have about your retirement savings



CALL 800.462.8328, ext. 4116
Option 1 to schedule an appointment

CLICK nationwide.com/schoolsfirst

A 457(b) account must be opened prior to your first contribution. A complete list of approved providers is available upon request.

SchoolsFirst Plan Administration, LLC is a wholly-owned affiliate of SchoolsFirst Federal Credit Union. Securities sold, advisory services offered through CUNA Brokerage Services, Inc. (CBSI), member FINRA/SIPC, a registered broker/dealer and investment advisor. CBSI is under contract with SchoolsFirst FCU to make securities available to Members. **Not NCUA/NCUSIF/FDIC insured, may lose value, no financial institution guarantee and not an obligation of the Credit Union. Not a deposit of any financial institution.** CUNA Brokerage Services, Inc., is a registered broker/dealer in all fifty states of the United States of America. **1.** Overview of the California State Teachers' Retirement System and Related Issues. **2.** California Public Employees' Retirement System Overview, 2016. **3.** "How much do you really need for retirement?" Forbes.com, 2015.

MK354 11/21

Representatives are not tax advisors. For information regarding your specific tax situation, please consult a tax professional.

Insurance Plans

American Fidelity Assurance Company is one of the benefit providers for the Riverside Community College District. We encourage you to reach out to out representative, Stephanie Hopkins, at 800-365-9180 ex: 334 for more information. The following is a brief description of what American Fidelity offers here at our district:

Disability Income Insurance

Are you protecting your income? Many people forget their most valuable asset-the ability to provide an income. You should consider Disability Income Insurance to protect your ability to pay for the rent/mortgage, utilities, car payment, etc. Disability Insurance Benefits are payable when you are unable to work due to a covered accident or sickness. **Current Disability Income Insurance Policyholders: Don't forget to check your current Disability Income Insurance benefit amount. Disability Income Insurance coverage does not automatically increase with a salary increase. See your American Fidelity Account Representative if you need to increase your coverage amount to match your current salary.**

Ask your American Fidelity Account Representative for a brochure covering full plan details, benefits, limitations and exclusions.

Portable Life Insurance

Life Insurance At Retirement Can Be Very Costly. Your employer may provide you with Group Life Insurance – but do you have portable life insurance that you can take with you after your employment ends?

American Fidelity has several types of individual coverage to help you protect yourself and your family, including:

- ***Versatile Term*** (RCTL-99 series)* gives you the choice of 10, 20, or 30 Year initial term periods in this Renewable and Convertible term life insurance policy. It offers fully guaranteed level death benefit coverage with a guaranteed premium schedule. Premiums adjust at each renewal based upon your attained age.
- ***Secured Life Plus*** (L-97 series)** is a whole life insurance product that provides a guaranteed level death benefit, guaranteed schedule of cash value, and guaranteed premiums.

Cancer Expense Insurance

Cancer can be a very costly disease. Even people who do have medical insurance to help shoulder the expensive medical procedures and drugs that fight cancer often overlook the indirect costs of cancer, such as loss of income, spouses' loss of income, transportation and lodging. American Fidelity's Cancer Policy can help with the indirect costs of cancer. Our policy offers wellness benefits to help with the early detection of some cancers, as well as the financial aid you may need if diagnosed with cancer. (C10-98 series) This highlights some of the features of these products. This policy contains limitations and exclusions. This product is inappropriate for people who are eligible for Medicaid coverage. Waiting periods apply.

Benefit Accident Only Insurance

Do you need accident protection? Over 20,700,000 disability injuries occurred in the U.S. during 2003 (Injury facts, 2004 published by National Safety Council). See your American Fidelity Account Representatives for more information.

Provided by:

SB-20645

Stephanie Hopkins (lic. 0C68758)
36310 Inland Valley Dr., #100
Wildomar, Ca 92595
800-365-9180 ex: 334
Stephanie.Hopkins@americanfidelity.com

*These products may not be available on a pre-tax basis. See your American Fidelity Account Representative for more information. *The Versatile Term 10, 20, and 30 Year initial term periods are only available on an after-tax basis. **The Secured Life Plus product is only available on an after-tax basis.*

Save More Worry Less

What is a Flexible Spending Account (FSA)?

An FSA account is an employer sponsored benefit that allows you to pay for eligible expenses on a pre-tax basis. There are two account categories: Health Care FSA (HCFSA) and the Child/Dependent Care FSA (DCFSA).

How Does it Benefit Me?

An FSA saves you money. The contributions you make to an FSA are deducted from your pay **BEFORE** Federal, FICA and State Taxes are calculated, and are not reported to the IRS as taxable wages. The end result is that you decrease your taxable income and increase your spendable income.

You can choose to participate in one or both of these FSAs:

Health Care FSA

HCFSAs allow you to spend tax-free money to pay for a wide range of out-of-pocket health care costs. The full annual amount you elect is immediately available, so you don't have to wait until your paycheck contributions have added up to get the care you need.

Child/Dependent Care FSA

A DCFSA allows you to use tax free monies to pay for child or dependent care expenses so you can work. DCFSA funds are available as they are deducted from your payroll.

How FSAs Work:

1 Estimate your upcoming plan year expenses.

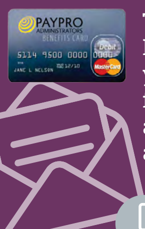
This will help you determine the total for your FSA contributions.

Go to **pagroup.us** for worksheets and tools to help calculate your expenses.

2 Tax free money from each paycheck goes into your FSA.

Your election amount will be deducted evenly out of each payroll check and placed into your FSA.

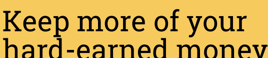
3 Access your funds by submitting a claim for reimbursement or use the PayPro Benefits Card™ to pay for the expense.



The PayPro Benefits Card™ is a Debit card tied to your FSAs. If your plan offers the card use it for payment, and the funds will automatically be paid from your account.

Please read the cardholder agreement. Always obtain and save itemized receipts as they may be requested. Failure to provide these items may result in card suspension per IRS requirements.

4 Download the mobile app or check your balance and claims at pagroup.us



Keep more of your hard-earned money!

Election amounts can not be changed mid-year unless you experience a qualifying event.

Health Care FSA

Flexible Spending Accounts (FSA) reduce your taxable income by setting aside pre-tax dollars to pay for eligible healthcare expenses.*

Each plan year you select a specific amount to contribute to your HCFSA. Your election amount will be deducted evenly out of each payroll check and placed into your FSA. You can then use the funds to pay for eligible expenses.

A big perk to the HCFSA is that **it is pre-funded, meaning that you will have access to your full annual election amount at the very beginning of the plan year**, regardless of the amount contributed to date. That is like having a tax-free, interest-free loan to help you pay for healthcare expenses.

Who's Covered

The HCFSA covers eligible expenses for you and your dependents, even if they are not covered under your primary health plan.

What's Covered*

For a complete list of eligible expenses go to pagroup.us:

Examples of Eligible Expenses:

- Allergy Medicine**
- Bandages
- Blood Pressure Monitors
- Chiropractic Care
- Cold Medicine**
- Condoms/Birth Control
- Contact Lenses & Cleaners
- Copays, Co-Insurance & Deductibles
- Dental Care
- Dental Implants
- Diabetic Supplies
- Eyeglasses
- First Aid Kits
- Hearing aids
- Laser Eye Surgery
- Orthodontia
- Over the counter (OTC) drugs and medicines
- Pain Relievers**
- Pregnancy Tests
- Prescription Drugs
- Smoking Cessation Programs**
- Sunscreen SPF 15+

Examples of Ineligible Expenses:

- Elective cosmetic treatments
- Teeth whitening
- Insurance premiums
- HSA contributions

*Plan designs vary amongst employers. Refer to plan documents for year end options, limits, and eligible expenses.

** Over the counter drugs and medicines are eligible for reimbursement.

Child/Dependent Care FSA

Participating in a Child/Dependent Care FSA is like receiving a 30% discount from your care provider.*

A Child/Dependent Care FSA (DCFSA) is a flexible spending account that allows you to set aside pre-tax dollars for dependent care expenses. Since DCFSA contributions are deducted from your paycheck pre-tax, your taxable income is reduced. **Participants enjoy a 30% average tax savings on their annual DCFSA contribution.**

Qualifying Dependents

Your qualifying child under the age of 13, who shares the same residence with you, or your spouse or qualifying child or relative who is physically or mentally unable to care for him/herself who shares the same residence with you and has income less than the federal exemption amount.

Annual Contribution Limits

The IRS limits annual contributions to $5,000 on income tax returns for single or married persons filing jointly, and $2,500 for married individuals filing separately.

The IRS $5000 maximum is a plan year, calendar year and household maximum amount.

What's Covered*

For a complete list of eligible expenses go to pagroup.us:

Examples of Eligible Expenses:

- Cost for the care of your eligible dependents while you are at work.
- Before school or after school care (other than tuition)
- Custodial care for dependent adults
- Private sitter or day care provider
- Licensed day care centers
- Nursery schools or pre-schools
- Day camp & summer or holiday day camps

Examples of Ineligible Expenses:

- Expenses for children 13 and older (unless physically/mentally unable to care for him/ herself).
- Care provided by a relative that lives in your household or your dependent under the age of 19.
- Educational expenses including kindergarten or private school tuition fees.
- Overnight camp expenses

*Plan designs vary amongst employers. Refer to plan documents for year end options, limits, and eligible expenses.

Unused Funds
Every FSA plan is different—

Ask your employer which option(s) applies to your plan at year end:

Use it or Lose it

Any remaining funds are forfeited at year's end.

2—1/2 month Extension

2

This allows you to spend "old plan year" dollars during the first two and a half months of the new plan year.

Carry Over

Unused HCFSA funds up to $610 will be carried over to the next plan year (must be an active employee).

Carry Over Amount is limited to 20% of the IRS annual HCFSA Limit.

Expenses must be incurred during the plan year—which is the date of service—in order to be considered eligible for that plan year. The 'incurred' date is the actual date of service—not when the expense was billed or paid.

At the end of the plan year, you may have a grace period in which you can submit claims. The grace period, if any, is outlined in your plan documents.

The HCFSA may be subject to COBRA through the remainder of the plan year.

Questions?

phone: **951.656.9273** • fax: 951.656.9276
customerservice@pagroup.us

pagroup.us

View Status of Claim

Submit Your Claim

Download the app at your app store!

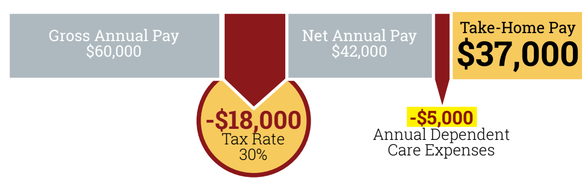
If you and or your family contribute to an HSA, you may be able to participate in a limited purpose FSA. See employer for details.

Why should I enroll?

You'll save on average 30% on every dollar you pre tax. Imagine how much you can save in five years!

Examples*:

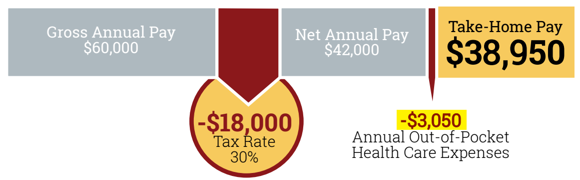
Without DCFSA



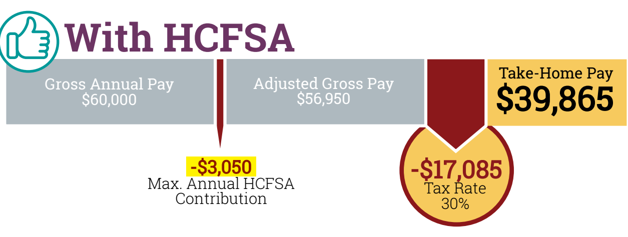
With DCFSA

You could save up to
$1500 per year
by participating in the DCFSA

Without HCFSA



With HCFSA



You could save up to
$915 per year
by participating in the HCFSA

*For illustrative purposes only. Based on 30% average savings. Your tax situation may be different. Consult a tax advisor.

CA LIC. #0G76414

phone: 951.656.9273 • 800.427.4549 fax: 951.656.9276 • email: customerservice@pagroup.us • pagroup.us

PayPro Administrators will process claims, reimbursements, and track all account activity.

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Additional Information

Retirement

The District shall provide for retirees who qualify, paid medical benefits after retirement and until retiree reaches age 65.

- **CalSTRS:** Employee contributions is 10.25% for classic members; 10.205% new members.
- **CalPERS:** Employee contributions is 7% for classic and new members.
- **PARS:** Employee retirement contributions is 7.5%.

What Else Can I Do?

Tax Shelter Annuity (TSA)

A Tax Shelter Annuity (TSA) program that provides employees with opportunities to contribute earnings to a personal investment account. Currently, we offer 403(b) and 457(b) programs with select vendors. No employer contributions are made. Contact the District's approved Plan Administrator, SchoolsFirst (see pages 58-60).

Visit the Human Resources Benefits website at: www.rccd.edu/Admin/hrer/pages/benefits.aspx.

Important Notices

No Surprises Act Notice

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

Discrimination Is Against the Law

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

Newborns' and Mothers' Health Protection Act (NMHPA)

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

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

Your plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services, including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema. For more information, you should review the Summary Plan Description or call your Plan Administrator at (951) 222-8136.

Patient Protections

The medical plan requires the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. Until you make this designation, the plan will designate one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, you may contact Customer Service at either Health Net or Kaiser.

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

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

Networks/Claims/Appeals

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

Notice of Extended Coverage to Children Covered as Students

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

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

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

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

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

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

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

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

COBRA Continuation Coverage

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

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

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

WHAT IS COBRA CONTINUATION COVERAGE?

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

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

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

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

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

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

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

WHEN IS COBRA CONTINUATION COVERAGE AVAILABLE?

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

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

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

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

NOTICE AND ELECTION PROCEDURES

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

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

ELECTION AND ELECTION PERIOD

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

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

HOW IS COBRA CONTINUATION COVERAGE PROVIDED?

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

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

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

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

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

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

OTHER OPTIONS BESIDES COBRA CONTINUATION COVERAGE

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

ENROLLMENT IN MEDICARE INSTEAD OF COBRA

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period[1] to sign up for Medicare Part A or B, beginning on the earlier of:

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

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

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

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

IF YOU HAVE QUESTIONS

For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans subject to ERISA, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Address and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

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

[1] https://www.medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b/part-a-part-b-sign-up-periods

KEEP YOUR PLAN INFORMED OF ADDRESS CHANGES

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

EFFECTIVE DATE OF COVERAGE

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

COST OF CONTINUATION COVERAGE

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

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

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

The Plan will notify the Qualified Beneficiary, in writing, of any termination of COBRA coverage based on the criteria stated in this Section that occurs prior to the end of the Qualified Beneficiary's applicable maximum coverage period. Notice will be given within 30 days of the Plan's decision to terminate. Such notice shall include the reason that continuation coverage has terminated earlier than the end of the maximum coverage period for such Qualifying Event and the date of termination of continuation coverage.

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

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

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

Special Enrollment Rights Notice

CHANGES TO YOUR HEALTH PLAN ELECTIONS

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

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

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

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

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

For information about Special Enrollment Rights, please contact:

Edwina Cardenas
Benefits Specialist
(951) 222-8136

Medicare Part D – Important Notice 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 Riverside Community College District and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

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

- **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.**
- **Riverside Community College District has determined that the prescription drug coverage offered by Riverside Community College's Medical Plan(s) 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 current Riverside Community College District coverage will not be affected. If you keep this coverage and elect Medicare, the Riverside Community College District coverage will coordinate with Part D coverage.

If you do decide to join a Medicare drug plan and drop your current Riverside Community College District coverage, be aware that you and your dependents will be able to get this coverage back.

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 Riverside Community College District and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without Creditable Coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (i.e., 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. **Note:** You will 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 Riverside Community College District changes. You also may request a copy of this notice at any time.

FOR MORE INFORMATION ABOUT YOUR OPTIONS UNDER MEDICARE PRESCRIPTION DRUG COVERAGE

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You will 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 www.medicare.gov
- Call your State Health Insurance Assistance Program (see 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 www.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:	October 2023
Name of Entity / Sender:	Riverside Community College District
Contact:	Edwina Cardenas, Benefits Specialist
Address:	3801 Market Street Riverside, CA 92501
Phone:	(951) 222-8136

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

Riverside Community College District Group Health Plan (Plan) maintains a Notice of Privacy Practices that provides information to individuals whose protected health information (PHI) will be used or maintained by the Plan. If you would like a copy of the Plan's Notice of Privacy Practices, please contact Edwina Cardenas, Benefits Specialist, 3801 Market Street, Riverside, CA 92501, (951) 222-8136.

Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: GENERAL INFORMATION

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

WHAT IS THE HEALTH INSURANCE MARKETPLACE?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget by offering “one-stop shopping” to find and compare private health insurance options. You may also be eligible for a tax credit that lowers your monthly premium right away. Open Enrollment for health insurance coverage through Covered California will begin November 1, 2022, and is anticipated to end on January 31, 2023. Open Enrollment for most other states will begin on November 1 and close on January 15 of each year. Some states have expanded the open enrollment period beyond January 15, 2023 for coverage to begin in 2023. Notably, Covered California continues its special enrollment periods for coverage beginning in 2023.

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

You may qualify to save money and lower your monthly premium, but only if your employer does not offer you coverage, offers medical coverage that is not “Affordable,” or does not provide “Minimum Value.” If the lowest cost plan from your employer that would cover you (and not any other members of your family) is more than 9.12% (for 2023) of your household income for the year, then that coverage is not Affordable. Moreover, if the medical coverage offered covers less than 60% of the benefits costs, then the plan does not provide Minimum Value.

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

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

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

PART B: INFORMATION ABOUT HEALTH COVERAGE OFFERED BY YOUR EMPLOYER

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

3. Employer name Riverside Community College District	**4. Employer Identification Number (EIN)** 95-6000029	
5. Employer address 3801 Market Street	**6. Employer phone number** (951) 222-8136	
7. City Riverside	**8. State** CA	**9. ZIP code** 92501
10. Who can we contact about employee health coverage at this job? Edwina Cardenas, Benefits Specialist		
11. Phone number (if different from above)	**12. Email address** Edwina.Cardenas@rccd.edu	

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

Important Notices (continued)

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 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 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 July 31, 2022. Contact your State for more information on eligibility.

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

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

ARKANSAS – Medicaid
Website: http://myarhipp.com/
Phone: 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 (CHIP+)
Health First Colorado Website:
https://www.healthfirstcolorado.com/
Health First Colorado Member Contact Center:
800-221-3943 | TTY: Colorado relay 711
CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus
CHP+ Customer Service:
800-359-1991 | TTY: Colorado relay 711
Health Insurance Buy-In Program (HIBI):
https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program
HIBI Customer Service: 855-692-6442

FLORIDA – Medicaid
Website:
http://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html
Phone: 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
Healthy Indiana Plan for low-income adults 19-64
Website: http://www.in.gov/fssa/hip/
Phone: 877-438-4479
All other Medicaid
Website: https://www.in.gov/medicaid/
Phone: 800-457-4584

Important Notices (continued)

IOWA – Medicaid and CHIP (Hawki)
Medicaid Website: https://dhs.iowa.gov/ime/members
Medicaid Phone: 800-338-8366
Hawki Website: http://dhs.iowa.gov/Hawki
Hawki Phone: 800-257-8563
HIPP Website:
https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp
HIPP Phone: 888-346-9562

KANSAS – Medicaid
Website: https://www.kancare.ks.gov/
Phone: 800-792-4884

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

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

MAINE – Medicaid
Enrollment Website:
https://www.maine.gov/dhhs/ofi/applications-forms
Phone: 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: 800-862-4840
TTY: 617-886-8102

MINNESOTA – Medicaid
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp
Phone: 800-657-3739

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

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

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

NEVADA – Medicaid
Medicaid Website: http://dhcfp.nv.gov/
Medicaid Phone: 800-992-0900

NEW HAMPSHIRE – Medicaid
Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program
Phone: 603-271-5218
HIPP Program Toll-Free Phone: 800-852-3345, ext. 5218

NEW JERSEY – Medicaid and CHIP
Medicaid Website:
http://www.state.nj.us/humanservices/dmahs/clients/medicaid/
Medicaid Phone: 609-631-2392
CHIP Website: http://www.njfamilycare.org/index.html
CHIP Phone: 800-701-0710

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

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

NORTH DAKOTA – Medicaid
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/
Phone: 844-854-4825

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

OREGON – Medicaid
Websites: http://healthcare.oregon.gov/Pages/index.aspx
http://www.oregonhealthcare.gov/index-es.html
Phone: 800-699-9075

PENNSYLVANIA – Medicaid
Website:
https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx
Phone: 800-692-7462

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

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

Important Notices (continued)

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

TEXAS – Medicaid
Website: http://gethipptexas.com/
Phone: 800-440-0493

UTAH – Medicaid and CHIP
Medicaid Website: https://medicaid.utah.gov/
CHIP Website: http://health.utah.gov/chip
Phone: 877-543-7669

VERMONT – Medicaid
Website: http://www.greenmountaincare.org/
Phone: 800-250-8427

VIRGINIA – Medicaid and CHIP
Website: https://www.coverva.org/en/famis-select
https://www.coverva.org/en/hipp/
Medicaid Phone: 800-432-5924
CHIP Phone: 800-432-5924

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

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

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

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

To see if any other states have added a premium assistance program since July 31, 2022, or for more information on special enrollment rights, contact either:

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

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

Glossary

Affordable Care Act and Patient Protection (ACA)

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

Allowed Amount

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

Balance Billing

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

Brand Name Drug

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

COBRA (Consolidated Omnibus Budget Reconciliation Act)

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

Children's Health Insurance Program (CHIP)

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

Claim

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

Coinsurance

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

Copayment (Copay)

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

Comprehensive Coverage

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

Deductible

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

Formulary

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

Generic Drug

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

High-Deductible Health Plan (HDHP)

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

Glossary (continued)

Health Savings Account (HSA)

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

Health Reimbursement Arrangements (HRAs)

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

In-Network

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

Non-Preferred Provider

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

Out-of-Pocket Maximum

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

Out-Of-Network

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

Out-Of-Pocket Limit

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

Plan Year

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

Preferred Provider

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

Premium

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

Preventive Care

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

Qualifying Life Event

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

Skilled Nursing Care

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

Urgent Care

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

Contact Information

	Phone	E-mail / Web Site
Riverside Community College District		
• Edwina Cardenas, Benefits Specialist / Retirement Process	951.222.8136	Edwina.Cardenas@rccd.edu
Benefit Consultant		
• Keenan & Associates		keenan.com
– Leanne Perez, Senior Service Coordinator	800.654.8347 ext. 1168	lperez@keenan.com
– ChrisAnn Galeotti, Service Representative	949.940.1760 ext. 5130	cgaleotti@keenan.com
– Carmen Crane, Senior Account Manager	800.654.8347 ext. 1169	ccrane@keenan.com
Medical		
• Health Now Administrative Services (HNAS) / Blue Shield	855.581.1811 800.810.2583	myhnas.com blueshieldca.com
• Express Scripts	866.832.9259	express-scripts.com
• Health Net	800.522.0088	healthnet.com
• Kaiser Permanente	800.464.4000	kaiserpermanente.org
Employee Assistance Program		
• Deer Oaks	888.993.7650	www.deeroakseap.com Password: RCCD
Dental		
• Delta Dental of California	866.499.3001	deltadentalins.com/ca
Vision		
• Vision Service Plan (VSP)	800.877.7195	vsp.com
Life		
• Lincoln Financial	800.423.2765	lincolnfinancial.com
Flexible Spending Accounts		
• PayPro Administrators	Gabby Reyes 951.656.9273	pagroup.us Gabbyr@pagroup.us
CalSTRS	800.228.5453	calstrs.com
CalPERS	888.225.7377	calpers.ca.gov
PARS	800.540.6369	pars.org
TSA		
• 403(b)	800.462.8328 ext. 4277	schoolsfirstfcu.org
• 457	800.462.8328 ext. 4727	retirement@schoolsfirstfcu.org
• Roth	800.462.8328 ext. 4727	retirement@schoolsfirstfcu.org
Standard	800.522.0406	
Section 125 and Voluntary Products		
• American Fidelity	Stephanie Hopkins 800.365.9180 ext. 334	Stephanie.Hopkins@americanfidelity.com