VCSBSA MEMBER DISTRICTS & CHARTERS

RETIREE EMPLOYEE BENEFITS

2022

Welcome to Your Ventura County Schools Business Authority Retiree Benefits

This guide provides a summary of your benefit options and is designed to help you make choices and enroll for coverage. If you would like more information about any of the benefits described here, please contact Human Resources or District Office.

Table of Contents

Enrollment Information

Who May Enroll

If you are a retiree, you and your eligible dependents may participate in VCSBSA's benefits program. Your eligible dependents include:

- Legally married spouse
- Registered domestic partner
- Children under the age of 26, regardless of student or marital status

Required Enrollment Documentation

- Medicare Part A & B – Provide a copy of each enrollee's Medicare card with Medicare Beneficiary Identifier (MBI).
- To Enroll a Spouse – Prior year's Federal Tax Form that shows the couple was married (financial information may be blocked out). If taxes were not filed jointly, you can complete an Affidavit of Marriage with a copy of the marriage certificate. A marriage certificate will be accepted for newly married couples where prior year tax return is unavailable.
- To Enroll a Domestic Partner – Certificate of Registered Domestic Partnership issued by State of California.

When You Can Enroll

As an eligible retiree, you may enroll at the following times:

- As a new retiree, you may participate in VCSBSA's benefits program within 30 days of your eligibility date. If you do not enroll for coverage within 30 days of your eligibility date, you will lose eligibility.
- Each year, during open enrollment
- Within 30 days of a qualifying event as defined by the IRS (see Changes To Enrollment below)

Benefits Enrollment

All health benefit plans are effective October 1st through September 30th of each year. There is an annual open enrollment period each year, during which you can make new benefit elections for the following October 1st effective date.

Changes To Enrollment

Our benefit plans are effective October 1st through September 30th of each year. There is an annual open enrollment period each year, during which you can make new benefit elections for the upcoming October 1st effective date. Once you make your benefit elections, you cannot change them during the year unless you experience a qualifying event as defined by the IRS. Examples include, but are not limited to the following:

- Marriage, divorce, legal separation or annulment
- Birth or adoption of a child
- A qualified medical child support order
- Death of a spouse or child
- A change in your dependent's eligibility status
- Loss of coverage from another health plan
- Change in your residence or workplace (if your benefit options change)
- Loss of coverage through Medicaid or Children's Health Insurance Program (CHIP)
- Becoming eligible for a state's premium assistance program under Medicaid or CHIP

Coverage for a new dependent is not automatic. If you experience a qualifying event, you have 30 days to update your coverage. Please contact Human Resources immediately following a qualifying event to complete the appropriate election forms as needed. If you do not update your coverage within 30 days from the qualifying event, you must wait until the next annual open enrollment period to update your coverage.

Online Carrier Resources

Take advantage of the online resources available through our insurance carriers. You can locate network providers, manage your claims, obtain health and wellness information, and much more! Insurance carrier website addresses are located on **page 5** of this guide.

Medicare Guidelines

Important Medicare Guidelines

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

Retirees and covered dependents should contact Social Security three months in advance of their 65th birthday or retirement and provide proof of Medicare A and B enrollment to the district to avoid surcharges.

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

If proof of Medicare is not provided to SISC, a non-refundable surcharge will be applied to the monthly premium of the under-65 groups. The surcharge will be applied the first of the month in which the member turns 65 until the Medicare card is produced.

2022-2023 Missing Medicare Surcharge—Monthly	
Missing Part A	$625
Missing Part B	$625
Missing Parts A and B	$1,250

Options for Retiree and/or Spouse/Domestic Partner

When One Is Over Age 65 And One Is Under Age 65

In the case of a retiree two-party contract where one person is over the age of 65 and one is under the age of 65, the following (enrollment options are available:

- Both parties remain enrolled on the group suffix for retirees under age 65 (until both parties turn 65); or
- Split the enrollment: the under age 65 person enrolls on an under age 65 group number and the over age 65 person enrolls on an over age 65 group number (different group numbers, same benefits); or
- The age 65 person with both parts of Medicare can enroll on a SISC Individual Retiree plan (if offered by the district) and the under age 65 person can remain on the under age 65 group suffix.

All of the above scenarios require the person who is age 65 or older to provide proof of Medicare enrollment to SISC. A separate enrollment form completed by the spouse or domestic partner is required if they are enrolling on a separate group number as they then become a subscriber. If the spouse/domestic partner is age 65 and actively working elsewhere and does not enroll in Medicare, SISC will require proof of other coverage. In certain circumstances a surcharge may be avoided if the spouse/domestic partner is employed and enrolled in other coverage.

Medicare Guidelines

Anthem Blue Cross Medical Plan Options

PPO Plan Options

The Anthem Blue Cross Preferred Provider Organization (PPO) plans allow you to direct your own care. You are not limited to the physicians within the network and you may self-refer to specialists. If you receive care from a physician who is a member of the PPO network, a greater percentage of the entire cost will be paid by the insurance plan. You may also obtain services using a non-network provider; however, you will be responsible for the difference between the covered amount and the actual charges and you may be responsible for filing claims. The percentage copay for non-emergency services from non-network providers is based on the scheduled amount.

HDHP/HSA Plan (Minimum Value)

The Anthem Blue Cross PPO High Deductible Health Plan (HDHP) is similar to the other PPO plans, but with some important differences. The HDHP includes a high deductible, and no coinsurance applies until the deductible is met for both medical and pharmacy benefits.

Kaiser Permanente | HMO Medical Plan

With the Kaiser Permanente Health Maintenance Organization (HMO) plan, all of your care must be directed through a Kaiser Permanente facility including any specialty care. You will receive benefits only if you use the doctors, clinics, and hospitals that belong to the Kaiser medical group except in the case of an emergency.

Prescription Drug Coverage

Anthem Blue Cross | Pharmacy Benefits

Navitus Health Solutions is the Pharmacy Benefits Manager (PBM) for our Medical plans. You are urged to use generic drugs when they are available. If you or your physician requests a brand name drug when a generic equivalent is available, you will pay the generic copay plus the difference in cost between the brand name drug and the generic drug. In addition, the difference in cost between the brand name drug and generic drug will not count toward your annual out-of-pocket maximum.

Kaiser Permanente | Pharmacy Benefits

You must obtain covered items at a Plan Pharmacy or through Kaiser Permanente's mail-order service unless you obtain the item as part of covered Emergency Services, Post-Stabilization Care, or Out-of-Area Urgent Care. Please refer the facility directory on Kaiser Permanente's website at kp.org for a list of Plan Pharmacies in your area, except that Plan Pharmacies are subject to change at any time without notice. Mail-order services vary by item and are subject to change at anytime without notice. For the current locations of Plan Pharmacies, please call our Member Service Contact Center 24 hours a day, seven days a week (except closed holidays) at 1-800-464-4000.

Costco Retail Pharmacy and Mail Order Program

Costco makes it easy for you to receive a 90 day supply of your long-term or maintenance medications. In addition, **when you use the Costco pharmacy, your generic medications will be free of charge!** Visit any Costco retail location or use the mail order feature and benefit by having your prescriptions delivered to your door, saving you a trip to the pharmacy.
Here's how it works:

1) Take your prescription to any Costco pharmacy, You do not need to be a Costco member.
2) Present the pharmacist with your insurance card.
3) Get your generic medications (excluding some narcotic plan medications and some cough medications) for free. You will pay $35 for a 30 day supply of brand name drugs or $90 for a 90 day supply of brand name drugs.

Due to Medicare Part D restrictions, this program does not apply to the CompanionCare pharmacy benefit.

Medical Benefits (Under 65)

	Option 1 Anthem Blue Cross PPO 100% D/$20	Option 2 Anthem Blue Cross PPO 90% G/$20	Option 3 Anthem Blue Cross PPO 80% G/$20
	In- Network	In- Network	In- Network
Health Benefits			
Lifetime Maximum	Unlimited	Unlimited	Unlimited
Deductible (Annual) Out of Pocket Maximum	$300 Individual/$600 Family $1,000 Individual /$3,000 Family	$500 Individual/$1,000 Family $1,000 Individual/$3,000 Family	$500 Individual/$1,000 Family $2,000 Individual/$4,000 Family
Co-Insurance (Plan Pays)	100% after Ded	90% after Ded	80% after Ded
Office Visit Copay	$20 Copay[1]	$20 Copay[1]	$20 Copay[1]
Hospitalization	0% after Ded	10% after Ded	20% after Ded
Lab and X-Ray	0% after Ded	10% after Ded	20% after Ded
Emergency Services	$100 Copay, 0% after Ded	$100 Copay, 10% after Ded	$100 Copay, 20% after Ded
Urgent Care	$20 Copay	$30 Copay	$20 Copay
Chiropractic (Limits Apply)	0% after Ded	10% after Ded	20% after Ded
Pharmacy Benefits			
Pharmacy Deductible Out of Pocket Maximum	none $2,500 Individual /$3,500 Family	none $2,500 Individual /$3,500 Family	none $2,500 Individual /$3,500 Family
Retail Pharmacy - Generic Formulary - Brand Name Formulary - Supply Limit	 $9 Copay $35 Copay 30 Days	 $9 Copay $35 Copay 30 Days	 $9 Copay $35 Copay 30 Days

1. The first three visits with a primary care provider for each calendar year will be no charge.

Benefit Video – Medical Plan Terms

Medical plan terms, such as coinsurance, copays, deductibles, and out-of-pocket maximums can be confusing. For a quick video that shows how these work, visit **http://video.burnhambenefits.com/terms**.

Finding a Medical Provider

Anthem PPO participants should go to **www.anthem.com/ca/sisc** or call **(800) 322-5709.**
Kaiser Permanente HMO participants should go to **www.kp.org** or call **(800) 464-4000.**

Medical Benefits (Under 65)

	Option 4 Anthem Blue Cross PPO 80% L/$30	Option 5 Anthem Blue Cross HSA Minimum Value	Option 6 Kaiser Traditional HMO $10
	In- Network	In- Network	In- Network Only
Health Benefits			
Lifetime Maximum	Unlimited	Unlimited	Unlimited
Deductible (Annual) Out of Pocket Maximum	$2,000 Individual/$4,000 Family $4,000 Individual /$8,000 Family	$5,000 Individual/$10,000 Family $6,350 Individual/$12,700 Family	$0 Individual/$0 Family $1,500 Individual/$3,000 Family
Co-Insurance (Plan Pays)	80% after Ded	70% after Ded	100% after Ded
Office Visit Copay	$30 Copay[1]	30% after Ded	$10 Copay
Hospitalization	20% after Ded	30% after Ded	0%
Lab and X-Ray	20% after Ded	30% after Ded	0%
Emergency Services	$100 Copay, 20% after Ded	$100 Copay, 30% after Ded	$100 Copay
Urgent Care	$30 Copay	30% after Ded	$10 Copay
Chiropractic (Limits Apply)	20% after Ded	30% after Ded	$10 Copay / 30 visit limit
Pharmacy Benefits			
Pharmacy Deductible Out of Pocket Maximum	$200 Individual/$500 Family $2,500 Individual /$3,500 Family	Medical deductible applies Medical Out-of-pocket applies	none Medical Out-of-pocket applies
Retail Pharmacy - Generic Formulary - Brand Name Formulary - Supply Limit	 $10 Copay $35 Copay 30 Days	 $9 Copay $35 Copay 30 Days	 $10 Copay $10 Copay 100 Days

1. The first three visits with a primary care provider for each calendar year will be no charge.

Health Savings Account (HSA) – For Anthem HSA-B Plan Members Only

What is an HSA?

A Health Savings Account, also known as an HSA, is a tax savings account that can be funded with tax-exempt dollars by you, a family member or anyone else on your behalf. When you contribute to an HSA, your taxable income is lowered and your take-home pay may increase. Interest and investment earnings on HSA funds are generally tax-free.

You can open up a HSA bank account with any financial institution of your choice. Money from the HSA can help pay for eligible medical expenses not covered by the Anthem, including the deductible and coinsurance. See **www.irs.gov** for a full list of eligible expenses. You can only have this account if you are enrolled in a qualified high deductible plan such as Guadalupe Union School District's Anthem HDHP MV Plan.

Who's Eligible

You're eligible to open an HSA if:

- You enroll in a qualifying high-deductible health plan such as the Anthem Blue Cross HDHP Plan.
- Your **only** coverage is a high-deductible health plan. If you are covered under your spouse's plan and that plan is not a high-deductible plan, you are not eligible to contribute to an HSA.
- You are not covered by a traditional Health Care Flexible Spending Account (FSA) through your spouse.
- **You have not signed up for Medicare coverage.**

HSA Contributions

The maximum contribution that can be made into an HSA account in 2022 is $3,650 for an individual and $7,300 for a family, and in 2023 it is $3,850 for an individual and $7,750 for a family.

Important HSA Facts

Pay Healthcare Expenses

Each time you have a qualified health expense, you decide whether to:

- Pay out of your pocket and let your HSA grow, earning interest for future eligible expenses (e.g., medical expenses during retirement).
- Use your HSA to pay for eligible medical expenses such as your annual deductible and coinsurance. Your HSA can also help pay for vision care, dental care and prescription drugs. (For a complete list of eligible expenses, visit **www.irs.gov**.)

HSA Accounts are Portable

Any money in your HSA that you don't spend rolls over from year to year. If you change jobs, switch to another medical plan or even retire, your HSA and the money in it is yours to keep. You can choose to save it to pay for eligible health care expenses tax-free in retirement.

Medical Benefits

Tips on Getting the Most from Your Health Benefits

1 Ask Questions

If you are having a procedure or planning an upcoming procedure, make sure you know how the procedure will be covered and what your out-of-pocket cost will be, if any.

2 Utilize your Free Preventive Care Benefits to Stay Healthy

Preventive care benefits are covered at no charge to you. Regular preventive care can reduce the risk of disease, detect health problems early, protect you from higher costs down the road, and most importantly… potentially save your life. Take advantage of these no cost benefits now to hopefully avoid major illnesses and costs in the future.

3 Get the Right Health Care and Save Money

Choosing the right care for your medical situation will help save you money out-of-pocket:

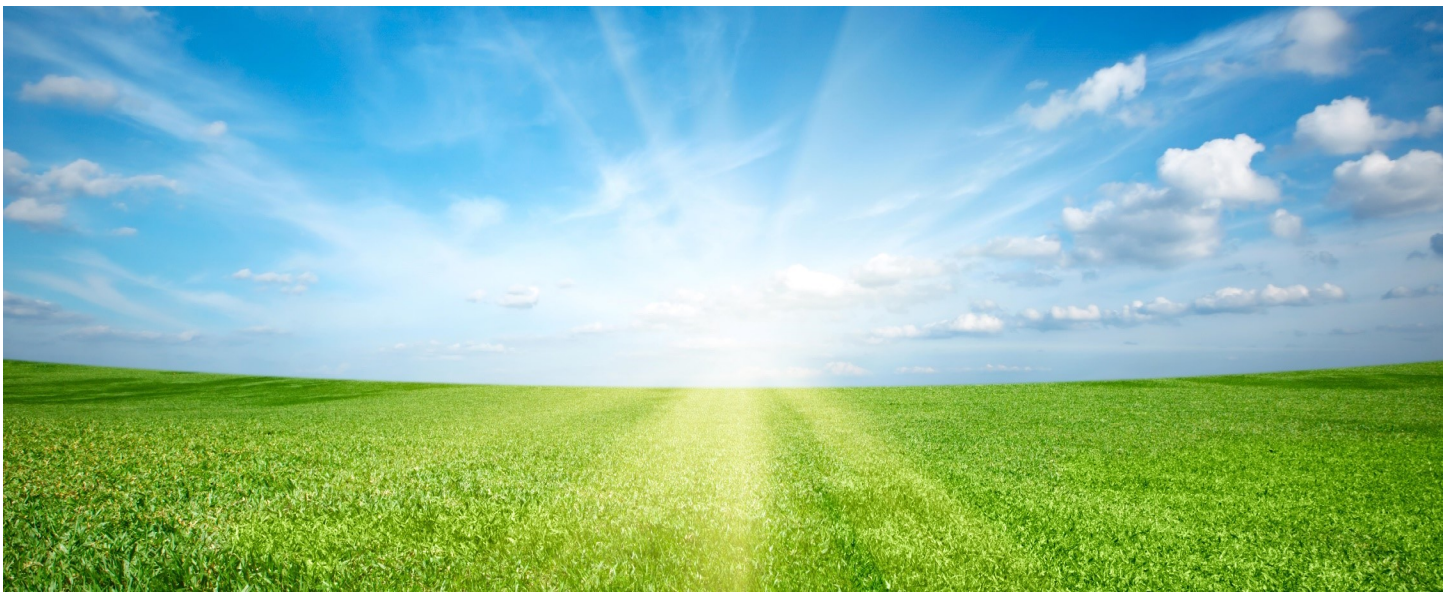
- **Doctor's Office Visit or Telemedicine visit:** This is a good choice for non-urgent medical issues.
- **Urgent Care:** This is the best choice for non-life threatening medical issues that require immediate, in-person care when you can't get an appointment for a Doctor's Office Visit.
- **Emergency Room:** You should use the Emergency Room for life threatening emergencies, or for other issues that require immediate medical care outside Urgent Care hours.

4 Use Generic Drugs When Available

The best way to save on prescriptions is to use generic medications as opposed to brand name drugs. When you use generic medications, you will pay the lowest copay.

Generic drug companies do not have to develop a medication from scratch, so the costs are significantly less to bring the drug to the market. Once a generic medication is approved, several companies can produce and sell the drug. This competition helps lower prices. In addition, many generic drugs are well-established, frequently used medications that do not require expensive advertising.

Generic drugs must use the same active ingredients as the brand name version of the drug. A generic drug must also meet the same quality and safety standards.



Additional Benefits

Anthem Blue Cross Retiree Assistance Program

If you are enrolled in one of our medical plans, you will automatically be enrolled in the Employee Assistance Program (EAP) through Anthem Blue Cross. The EAP provides you and your household members with free, confidential assistance to help with personal/professional problems that may interfere with work or family responsibilities. You are encouraged to utilize services early in the progression of a problem before situations significantly impact your personal life or work.

This plan may help in situations such as relationship difficulties, marriage/family situations, stress, managing change, legal and financial problems, work-related concerns, anxiety and depression. The EAP also serves more serious concerns such as alcohol and drug problems, family violence and threats of suicide.

- You and your household members can receive up to six counseling sessions per problem. If a problem requires more lengthy or specialized treatment than the EAP is intended to provide, the EAP will refer you to Anthem Blue Cross to help you locate a participating Anthem Blue Cross Medical provider.
- Emergencies handled by staff members are available by phone 24/7 on a toll-free basis.
- The EAP will make every effort to see you within 48 hours, but if you are in crisis, you will be provided same-day service.
- Evening appointments are available.

Accessing the EAP

To access EAP benefits, go to **www.anthemeap.com** or you may call **(800) 999-7222** to be immediately connected to an EAP counselor.

2022 – 2023 Value Based Purchasing Reminder!

Reference pricing for five common procedures that can be performed safely at an Ambulatory Surgery Center (ASC) at costs significantly lower than at a hospital are listed below.

- If you choose to have you procedure at an in-network outpatient facility, only the amounts below will be paid for the procedure.
- The remaining amount will be paid in full by the member.
- There is no limit at an in-network Ambulatory Service Center.
- Members with questions should contact the customer service number on their ID cards.

	Maximum Benefit at an in-network outpatient hospital facility	There is no limit at an in-network Ambulatory Service Center (ASC)
	In-Network	ASC Facility
Arthroscopy	**$4,500**	**n/a**
Cataract Surgery	**$2,000**	**n/a**
Colonoscopy	**$1,500**	**n/a**
Upper GI Endoscopy with Biopsy	**$1,250**	**n/a**
Upper GI Endoscopy without Biopsy	**$1,000**	**n/a**

Additional Medical Benefits Provided Through SISC

Health Smarts Health Improvement Program

Health Smarts is voluntary, confidential and offered to you at no cost if you participate in a District-offered Medical plan. Health Smarts is a comprehensive program that includes an online health assessment, digital health coaching, and condition management (administered by Anthem Blue Cross).

To access the Health Smarts health improvement program, contact SISC at the number shown on your medical ID card.

MDLive

As a Medical plan participant, you have access to MDLive, a service that provides 24/7 access to board certified doctors and pediatricians by online video, phone or secure email. Doctors will ask you some questions to help determine your health care needs. Based on the information you provide, advice will include general health care and pediatric care specific to you or your dependent's condition. This service is subject to a **$0 copay** regardless of your Medical plan's regular office visit copay, except HDHP participants who will need to pay the cost in full until the plan deductible has been satisfied.

When to use MDLive:

- If you're considering a visit to an emergency room or urgent care center for a non-emergency medical issue.
- When your primary care doctor is not available.
- When you are traveling and in need of medical care.
- During or after normal business hours, nights, weekends and holidays.
- To request prescription drugs or to get refills.

Common Conditions Treated by MDLive			
General Care			Pediatric Care
Allergies	Fever	Respiratory Infections	Cold & Flu
Asthma	Headache	Sinus Infections	Constipation
Bronchitis	Infections	Skin Infections	Ear Infections
Cold & Flu	Insect Bites	Sore Throat	Nausea
Diarrhea	Joint Aches	Urinary Tract Infections	Pink Eye
Ear Infections	Rashes	And More!	And More!

To access MDLive, go to **www.mdlive.com/sisc** or call **800-657-6169**. Be prepared to provide your name, the patient's name (if you're not calling for yourself), your member identification number and your phone number.

SISC Medical Experts Opinion (through Teladoc)

SISC offers a valuable expert second opinion service through Teladoc. This benefit can be used to ensure that you and your family get the best healthcare possible. The service is free, easy and 100% confidential.
Teladoc matches patients to the leading doctors on their specific conditions. They will work with the patient to be sure of their diagnosis and recommend the best path for treatment. You should use Teladoc when you:

- Have a documented diagnosis from a doctor and would like an expert's second opinion regarding the diagnosis and treatment plan
- Find yourself confronting a complex medical condition
- Would like your medications or treatment plan reviewed
- Are scheduled for surgery or a major procedure

With SISC Medical Experts Opinion through Teladoc, members receiving a medical opinion have unlimited concierge access to a specialist. To take advantage of this benefit, go to **www.teladoc.com/sisc** or call **(800) 835-2362**.

Additional Medical Benefits Provided Through SISC

Lark Diabetes Prevention Program

- Anthem has partnered with Lark to offer a diabetes prevention program that can help you determine if you're at risk for prediabetes and if needed, take steps to address it.
- You can participate in this program at no extra cost as part of your health plan. Track your progress, check in with your coach, and learn more about prediabetes right in Lark's free mobile app. This program is flexible, convenient, and follows guidelines from the Centers for Disease Control and Prevention (CDC) to help you make small changes that can improve your health and decrease your risk over time

Go to **www.lark.com/anthemBC** and take a quick one-minute survey to see if you could benefit from Lark's diabetes prevention program.

Active&Fit

- With the Active & Fit Direct program, you can choose from over 9,000 participating fitness centers and YMCAs nationwide for a much lower cost than you would pay on your own
- Use the online fitness tracking feature, which uses a variety of wearable devices and apps
- You pay only $25 a month (plus $25 enrollment fee and taxes)
- To learn more:
  - Log into **www.anthem.com/ca/sisc**
  - Click "Discounts"
  - Visit "Special Offers"

Silver&Fit

This program is now available with the Companion Care - Medicare Supplemental Plan at no cost to you. Register online to get more details on local fitness centers, home fitness programs and fun fitness challenges. Learn how to track your exercise and get rewarded for being active. Go to **www.SilverandFit.com** to register and find more details on program offerings.

Hinge Health

- Personalized, digitally delivered therapy for back, knee, shoulder, neck and hip pain
- To access your Hinge Health benefit, call **(855) 902-2777** or visit **www.hingehealth.com/sisc** .

Vida Digital Coaching

- Anthem plan members have access to Vida Digital Coaching, a virtual care platform that treats a full range of lifestyle, chronic and behavioral health conditions. Examples include nutrition, weight loss, mental health, and building healthy habits
- To learn more, call **(855) 442-5885** or visit **www.vida.com/sisc**.

Contigo Health Enhanced Cancer Program

- If you receive a cancer diagnosis, this benefit provides an in-person evaluation with confirmation of diagnosis and development of a customized treatment plan at no charge
- To learn more, visit **www.contigohealth.com/sisc** or call **(877) 220-3556**.

Medical Transport and Meal Delivery *(Kaiser Senior Advantage Members Only KPSA)*

- For retirees who don't drive, this benefit can provide up to 24 one-way rides to Lab visits, Doctor appointments or to pick up medications or medical equipment.
- After an inpatient stay at a hospital or skilled nursing facility, you can get back to health more quickly with fresh and nutritious meal deliveries. This benefit includes 3 meals a day for up to 4 weeks, delivery to any address in coverage region with more than 70 entrée options, including heart-healthy, diabetic-friendly, and gluten-free meals.
- go to kp.org/sisc for more information

Medical Benefits (Over 65)

Medical Plan Options

	Option 1 Anthem Blue Cross PPO Plan 100-A EGWP Rx $0/$35 **Direct Bill available**	Option 2 Anthem Blue Cross PPO Plan 100-A EGWP Rx $0/$35; $200 Ded **Direct Bill available**	Option 3 Kaiser (KPSA) HMO $10; Rx $10 **Direct Bill available**
	PPO Network	PPO Network	In-Network Only
Health Benefits			
Lifetime Maximum	Unlimited	Unlimited	Unlimited
Deductible (Annual)	None	None	None
Out-of-Pocket Maximum[1]	$1,000 Individual / $3,000 Family	$1,000 Individual / $3,000 Family	$1,500 Individual / $3,000 Family
Co-Insurance (Plan Pays)	100%	100%	100%
Office Visit Copay	$0 Copay	$0 Copay	$10 Copay
Hospitalization[2]	0%	0%	0%
Lab and X-Ray	0%	0%	0%
Emergency Services	$100 Copay, 0%	$100 Copay, 0%	$100 Copay
Urgent Care	$0 Copay	$0 Copay	$10 Copay
Chiropractic (Limits Apply)[2]	Administered by ASH 0%	Administered by ASH 0%	Administered by ASH $10 Copay /30 visit limit
Pharmacy Benefits*	**EGWP Medicare Part D Rx Plan**	**EGWP Medicare Part D Rx Plan**	
Pharmacy Deductible	None	$200	$0
Pharmacy Copay - Tier 1 Drugs - Tier 2 Drugs - Supply Limit	Retail $0 Copay $35 Copay 30 Days	Retail $0 Copay $35 Copay 30 Days	Retail $10 Copay $10 Copay Up to 100 Days

[1] When using the non-network tier, you are responsible for all amounts exceeding the fee schedule. Non-covered expenses do not apply to Out-of-Pocket maximum. Member copayments and coinsurance for Emergency Medical Care with a Non-PPO provider also apply to the Out-of-Pocket maximums.

[2] Subject to utilization review or medical necessity.

***Important Note:** The 65+ PPO Retiree Prescription Plan for Option 1 is EGWP Medicare Part D Rx Plans. You will be auto-enrolled into Medicare Part D plan and will receive a separate ID card from your medical plan. Medicare Part D Income Related Monthly Premium Adjustment Amount (IRMAA) will apply. High income earners must pay a monthly amount to Medicare.

Benefit Video – Medical Plan Terms

Medical plan terms, such as coinsurance, copays, deductibles, and out-of-pocket maximums can be confusing. For a quick video that shows how these work, visit **http://video.burnhambenefits.com/terms**.

Medical Benefits (Over 65)

CompanionCare Medicare Supplement Plan

CompanionCare is for retirees over the age of 65 and is a supplement insurance coverage for Medicare. Retiree must have Medicare parts A & B in order to participate. Medicare is billed as the primary insurance. CompanionCare is billed as the secondary insurance. It is to your advantage to use a participating Blue Cross provider who accepts assignment of Medicare benefits. If you use a provider who does not accept assignment of Medicare benefits, the provider of service or member must file the claim twice; once for the Medicare payment and then again for the plan payment. Vision wear is covered through VSP (Vision Service Plan).

Prescription program is through Navitus. SISC will automatically enroll CompanionCare members in Medicare Part D for prescription medications.

Please remember! If you are enrolled in CompanionCare, you may not move back to a District sponsored plan (Blue Cross PPO). Exception to this rule: If you move out of California, you may enroll in a District sponsored plan.

	Companion Care Medicare Supplement Plan - 40003A **(Direct Bill)**	
	Medicare**	CompanionCare
Health Benefits		
Inpatient Hospital (Part A)	Pays all but first $1,556 for 1st 60 days	Pays $1,556
	Pays all but $389 a day for the 61st to 90th day	Pays $389 a day
	Pays all but $778 a day Lifetime Reserve for 91st to 150th day	Pays $778 a day
	Pays nothing after Lifetime Reserve is used (refer to Evidence of Coverage)	Pays 100% after Medicare and Lifetime reserve are exhausted up to 365 days per lifetime
Skilled Nursing Facilities (must be approved by Medicare)	Pays 100% for 1st 20 days	Pays nothing
	Pays all but $194.50 a day for 21st to 100th day	Pays $194.50 a day for 21st to 100th day
	Pays nothing after 100th day	Pays nothing after 100th day
Deductible (Part B)	$233 Part B deductible per year	Pays $233
Basis of Payment (Part B)	80% Medicare Approved (MA) charges after Part B deductible	20% MA charges including 100% of Medicare Part B deductible
Medical Services (Part B) - Doctor, x-ray, appliances and ambulance - Laboratory	 80% MA charges 100% MA charges	 20% MA charges Pays nothing
Physical/Speech Therapy (Part B)	80% MA charges up to the Medicare annual benefit amount	20% MA charges up to the Medicare annual benefit amount (PT & ST combined)
Blood (Part B)	80% MA charges after 3 pints	Pays 1st 3 pints un-replaced blood and 20% MA charges
Travel Coverage (when outside the US for less than 6 consecutive months)	Not covered	Pays 80% inpatient hospital, surgery, anesthetist and in hospital visits for medically necessary services for 90 days of treatment per lifetime
Pharmacy Benefits	Navitus	
Outpatient Prescription Drugs - Retail Pharmacy (30 day supply) - Mail Order / Costco (90 day supply)	 $9 generic / $35 brand-name $18 generic / $90 brand-name	
	Pharmacy benefits administered through Navitus Health Solutions Medicare Rx using a Medicare D formulary. Some exclusions and prior authorizations may apply. Members that have questions regarding their medication coverage can call Navitus Health Solutions Medicare Rx at 866.270.3877 or TYY users please call 711.	
	*** Medicare deductible amounts listed are adjusted annually.*	

Dental Benefits

Delta Dental PPO Incentive Plan—(SISC)

With the Delta Dental Preferred Provider Organization (PPO) Incentive plan, you may visit a PPO Dentist, a Premier Dentist, or an out-of-network Dentist. When you utilize a PPO or Premier Dentist, your out-of-pocket expenses will be less, however, you will usually pay the lowest amount for services when you visit a Delta Dental PPO Dentist. Delta Dental PPO Network Dentists are contracted dentists that have agreed to a fee schedule as payment in full.

Premier Network Dentists are contracted dentists that are not in the PPO Network, so members can still receive the benefit of the dentist's contracted fee. When you see an out-of-network dentist, Delta will pay the Usual, Customary and Reasonable (UCR) up to the Annual Maximum. If you obtain services using an out-of-network dentist, you will incur much higher out-of-pocket expenses and you may be responsible for filing claims.

The Delta Dental Incentive Plan offers the largest network of providers. You may change providers at anytime. The Incentive Plan starts coverage at 70% the first year and percentages increase by 10% for each year of participation (two office visits within a 12-month period). Upon completion of 4 years of active participation, coverage is set at 100% allowable.

	Delta Dental (SISC) DD Incentive 1000; 3rd cleaning			Delta Dental (SISC) DD Incentive 1500—**Direct Bill**		
	PPO Network	Premier Network	Out of Network	PPO Network	Premier Network	Out of Network
Dental Benefits						
Calendar Year Maximum	$1,200	$1,000	$1,000	$1,700	$1,500	$1,500
Deductible (Annual) - Individual / Family	None			None		
Preventive (Plan Pays) Exams, X-Rays, Cleanings	70-100% 3 cleanings per year	70-100%	70-100%	70-100%	70-100%	70-100%
Basic Services (Plan Pays) Fillings, Oral Surgery, Endodontics, Periodontics	70-100%	70-100%	70-100%	70-100%	70-100%	70-100%
Major Services (Plan Pays) Crowns, Prosthetics	70-100% 50% Prosthetics	70-100% 50% Prosthetics	70-100% 50% Prosthetics	70-100% 50% Prosthetics	70-100% 50% Prosthetics	70-100% 50% Prosthetics
Orthodontia	No benefit			No benefit		

Finding a Dental Provider

Go to **www.deltadentalins.com** or call **(866) 499-3001**.

- Option 1: Refer to the "Delta PPO" or "Delta Premier" network.
- Option 2: Refer to the Delta PPO network.

Note: We strongly recommend you ask your dentist for a predetermination if total charges are expected to exceed $300. Predetermination enables you and your dentist to know in advance what the payment will be for any service that may be in question.

Vision Benefits

Vision Service Plan (VSP)

The VSP vision plan provides professional vision care and high quality lenses and frames through a broad network of optical specialists. You will receive richer benefits if you utilize a network provider. If you utilize a non-network provider, you will be responsible to pay all charges at the time of your appointment and will be required to file an itemized claim with VSP. VSP has the largest network of private-practice eye care doctors in the industry. VSP's network includes 37,000 access points nationwide. Most of the U.S. population lives within four miles of a VSP provider.

	VSP (SISC) Signature C $20/$25	VSP (SISC) Signature C $20—Direct Bill
	VSP Network	VSP Network
Vision Benefits		
Copay - Examination - Materials	 $20 Copay $25 Copay	 $20 Copay Combined with Exam
Examination	$20 Copay 15% savings on a contact lens exam (fitting and evaluation)	$20 Copay 15% savings on a contact lens exam (fitting and evaluation)
Lenses - Single Vision - Bifocal - Trifocal - Standard Progressive - Premium Progressive - Custom Progressive	 100% covered after copay 100% covered after copay 100% covered after copay 100% covered after copay $80-$90 $120-$160	 100% covered 100% covered 100% covered 100% covered $80-$90 $120-$160
Frames	***Allowance after $25 Copay*** $170 Featured Frame Brands $150 All other frames $80 Walmart & Costco Plus 20% savings on the amount over your allowance	***Allowance*** $170 Featured Frame Brands $150 All other frames $80 Walmart & Costco Plus 20% savings on the amount over your allowance
Contact Lenses	$150 Allowance after copay In Lieu of Frames and Lenses	$150 Allowance In Lieu of Frames and Lenses
Laser Vision Correction	Discounts Apply	Discounts Apply
Frequency - Examination - Lenses - Frames - Contact Lenses	 Every Calendar Year Every Calendar Year Every Other Year Every Calendar Year	 Every Calendar Year Every Calendar Year Every Calendar Year Every Calendar Year

Finding a Vision Provider

Go to www.vsp.com or call (800) 877-7195. Refer to the "VSP Signature" network when prompted.

TruHearing

VSP members can save 30-60% on a pair of hearing aids with TruHearing pricing discount. Dependents and extended family members are also eligible. For more information, visit www.TruHearing.com or call (866) 754-1607.

Resources and Contacts

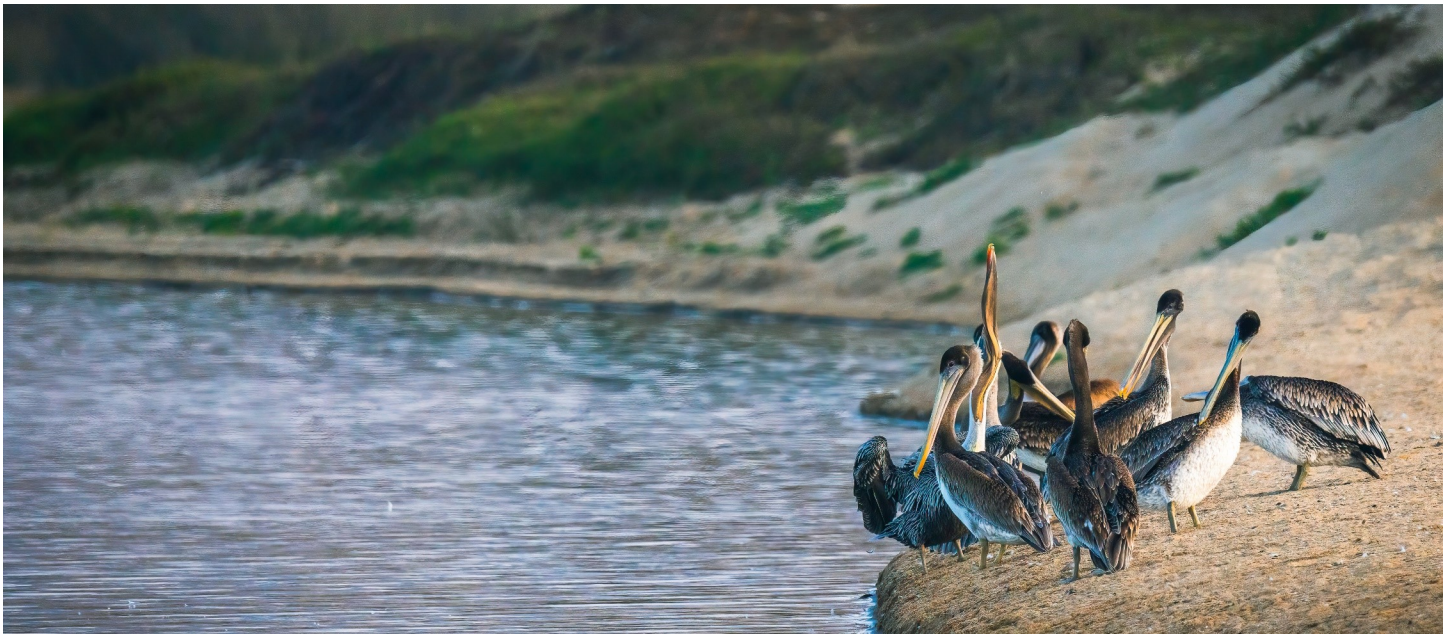
Below is a list of insurance carrier contacts should you require assistance with your benefit questions following open enrollment. If you are unable to resolve your issues or questions with the insurance carriers, please contact Human Resources of District Office.

Medical - SISC/Anthem Blue Cross	
Member Services	(800) 564-7475
Anthem Website	www.anthem.com/ca/sisc
Navitus Pharmacy	(866) 333-2757
Costco Mail Order Pharmacy	(800) 607-6861

Dental - Delta Dental	
Member Services	(866) 499-3001
Carrier Website	www.deltadentalins.com

Vision - VSP	
Member Services	(800) 877-7195
Carrier Website	www.vsp.com

Additional Benefits Provided by SISC	
Health Smarts Member Services	(661) 636-4410
Health Smarts Website	www.sischealth.com
MDLive Member Services	(800) 657-6169
MDLive Website	www.mdlive.com/sisc
SISC Medical Experts Opinion Member Services (through Teladoc)	(800) 835-2362
Teladoc Website	www.teladoc.com/sisc
Hinge Health Member Services	(855) 902-2777
Hinge Health Website	www.hingehealth.com/sisc
Vida Digital Coaching	(855) 442-5885
Vida Digital Coaching Website	www.vida.com/sisc
Contigo Health Member Services	(877) 220-3556
Contigo Health Website	www.contigohealth.com/sisc



Important Information

The Affordable Care Act and You

The Affordable Care Act (ACA) requires nearly every American to be enrolled in medical coverage or pay a penalty. This is referred to as the individual mandate. You have several options to satisfy this requirement:

- Enroll in a medical plan offered by Ventura County Schools Business Authority (VCSBSA) or another group plan
- Purchase coverage through a health insurance marketplace
- Enroll in coverage through a government sponsored program
- Have no coverage and incur a tax penalty

For more information on your coverage options, please visit **www.healthcare.gov**.

Annual Notices

ERISA and various other state and federal laws require that employers provide disclosure and annual notices to their plan participants. VCSBSA has posted all federally required annual notices on our VCSBSA website for you to download and read at your convenience.

The following is a list of the annual notices:

- Medicare Part D Notice of Creditable Coverage
- HIPAA Notice of Privacy Practices
- Women's Health and Cancer Rights Act (WHCRA)
- Newborns' and Mothers' Health Protection Act
- Special Enrollment Rights
- Medicaid & Children's Health Insurance Program
- Summary of Benefits and Coverages (SBC)

NOTES

Burnham
A BALDWIN RISK PARTNER

Learn more at **www.burnhambenefits.com**

This Employee Benefits Guide provides an overview of some of your benefit plan choices. It is for informational purposes only. It is not intended to be an agreement for continued employment. Neither is it a legal plan document. If there is a disagreement between this guide and the plan documents, the plan documents will govern.

In addition, the plans described in this guide are subject to change without notice. Continuation of any benefit plan or coverage is at the company's discretion and in accordance with federal and state laws. If you need additional information or have any questions about the benefit program, please contact the Human Resources Department or District Office.